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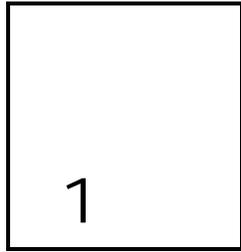
Capitation Rate Development
Process and Reimbursement
Structure Review
California Department of Health Services

MERCER

Government Human Services Consulting

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Executive Summary

Introduction and Project Objectives

Mercer Government Human Services Consulting (Mercer) was engaged by the California Department of Health Services (CDHS) to conduct a review of both the process utilized to develop Medi-Cal capitation rates, and the reimbursement structure (i.e., the various capitation rates paid to the health plans) currently in place for the Medi-Cal managed care program. Both the rate development itself and the reimbursement structure contribute to the end goal of ensuring that reimbursement under an at-risk managed care program is reasonable, appropriate, and attainable, and results in actuarially sound capitation rates. Either piece alone (rate development process or reimbursement structure) cannot fully achieve the end goal if the other is significantly lacking. CDHS requested these reviews to identify potential options for improvement in both aspects, for consideration by CDHS for future implementation. The reviews were done with a focus on prospective opportunities, and in no way represent any judgment on the actuarial soundness of prior or current rates for any Medi-Cal program or managed care plan.

Mercer approached these reviews based on several key premises. The first was that CDHS was open to any and all potential opportunities for improvement with respect to capitation rate development and reimbursement structure. Second, that there is no one-size-fits-all solution, and there is more than one way to accomplish the end goal of appropriately matching payment to risk. Finally, and perhaps most importantly, CDHS' Medi-Cal program goals and operational and resource realities need to be taken into consideration when determining which options identified and recommended are most appropriate to pursue and implement.

On a related note, CDHS also engaged Mercer in a separate project to assess the overall viability of the base data sets available to the State for capitation rate development. That project included reviewing managed care plan encounter and other financial data for completeness, accuracy, and applicability for use in rate development. The results of this related project are documented in a separate report to be released in September 2006.

Review Approach/Methodology

The key steps in the approach/methodology to our reviews were as follows:

- Obtain an understanding of the three primary managed care contracting models; Two-Plan, County Organized Health System (COHS), and Geographic Managed Care (GMC). The populations covered (mandatory versus voluntary), and the covered services provided, vary somewhat among these three models.
- Perform a thorough review of the current capitation rate development processes utilized by CDHS for the Medi-Cal managed care program. This included a review of all rate development elements/processes from the base data utilized through all trend and other adjustments applied that result in the final rates.
- Review the July 22, 2003 Centers for Medicare and Medicaid Services (CMS) Medicaid Rate Setting Checklist, “PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting.”
- Review the American Academy of Actuaries (AAA) Practice Note, August 2005, “Actuarial Certification of Rates for Medicaid Managed Care Programs.”
- Survey other Mercer client states on the rate development processes and reimbursement structures utilized in their Medicaid programs. Create an inventory of key findings from this survey.
- Summarize the key observations/findings from our reviews and develop a list of potential opportunities for improvement to the Medi-Cal rate development process and reimbursement structure.
- Identify Mercer’s highest priority recommendations for consideration by CDHS for implementation.

In an effort to appropriately obtain input/reaction from the Medi-Cal contracted health plans, the objectives of, and approach to, these reviews were presented to the Medi-Cal contracted health plans initially in December of 2005. CDHS and Mercer asked the health plans to provide feedback based on this presentation. The correspondence received from the health plans in response to that request is included in this report as Appendix A. Generally speaking, the health plans indicated their support for the efforts of CDHS to improve their rate development processes and reimbursement structure. However, the health plans also offered some cautionary notes and other suggestions to be considered by CDHS and Mercer in performing the reviews.

Upon completion of preliminary findings and recommendations, another presentation was made to the Medi-Cal health plans in May of 2006. Again, CDHS and Mercer requested feedback based on the presentation of preliminary findings and

recommendations. The correspondence received from the health plans in response to that request is included in this report as Appendix B. Overall, the health plans' comments received were generally supportive of the findings and recommendations, however there were sometimes differing opinions on particular findings or recommendations.

Prioritized List of Recommendations for Consideration by CDHS

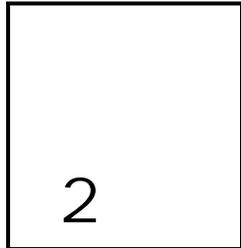
The reviews resulted in the identification of several options that may provide opportunities for potential improvement to both the rate development process, and the reimbursement structure. In some cases, the options presented are mutually exclusive of one another, and in other cases, they can be either entirely independent or even complimentary to each other. As mentioned previously, Mercer strongly believes that there is more than one way to accomplish the end goal of appropriately matching payment to risk (i.e., there is not a one-size-fits-all approach). This belief is widely shared by the actuarial community and is reflected in many actuarial writings, including the American Academy of Actuaries' discussion papers. In addition, the options identified and recommendations contained in this report must be considered in terms of their potential short- and long-term benefits, as compared to the realities of systems and other resource limitations of CDHS — or any state Medicaid agency.

The following list contains the recommendations Mercer considers most important for earlier consideration by CDHS.

- Utilize up-to-date health plan encounter data, as well as data beyond the COHS plans, supplemented as necessary and appropriate, as the base data source for future rate development efforts.
- Develop county and/or model specific capitation rate processes.
- Implement standardized Medi-Cal specific financial reporting for health plans by major capitation risk group.
- Perform a detailed review of health plan financial statements to identify appropriate costs and/or factors for use in rate development.
- Revise the capitation rate calculation model to capture both utilization and unit cost values. See “Typical” Mercer Capitation Rate Calculation Sheet (CRCS) in Appendix C.
- Further analyze data to identify the best possible capitation risk groups and service categories for future rate-setting. A reconfiguration of capitation risk groups and service categories may be employed based on the outcome of such analysis.
- Implement a maternity supplemental payment to cover the cost of all deliveries (may consider implementing a separate < age 1 rate at the same time).
- Develop a mechanism to measure the relative risk of each health plan in order to identify adverse/positive selection. Aside from potentially adjusting capitation payments, an additional result of this analysis could be the implementation of performance incentives to reward better quality/performance.

Additional analyses will likely be necessary by CDHS to thoroughly understand and identify the resources required and operational changes necessary to implement any of these recommendations. Engaging in those analyses is the most logical next step for CDHS.

Mercer would like to take this opportunity to thank the many individuals within the Medi-Cal Managed Care Division, and specifically the Capitation Rate Unit, who graciously gave of their time in order to strengthen Mercer's understanding of the Medi-Cal specifics contained within this report. The CDHS staff has a strong understanding of their program, and the details of their capitation rate development process and reimbursement structure. They are dedicated to continuous improvement in the Medi-Cal program.



Introduction

Background

California utilizes a unique blend of managed care contract models to provide services to more than half of the State's Medi-Cal eligible members. As of June 2006, approximately 3.4 million (51 percent) of all Medi-Cal enrollees (approximately 6.7 million), were served through one of the three primary managed care contract models. They include the Two-Plan model, County Organized Health Systems (COHS) model, and the Geographic Managed Care (GMC) model. Covered populations (i.e., which members must enroll on a mandatory basis versus a voluntary basis) and the covered Medi-Cal services included in the full risk contracts, vary among these three models. In total, there are currently 20 health plans that hold contracts with the State to provide services to Medi-Cal members in 22 counties. Some of these health plans contract with the State under more than one of these models, and some may even act as subcontractors for other Medi-Cal health plans. The State contracts with commercial health plans, as well as health plans whose primary or sole line of business is Medi-Cal and other government-funded populations.

Within the Federal Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), is the agency that oversees and regulates the Medicaid program. CMS requires that capitation rates paid to at-risk managed care health plans be developed in an actuarially sound manner — Federal Register, Friday, June 14, 2002, 42 CFR 438.6(c)(1)(i).

Mercer was engaged by the California Department of Health Services (CDHS) to conduct a review of both the process utilized to develop Medi-Cal capitation rates and the reimbursement structure currently in place for the Medi-Cal managed care program. This report includes a description of Mercer's methodology, findings and opportunities for improvement related to this engagement. A project summary is included on the next page. This review did not cover the rate development process or structure for any specialty managed care contractors such as PACE or SCAN.

CDHS also engaged Mercer in a separate project to assess the overall viability of the base data sets available to the State for capitation rate development. That project included reviewing managed care plan encounter and other financial data for completeness, accuracy, and applicability for use in rate development. The results of this related project are documented in a separate report.

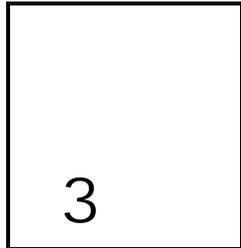
Project Summary and Objectives

As mentioned above, Mercer was engaged by CDHS to conduct a review of both the process utilized to develop Medi-Cal capitation rates, and the reimbursement structure currently in place for the Medi-Cal managed care program. Both the rate development process itself and the reimbursement structure utilized, contribute to the end goal of ensuring that reimbursement under an at-risk managed care program is reasonable, appropriate, and attainable, and results in actuarially sound capitation rates. Either piece alone (the rate development process or reimbursement structure) cannot fully achieve the end goal if the other is significantly lacking. CDHS requested these reviews to identify potential options for improvement in both aspects, for consideration by CDHS for future implementation. The reviews were done with a focus on prospective opportunities, and in no way represent any judgment on the actuarial soundness of prior or current rates for any Medi-Cal program or managed care plan.

We approached these reviews based on several key premises. The first was that CDHS was open to any and all potential opportunities for improvement with respect to capitation rate development and reimbursement structure. We confirmed this with CDHS at the onset of the review project. Second, that there is no one-size-fits-all solution, and there is more than one way to accomplish the end goal of appropriately matching payment to risk. A variety of options exist and in fact we do not know of any two Medicaid programs that have identical rate development processes and reimbursement structures. Finally, and perhaps most importantly, in light of the previous premise, CDHS' Medi-Cal program goals and operational and resource realities need to be taken into consideration when determining which options identified and recommended are most appropriate to pursue and implement.

Report Layout

This report separately addresses the review of the capitation rate development process and the review of reimbursement structure over the next two sections. We will discuss the approach/methodology, as well as the observations and identification of potential opportunities for improvement for each component separately. However, because the two components are both critical to achieving the end goal of appropriate reimbursement, we have included a combined list of prioritized recommendations for consideration by CDHS for future rate development.



Medi-Cal Capitation Rate Development Process Review

Review Approach and Methodology

The approach used in this review included several components. The first was to obtain a complete understanding of the Medi-Cal managed care program structure and the differences among the three primary contracting models utilized (Two-Plan, COHS, and GMC). The populations covered on a mandatory versus voluntary basis, as well as services covered by the health plans vary somewhat among the three models. Therefore, understanding these differences is an important step toward evaluation of rate processes and reimbursement structures.

The next step was to thoroughly review the rate development processes currently utilized by CDHS. Mercer obtained and reviewed the Two-Plan Rate Manuals for the October 1, 2004 – September 30, 2005, and October 1, 2003 – September 30, 2004 time periods as part of this review. Interviews were also conducted with CDHS actuaries and actuarial staff regarding the rate development process. The interviews included discussions about the process in general, sources of and use of base data, and calculation of trend and other program and/or data adjustments that are applied to roll the base data forward to the contract time period. In some cases, the CDHS actuarial group walked us through actual calculations to more thoroughly explain their methods and approaches.

In addition, we used further resources including the CMS Medicaid Rate Setting Checklist (both the most current, and most recent prior, versions), the AAA Practice Note, additional actuarial literature, and professional judgment based upon Mercer's 20+ years of working with state Medicaid programs across the country. These resources were utilized to help us ensure we explored all of the appropriate questions regarding the current process used by CDHS, and as supplemental information to

consider in the development of other options and alternatives for CDHS' consideration.

Mercer reviewed rate development processes/methods used in the Medicaid programs in other states in order to gain a high-level perspective of the variety of, and alternative, processes utilized elsewhere. We compiled a summary of key rate development aspects from our survey of other client programs.

Actuarial Soundness

CMS and the American Academy of Actuaries have provided guidance regarding the definition of actuarial soundness for Medicaid. As mentioned above, Mercer utilized these (and other) points of reference regarding actuarial soundness while conducting this review of the Medi-Cal capitation rate-setting methodology.

- CMS¹ – Federal Register, Friday, June 14, 2002, 42 CFR 438.6(c)(1)(i).
Actuarially sound capitation rates means capitation rates that:
 - Have been developed in accordance with generally accepted actuarial principles and practices;
 - Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
 - Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.
- The July 22, 2003, CMS Medicaid Rate Setting Checklist, “PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting”. This 19-page document is used by CMS’ Regional Offices in their review and approval of state capitation rate submissions.
- The AAA Practice Note, August 2005, “Actuarial Certification of Rates for Medicaid Managed Care Programs.”

AAA Practice Note Proposed Definition of Actuarial Soundness:

Medicaid benefit plan premium rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.

¹ Note: CMS has indicated 1903(m)(2)(A)(iii) was really the initial legal authority for payments to be “made on an actuarially sound basis.” CMS did not enforce this previous requirement.

The Practice Note provides “nonbinding guidance” to a Medicaid actuary. It does not have the binding authority of an Actuarial Standard of Practice (ASOP). Still, the Practice Note carries considerable weight within the Medicaid actuarial profession.

In addition, there are other considerations to be made regarding actuarial soundness and appropriateness of capitation rates. Mercer believes that CDHS and CMS administrators and regulators, as well as California and federal taxpayers, have the flexibility to be able to demand optimal achievable value from health plans. CDHS and CMS may (or may not) choose to fully exercise this right. Simply put, just as there are superior, good, mediocre, and poor consulting actuaries, there are superior, good, mediocre, and poor health plans from an efficiency and effectiveness standpoint. CDHS and CMS do not have to pay for mediocre or poor health plans. Further, since no entity is perfect, even the superior health plans can improve. This concept can play a key role in the discussion on base costs.

Observations and Opportunities

The following section summarizes Mercer’s observations regarding the current methodology employed for the development of Medi-Cal capitation rates. Then, we identify potential opportunities for improvement after each rate development subsection.

Base costs

Underlying Data

The base period of the claims/encounters and financial data includes dates of service from July 1, 2001 to June 30, 2002, with claims run out through December 31, 2002. Base data is from four COHS plans operating in seven counties. Therefore, the base data set is comprised of only 8 percent of Medi-Cal’s managed care membership. The base data set utilized historically was believed by CDHS to be the most complete and reliable data at that time.

CDHS developed rates for six eligibility Aid Code groups for Two-Plan model counties including Family, Disabled, Aged, Adult, AIDS, and Breast and Cervical Cancer Treatment Program (BCCTP). As a result of adjustments for Medicare Part D, these have expanded to nine Aid Code groups (Disabled, Aged and AIDS are separated into ‘with Medicare’ and ‘without Medicare’). In addition, CDHS analyzes costs by 4 provider types (consolidated categories of service) including Pharmacy, Hospital Inpatient, Outpatient (includes physicians, clinics, hospital outpatient, laboratory services, and almost all other providers), and Long Term Care (LTC) facilities.

Opportunities

- Utilize Two-Plan Model data for Two-Plan Model rate development, COHS Model data for COHS Model rate development, and GMC Model data for GMC

Model rate development. In addition to increasing the underlying data representation by contract type, it would also decrease capitation rate reliance upon such a small percentage of the total managed care population. Area/geographic adjustment factors (see below) could also be moderated under this scenario.

- Increase the number of provider types (categories of service) to be analyzed, segmenting such categories as outpatient facility, ER, primary care physician and specialty physician services.
- Split base data into two components (utilization and unit cost).
- Explore shadow pricing (use of a standardized fee schedule, or multiplier of a standardized fee schedule) methods for encounter data.
- Utilize more ad hoc data requests to health plans to fill in missing data elements.
- For counties or aid codes with small numbers of individuals, consider adding a second year of base data. Employ credibility adjustment to smooth data.
- For Voluntary models, analyze and adjust for any “selection” bias (where less healthy individuals have a tendency to remain in the FFS program). Apply voluntary selection adjustments, where appropriate.

Underlying Data Adjustments

Once the base encounter data was collected and summarized, it was adjusted to tie to audited financial statements. This included an analysis of sub-capitation payments by the COHS plans to their providers. In addition, adjustments were applied by provider type and Aid Code group to the extent possible. CDHS makes coverage adjustments (additions and subtractions) for such items as: Child Health and Disability Prevention (CHDP) services, psychotropic drugs, abortion, and California Children's Services (CCS) claims to standardize benefits over all base plans. Finally, a further adjustment is made that uses a more current distribution of eligible member months, by Aid Code group.

Opportunities

- Utilize more directly applicable data, resulting in fewer adjustments to the base data.
- Perform periodic on-site and/or desk reviews of any financial statement data used in rate development to ensure it is directly applicable and represents only the costs for Medi-Cal eligible members and Medi-Cal covered services.
- Improve the usefulness of financial reporting from the contracted health plans by implementing a Medi-Cal specific financial reporting requirement.

Adjustments - Explicitly Displayed Factors (Age/Sex, Duration, Coverage, Program Changes)

There are several adjustments that are applied for each specific Aid Code group for a specific health plan. First, for Age/Sex there are separate male and female factors, with eight Age groupings for Family, six Age groupings for Disabled, and three Age

groupings for Aged. Relative costs for each of the four provider types are determined for each of the groupings.

The Duration factor accounts for COHS claims data, including coverage of a retroactivity period. Because enrollment in the Two-Plan model and GMC model takes at least two months, an adjustment must be made to account for the higher first months of claims experience inherent in the COHS data. The Coverage adjustment further adds or removes services from the rate calculations such as mental health, acupuncturist, and chiropractic costs. The cost of LTC facilities after the month of entry and the month following are also removed since they are not the responsibility of Two-Plan model and GMC model health plans after this time period. A Program Change adjustment accounts for changes in reimbursement levels or service coverage not accounted for within the base costs, but expected to be incurred by the health plans.

Opportunities

- Develop and incorporate Area/Geographic differentiation that would be applicable for all categories of aid groups (capitation risk groups).
- Utilize COHS, Two-Plan, and GMC plan-specific data for adjustments to the extent possible. If it is not possible due to data limitations, utilize statewide managed care and/or Fee-for-Service (FFS) data as alternatives.
- Base Age/Sex adjustment factors on a broader database.
- Review large or “outlier” claims periodically to determine any unusual one-year impact upon base data adjustment factors. If anything out of the norm is identified, budget-neutral data smoothing should be employed. This is particularly important when data is sliced into finer gradations.

Trend: Unit Cost, Utilization

CDHS applies both utilization and unit cost trend percentages for each year. There are five service categories for which trends are received from the actuarial consulting firm Milliman, Inc. (Hospital Inpatient, Hospital Outpatient, Physician, Pharmacy, Other). Within rate development, the Hospital Outpatient trend is applied to the Hospital Outpatient, Physician, and Other categories of service. CDHS determines the utilization and unit cost trends for LTC based on changes to the Medi-Cal FFS rates.

CDHS utilizes a range of trend values for unit cost trend and a point estimate for utilization. A review of the four service category distribution (Pharmacy, Hospital Inpatient, Outpatient, Long Term Care) from the Sample Capitation Rate Worksheet in the Two-Plan Rate Manual yielded weighted composite trends ranging from approximately 5.5 percent to 5.9 percent.

Opportunities

- Mercer would recommend an expansion into nine or more categories of service for trend analysis: Hospital Inpatient, Outpatient Facility, Emergency Room,

Primary Care Physician Services, Physician Specialty Services, Pharmacy, Lab/Radiology, Long Term Care Facilities, and All Other.

- Develop trend factors based on Medi-Cal specific data.

Administration Percentage, Adjustment, Contribution to Surplus/Reserves (Underwriting Profit)

CDHS currently sets administration loading at ten percent of medical costs. There is an adjustment of +1.5 percent for “Local Initiative” (LI) plans and -1.5 percent for “Commercial” plans in the Two-Plan model. This results in an administration loading of 11.5 percent for LI plans and 8.5 percent for Commercial plans. This adjustment does not apply to Fresno County, which has two commercial plans and no local initiative. The adjustment is intended to account for contracting requirements with Disproportionate Share Hospital (DSH) providers.

There was no loading for contribution to surplus/reserves (underwriting profit) during the two years of rate development reviewed. The underwriting profit loading was not explicitly described in the October, 2004 – September, 2005 Two-Plan Rate Manual.

Opportunities

- Use a fixed/variable approach for setting the administrative component of capitation rates. This results in a lower administration percentage to higher claim cost category of aid groups/rate cells and visa versa.
- The +/- 1.5 percent adjustment for contracting requirements with DSH providers should be analyzed, and if still appropriate it should be reflected in the hospital inpatient medical cost base, as was previously the case. Any differential would be due to provider contracting/unit cost and not related to health plan administration.
- Reflect Administration as a percentage of the total capitated premium.
- Add any mandated assessments and/or premium taxes in addition to the normal administration load.
- Utilize a combined underwriting profit/risk/contingency assumption range of 2 – 4 percent. In today’s environment, many states are towards the 2 percent end of that range. (Note that this range is not universal. From the AAA Practice Note, page 24, “If the target-operating margin is 0 percent for the entire system...” Followed a few sentences later by, “Many actuaries prefer the target-operating margin to be positive (i.e., rather than be 0 percent).”)

Budget Factor

CDHS currently includes a budget factor in the calculation of Medi-Cal capitation rates. The use of a budget factor limits health plan funds to those spent if rates from the prior state fiscal year (SFY) were frozen, adjusted positively or negatively for any appropriation item change (i.e., new legislation). The budget factor used by CDHS does take into account projected populations, and varies by health plan. The factor can also vary by Aid Code. Health plans in multiple counties may request to

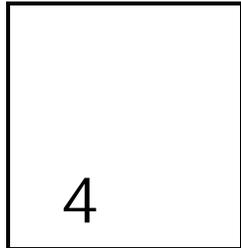
reallocate dollars on a county or aid group basis, but this must be projected to be budget neutral.

The AAA Practice Note indicates, “Actuarially sound rates or ranges of rates depend on the benefits provided and the population covered. These rates are normally independent of budget issues unless benefits or populations change.” The Practice Note also states, “In rate-setting, there is normally a range of reasonable assumptions. Budgetary constraints may influence the selection of certain assumptions toward the low end of the range. However, the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving the final premium rates.” Mercer supports the AAA’s statements, and notes the respective use of the phrases “normally independent” and “may influence”. Clearly, exceptional circumstances may exist in any situation. While the actuary must be able to justify all assumptions and factors to her/himself as part of the rate development and subsequent certification process, the actuary certifies to the complete rate, and not the individual components of the rate.

Opportunities

- As previously described, CDHS has the flexibility to demand optimal achievable value from health plans.
- As necessary, develop and apply financial experience adjustments for use in rate development, and employ during a rate update process (as opposed to a base data rebasing where more current claims/encounter data is analyzed).
- Price capitation rates on a risk-assessed/evaluated most efficient and effective current health plan basis, not on the Model weighted-average experience, or consider somewhere in between.
- Utilize health plan on-site operational and financial reviews to gain greater knowledge of the true level of health plan efficiency and effectiveness. This process generates recommendations on cost saving opportunities, which often can translate in whole or in part into capitation rate reductions (via base data adjustments). This should be a win-win for the health plan and state as health plan claims cost expenditures would be expected to be lowered.
- Analyze encounter/claims data for specific service category savings such as:
 - preventable hospital admissions;
 - reducing low acuity non-emergent emergency room visits; and
 - all pharmacy management program components.

A combined list of prioritized recommendations is presented later in this report.



Reimbursement Structure Review

The goal of a reimbursement structure (i.e., the various capitation rates paid to health plans) is to appropriately match payment to risk. Capitation rates are based upon the probability of a population costing a certain “average” amount. Even if a health plan’s capitation rates are appropriate for the probable average costs for the populations to be served, under full risk capitation, the health plan is always at risk for experience outliers, where unit cost, utilization, or both, are significantly higher than average. Conversely, if the reimbursement structure does not provide for sufficient differentiation, health plans may inappropriately benefit by covering demographically healthier-than-average individuals.

Proper matching of payment to risk is the most cost-effective way to operate an at-risk Medicaid managed care program. That is to say, it allows a state to spend funds in the most appropriate manner, avoiding significant overpayments, as well as underpayments. In addition, reimbursement structures fall under 42 CFR 438.6(c)(2)(i): “All payments under risk contracts and all risk sharing mechanisms in contracts must be actuarially sound.”

Review Approach and Methodology

Mercer created an inventory of reimbursement structures and approaches utilized by fourteen other state Medicaid programs. This was done in order to identify a reasonable representation of alternative approaches that are available and may be appropriate for consideration by CDHS. We conducted web-searches and interviews with key actuarial staff members of other Mercer teams who work with the fourteen other state Medicaid programs. These individuals are involved in the development of capitation rates for these Medicaid managed care programs and therefore have a very detailed knowledge of the reimbursement structures and payment methodologies utilized. A standard interview guide was developed to ensure consistency between interviews. A matrix that summarizes the results of the survey is included in this report as Appendix D.

We utilized the results of the survey to identify the prevalence of the various reimbursement structures/methods used elsewhere. In this report we discuss the various reimbursement structures identified, examine their typical applications, and consider the pros and cons they may have. While some of these concepts may be implemented in somewhat different ways in Medicaid managed care programs that were not part of our review, we believe the concepts discussed in this report easily cover the vast majority of options being utilized elsewhere.

Discussion of Reimbursement Structures/Approaches

Managed Care Program Design

Before evaluating which reimbursement mechanisms to employ, it is important to understand the key elements of a managed care program. Program design has a direct impact on risk and, therefore, must be accounted for in both capitation rate development and reimbursement approach. Specifically, the populations covered, restrictions on enrollments, health plans involved, and limitations on populations and benefits all can affect risk patterns. For example, voluntary versus mandatory enrollment managed care programs have different risk characteristics. The status of this component of program design is important in determining whether “average” risk can be achieved. In addition, the participation of multiple health plans in a Medicaid managed care program will also have an impact on risk. A single health plan would assume the risk of all members, while multiple health plans would have varied populations and, therefore, more varied risk. The exclusion of certain high-risk populations can lessen potential risk differentiation. In addition, the exclusion of certain services (typically high cost) can also help to mitigate potentially significant risk differentiation. But obviously, exclusions from managed care also means losing the presumed aspects of managed care related to access, quality, and cost. So clearly, there are multiple factors to be considered in any design approach. And finally, the inclusion of Long Term Care Services (Nursing Facilities) in a managed care program typically works best with the use of a special reimbursement mechanism as these services are very expensive.

Performance Incentives

Some states have financial performance incentives built into their contracts with the health plans. New York and Pennsylvania have incorporated such a financial component as an incentive to the health plans. This is a direct way to get additional funds to quality plans. Importantly, the incentives should be conditioned upon a specified activity that will occur or a target to be met. The incentives must be affected by the entity’s actual performance or non-performance of the contract. CMS limits performance incentives to 5 percent of the approved capitation rate, attributable to the enrollees or services covered by the incentive arrangement. In addition, incentives cannot be renewed automatically, must be for a fixed time period, and must be available to both public and private contractors.

Performance incentives can be structured so that they are budget neutral or to make available additional funds to the managed care plans in total. To achieve budget neutrality, the performance funding would be withheld from all health plan capitation and then paid out based on results to the plans that performed best. This results in a funding increase for the top quality plans. On the other hand, health plans typically prefer the approach where new funding is made available above and beyond current levels. Their argument would be that it costs money to continue to improve quality and that they should be rewarded for that upfront investment.

Risk Difference Adjustment Mechanisms

A variety of methods and approaches are available to adjust for risk differences including rate classification, risk adjustment, and risk sharing.

Rate Classification

Rate classification is one of the most basic forms of risk adjustment. The concept is to group the variety of eligible populations into homogeneous groups, from a risk perspective. This is typically done based on demographic and other risk characteristics including category of aid (i.e., how they became eligible for Medicaid coverage), age, gender, Medicare coverage status, and geography. The combination of these elements can provide valuable predictive information and allow payment to be structured in accordance with the risk of each group.

Consider, for example, the difference between a newborn and a 10 year old child. If both children are eligible for the program based purely on income, the likelihood is very high that the newborn, who automatically enters the world in an inpatient hospital stay and then has frequent recommended doctor visits during the first year of life, will be significantly more costly than the 10 year old child. In this case gender is not a key differentiator of risk. However, for otherwise healthy (i.e., non-disabled) 14 – 44 year olds, the health care risk difference between a male and a female is substantial due to maternity related costs. Finally, on average, a disabled individual who is eligible for Medicare is far less expensive for Medicaid than a disabled individual of the same age who is not eligible for Medicare. Utilizing this type of readily available information to create proper capitation risk groups can go a long way toward matching reimbursement to risk.

There is no downside to utilizing the most appropriate capitation risk groups. However, it does take time and resources to initially analyze the underlying cost drivers for each group to identify the best matches. In addition, Information Technology system modifications may be necessary to capture the necessary data for proper classification of individuals. Most states we reviewed utilize multiple capitation risk groups to drive capitation payments, but no two states used the exact same mix of risk groups.

Risk Adjustment

The typical forms of risk adjustment available include:

- state-sponsored reinsurance (i.e., stop-loss coverage),
- diagnosis-based risk adjustment, and
- supplemental payments.

State-sponsored reinsurance - Reinsurance is most typically thought of as a means to ensure financial viability of health plans, for which it can be quite appropriate and effective. However, when structured properly, it can also act as an effective risk-adjustment mechanism. In order for this to work best and be truly effective and budget neutral to the state, participation by the health plans must be mandatory. This is possible because the estimated “average” excess risk is withheld from capitation payments across all plans (assuming each plan has the same fundamental risk), but the reinsurance reimbursement is made to the health plans that experience the actual high cost cases. In this way, the funding for this average excess risk is paid out to the health plans that experience above average excess risk, thereby not overpaying other health plans.

Under individual stop loss/reinsurance, coverage is provided for costs incurred for covered health care services provided to an individual enrollee over the course of a year (either total costs or for a specific service such as inpatient). Costs beyond a certain limit (the deductible or attachment point) are either entirely or partially assumed by the state (and CMS). By only partially assuming costs above the deductible level, the state provides a continued incentive to the health plan to actively manage the care of the member.

During development of a self-funded reinsurance program, a state must specify how the encounters/claims will be valued. Use of the Medicaid fee schedule is most common and ensures the health plan is not reimbursed based on excessive rates. A state-run reinsurance program also takes staffing and systems resources to operate. However, by automating the reinsurance process to run off health plan submitted encounters, the state can provide an incentive for timely, accurate, and complete encounter submissions. States can realize a cash-flow benefit by pulling this funding out of the capitation rates and holding it until the occurrence of the excess risk event. However, it can be tricky to budget properly for reinsurance payments. Only two of the states from our survey currently utilize state-run reinsurance programs.

Diagnosis-based risk adjustment – Various states utilize diagnosis-based risk adjustment for some of their Medicaid managed care capitation rates. Under this type of risk difference adjustment mechanism, costs are identified and analyzed based on historical diagnosis information, and in some cases demographic factors. The benefit of analysis based on diagnosis is that it is a better predictor of future costs than age/sex alone. There are several types of risk adjustment models. We have identified the most widely used models below along with some characteristics of each.

- **Chronic-Illness Disability Payment System (CDPS)**
 - Developed by the University of California, San Diego
 - Utilizes 67 category groupings
 - Base data (weights) from early 1990s
 - Medicaid-specific (separate TANF and SSI models)
 - No future updates scheduled unless funding becomes available (pharmacy is separate)
 - Most popular with state Medicaid agencies
 - No fees (except to classify new ICD codes into CDPS categories)
- **Adjusted Clinical Groups (ACG)**
 - Developed by Johns Hopkins University
 - Utilizes 81 category groupings
 - Base data (weights) from 1996 – 2000, but from commercial (non-Medicaid) population
 - Flat dollar base fee, then sliding scale per life fee
 - Only a few Medicaid agencies use, but over 200 commercial health plans utilize
 - Well supported
 - Pharmacy being considered
 - Clinical-based applications readily available
- **Diagnostic Cost Groups (DCG)**
 - Developed by a private firm: DxCG
 - Believed to have the highest estimation power
 - 136 category groupings
 - Base data (weights) from 2000–2001 (1 Medicaid program data available)
 - Used by Medicare and over 150 commercial health plans
 - Well supported
 - Flat dollar base fee, then sliding scale per life fee
 - Clinical-based applications readily available
- **Medicaid Rx**
 - Developed by the University of California, San Diego
 - 45 condition categories and 11 age/sex categories
 - Developed and released in 2000 (Medicaid-specific data)
 - Generally believed to be not as predictive as other three models
 - Pharmacy data completes much more quickly so more current data can be utilized
 - Due to high level of automated claims submission and PBMs, pharmacy data usually thought to be more accurate and complete than other types of claims
 - Scheduled to be used by Florida to adjust individual premiums

All of these diagnosis-based risk adjustment tools require good quality and relatively complete data to be most effective. They are most commonly used to drive payment for higher risk populations such as Seniors and Persons with Disabilities (SPD). That is because these eligibility groups are by definition higher risk, typically stemming from chronic conditions that can be reasonably well predicted using these models. It

is typically more expensive to set capitation rates using these models. So, it is important to assess whether it is worth the potential extra time and money to use these tools (i.e., are other risk difference adjustment mechanisms available and reasonably effective?). In addition, if risk adjustment is utilized on voluntary populations, FFS data must be analyzed and scored as well.

Maternity and Other Supplemental Payments – Supplemental payments can be used in conjunction with Medicaid capitation rates. Most states that attempt to account for maternity selection, other than via inclusion within age/sex rating cells or factors, provide for a lump-sum payment upon the birth of a child to an eligible and enrolled member. Payment typically covers costs related to pre-natal, delivery, and post-partum care expenses. Payment can be triggered by a notification/certification from the health plan (with follow-up verification by the state — by way of vital records for instance), or via encounter data submission. Validation is highly important. Some states have transferred pregnancy-related expenses to separate newborn rate cells. While this may be an improvement over no adjustment at all, Mercer views the separate maternity supplemental payment as preferable.

States sometimes utilize supplemental payments for other eligible conditions as well: HIV/AIDS is a good example of this. The members with HIV/AIDS are included in the regular capitation approach, as would be pregnant women, but then supplemental payments are made to health plans to cover the higher expected costs of these members.

Supplemental payments are calculated on a budget neutral basis. Therefore, there is actually some cash-flow benefit to the state by withholding payment from regular capitation until the actual expensive episode occurs. In the same way as other risk adjusters, the funding is directed only at the health plans that incur the higher risk individuals. The majority of the states we interviewed utilized some type of supplemental payments in addition to their regular capitation rates.

Risk Sharing

Risk Corridors - Health plans and states (and CMS) may use risk corridors where they share in both profits and losses under the contract, outside of a predetermined threshold amount. After an initial corridor, in which the health plan is responsible for all losses or retains all profits, the state (and CMS) contributes a portion toward any additional losses, and receives a portion of any additional profits. These risk corridors are typically symmetrical percentages around the capitation rate or claim cost component of the capitation rate. However, symmetry is not required.

If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered by CMS to be actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a FFS basis, for the state plan services actually furnished to enrolled individuals, plus an amount for entity administrative costs directly related to the

provision of these services. In order to compute the FFS cost of providing services, the state must “price” the health plan’s encounter data through the state’s FFS MMIS system. Risk corridors can be particularly effective during implementation of a new program or population; however Mercer would not typically recommend risk corridors as a long-term reimbursement tool because of their relatively high administrative burden. Due to the potential limit of CMS’ Federal Financial Participation (FFP) if payments are required, and the data issues surrounding pricing of the health plan encounters, risk corridors have decreased in popularity as a risk sharing alternative. CMS has indicated potential flexibility in the pricing of the health plan’s encounter data by the state, so if risk corridors are a desired option, it is important to work closely with the state’s CMS Regional Office. Just two of the states from our survey currently utilize risk corridors.

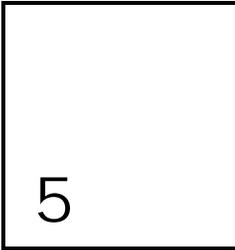
Risk Pools – Risk pools are another risk sharing mechanism used by states. With the use of risk pools, a portion of the capitation amounts are withheld from the health plans and set aside for funding “pools.” Funds are then distributed to health plans based upon pre-set criteria (typically pro-rata based upon claims experience among plans). The use of risk pools can limit a state’s liability (unlike typical stop-loss or risk corridor arrangements), and so may not be viewed as true risk sharing by the health plans. Risk pools are most often used in states with very few rate cells. Only one of the states in our survey was currently using risk pools.

Reporting Requirements

The reporting of cost and utilization information to the state by health plans is a critical component of the rate-setting process. As managed care programs grow, the volume of FFS data diminishes. This loss of FFS data creates a need to have other sources of data, including Medicaid specific financial and utilization data, as well as complete and accurate encounter data. The adequacy of reported information also enables and/or limits a state’s ability to utilize some risk difference adjustment mechanisms discussed previously.

Conclusion

A variety of reimbursement structures and payment mechanisms exist that are being utilized by other states. It is important to keep in mind that no two of the fourteen other states included in our survey structure their reimbursement exactly the same. In addition, some of the concepts discussed in this section would be complementary to each other, while others would not. Therefore, not all of the approaches identified above would be appropriate to implement in combination with each other. In attempting to identify and select the best mix of risk difference adjustment mechanisms and payment structures to complement Medi-Cal’s unique program design elements, CDHS will have to consider (as would any state Medicaid agency) staffing resource and system limitation realities. The next section of this report includes a combined list of prioritized recommendations.



Recommended Priorities

The following are Mercer’s recommended priorities for CDHS moving forward. This report was organized into two main sections, the capitation rate development process review and the reimbursement structure review. Because the two are interrelated, the recommended priorities for both are included here. Some important considerations to keep in mind while reviewing these recommendations include the level of effort involved, responsible parties and stakeholders, return on investment, and whether it is achievable in the short- or long-term.

- Utilize up-to-date health plan encounter data, as well as data beyond the COHS plans, supplemented as necessary and appropriate, as the base data source for future rate development efforts.
- Develop county and/or model specific capitation rate processes.
- Implement standardized Medi-Cal specific financial reporting for health plans by major capitation risk group.
- Perform a detailed review of health plan financial statements to identify appropriate costs and/or factors for use in rate development.
- Revise the capitation rate calculation model to capture both utilization and unit cost values. See “Typical” Mercer Capitation Rate Calculation Sheet (CRCS) in Appendix C.
- Further analyze data to identify the best possible capitation risk groups and service categories for future rate-setting. A reconfiguration of capitation risk groups and service categories may be employed based on the outcome of such analysis.
- Implement a maternity supplemental payment to cover the cost of all deliveries (may consider implementing a separate < age 1 rate at the same time).
- Develop a mechanism to measure the relative risk of each health plan in order to identify adverse/positive selection. Aside from potentially adjusting capitation payments, an additional result of this analysis could be the implementation of performance incentives to reward better quality/performance.

Additional analyses will likely be necessary by CDHS to thoroughly understand and identify the resources required and operational changes necessary to implement these recommendations. Engaging in those analyses is the most logical next step for CDHS.



Appendix A

Health Plan Reaction A

This section contains comments received from the Medi-Cal health plans based on a presentation made by Mercer in December 2005.



**Discussion of State of California Department of Health Services
Two-Plan Model Rate Methodology for the 06-07 Rate Year
Presented at the request of the
Local Health Plans of California**

Prepared by:

**Prepared by Stanley A. Roberts, FSA, MAAA
Peer Reviewed by Timothy S. Barclay, FSA, MAAA**

January 20, 2006

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Milliman, Inc.



**Discussion of State of California Department of Health Services
Two-Plan Model Rate Methodology for the 06-07 Rate Year**

Introduction

Milliman is pleased that the State of California has engaged Mercer to assist them in the rate calculation process. Given the complexity of the rate calculation process and the large number of rate disputes that are occurring between the plans and the state, having a third party actuary should help the process. Unfortunately, due to the time constraints on submitting comments, our report addresses the issues at a high level. In reviewing the plan that Mercer has presented, we believe it is a good plan and is consistent with sound actuarial methodologies. I personally have nearly 20 years of experience working with Medi-Cal managed care programs. The following presents our comments on the Mercer proposal.

Lack of clarity regarding outcomes sought by the State

The most notable omission from the Mercer project is the lack of any clarity from the state on what outcomes the state seeks from managed care. Put another way, there are quite a number of rate-setting methodologies that an actuary can develop, but the actuaries need policy direction to choose among them. Does DHS want the lowest cost coverage? If so, a rate-setting system may not be appropriate but rather a bidding system (note: bidding would not make sense under a two-plan model). Does DHS seek the highest quality coverage? If so, the rates should be set with an eye toward incentivizing or rewarding quality by giving plans a bump in rates (or even protection from rate reductions) for meeting certain targets such as HEDIS scores. How important is timely access? If access is important, rates need to be set closer to commercial rates to keep providers in networks. How important is keeping plans stable so DHS does not have plans failing or exiting the market frequently? If this is important, then risk-corridors or a cost + formula might be important. All of these issues would have consequences that need to be thought through carefully.

We are concerned that this project leaves Mercer with no guidance or conversely, that Mercer will make these decisions without policy input. In addition, it leaves the plans and other interested parties with no direction, opening DHS to criticism from all sides for not pursuing one or more priorities in its rate-setting process. We strongly urge DHS to articulate their priorities

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Milliman, Inc.

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so that Mercer can design rate-setting methodologies that meet DHS's need and so plans can understand and comment on the rate-setting methodologies in light of DHS's stated priorities.

Let me now turn to specific issues relating to the way rates have been set in the past.

Use of Arbitrary Budget Adjustment Factor Set by DHS

California, like most other states, has faced significant budgetary constraints over the past few years. California has decided to apply an arbitrary budgetary adjustment factor to the rates that the state actuaries have calculated. In most cases, that has resulted in the rates being reduced, regardless of the recommendations from the state's actuaries. For example, for the 03/04 rate year, the state applied an average 19% budget reduction to rates that were actuarially sound prior to this adjustment.

Often the state actuaries have been asked to use actuarial methods to distribute the budgeted funds. It is our strong view that using actuarial methods to allocate inadequate rates does not make the rates actuarially sound. Budget freezes or rate reductions have a negative impact on the plans, the providers and the Medicaid clients. In our view, the most significant impact is likely to be experienced by the Medi-Cal eligibles in reduced access to care and in receiving poorer quality care from underpaid providers. With continued use of the budget adjustment factor, the ability of the plans to keep their networks intact will end and/or plans will leave Medi-Cal, voluntarily or involuntarily. Budget crunches are inevitable, but the state is risking its entire managed care delivery system by forcing plans to make up the state's budget deficit.

The state should want the plans to build surplus or reserves. They should not wait until plans are already insolvent before they make corrections.

Impact of Part D

Mercer needs to review carefully the amount the state removed for prescription drugs due to the impact of Part D coverage for dual eligibles.



Trend Adjustment

The state has historically used very low trends in developing prospective rates. Always using the low end of a range of trend assumptions or making budget reductions to trend rates is a recipe for disaster.

Lack of Proper Notice and Information to Plans

In the past, rates have almost always been finalized after the start of the plan year, which is October 1. Getting rates finalized well after the plan year has commenced makes it exceedingly difficult for plans to prepare and take action in response to the rates. Rates need to be published sooner, at least 3-6 months prior to the start date.

The proposed rates need to be included with the rate adjustment sheets and the rate manual. Final rates and documentation need to be completed prior to October 1. Plans need to have the rates sooner so they can effectively negotiate contracts with their providers. In addition, plans need the rates sooner so that their actuaries can review the rates for reasonableness and, if errors are discovered, give time for the state actuaries to make corrections.

Data Sources

Originally, the Two-Plan Model rates were based on fee-for-service data. The state actuary, Bob Ruderman, reached the conclusion a few years ago that the fee-for-service data was insufficient as a basis for developing rates. As an actuary working for health plans, I strongly concurred with his conclusion. In my view, the rates should be based upon managed care experience. The question is, which managed care experience should be used? Ultimately, I believe the best source of data for the two-plan model would be those 12 counties that are under the Two-Plan Model. However, for the near term, I believe the best data source is the data from the County Organized Health System plans.

There are issues with using data from the Two-Plan Model plans. First, most of these plans use a capitation model with their providers. Often, the compensation providers receive is very low relative to payments for non-Medi-Cal patients. As a result, capitated providers usually allocate very few resources to accurately report encounter data. Consequently, the utilization rates being gathered by the Two-Plan Model plans are likely grossly understated. Another issue is that due to low reimbursement rates and the lack of investment by DHS in creating usable encounter data reporting back to plans, many of the plans and the providers have not spent resources to



accumulate accurate and complete encounter data, consequently making the job of the state very difficult if they decided to use the two-plan model data.

Like Bob Ruderman, I agree that the best source for managed care data would be the County-Organized Health Systems model. Care should be taken when using this data as well, since there may also be underreporting issues. In cases where underreporting occurs, Mercer needs to either adjust that data or, in some cases, a given county's data may need to be removed.

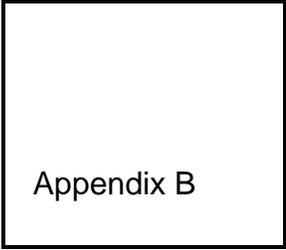
Risk Sharing/Risk Adjustments for Disableds

Historically, the Two-Plan Model rate for the disabled category has been very low relative to fee-for-service costs. We believe this is due to the actuaries believing there is positive selection occurring due to the voluntary nature of disableds joining managed care plans. Accordingly, the managed care costs should increase significantly when disableds are mandated to enroll in the Two-Plan model. County-Organized Health System Model counties have much higher claim costs for disableds than the Two-Plan Model health plans because of the mandatory enrollment of disableds. Further, not all of the Two-Plan model plans believe they are experiencing positive selection.

Accordingly, Mercer should significantly increase the rate for disableds with the introduction of mandatory enrollment. In addition, they should consider risk sharing, such as aggregate stop loss protection, because the increased rate may not protect the plans adequately if the new rate is in fact still too low. The state should also consider adding risk adjustments for the disabled category because the risk mix may differ between the county plans and the commercial plans. Risk adjustment for the disabled aid category is commonplace in virtually all other states with managed care plans.

Disclosure of Rate Methodology

We believe the state should continue to calculate and publish rates, as they have done in the past. We believe it is critical that baseline costs and all rate development assumptions be disclosed for review by the health plan actuaries, but this information needs to be received by the plans in a timely fashion, not months after the rates are published as has been happening over the past several years.



Appendix B

Health Plan Reaction B

This section contains comments received from the Medi-Cal health plans based on a presentation made by Mercer in May 2006.



Chad Westover
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June 7, 2006

Luis Rico
Assistant Chief, Medi-Cal Managed Care
California Department of Health Services
1501 Capitol Avenue, Suite 4040
Mail Stop 4400
Sacramento 95814

Dear Mr. Rico

Blue Cross of California Partnership Plan, Inc. (Blue Cross) would like to submit comments on the Mercer rate methodology study's preliminary findings that were presented to the health plans on May 24, 2006. Blue Cross is in agreement with many of the proposals suggested by Mercer. Listed below are Blue Cross' comments concerning the presentation.

Blue Cross supports the recommendation of using model specific data for developing rates and the use of neutral adjustment factors for outlier data.
Blue Cross supports the use of a reimbursement schedule that matches payment to risk as well as using fixed and variable administrative expenses as an opportunity to better reflect administrative costs for Aid Codes/rate cells with lower premiums.
Blue Cross strongly supports the use of rate classifications, particularly for maternity supplemental payments. Current premiums disadvantage plans with a disproportionate share of deliveries.
Blue Cross does not support the use of risk adjustment mechanisms particularly risk corridors. These methods seem to penalize the more efficient plans.
Blue Cross has concerns about the volume of reporting requirements proposed in the presentation. This places a tremendous burden on the health plans to complete detailed reports when capitation rates could be built upon encounter data already provided by the plans.
Blue Cross suggests that rates reflect an average cost and not be determined on a "by plan" basis. This would reward the more efficient plans.
Blue Cross does not support the use of budget considerations for determining rates. Rates should reflect an actuarially sound method.

Blue Cross appreciates the opportunity to review the preliminary rate study findings and to provide comment. Thank you for your consideration.

Sincerely,

A handwritten signature in blue ink that reads "Chad Westover".

Chad Westover

cc: John P. Monahan, President & SVP – BCC, State Sponsored Business
Shawn Freeman, Staff Vice President, Finance – BCC, State Sponsored Business
Scott Geske, Staff Vice President & Actuary – BCC, State Sponsored Business



Board Chair

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Leona M. Butler
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Cherie L. Fields

Lobbyist

James C. Gross
Nielsen, Merksamer, Parrinello,
Mueller & Naylor, LLP

June 16, 2006

Ms. Vanessa Baird
Chief, Medi-Cal Managed Care Division
California Department of Health Services
PO Box 997413, MS 4400
1501 Capitol Avenue
Sacramento, CA 95899-7413

RE: Mercer Rate Methodology Study

Dear Ms. Baird:

On behalf of the Local Health Plans of California (LHPC), representing eight local publicly accountable health plans in nine Two-Plan Model counties that serve over 1.4 million Medi-Cal beneficiaries, we thank you for the opportunity to again provide feedback on the Mercer rate-setting methodology study. The comments contained in this letter are specific to the May 24, 2006 presentation conducted by Mercer representatives.

On January 20, 2006, on behalf of LHPC, Milliman Inc. submitted feedback to the Department on the Mercer Study (copy enclosed). While Mercer did provide clarification on a few of the issues described in our January 2006 document, most of the issues raised in our letter remain unaddressed. As a result, this letter focuses on issues contained in our January 2006 correspondence that remain outstanding in Mercer's preliminary findings and recommendations to date.

Outcomes

We are pleased that the state has engaged Mercer for assistance in developing recommendations to develop a new rate-setting methodology. However, we remain concerned that, despite our prior communication on this issue, the state still has not communicated to Mercer the outcomes being sought from the Medi-Cal managed care program. For instance, if the state is purely seeking to provide coverage at the lowest rate possible, then this goal may be best served by setting rates through a bidding system in GMC model counties; if the state is seeking to provide high quality coverage, then quality incentive programs should be developed to reward high-performing plans, etc. Please

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refer to our January 20, 2006 correspondence for a more detailed discussion on our concerns previously communicated.

Disabled Enrollees

In its January 2006 communication to Mercer, we recommended that the Mercer study examine the impact of the disabled enrollee category on plan rates. However, Mercer has not addressed this concern and we bring it to your attention again. Currently, in the Two-Plan Model the disabled category is a voluntary care enrollment category. Historically, the managed care rate for the disabled category has been very low compared to payments for services received by disabled beneficiaries in Medi-Cal fee-for-service. However, as the state begins enrolling more of the disabled population into Medi-Cal managed care, actuaries predict plan costs should increase significantly. One need only look at the financial difficulties of the County Organized Health System (COHS) plans, which have mandatory enrollment of the disabled, which result from higher claim costs for the disabled category when compared to the Two-Plan Model plans.

In addition to increasing the rate for the disabled population, we previously recommended that the state consider risk-sharing to protect the plans if the new rate established for this category is still insufficient. During the May 24, 2006 meeting, Mercer representatives rejected this recommendation, stating it would not recommend risk corridors as a long-term reimbursement tool due to complex auditing requirements. However, Mercer does discuss the possibility of using a diagnosis-based risk adjustment structure. According to Mercer, this methodology may be a better predictor of costs than age/sex ratings. As a result, in the absence of a risk-corridor, we recommend that a diagnosis-based risk adjustment structure be considered for the disabled category.

Budget Adjustment Factor

Although Mercer has gone to great effort to identify measurement indicators such as utilization, financial experience, and claims data for specific service categories, we note that there is no reference or acknowledgement of California's current practice of applying the "budget adjustment factor." As you know, over the past several years, the state has applied an arbitrary budget adjustment factor to plan capitation rates after the development process is completed. In most cases, this has resulted in plan rates being significantly reduced. For instance, plans experienced a 19 percent rate reduction in fiscal year 2003-2004 to meet state budget goals, thereby severing any connection to an actuarially sound rate setting methodology.

LHPC maintains that the use of the budget adjustment factor specifically violates CMS actuarial soundness requirements and, as a result, it is vital that this issue be thoroughly examined and addressed as part of the state's rate development process project. As the Academy of Actuaries maintains in its practice note, "*Actuarially sound rates or ranges depend on the benefits*

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provided and the population covered. These rates are normally independent of budget issues unless benefits or populations change.”¹

If California continues to set actuarially unsound plan rates by applying the budget adjustment factor, then the adoption of a new rate setting methodology will not accomplish the goal of “appropriately matching payment to risk” as the Mercer presentation states it is aiming to do. As a result, the plans will continue to be placed in financially precarious positions which threaten the well-being of the vulnerable Medi-Cal beneficiaries who depend on the managed care system.

We understand that states go through budget cycles and revenues fluctuate from year to year. However, we encourage Mercer and the state to identify methodologies in use by other states, or can Mercer devise any methodologies, that could help smooth these cycles? In addition, when the state is experiencing a budget year with low revenues, we recommend the state partner with the health plans and other stakeholders to identify program reduction options (e.g., reducing certain administrative requirements on health plans in exchange for the lower capitation rate, eliminating or reducing certain benefits, establishing copayments, etc.). While making the above changes would require tough conversations and decisions, the state’s current solution of shifting the entire impact of the state revenue shortfalls to the plans is unrealistic.

In addition, we believe that the rates need to be developed and disseminated prior to the presentation of the May Revise to the Legislature so that all parties have full information available when making budget decisions.

Lack of Proper Notice and Information to Plans

In the past, the State has finalized rates after the start of the plan year. This is an unacceptable practice as it deprives the Legislature and the plans of information needed to assess the budget impact. Mercer should address the feasibility of doing this.

Even if for some reason the May deadline cannot be met (which seems hard to believe since some calculations must support the budget estimates given to the Legislature), we believe it is critical that the final rates be included with the rate adjustment sheets and the rate manual prior to the start of the plan year, which for the Local Health Plans is October 1. Without adequate notice and information, plans are not able to negotiate contract amendments with their provider network. In addition, the Local Health Plans have not been able to adjust provider contracts to accommodate rate changes that are retroactively implemented.

Additionally, the rate manual includes a discussion of the rate setting methodology used to develop the capitation rates, programmatic changes, historical rate information, trend

¹ Medicaid Rate Certification Work Group of the American Academy of Actuaries, *Health Practice Council Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs*, August 2005, p. 12.

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assumptions, rate exhibits, and the impact of any other necessary adjustments by service category. Given that in most circumstances, plans do not receive this information until the end of each rate year, they are not able to verify the rates for reasonableness and discuss any errors with the state actuaries. We instead encourage a rate setting process that incorporates feedback from the plans prior to finalization of the rates.

Data Sources

During the May 2006 meeting, Mercer representatives stated that it believes there is sufficient encounter data to obtain Two-Plan Model data for the development of Two-Plan Model rate methodology. While we agree that the best data source would be to use Two-Plan Model data, we believe the data is insufficient. We also maintain that the fee-for-service data is not a good data source to use anymore. Instead we continue to recommend that the County Organized Health System plan data be used in the short-term, transitioning to the use of Two-Plan Model data for the reasons described in our January 2006 correspondence.

Conclusion

Once again, we commend DHS specifically for embarking upon this long-needed study. LHPC is committed to helping you identify ways to strengthen the program's efficiency and integrity in the rate-setting process, while maintaining access to beneficiaries in a cost-effective and high-quality environment.

We also thank you for this opportunity to provide feedback on this very important issue facing the Medi-Cal managed care program.

Sincerely,



Cherie L. Fields
Chief Executive Officer

Enclosure

cc: Stan Rosenstein, Department of Health Services
Russ Hart, Department of Health Services
Luis Rico, Department of Health Services
Greg Rose, Department of Health Services
LHPC Governing Board



CAHIO

CAHIO COMMENTS ON MERCER STUDY – JUNE 8, 2006

The Mercer Report brings up several possible improvements to the Medi-Cal rate setting process. However, without additional clarification and details it is impossible to determine from the discussion draft whether all components for an actuarially sound method have been considered.

While the standardized financial reporting would ultimately be a good thing, there are organizational and reporting differences, even between COHS plans that would distort financial results unless clear definitions of line items and departmental relationships were established and consistently applied.

The following questions or concerns need to be addressed:

- What exactly is the *financial experience adjustment* and how is it calculated? Is it similar to the *budget reduction factor* applied to previous rate setting calculations?
- Risk adjustments based on diagnosis or health status would provide more accurate rates, however this could be a challenge for current IT reporting capabilities.
- How is the fixed/variable approach to administrative expense applied (higher administration percentage to lower claim cost aid codes/rate cells)?
- Many significant unit price increases have occurred since the base period (7/1/02 – 12/31/04). While Mercer points out that this was not a rate setting attempt but a methodology analysis, the methodology needs to include the most current time period.
- Doing a Medi-Cal withhold to cover the inefficient plans would seem to penalize the efficient plans.
- How are we going to account for the differences between COHS plans, LIs and GMC?
- New reporting requirements should be offset by not providing some current data. If the usefulness of the long paid claims tape is being questioned, perhaps it should be discontinued.
- After gathering feedback and finalizing findings and recommendations, Mercer plans to share the results with the Executive Branch, Department of Finance and the Legislature. What about the health plans?
- Doing a separate “Orange Blank” financial report for just Medi-Cal is going to be onerous unless the current “Orange Blank” can be modified.
- The risk corridors as described could work.
- Mandatory reinsurance has lots of potential as long as we don’t all pay a flat rate and anything that rewards efficiency should be encouraged.
- County specific rates/geographic adjustments are a good idea.
- Expansion to nine service categories (particularly ER and outpatient facility breakout) will be an improvement.
- Performance incentives would be a good addition.



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June 16, 2006

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Via Email: vbaird@dhs.ca.gov

RE: Mercer Study Feedback

Dear Ms. Baird,

On behalf of the Medi-Cal managed care plans represented by the California Association of Health Plans (CAHP), thank you for the opportunity to provide additional feedback on the Mercer rate methodology study. Our members appreciate the Department of Health Services' (DHS) commitment to improve the development of capitation rates for Medi-Cal managed care, and value the ability to comment on the findings presented to our members at the meeting CAHP hosted on May 24, 2006. Nevertheless, we have concerns about certain aspects of the study.

Our sense is that the Mercer study has two objectives. It appears that the first charge to Mercer is to examine how other states are setting rates with the implication that Mercer could recommend alternatives for an entirely new rate setting process for California. Secondly, Mercer is to recommend priorities for change that are largely tactical in nature. Our comments will focus on both the broad systemic question and the more specific tactical priorities.

In a broad sense, we must stress that current federal regulation (*42 CFR 438.6*) requires that rates be actuarially sound in that they are based on the cost of care and the population being served. State budgetary constraints should not be a factor in setting reimbursement rates. The Mercer study should be premised upon the notion that sound actuarial rate development must reflect the needs of the population served and the cost structure of the Medi-Cal managed care program.

We also urge Mercer and DHS to seriously consider a "value based" purchasing approach. That is, DHS should consider shifting its focus to emphasize ensuring that Medi-Cal beneficiaries are receiving good value for the resources the state spends for their health care. Evaluating plans based on quality, access, and health status metrics would reward participating plans for delivering quality care to Medi-Cal beneficiaries that then allows DHS to determine the value of the rates it pays to a specific plan.

On the more tactical side, we offer two groups of comments. First, we support Mercer's call to better match rates to the underlying risks and costs of the populations being served. The key will be balancing between the availability and collection of credible encounter data at the county and plan level to support this type of rate setting. We respect Mercer's claim that sufficient encounter data may exist to set rates at a more granular level. We will be better able to evaluate these

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claims, however, when we have seen more specifics. *We fear that an assumption could be made which calls for collecting credible encounter data at the plan level, and in so doing put a substantial new cost burden on plans already under intense pressure to make ends meet with the rates currently being paid. Moreover, as plans generally pay providers on a capitated basis, it may be difficult to dig down to the level of detail Mercer is requesting.*

Second, we reiterate the concern expressed in our previous comments about the emphasis placed on plan level or line of business level profit and loss statements. We see a growing trend in the Legislature and at DHS for increasing plan rates because of potential solvency issues. While this may be appropriate in certain circumstances, and in the context of corrective action, it is not an acceptable long-term rate setting policy. Furthermore, it supports our claim that current rates are inadequate. *We continue to be concerned that the Mercer and DHS call for plan profit and loss data may institutionalize a rate setting process that continues the need for one-time cash infusions to troubled plans and undervalues prudence with limited public resources.*

The health plans represented by CAHP appreciate DHS' efforts to develop a rate setting process that allows Medi-Cal managed care plans to continue to deliver cost effective, high quality care to their members. The work that DHS is doing to study the current system is encouraging. It is our hope that if a new process is developed to set rates that it results in the application of actuarially sound rates without the imposition of arbitrary budget related reductions that complicate the ability of health plans to meet the needs of Medi-Cal beneficiaries.

This letter represents many of the common themes forwarded to CAHP by our members. We have attached a document with other more technical comments and questions that we received. In the meantime, we look forward to the outcome of the Mercer Study and are prepared to engage in additional opportunities that encourage the development and application of actuarially sound reimbursement rates to our members. Thank you for your consideration.

Sincerely,



Christopher Ohman
President and CEO

Enclosure

cc: Stan Rosenstein, California Department of Health Services
Toby Douglas, Department of Health Services
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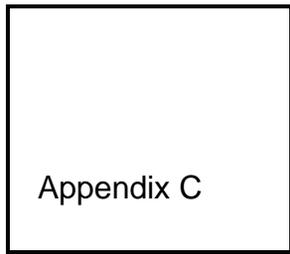
Below are other important questions and comments forwarded to CAHP by some of its member plans.

QUESTIONS

- What is the “financial experience adjustment” and how is it calculated?
- How is a fixed/variable approach to administrative expense applied?
- How will we account for the differences between COHS plans, LIs and GMC?
- Does Mercer plan on sharing its findings with the Legislature and Executive branch?

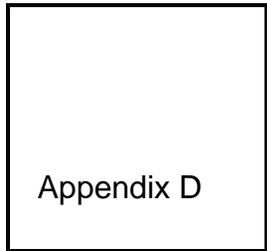
COMMENTS

- An improved rate setting process must meet the current standards set forth in the Welfare and Institutions Code 14087.3 regarding the rate setting process.
- Expanding current service categories would be effective in ascertaining the cost of care. However, new categories need to be further defined in order to ensure accuracy.
- Safety Net adjustments do not necessarily reflect the actual cost of care, but are merely a contract requirement.
- Diagnosis based risk adjustments could provide more accurate rates, but reporting capabilities could be a barrier. Additionally, these methods could punish more efficient plans.
- Some plans feel that the use of risk corridors could work, while others caution that they simply move rates to the low end of the scale and do not guarantee that an appropriate rate is being paid.
- Risk pools may lead to rewarding poorly managed plans and take funds away from better plans that better manage their populations.
- Reinsurance should remain a health plan choice. As a mandate, it may be costly and unnecessary in many cases.
- Mercer’s study is not looking into the credibility of dual eligible assumptions. The use of CMS assumptions for developing split capitation rates for Medi-Cal only and dual Medi-Cal/Medicare members creates reasonable doubt regarding the credibility of the adjustment factors and its impact on the calculation of capitation rates.
- The growing number of uninsured is taking its toll on the provider network, particularly in the safety net. Such providers are seeing patients stay after they have lost funding so that the Health Plan is out of the picture but the uninsured patient remains in the safety-net. Low reimbursement rates are an important factor, but many who treat the uninsured are running out of capacity because of their growing numbers.



Sample CRCS Sheet

Category of Service	Base Data - Encounters			Annual Trend ¹			Trended SFY07 Encounters			Program Changes		Cost PMPM
	Util/1000	Unit Cost	PMPM	Util/1000	Unit Cost	PMPM	Util/1000	Unit Cost	PMPM	New Service	Network Access	
Inpatient	373	\$ 2,336.03	\$ 72.66	-2.0%	3.8%	1.7%	355	\$ 2,564.32	\$ 75.84	\$ -	\$ -	\$ 75.84
Outpatient	987	\$ 440.52	\$ 36.23	1.0%	2.5%	3.5%	1,012	\$ 468.57	\$ 39.51	\$ -	\$ -	\$ 39.51
Physician	6,113	\$ 99.63	\$ 50.75	1.0%	2.9%	3.9%	6,267	\$ 107.01	\$ 55.88	\$ -	\$ -	\$ 55.88
Pharmacy	2,198	\$ 219.60	\$ 40.21	2.0%	15.5%	17.8%	2,309	\$ 314.84	\$ 60.58	\$ -	\$ -	\$ 60.58
DME	915	\$ 197.83	\$ 15.09	1.0%	4.0%	5.0%	938	\$ 218.21	\$ 17.06	\$ -	\$ -	\$ 17.06
Non-Physician Professional	1,940	\$ 57.43	\$ 9.28	1.0%	3.2%	4.2%	1,988	\$ 62.14	\$ 10.30	\$ -	\$ -	\$ 10.30
Lab/Radiology	857	\$ 53.30	\$ 3.81	0.0%	2.5%	2.5%	857	\$ 56.69	\$ 4.05	\$ -	\$ -	\$ 4.05
Dental	215	\$ 70.32	\$ 1.26	2.0%	0.5%	2.5%	226	\$ 71.20	\$ 1.34	\$ -	\$ -	\$ 1.34
Other	1,751	\$ 34.77	\$ 5.07	1.0%	2.5%	3.5%	1,795	\$ 36.98	\$ 5.53	\$ -	\$ -	\$ 5.53
Non-Encounterable Expenses			\$ 2.34			3.0%			\$ 2.52	\$ -	\$ -	\$ 2.52
Total			\$ 236.71	1.0%	4.8%	5.8%			\$ 272.61	\$ -	\$ -	\$ 272.61
¹ Annual trend factors are applied for 30 months.										Administration 10.0%		\$ 31.16
										Underwriting Profit / Risk / Contingency 2.5%		\$ 7.79
										Subtotal		\$ 311.55



Rate Method Matrix

Base Rates

Region	Approach			Expense Loading					
	FFS Data, Encounter Data or Financial Reports	Efficiency (Least, Average, Most)	Competitive Bids	Administrative % (3)	Underwriting Gain %	Risk / Contingency %	Total Non-Medical %	Premium Tax	Performance Incentives
CA COHS	ED/ FR	L-A		10.0%	(2)		10.0%		
CA Two Plan/GMC	ED/ FR	L-A		8.5 - 11.5%	(2)		8.5 - 11.5%	6.0%	
NE	ED/ FR	A-M		7.5 - 9.0%	1.0 - 2.0%	(1)	8.5 - 10.0%	6.0%	✓
South	FFS/ FR	M		10.1%	(2)	(2)	10.1%		
NE	ED/ FR	A		10.3%	(2)	(2)	10.3%		
West	ED/ FR	A	✓	8.6%	2.4%	(1)	11.0%	2.0%	✓
South	ED/ FR	A		9.5%	1.3%	0.3%	11.1%	2.0%	
Midwest	FFS/ FR	A-M		10.0%	1.0 - 3.0%	(1)	11.0 - 13.0%		✓
NE	FFS	A		7.5 - 10.0%	1.5 - 5.0%	(1)	9.0 - 15.0%		
West	All	A		12.0%	(2)	(2)	12.0%	4.0%	
Midwest	All	A		9.0 - 11.0%	1.0 - 3.0%	(1)	12.0%		✓
NE	FR	A-M		10.7%	2.0%		12.7%	1.0%	
South	FFS	Range	✓	10.0 - 11.0%	2.0 - 3.0%		12.0 - 14.0%		
NE	FFS/ FR	Range		13.0%	(2)	(2)	13.0%		✓
NE	FFS	L		13.0%	2.0%	(2)	15.0%		
South	FR	A		15.0%	(2)	(2)	15.0%		

- (1) Included in Underwriting Gain %.
- (2) Included in administrative expenses.
- (3) California administrative percentage is applied to claims, other percentages are percent of total capitation.

Managed Care	Managed Care Program Design						Risk Adjustment Mechanisms							Reporting Requirements						
	Population Covered (per CMS, 12/31/2004)	General	Multiple MCOs	Services	LTC Service Provided	Population Carveouts	Service Carveouts	Rate Classification	Risk Adjustments	Risk Sharing	Financial	Utilization	Encounters							
	Voluntary/Mandatory/Both						# of Capitation Risk Groups	Age / Sex Adjustments (2)	Geographic Adjustments	Mandatory State Sponsored Reinsurance	Diagnosis Based Risk Adjustments	Supplemental Payments	Risk Corridors	Risk Pools	Medicaid Specific	Risk Group Specific	Medicaid Specific	Risk Group Specific	Required	Validated
CA COHS	8%	M		Yes		✓	12	✓	(8)										✓	
CA Two Plan/GMC	44%	B	✓	45 days	✓	✓	9	✓											✓	
Arizona	88%	M	✓	90 days	✓	✓	13	✓★	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓
Connecticut	72%	M	✓	Yes		✓	1	✓	✓						✓	✓	✓	✓	✓	✓
Georgia	(1)	M	✓		✓		17	✓★	✓			✓			(6)	(6)	(6)	(6)	(6)	(6)
Maine	(1)	V		100 days		✓	4	✓					✓						✓	
Maryland	68%	M	✓	30 days	✓	✓	51	✓★	✓	(3)	✓	✓			✓	✓	✓	✓	✓	✓
Massachusetts	30%	V	✓	Yes		✓	8	✓	✓	(4)					✓	✓	✓	✓	✓	✓
Missouri	44%	M	✓		✓	✓	15-19	✓★	✓			✓			✓	✓	✓	✓	✓	
New Jersey	70%	B	✓		✓	✓	26	✓★	✓		✓	✓			✓	✓	✓	✓	✓	✓
New Mexico	64%	M	✓	30 days	✓	✓	17	✓★		(5)					✓	✓			✓	
New York	61%	B	✓	30 days	✓	✓	16	✓★	✓	(3)		✓			✓	✓	✓	✓	✓	
North Carolina	1%	V		30 days		✓	19	✓★				✓			✓	✓	✓	✓	✓	✓
Ohio	31%	B	✓		✓	✓	10	✓★	✓	(5)		✓			✓	✓			✓	✓
Pennsylvania	67%	B	✓	30 days	✓	✓	8	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Washington DC	64%	B	✓	30 days	✓	✓	10	✓★		(5)		✓			(7)	(7)	(7)	(7)	✓	

- Notes:
- (1) Plans were not yet effective on 12/31/2004.
 - (2) Check-star acknowledges age/sex in distinct risk groups (other than <->1).
 - (3) Mandatory reinsurance through State or commercial carrier
 - (4) Non TANF only.
 - (5) Mandatory through Commercial carrier.
 - (6) Reporting guidelines have not been finalized.
 - (7) MCOs respond to annual rate setting data request.
 - (8) Geographic adjustments are only applied to Long Term Care.

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