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FINAL

December 4, 2013

Revision to Original Certification Dated February 22, 2013

Subject: Revised Two-Plan Model Seniors and Persons with Disabilities Expansion — Rate Range Development and Certification for July 1, 2011 through September 30, 2012 — Revised Methodology

Dear Ms. Liston:

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the Two-Plan managed care model Seniors and Persons with Disabilities (SPD) expansion for use during the Two-Plan model 15 month contract period of July 1, 2011 through September 30, 2012, hereafter referred to as Contract Period ending in 2012 or CP12. The original capitation rate ranges were developed by Mercer and certified in a letter dated February 22, 2013 (please see attached document, *TP SPD DOC 2 - CA Two-Plan 15 Month SPD Expansion CP12 Rate Range Cert with SB335 SB208 02 22 2013.pdf*). Further review of the original rate development led to the need for these revised rates as the methodology has been updated. These updated rates reflect a change in our methodology (consistent with the October 2013 Two-Plan and January 2014 Geographic Managed Care (GMC) methodology) that now utilizes a full 100% managed care adjusted fee-for-service (FFS) base data structure instead of the previous 75% managed care adjusted FFS base blended with a 25% risk adjusted existing managed care base.

Actuarially sound is being defined by Mercer as follows: 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 government mandated assessments, fees, and taxes, and the cost of capital. (Note: Please see pages 8-9 of

the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.)

Part of the reason for this change in methodology is related to our further review of the risk adjusted existing managed care methodology component of our prior rate development process. In conducting this review, we identified that the risk adjustment cost weights contained costs associated with California Children's Services (CCS) which were not part of the responsibility for managed care plans within the Two-Plan and GMC models and therefore, should have been excluded from the model. These costs being included within the cost weights had the effect of producing higher risk scores for the younger populations than if the costs were excluded. In turn, this younger population was more predominant within the existing managed care population which was being risk adjusted within the rate development process. The end result was that the risk adjustment factors applied within the 75/25 rate-setting methodology understated the risk adjusted existing managed care portion of the rates, and ultimately, the current final rate ranges.

Our new end result of moving to 100% managed care adjusted FFS data removes any further potential concerns that could be associated with utilizing the risk adjusted existing managed care methodology as part of our ratesetting process.

This letter presents an overview of the analyses and methodology used in Mercer's revised managed care rate range development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS).

Rate Methodology

Overview

The revised capitation rate ranges for the DHCS Two-Plan Model managed care program SPD expansion were developed in accordance with rate-setting guidelines established by CMS, and include the changes described in this revision letter. Highlights of the changes (or no changes) in the revised SPD methodology are described for the various rate components in the remainder of this document.

Base Data

There have been no changes made to the base data in the development of the revised capitation rate ranges outside of the current shift to 100% managed care adjusted FFS data versus the prior 75% utilization of this base data. The underlying FFS data now being 100% utilized is unchanged.

For more detail related to the development of the base data, please refer to the February 22, 2013 certification letter and supporting documents.

Other Elements

There have been no changes made to the maternity supplemental payments, data smoothing methods, trends, managed care adjustments, profit/risk/contingency loading, or prior program changes analyses (except for the SB 335 and SB 208 changes described below). For more detail related to these elements of the certification, please refer to the February 22, 2013 certification letter and supporting documents.

Revisions

As stated previously, these updated rates reflect a change in our methodology that now utilizes a full 100% managed care adjusted FFS base data structure instead of the previous 75% managed care adjusted FFS base blended with a 25% risk adjusted existing managed care base. With this update, certain components of the rate development process did change, and these are highlighted in the following sections.

Base Data

The underlying FFS data is now being utilized 100% in the revised rate development process. The subsequent adjustments to this FFS data are unchanged from the prior process, except for the updated program changes related to SB 335 and SB 208. For more detail related to the development of the base data and subsequent adjustments, please refer to the February 22, 2013 certification letter and supporting documents.

Program Changes

The program changes associated with the SB 335 and SB 208 legislative adjustments have changed slightly with the updated methodology. The update is related to the SB 208 adjustment maintaining the same total dollar amount within the new process. This required end result led to the need for an updated percentage being applied to the new rates that would produce this same dollar amount associated with SB 208 for each of the impacted counties. The new percentages are included in Attachment D (page 7) of the attached, updated program change charts (TP SPD DOC 5 - CP 12 15 Month Two-Plan FFS Program Change Charts [07 01 2011 – 09 30 2012].pdf). SB 335 was also impacted as we maintained the same methodology from the prior rates, whereby no adjustments for SB 335 were applied to costs associated with SB 208. Therefore, because SB 208 changed slightly, SB 335 also changed slightly. The SB 335 factors are included in

Attachment C (page 6) of the aforementioned updated program change chart. For more detail related to the development of the original SB 335 and SB 208 program changes, please refer to the February 22, 2013 certification letter and supporting documents.

Administration

Part of this updated methodology also required some minor adjustments to the administration component of the rate development process. The previous final administrative load after the 75/25 blend was approximately 0.5% lower at the lower bound than the administrative load included exclusively within the prior managed care adjusted FFS component. With the shift to the 100% FFS methodology, the administrative load has been adjusted to align with the previous blended administrative levels. This process maintained similar final administrative loads across the two methodologies at the lower bound. The new methodology is now utilizing a 100% managed care adjusted FFS model instead of the previous model, which was a blend of managed care adjusted FFS experience and risk adjusted existing managed care experience. The new midpoint administration loading has been reduced from 6.00% to 5.90%. The administration range around this midpoint has also been decreased from +/-1.00% to +/-0.75%. The overall variation of the administration rate range is relatively unchanged as the prior risk adjusted managed care component included lower administration at the lower bound and higher administration at the upper bound (this is the opposite of the managed care adjusted FFS administration which is higher at the lower bound and lower at the upper bound). Therefore, the smaller range variations (but now being utilized 100%), actually produces similar end results as the prior 25% component of the risk-adjusted managed care component is no longer tightening the final variation. For more detail related to the development of the original administration/profit load, please refer to the February 22, 2013 certification letter and supporting documents.

Rate Range Certification

In preparing the revised rate ranges described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by DHCS, its managed care organizations (MCOs), and its vendors. DHCS, its MCOs, and its vendors are responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, the data used for the rate development process is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report and associated exhibits may need to be revised accordingly.

Mercer certifies that the revised rate ranges for July 1, 2011 through September 30, 2012 were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Cal covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual MCO costs 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 accordance with applicable law and regulations. There are no stop-loss, reinsurance, risk-sharing or incentive arrangements in these rates. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by 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 before deciding whether to contract with DHCS.

This certification letter assumes the reader is familiar with the Medi-Cal program, Medi-Cal eligibility rules, and actuarial rating techniques. It is intended for DHCS and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.



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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

MEN/JJM

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