

January 25, 2008

**Two-Plan Model**  
**Contract Year 2008**  
**Rate Range Development and**  
**Certification**  
State of California

**MERCER**

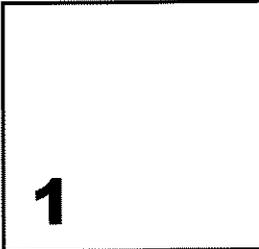


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## **Contents**

<b>1.</b>	Rate methodology .....	1
▪	Overview .....	1
▪	Base data .....	2
▪	Category of Aid (Aid Code) groupings.....	3
▪	Data smoothing.....	3
▪	Trend .....	3
▪	Program Changes/other adjustments.....	4
▪	Administration and Underwriting Profit/Risk/Contingency loading .....	4
▪	Rate ranges .....	5
<b>2.</b>	Rate range certification.....	6



## **Rate methodology**

### **Overview**

Capitation rate ranges for DHCS' Two-Plan managed care program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). For rate range development for the Two-Plan MCOs, Mercer used a combination of fiscal years 2004 and 2005 (FY03 — 04 and FY04 — 05) Two-Plan MCO reported encounter data, and FY03 — 04 and FY04 — 05 ad hoc claims data reported by the Two-Plan MCOs. The most recently available (at the time the rate ranges were determined) Medi-Cal-specific financial reports submitted to the Department of Managed Health Care (DMHC) were also considered in the rate range development process.

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for the contract year 2008 (ContractY08) contract period. Additional adjustments were then applied to the selected base data to incorporate:

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

A single and consistent process of developing capitation rate ranges was used for the Two-Plan program. DHCS will offer final rates within the actuarially sound rate ranges with each MCO. Each MCO has the opportunity and responsibility to independently review the rates offered by DHCS, and to determine whether the rates are acceptable based on their individual financial requirements.

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

### **Base data**

The information used to form the base data for the Two-Plan rate range development was MCO encounter data, requested MCO ad hoc claims data and DMHC required Medi-Cal-specific financial reporting. The encounter and ad hoc claims data included utilization and unit cost detail by COA, by county, by MCO, by FY and by 13 consolidated provider types or categories of service (COS) including:

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

Utilization and unit cost information from the plan-specific encounter and ad hoc data was reviewed at the COA and COS detail levels for reasonableness. Ranges of reasonable and appropriate levels of utilization and unit cost were then established for each COS within each COA. Averages of the reasonable and appropriate levels were also established for the encounter and the ad hoc data. This process in essence produced four potential data elements of utilization and unit cost for each COS within each COA: 1) plan-specific encounter data; 2) plan-specific ad hoc data; 3) average encounter data and 4) average ad hoc data. These four data elements were then applied credibility factors dependent upon the plan-specific data being reasonable and appropriate, and also based on the enrollment size of the population of the COA.

FY03 — 04 and FY04 — 05 (July 2003 through June 2005) make up the base data period. All selected base data was adjusted (as appropriate) to reflect the impact of historical program changes within this period. This is discussed further in the Program Changes section. Mercer blended these two years at a one-third (FY03 — 04) and two-thirds (FY04 — 05) ratio. Prior to blending the two years of data, the FY03 — 04 data was first trended forward to FY04 — 05 based on retrospective trend factors so that the two years were on the same time period for future trending to the ContractY08 period. The DMHC financial reporting Revenue, Expenses and Net Worth exhibits for each MCO that were available at the time the rate ranges were determined were reviewed and analyzed by DHCS and Mercer.

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

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

### **Category of Aid (Aid Code) groupings**

The base data sets used to develop the Two-Plan ContractY08 capitation rate ranges were divided into cohorts that represent consolidated COA (or Aid Code) groupings which inherently represent differing levels of risk. These nine COA cohorts are (alphabetically):

- Adult
- Aged/Dual Eligible
- Aged/Medi-Cal Only
- AIDS/Dual Eligible
- AIDS/Medi-Cal Only
- BCCTP
- Disabled/Dual Eligible
- Disabled/Medi-Cal Only
- Family

### **Data smoothing**

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

### **Trend**

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the ContractY08 rate range development for the Two-Plan program, Mercer developed trend rates for each provider type or COS, separately by utilization and unit cost components.

Trend information and data were gathered from multiple sources including the MCO encounter data, the MCO requested ad hoc data, MCO financial statements, Medi-Cal fee-for-service experience, historical California Medical Assistance Commission (CMAC) adjustments, CPI and multiple industry reports. Mercer also relied on professional judgment based upon our experience in working with the majority of the largest Medicaid programs in the country. Base data used was trended forward 39 months to the mid-point of the rating period.

Annual mid-point claim cost trends, across all MCOs, all COAs and all 13 COS, average 1.5 percent for utilization and 2.9 percent for unit cost or 4.4 percent per member per month (PMPM). The weighted COS PMPM trends vary from a high of 6.0 percent for

Emergency Room (1.025 for utilization times 1.034 for unit cost equals 1.05985 or 6.0 percent) to a low of 3.0 percent for "All Others." Note trends for the LTC provider type are 0.0 percent for both utilization and unit cost. Due to the high level of legislatively-mandated changes surrounding LTC, Mercer has handled LTC trends through the Program Changes portion of the methodology. Given the recent financial information available at the time the rate ranges were developed, the range for the claim cost trend component is +/- 0.25 percent per year for each of the utilization and unit cost components, or roughly +/-0.5 percent PMPM per year. Over the 3.25 years from FY04 – 05 to ContractY08, this contributes a little over +/- 1.6 percent to the upper and lower bounds.

### **Program Changes/other adjustments**

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rate ranges were based on information provided by DHCS staff. Following are the program changes (with effective dates) that were viewed to have a material impact on capitation rates, and which were analyzed and evaluated by Mercer with the assistance of DHCS' Managed Care Division and Fiscal Forecasting and Data Management Branch staff:

- LTC rate adjustments — multiple dates
- LTC quality assessment fee — August 2004
- Podiatrist office visit rate increase — November 2003
- HIV testing during pregnancy — January 2004
- Nurse-to-patient ratios for hospitals — multiple dates
- Drug coverage: SENSIPAR — April 2004
- Five percent provider rate reduction — October 2004
- Hospice rate increases — multiple dates
- Medicare Part D drug benefit — January 2006
- Fluoride varnish — May 2006
- Drug coverage: HPV — May 2006
- Restoration of provider rate decrease — January 2007
- Drug coverage: Albuterol — January 2007

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

### **Administration and Underwriting Profit/Risk/Contingency loading**

The administration loading for the Two-Plan model MCOs was developed in aggregate. The administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium). This mid-point percentage was developed from a review of the MCOs' historical reported administrative expenses. Mercer also utilized its experience and professional judgment in determining the mid-point and lower and upper bound percentages to be reasonable. The mid-point Administration load is 9.5 percent across all Two-Plan MCOs. The range for the Administration component is +/- 1.0 percent upper/lower bound from the mid-point value. DHCS and the Two-Plan MCOs have negotiated an additional administrative expense of 6.0 percent under a Quality Improvement Fee (QIF) contractual requirement.

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

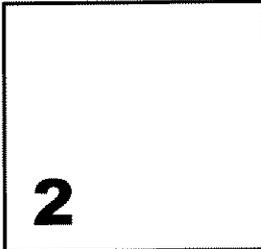
Certain COAs have capitation rates ten (or more) times larger than other COAs. In these instances, the uniform allocation methodology will produce an administrative component for the more expensive COA ten (or more) times larger than the administrative component for the less expensive COA. While a more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

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

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

### **Rate ranges**

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



### **Rate range certification**

Mercer certifies that the Two-Plan ContractY08 rate ranges were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual results will differ from these projections. Mercer has developed these rate ranges on behalf of DHCS to demonstrate compliance with the CMS requirements under 42 CFR § 438.6(c) and in accordance with applicable law and regulations. MCOs are advised that the use of these rate ranges, or the resulting final rates within these ranges, may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges or rates by the MCOs for any purpose. Mercer recommends that any MCO considering contracting with DHCS should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rate ranges and resulting rates before deciding whether to contract with DHCS. Use of these rate ranges and resulting rates for any purpose beyond that stated may not be appropriate.

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