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September 6, 2012

Subject: Two-Plan and Geographic Managed Care (GMC) models Community Based Adult Services (CBAS) program rate range development and certification – October 1, 2012 through February 28, 2013

Dear Ms. Liston:

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound rate ranges for the CBAS program for Two-Plan and GMC model counties for use during the October 1, 2012 through February 28, 2013 contract period (CP13). This letter presents an overview of the analyses and methodology used in Mercer's rate range development for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS).

Effective October 1, 2012 in Two-Plan and GMC counties, Medi-Cal managed care health plans will be required to provide CBAS services for their eligible members (i.e., only the CBAS-eligible members). Since there are so few (relatively) members that will utilize CBAS services and it is not yet fully known which health plans the CBAS-eligible member will enroll in, it is difficult to appropriately build the risk of the CBAS service delivery into the normal Category of Aid group managed care capitation rates on a prospective basis. As a result, Mercer has developed a full risk payment process to cover the facility-specific component of providing CBAS services until an all inclusive capitation rate can be developed and approved.

The payment made to the managed care organizations (MCOs) is designed to cover the average projected cost of providing CBAS facility-specific services to a utilizing member for a full month. As a result, health plans will receive payment for the additional risk assumed, but are not guaranteed the funding would exactly match the actual costs of providing the facility-specific component for CBAS. Mercer believes that this approach considers the element of risk necessary for an actuarial certification and will provide the proper incentives for the health plans to appropriately manage the utilization of CBAS services.

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In Mercer's opinion, the rate ranges developed result from an actuarially sound process and should, along with MCO investment income and any reinsurance or stop-loss cash flows, provide for all reasonable, appropriate and attainable costs.

If you have any questions on 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,



James J. Meulemans, ASA, MAAA

MEN/JJM/jb

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**TWO-PLAN AND GMC MODEL COUNTIES
CBAS RATE RANGE DEVELOPMENT AND
CERTIFICATION (10/01/2012–2/28/2013)
STATE OF CALIFORNIA**

September 6, 2012

Government Human Services Consulting

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Rate Methodology

Overview

Rate ranges for DHCS' CBAS program in the Two-Plan and GMC counties were developed in accordance with rate-setting guidelines established by CMS. For rate range development for the Two-Plan and GMC MCOs, Mercer utilized data for CBAS-eligible recipients from December 2011 through May 2012.

Separate experience was utilized for recipients who have already chosen a MCO and those who are still in fee-for-service (FFS). In instances where the plan-specific or FFS experience was not fully credible, data smoothing techniques were used. Since the FFS recipients must choose a MCO by October 1, 2012 to retain their CBAS service privileges, the experience for those still in FFS was combined with the experience of those in a managed care plan to arrive at a plan-specific rate.

An additional adjustment was then applied to the selected base data to incorporate administration and underwriting profit/risk/contingency loading.

A single and consistent process of developing capitation rate ranges was used for the CP13 Two-Plan and GMC CBAS rates. DHCS will offer final rates within the actuarially sound rate ranges of 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 base data is only for services covered under the definition of CBAS in the 1115 waiver and calculated projection of services are only for Medicaid-eligible individuals.

The information used to form the base data for the Two-Plan and GMC rate range development was CBAS utilization and cost data for CBAS-eligible recipients provided by DHCS. The data consisted of all recipients who receive CBAS services, including recipients who have already chosen to join a MCO and those who are still in FFS. The data utilized was CBAS services that did not include any DSH payments or include any adjustments for FQHC or RHC reimbursements.

The data was limited to exclude recipients who have a share of cost liability. Also, only the recipients whose CBAS facility utilization was approved were used in this analysis. Recipients who are approved to utilize CBAS services were approved by qualified case managers under the purview of DHCS in each county. The data was reviewed for completeness and determined not to

need any additional completion factors. The data was also reviewed for any catastrophic claims and none were found. Therefore, no adjustments for catastrophic claims were needed.

The data was reviewed for those recipients that had already chosen a MCO. The count of CBAS-eligible recipients, the total number of days these CBAS-eligible recipients utilized CBAS facilities and the total dollars for these CBAS-eligible recipients were calculated on a monthly basis. By dividing the total days by the CBAS-eligible recipients, the monthly average number of days per CBAS-eligible recipient was calculated. Also, by dividing the total CBAS dollars by the total number of days, the monthly average CBAS facility cost per day was calculated. From reviewing these data points, it was deemed most appropriate to use only the December 2011 through May 2012 data because these months offered the most consistent information across all of the reporting and were deemed the most reasonable source of information for developing the rate ranges.

Averages of the monthly count of eligible recipients, average days per recipient and average cost per day were then calculated using the December 2011 through May 2012 data. The monthly average days per recipient was then multiplied by the monthly CBAS cost per day to arrive at the monthly average cost per recipient for each MCO. In situations where the average monthly count of eligible recipients was small, smoothing techniques were used (as described in the data smoothing section below). The resulting monthly CBAS cost per recipient applies to only those who chose a MCO.

For recipients who still remain in FFS, the same statistics and subsequent averages were also calculated by county (count of eligible recipients, average days per recipient and average cost per day). Using these same statistics, the monthly CBAS cost per recipient was also calculated by county for the FFS recipients. Beginning on October 1, 2012 the only way these recipients can continue receiving CBAS services is if they enter a MCO. As such, these FFS costs were combined with the managed care costs to arrive at a MCO-specific cost per recipient.

It should be noted that there are two possible different daily rates payable. Each facility will receive one rate or the other for all beneficiaries based on whether it is identified as “rural” or “non-rural”. The daily rate for rural facilities is \$76.27. The daily rate for non-rural facilities is 90% of the rural rate, or $0.90 \times \$76.27 = \68.64 . Rural facilities are exempt from the 10% discount due to access issues. Thus, the average daily rate for a plan will be between the lower and higher of the two possible rates and will vary depending on the relative mix of beneficiaries in each type of facility.

With regards to Graduate Medical Education (GME) costs and 42 CFR 438.6(c)(5)(v) (along with item AA.3.8 of “Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03”), DHCS staff has confirmed that there are no provisions in the managed care contracts regarding GME. The MCOs do not pay specific rates that contain GME or other GME-related provisions. As the CBAS services serve as

the base data and also do not contain GME expenses, GME expenses are not part of the capitation rate development process.

Category of Aid (Aid Code) Groupings

Category of Aid groupings that inherently represent differing levels of risk are used in setting the managed care capitation rates for the MCOs for all non-CBAS rates. In the development of the CBAS rates, no distinction was made for Category of Aid group. The rates to be paid for a CBAS-eligible member will be the same regardless of that member's Category of Aid group. However, once it is known which MCO all CBAS-eligible recipients choose, it is DHCS' intent to include these services in their regular prospective Medicaid-managed care capitation rates in the future.

Data Smoothing

As mentioned in the "Base Data" section above, there were instances where the plan-specific data and FFS data by county were not fully credible to use in the rate-setting process. This occurred mainly in counties where CBAS services are not utilized at high levels. For instance, some of these counties averaged one CBAS-eligible recipient per month. In these instances, average CBAS days per recipient at a more aggregate level was blended with the plan-specific days per recipient to overcome any excessive variation brought on by small utilization of CBAS services in specific counties and MCOs.

Trend

Due to the nature of this data analysis, there are no trend factors that need to be applied. The data being used to develop the rates is very current and it is being used to pay the MCOs for costs of known users of CBAS services. This assumes that the current experience applies to the near future, which is appropriate because all of the current CBAS beneficiaries have recently been approved as eligible. Since the rates were developed based on known users, no changes in the mix of rural versus non-rural facilities or average number of days per month is assumed.

Program Changes

Effective January 1, 2009, DHCS implemented a legislative policy change. The change, referred to as "AB 1422 Tax," categorizes Medi-Cal managed care plans under California Revenue and Taxation Code 12201, and at a tax rate under Code 12202, as administered by the California Department of Insurance. The AB 1422 Tax rate is 2.35%. Two sets of rate ranges were provided: one that includes this tax and one that excludes the tax. Continuation of this tax is currently under review.

Administration and Underwriting Profit/Risk/Contingency Loading

The administration load factor applied to these rates 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 which are submitted as part of their attested rate development templates on an annual basis. The administrative costs are reviewed to ensure that they are appropriate for the approved state plan services and Medicaid eligible members. 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 3% across all MCOs. The range for the Administration component is +/- 0.5% upper/lower-bound from the mid-point value.

The underwriting profit/risk/contingency load is 3% at the mid-point, 2% at the lower-bound and 4% 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 a 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 provided DHCS rate ranges which were developed using an actuarially sound process. The rate ranges were developed using a combination of a modeling process which varied the administration loading percentage and the underwriting/profit/risk/contingency loading percentage to arrive at both a lower- and upper-bound capitation rate. The final contracted rates agreed to between DHCS and each MCO fall within the rate ranges provided by Mercer.

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Rate Range Certification

In preparing the rate ranges described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, financial data and information supplied by DHCS, its MCOs and its vendors. DHCS, its MCOs and its vendors are responsible for the validity and completeness of this supplied data and information. We have 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 Two-Plan and GMC counties CBAS program rate ranges for the CP13 time period, October 1, 2012 through February 28, 2013 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 actuary is a member of the American Academy of Actuaries and meets 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.



James J. Meulemans, ASA, MAAA

