Report to the Legislature

Behavioral Health Organizations Reserve Levels

Engrossed Substitute Senate Bill 6052, Section 204(1)(q)
Chapter 4, 2015 Laws, 3rd Special Session

March 15, 2016

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Engrossed Substitute Senate Bill (ESSB) 6052 (Chapter 4, 2015 Laws, 3rd Special Session) was enacted by the 2015 Legislature to make 2015 fiscal year and 2015-2017 fiscal biennium operating appropriations. Section 204(1)(q) of that law states the following:

> The appropriations in this section include a reduction of $16,462,000 in general fund—state and $16,468,000 of general fund—federal expenditure authority. This reduction must be achieved by reducing regional support network medicaid rates for disabled adults, nondisabled adults, disabled children, and nondisabled children. No regional support network rate may be lowered below the low end of the rate range that is certified as actuarially sound. The department must work to develop updated minimum and maximum reserve levels that reflect the changes in the number of medicaid eligible individuals since reserve levels were originally set as well as the integration of substance use disorder services into managed care contracts funded within the amounts appropriated in this section. *The department must submit a report to the office of financial management and the appropriate fiscal committees of the legislature by December 1, 2015, that includes the revised minimum and maximum reserve levels for medicaid and nonmedicaid behavioral health organization contracts.*

The Department contracted with an actuarial firm, Mercer Health & Benefits LLC ("Mercer"), to conduct an analysis of the Medicaid and non-Medicaid reserve methodologies for the BHOs. Mercer completed an in-depth analysis of the type of reserves needed for Medicaid as described in 42 CFR 438.116. Currently, the Inpatient Reserve is mandatory and the operating reserve is optional only up to the amount to maintain adequate cash flow for the provision of Mental Health services. Mercer is recommending that operating reserves be mandatory in the future which will be incorporated into the BHO contracts.

In addition to the Medicaid reserves, Mercer completed an analysis of the non-Medicaid reserves which are required for Crisis, Inpatient, Involuntary Treatment Act service costs as the BHOs are required to pay for these services even if costs exceed funding levels in a particular year. For information and methodology for the Medicaid and Non-Medicaid Reserves, please refer to Appendix A (BHO Reserve Requirements).

The Department also requested that Mercer review the definitions currently in place for encumbrance and reserve funds. Mercer more clearly defined the use of encumbrances which will be included in the April 1, 2016, BHO, Fiscal Program Requirements & Revenue and Expenditure report instructions which is an appendix to the BHO contract. Appendix B (Encumbrance Guidance) explains the approach and provides clearer definitions of encumbrances.

Appendix A: BHO Reserve Requirements

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February 17, 2016

Subject: Actuarial Consulting Services for Medicaid and Non-Medicaid Reserve Analysis for the Behavioral Health Organizations (BHOs)

Dear Melissa:

The State of Washington Department of Social and Health Services (State) has contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to provide actuarial and financial consultation for the BHO reserve requirements. This analysis was based on the utilization and premium levels of the regional support networks (RSNs). It also includes consideration of the Medicaid reserve requirements for the BHOs, including the addition of Chemical Dependency (CD) services to managed care and the county reconfigurations. Finally, non-Medicaid reserve requirements were reviewed based on expense levels documented in the non-Medicaid revenue and expense reports (R&Es). This letter provides a summary of Mercer's observations and recommendations, as well as any limitations of the analyses.

Note that the reserves developed as a part of this analysis are specific to the integrated Mental Health (MH)/CD BHO program. Effective April 1, 2016, Southwest BHO will be managed under the fully integrated managed care program through Early Adopter. Because the reserve calculations contained here reflect MH/CD services only, the calculated reserve percentages for Southwest BHO may not be applicable for the Early Adopter program.

Medicaid Reserves Methodology

Overview

The current managed care contract requires each RSN to hold specific levels of reserves to account for outstanding claim liabilities and ensure ongoing solvency of the RSNs. The required reserve levels were determined based on prior actuarial analyses performed by Milliman during 2007. Specifically, the reserves requiring analysis are:

- The Risk Reserve — The Risk Reserve is established to cover claims and liabilities if premium revenue is less than incurred expenses and, as such, is essentially a solvency reserve for the program.

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- The Inpatient and Operating Reserves — The Inpatient and Operating Reserves are provisions for funding outstanding incurred but not reported (IBNR) claim liability for Inpatient and Other services, respectively. As such, Mercer reviewed Inpatient and non-Inpatient claim patterns by BHO, in addition to typical IBNR levels in other states to help develop the Inpatient and Operating Reserve level assumptions.
- Encumbrance and Other Unobligated Reserves — Review of these reserves will be submitted in a separate document.

Reserves are maintained to ensure sufficient solvency and cash flow to pay for future obligations. The structure of provider contracts and payments are critical considerations in the evaluation and analysis of minimum reserve requirements. Where providers are paid upfront for services through a capitation arrangement, the risk of future obligations for the BHO are small. Similarly, the provider payments are not impacted by IBNR considerations, as the payment was based on a member's eligibility for services rather than the actual delivery of services and submission of a claim for payment.

To inform the reserve calculations, the State collected information from the BHOs regarding expected provider payment arrangements specific to Outpatient and Per Diem (Evaluation and Treatment (E&T) and Residential) Mental Health (MH) and CD services. For BHOs that did not provide contracting detail, information reported in the State Fiscal Year (SFY) 2015 R&Es was referenced to determine the provider payment arrangements. In those instances, the 'Expenditure Allocation Method' from the R&Es was used to categorize BHOs as having primarily capitation or fee-for-service (FFS) provider contracting arrangements. A summary of the source for determining the expected provider payment arrangements by BHO is outlined below:

BHO	Source of Provider Payment Arrangement Information
North Central	BHO Provided
Greater Columbia	BHO Provided
King	BHO Provided
North Sound	R&E
Salish	BHO Provided
Pierce	BHO Provided
Southwest	R&E
Spokane	BHO Provided
Thurston Mason	BHO Provided

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BHO	Source of Provider Payment Arrangement Information
Great Rivers	R&E

To the extent the actual contracting arrangements vary from what is assumed here, modifications to this analysis may be appropriate.

For the purposes of this analysis, Mercer defined a sub-capitated arrangement as one where the BHO makes an upfront payment to providers to deliver an array of services to eligible participants. This payment is not ultimately tied to the actual delivery of services or submissions of claims. Under this sub-capitated arrangement, the BHO transfers claim risk to the provider, since payments from the BHO to the provider will not vary if actual expenses are different than the initial capitation payment. This factor plays a critical role in the development of the first two bulleted items above: the Risk and Operating Reserve levels.

The methodology for analyzing each reserve is described further in the following pages.

Risk Reserve

Background

The purpose of the Risk Reserve is to ensure the solvency of the BHO, consistent with requirements described in 42 CFR 438.116. According to section 6.12 of the Prepaid Inpatient Health Plan (PIHP) contract, "Risk Reserve funds may only be used in the event costs of providing service exceed the revenue the RSN receives." This reserve is necessary to fund claims and liabilities if the revenue is less than the expenses incurred. For managed care entities regulated by state departments of insurance, solvency is usually monitored through the review of risk-based capital (RBC) requirements. The current reserve requirements vary by RSN from 3.5% of revenue to 14.3% of revenue, depending on the enrollment levels observed as part of the prior study.

For health insurance, the underwriting risk component of the minimum RBC requirements is the vast majority of the RBC amount required for insurance companies. Other asset and liability risks are minor contributors to a health insurers RBC, as the assets are typically cash or equivalent instruments and the liabilities are typically short-term in nature. As such, Mercer focused the BHO reserve analysis on evaluating the underwriting risk considerations as a proxy for the RBC calculation.

Methodology

Mercer summarized Inpatient, E&T (inclusive of Residential services) and Outpatient BH service costs to use in the proxy RBC calculation based on projected SFY 2017 capitation dollars. The

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overall service costs were estimated using projected SFY 2017 member months and fiscal year (FY) 2016/2017 BHO lower bound capitation rates, excluding administrative costs, as of December 28, 2015, for both MH and CD. Note that Mercer also summarized and reviewed the SFY 2015 R&E reported paid claims as a benchmark. However, these dollars were not used as part of the RBC calculation as the BHO program will serve more individuals (through newly eligible growth) and contain a higher volume of service spend (through the addition of CD services).

Assumed BHO service revenues are as follows:

BHO	Projected Service Revenues
North Central	$16,927,128
Greater Columbia	$76,400,770
King	$213,168,021
North Sound	$111,173,139
Salish	$37,263,892
Pierce	$89,511,426
Southwest	$47,976,485
Spokane	$84,889,522
Thurston Mason	$36,178,091
Great Rivers	$44,768,787

The tiered RBC factors noted below were applied to these projected SFY 2017 capitation dollars. The tiered factors are intended to reflect differences in the relative volatility of experience. As such, as a BHO increases in size, the proportion of risk is expected to decrease.

Comprehensive Major Medical Spend	RBC Factor
$0–$3 million	0.15
$3–$25 million	0.15
$25 million and over	0.09

After application of these RBC factors, the gross RBC values are as follows:

BHO	Gross RBC
North Central	$2,539,069

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BHO	Gross RBC
Greater Columbia	$8,376,069
King	$20,685,122
North Sound	$11,505,582
Salish	$4,853,750
Pierce	$9,556,028
Southwest	$5,817,884
Spokane	$9,140,057
Thurston Mason	$4,756,028
Great Rivers	$5,529,191

A BHO-specific managed care discount was then applied to the gross RBC. This discount is based on classifications regarding payments made according to contractual arrangements with providers. Certain contractual arrangements can lead to greater predictability of future claim levels. This, in turn, reduces the need for additional capital to support fluctuations in experience.

Managed Care Discount Description	Discount Factor
Arrangement Not Included Below (% of charges, for example)	0.0%
Contractual Fee Payments	15.0%
Bonus/Withhold Arrangements	0.0%–25.0%
Provider Capitation	60.0%
Non-Contingent Expenses (Flat Fee)	75.0%

For purposes of this analysis, the provider arrangements were classified into contractual fee payments FFS or provider capitation.

Inpatient
The Inpatient assumption noted below is the same across all BHOs, as the contracting arrangements are not assumed to vary. Additionally, as contracts are not expected to be arranged differently between MH and CD providers, the same assumptions were applied to both sets of data.

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Inpatient	
Managed Care Discount	Portion of Payments Based on Contractual Arrangements
15.0%	100.0%

E&T and Outpatient

Based on the expected provider payment arrangements, Mercer has developed managed care discount assumptions for E&T and Outpatient services. This discount factor allows for reductions in required capital based on the relative risk that each BHO retains. These assumptions take into consideration variations in provider payment arrangements for MH and CD services as well.

A 15.0% managed care discount assumption reflects the expectation that provider payment arrangements will be based on a fee schedule once in managed care. Provider payment arrangements that are expected to be based on sub-capitation contracts received a 60.0% managed care discount assumption. Consideration was included to account for a mix of both provider payment arrangements within a BHO. This methodology also reflects a blending of managed care discount assumptions in instances where RSNs combined to form a BHO. Assumptions were developed separately for MH and CD and then blended together for E&T and Outpatient, respectively, based on projected SFY 2017 capitation dollars.

Mercer applied an additional assumption for the portion of E&T and Outpatient expenses subject to the corresponding provider payment arrangement. Mercer assumed the provider payment arrangement outlined in the BHO provided information (or based on the documented expenditure allocation method per the R&Es for BHOs that did not submit information) was applicable to 90.0% of the expenses, unless otherwise noted in the BHO provided information. This implicitly results in 10.0% of the expenses receiving a 0.0% managed care discount factor. Mercer determined this was appropriate given the potential for variation in future BHO provider contracting. Assumptions were developed separately for MH and CD, and then blended together for E&T and Outpatient, respectively, based on projected SFY 2017 capitation dollars.

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The resulting E&T and Outpatient managed care discount assumptions are shown in the table below.

BHO	E&T		Outpatient	
	Managed Care Discount	Portion of Payments Based on Contractual Arrangements	Managed Care Discount	Portion of Payments Based on Contractual Arrangements
North Central	15.0%	90.0%	51.0%	90.0%
Greater Columbia	15.0%	90.0%	49.0%	90.0%
King	15.0%	90.0%	15.0%	90.0%
North Sound	15.0%	90.0%	15.0%	90.0%
Salish	43.0%	90.0%	45.0%	90.0%
Pierce	15.0%	90.0%	15.0%	90.0%
Southwest	15.0%	90.0%	15.0%	90.0%
Spokane	15.0%	90.0%	20.0%	90.0%
Thurston Mason	22.0%	70.0%	15.0%	68.0%
Great Rivers	15.0%	90.0%	39.0%	90.0%

Additional details illustrating the managed care discounts are outlined in Appendix A.

The subsequent BHO RBC amounts after the managed care discounts were then compared to the calculated alternate risk charge, which represents the estimated maximum cost per single client within a year. It serves as a minimum risk requirement level. As such, the final RBC amount was calculated as the maximum of the calculated RBC and the alternate risk charge.

After application of the Managed Care Discounts, the Net RBC values by BHO are outlined below:

BHO	Net RBC (100% Proxy RBC)
North Central	$1,513,278
Greater Columbia	$5,414,234
King	$17,846,604
North Sound	$9,934,374
Salish	$2,951,170
Pierce	$8,261,832

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BHO	Net RBC (100% Proxy RBC)
Southwest	$5,025,820
Spokane	$7,593,320
Thurston Mason	$4,189,104
Great Rivers	$3,838,318

The final RBC amount for each BHO was then converted to a percentage of projected SFY 2017 revenues, as estimated based on SFY 2017 projected member months and lower bound FY 2016/2017 capitation rates, including Administrative costs.

Risk Reserve Review Process Example
An example of the RBC calculation is provided below.

Process Step and Description		Medical Expense	Row	Calculation
Projected SFY 2017 Capitation Payment: Estimated Comprehensive Major Medical Spend	$	50,000,000	A	
First Tier: $0 to $3 Million	$	3,000,000	B	Min(A, $3,000,000)
Remainder after First Tier	$	47,000,000	C	A - B
Second Tier: $3 to $25 Million	$	22,000,000	D	Min(C, $25,000,000 - B)
Remainder: $25+ Million	$	25,000,000	E	C - D
First Tier: First Tier $ after First Tier RBC Factor of 15% Applied	$	450,000	F	B x 0.15
Second Tier: Second Tier $ after Second Tier RBC Factor of 15% Applied	$	3,300,000	G	D x 0.15
Remainder: Remaining $ after Final RBC Factor of 9% Applied	$	2,250,000	H	E x 0.09
Total	$	**6,000,000**	I	F + G + H
Managed Care Discount for Payments made According to Contractual Arrangements		0.150	J	
Portion of Payments based on Contractual Arrangements		90%	K	
Managed Care Discount Calculated	$	**810,000**	L	I x J x K
RBC After Managed Care Discount	$	5,190,000	M	I - L
Alternate Risk Charge: Minimum RBC Required	$	500,000	N	
Net Underwriting Risk RBC: Maximum of RBC after Managed Care Discount and Alternate Risk Charge	$	**5,190,000**	O	Max(M,N)
Projected SFY 2017 Revenues (Inclusive of Administrative Costs)	$	75,000,000	P	
100% RBC as % of Projected SFY 2017 Revenues		**6.9%**	Q	O/P

Results
Based on the RBC analysis, the estimated, recommended RBC percentages are summarized below. Mercer summarized the RBC requirements for 100.0% RBC (200.0% authorized control level (ACL)) and 200.0% RBC (400.0% ACL) to provide a recommended range by BHO. Based on

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the table below outlining the action steps associated with various levels of RBC, the 100% RBC (200% ACL) represents the threshold for a minimum level of required reserve to result in no action necessary. From an insurance company perspective, the 200.0% RBC (400.0% ACL) is an acceptable alternative minimum requirement benchmark. The results of the reserve calculations are heavily influenced by provider payment arrangements (FFS versus sub-capitation) as well as the size of the BHO. As shown in the table below, smaller BHOs with a higher proportion of sub-capitated provider payment arrangements, like North Central, can have RBC requirements similar to larger BHOs with primarily FFS provider payment arrangements, like King and Spokane.

BHO	100.0% Proxy RBC (200.0% ACL)	200.0% Proxy RBC (400.0% ACL)
North Central	7.8%	15.6%
Greater Columbia	6.3%	12.6%
King	7.8%	15.7%
North Sound	8.1%	16.3%
Salish	7.0%	14.0%
Pierce	8.4%	16.8%
Southwest	9.5%	19.0%
Spokane	8.0%	15.9%
Thurston Mason	10.6%	21.2%
Great Rivers	7.6%	15.3%

Detailed calculations illustrating the development of the net RBC values can be found in Appendix A.

As discussed, RBC levels for insurance companies are monitored to ensure solvency of the insurance company. While RBC levels of 100.0% and 200.0% of ACL typically meet minimum reserve levels, actual contract requirements are determined based on State policy. Based on the actual RBC level, the National Association of Insurance Commissioners indicates that a number of actions, described below, are available to regulators if warranted. Note that the ACL dollar value is half the RBC dollar value, such that 200.0% of ACL is 100.0% of RBC.

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Authorized Control Level Range	Action Level	Action Steps
200.0% or more of ACL (100.0% or more RBC)	No Action	None.
150.0%–200.0% of ACL (75.0%–100.0% RBC)	Company Action Level	The insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.
100.0%–150.0% of ACL (50.0%–75.0% RBC)	Regulatory Action Level	The company is required to file an action plan, and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems.
70.0%–100.0% of ACL (35.0%–50.0% RBC)	Authorized Control Level	The regulator takes control of the insurer, even though the insurer may technically be solvent.
Less than 70.0% of ACL (Less than 35.0% RBC)	Mandatory Control Level	The regulator takes steps to place the insurer under control. Most companies that trigger this action level technically insolvent (liabilities exceed assets).

Inpatient and Operating Reserves

Background

The Inpatient and Operating Reserves are provisions for funding outstanding IBNR claim liability for Inpatient and Other services, respectively. These reserves reflect outstanding claim liability for which premiums have already been received and services already provided. Section 6.12 of the PIHP contract states that the Inpatient Reserve funds may only be set aside for "anticipated Psychiatric Inpatient costs."

While the Inpatient Reserve is mandatory, the Operating Reserve is optional. Section 6.13 of the PIHP contract states, "Operating Reserve funds may only be set aside to maintain adequate cash flow for the provision of MH services." Based on our discussions with State staff and review of various documents, Mercer's interpretation is that this reserve functions as the IBNR fund for non-Inpatient services, similar to the Inpatient Reserve.

The historical Department of Behavioral Health and Recovery (DBHR) reserve requirements vary from 0.9% of revenue to 5.7% of revenue for Inpatient Reserves, and from 5.0% of revenue to 15.2% of revenue for Operating Reserves, depending on the BHO.

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Methodology

In order to determine the required reserve percentages, Mercer analyzed the Inpatient claim payment patterns observed in Provider One payment data through July 2015. Mercer notes that these observed payment patterns were similar to what was observed as part of the previous Washington State reserves analysis. These IBNR figures are based on no claims payment runout for the most recent month of claims. In other words, the reserve percentage for Inpatient services is based on a comparison of the paid claims to date for services through July 2015, to the estimated ultimate incurred amounts for services through July 2015. For Inpatient services, the IBNR figure with zero months of runout amounts to 25.0% of the most recent 12-months of Inpatient payments.

Non-Inpatient data consists of the encounter data submitted by the RSNs. This data set does not contain the actual date the claim/encounter was paid by the RSN. As such, a traditional IBNR lag analysis cannot be performed. To develop the non-Inpatient IBNR assumptions, Mercer reviewed typical levels of IBNR in other states to help develop the Inpatient and Operating Reserve level assumptions. The Inpatient Reserves for other states were generally in alignment with the 25.0% observed for Washington State. The non-Inpatient Reserves for other programs were found to be 15.0% of the most recent 12 months of data. Mercer utilized this 15.0% assumption for the development of the Operating Reserve.

As the Inpatient and Operating Reserves are expressed as a percentage of the overall BHO revenue, Mercer calculated the portion of overall revenue associated with Inpatient and non-Inpatient services. These factors were applied to the 25.0% and 15.0% assumptions above, along with any considerations with respect to sub-capitated providers. As noted earlier, sub-capitated provider payments are not assumed to be subject to IBNR payment lag, as the providers are paid an upfront capitation payment.

For the purposes of this analysis, Mercer defined a sub-capitated arrangement as one where the BHO makes an upfront payment to providers to deliver an array of services to eligible participants. This payment is not ultimately tied to the actual delivery of services or claims submission. As such, the IBNR is assumed to be zero for sub-capitated providers.

Mercer reviewed BHO submitted information regarding expected provider payment arrangements specific to Outpatient and Per Diem (E&T and Residential), MH and CD services. For BHOs that did not provide contracting detail, information reported in the SFY 2015 R&E was referenced to determine the BHOs that are assumed to have sub-capitation arrangements. Specifically, the

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'Expenditure Allocation Method' was used to categorize BHOs as having primarily capitation or FFS provider contracting arrangements.

Based on this review, the BHOs were classified as follows:

E&T
- Primarily/Partially Sub-capitated BHO: Salish and Thurston Mason
- Primarily FFS BHO: North Central, Greater Columbia, King, North Sound, Pierce, Southwest, Spokane and Great Rivers

Outpatient
- Primarily/Partially Sub-capitated BHO: North Central, Greater Columbia, Salish, Spokane and Great Rivers:
  - Note that Great Rivers was a blended assumption of sub-capitation for Timberlands and Grays Harbor, along with FFS for Cowlitz
- Primarily FFS BHO: King, North Sound, Pierce, Southwest and Thurston Mason

Under a sub-capitated arrangement, Operating Reserves are mitigated, as the BHOs are not responsible for claim runout. However, Mercer recognizes that actual sub-capitation arrangements in future years may vary from what is assumed above.

For sub-capitation arrangements, Mercer assumed that 90.0% of E&T and Outpatient claims were not subject to claims runout. As such, only 10.0% of E&T and Outpatient claims were considered in the development of the Operating Reserve level. Consideration was included to account for a mix of both provider payment arrangements within a BHO. A blending of sub-capitation assumptions in instances where RSNs combined to form a BHO was also reflected. Assumptions were developed separately for MH and CD, and then blended together for E&T and Outpatient, respectively, based on projected SFY 2017 capitation dollars.

Due to the potential for variation as a result of uncertainty in provider contracting arrangements, Mercer applied a minimum Operating Reserve requirement of 5.0% for all BHOs.

The provider payment arrangement determination is the key driver of variability among the BHOs. As such, any significant variation from the information provided by the BHOs regarding expected provider payment arrangements, or from information in the R&Es for BHOs that did not provide information, may result in changes to the reserve levels.

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Results

The percentages in the table are represented as a percentage of a 12 month revenue figure. The resulting Inpatient Reserve percentage recommendations are fairly consistent across all BHOs, ranging from 0.5% for Salish to 3.5% for King. The variations in the reserve percentages are influenced by the proportion of BHO expenses related to Inpatient services. A higher proportion of Inpatient spending indicates a higher portion of revenue is needed to cover the Inpatient Reserve. The Operating Reserve percentage recommendations have wider variation from 5.0% for North Central, due to the above mentioned minimum Operating Reserve requirement, to 13.3% for Pierce. As noted above, this variation is driven by assumed sub-capitated versus FFS arrangements.

BHO	Inpatient	Operating
North Central	1.2%	5.0%
Greater Columbia	1.3%	6.1%
King	3.5%	11.9%
North Sound	2.4%	12.2%
Salish	0.5%	5.4%
Pierce	0.7%	13.3%
Southwest	1.7%	12.5%
Spokane	2.5%	10.9%
Thurston Mason	1.6%	12.2%
Great Rivers	1.2%	7.6%

Encumbrance and Other Unobligated Reserves

Encumbrance and other unobligated reserves are allowed per the current RSN contract. Mercer reviewed the R&E reporting requirements for these reserves, and consulted with the State on the appropriateness of continuing these reserve accounts in the future. Mercer financial reporting and monitoring consultants discussed these reserves with the State to understand their purpose and any current State concerns. Mercer researched alternative reserve options and developed a summary document to be submitted under a separate header.

Combined Results and Observations

Based on the completed analysis, Mercer's recommended range of appropriate combined risk and Inpatient and Operating Reserve levels are summarized in the below table. As both the Inpatient and Outpatient reserves are provisions for outstanding claim liability, Mercer recommends the

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Operating Reserve be mandatory as well. The considerations for provider contracting reflect the lesser reserve implications for BHOs with provider sub-capitation.

BHO	100.0% RBC (200.0% ACL)	200.0% RBC (400.0% ACL)
North Central	14.0%	21.8%
Greater Columbia	13.7%	20.0%
King	23.2%	31.1%
North Sound	22.7%	30.9%
Salish	12.9%	19.9%
Pierce	22.3%	30.7%
Southwest	23.7%	33.2%
Spokane	21.3%	29.3%
Thurston Mason	24.4%	35.0%
Great Rivers	16.4%	24.1%

At both ends of the range, Thurston Mason has the highest overall reserve level requirement, driven by high risk and Operating Reserves. Conversely, Salish has the lowest overall reserve level requirement at both ends of the range. The width of the range in recommendations varies from 6.3% for Greater Columbia to 10.6% for Thurston Mason, which reflects the variability in provider contractual arrangements. As noted throughout this letter, the variation in reserve assumptions across the BHOs is driven by the sub-capitation classifications related to provider contracting, which transfers financial risk from the BHO to providers and results in lesser IBNR considerations.

Observations

Compared to the current level of combined contractual reserves as reported in the SFY 2015 R&Es, adjusted for BHO reconfiguration, the 100.0% RBC requirements were at least two percentage points different for most BHOs. One of the main drivers for these differences is the E&T and Outpatient provider contracting assumptions underlying the E&T and Outpatient IBNR calculations within this analysis, which, as noted previously, greatly influence the resulting Operating Reserve level results.

- North Central decreased 14.1 percentage points, from 28.1% to 14.0%. This was driven by a fairly significant reduction in the estimated Operating Reserve level. The current 14.0% value reflects the increase in BHO size due to the addition of Grant County.

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- North Sound increased 7.5 percentage points, from 15.2% to 22.7%, which is attributable to an increase in the Risk Reserve requirement, as well as the Operating Reserve.
- Southwest decreased 3.3 percentage points, from 27.0% to 23.7%, driven by a decrease in the Inpatient Reserve.
- Spokane decreased 3.2 percentage points, from 24.5% to 21.3%. This was largely attributable to a decrease in the Operating Reserve.
- Thurston Mason decreased 4.1 percentage points, from 28.5% to 24.4%, driven by a large decrease in the Inpatient Reserve, as well as a moderate decrease to the Operating Reserve.
- Great Rivers decreased 6.3 percentage points, from 22.7% to 16.4%, mainly driven by the decrease in the Risk Reserve requirements due to the increased enrollment as a result of Grays Harbor and Cowlitz county moving into Great Rivers with the BHO reconfiguration:
  - The decrease was slightly offset under this methodology due to the blending of the 60.0% Outpatient MH managed care discount assumption with the 15.0% CD assumption.

Greater Columbia, King, Salish and Pierce all had 100.0% RBC requirements within 2.0 percentage points of the combined contractual reserves, as reported in the SFY 2014 R&Es.

In addition to developing a recommended range of reserve levels encompassing Risk Reserve, as well as Inpatient and Operating Reserves, Mercer compared the historical DBHR contractual combined reserve levels as of 2007 to the contractual reserve percentages as reported in the SFY 2015 R&Es by BHO. Overall, the contractual reserve percentages were generally consistent, with slight variation. Additional detail on this comparison can be found in Appendix A.

Non-Medicaid Reserves Methodology

Overview

Similar to the current managed care contracts, the non-Medicaid contracts require each BHO to hold specific levels of reserves to account for outstanding claim liabilities and ensure ongoing solvency of the BHOs. Specifically, the reserves requiring analysis are:

- The Risk Reserve — The Risk Reserve is established to cover claims and liabilities if premium revenue is less than incurred expenses and, as such, is essentially a solvency reserve for the program. For non-Medicaid reserves, the risk reserve is limited to Crisis, Inpatient and Involuntary Treatment Act (ITA) service costs as BHOs are required to pay for these services even if costs exceed funding levels in a particular year.
- The Inpatient and Operating Reserves — The Inpatient and Operating Reserves are provisions for funding outstanding IBNR claim liability for Inpatient and Other services, respectively. As such, Mercer reviewed Inpatient and non-Inpatient claim levels as reported in

Appendix A: BHO Reserve Requirements

the SFY 2015 R&E reports by BHO, in addition to typical IBNR levels in other states, to help develop the Inpatient and Operating Reserve level assumptions.

Risk Reserve

Background

The purpose of the Risk Reserve is to ensure the solvency of the BHO, consistent with requirements described in 42 CFR 438.116. This reserve is necessary to fund claims and liabilities if the revenue is less than the expenses incurred. Specific to non-Medicaid contracts, the BHOs are required to cover the cost for crisis, Inpatient and ITA services provided even if costs exceed funding levels in a particular year.

Methodology

Mercer leveraged the Medicaid Risk Reserve calculations by BHO, as detailed in the above sections, as the basis for the non-Medicaid Risk Reserve calculation. Since Risk Reserve is only applicable to a sub-set of services for non-Medicaid, Mercer utilized service costs reported in the SFY 2015 non-Medicaid R&E reports to summarize the costs associated with those services as a percent of total costs. This percentage was then applied to the Medicaid Risk Reserve levels to calculate a proportionate non-Medicaid Risk Reserve. The results of this analysis are summarized below.

BHO	Medicaid Risk Reserve		Non-Medicaid Portion of Service Cost Subject to Risk Reserve	Non-Medicaid Risk Reserve	
	100.0% RBC (200.0% ACL)	200.0% RBC (400.0% ACL)		100.0% RBC (200.0% ACL)	200.0% RBC (400.0% ACL)
North Central	7.8%	15.6%	45.6%	3.5%	7.1%
Greater Columbia	6.3%	12.6%	40.5%	2.6%	5.1%
King	7.8%	15.7%	56.2%	4.4%	8.8%
North Sound	8.1%	16.3%	42.9%	3.5%	7.0%
Salish	7.0%	14.0%	15.7%	1.1%	2.2%
Pierce	8.4%	16.8%	28.5%	2.4%	4.8%
Southwest	9.5%	19.0%	21.8%	2.1%	4.1%
Spokane	8.0%	15.9%	36.0%	2.9%	5.7%
Thurston Mason	10.6%	21.2%	23.9%	2.5%	5.1%
Great Rivers	7.6%	15.3%	34.5%	2.6%	5.3%

Appendix A: BHO Reserve Requirements

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Inpatient and Operating Reserves

Background

The Inpatient and Operating Reserves are provisions for funding outstanding IBNR claim liability for Inpatient and Other services, respectively. These reserves reflect outstanding claim liability for which premiums have already been received and services already provided.

Methodology

Mercer used 25.0% Inpatient and 15.0% non-Inpatient IBNR assumptions for the development of the non-Medicaid Inpatient and Operating Reserve levels, consistent with the Medicaid calculation outlined above.

As the Inpatient and Operating Reserves are expressed as a percentage of the overall BHO revenue, Mercer calculated the portion of overall revenue associated with Inpatient and non-Inpatient services, based on the SFY 2015 non-Medicaid R&E reports. These factors were applied to the 25.0% and 15.0% assumptions above, along with any considerations with respect to sub-capitated providers, consistent with the assumptions used for the development of the Medicaid Inpatient and Operating Reserves, as detailed in prior sections. As noted earlier, sub-capitated provider payments are not assumed to be subject to IBNR payment lag, as the providers are paid an upfront sub-capitation payment.

Under a sub-capitated arrangement, Operating Reserves are mitigated as the BHOs are not responsible for claim runout. However, Mercer recognizes that actual sub-capitation arrangements may vary from what is assumed above in the future.

Provider payment arrangement assumptions were applied consistent with the Medicaid assumptions outlined earlier in the document. For sub-capitation arrangements, Mercer assumed that 90.0% of E&T and Outpatient claims were not subject to claims runout. As such, only 10.0% of E&T and Outpatient claims were considered in the development of the Operating Reserve level. Consideration was included to account for a mix of both provider payment arrangements within a BHO. A blending of managed care discount assumptions in instances where RSNs combined to form a BHO was also reflected. Assumptions were developed separately for MH and CD, and then blended together for E&T and Outpatient, respectively, based on projected SFY 2017 capitation dollars.

The provider payment arrangement determination is the key driver of variability among the BHOs. As such, any significant variation from the information provided by the BHOs regarding expected provider payment arrangements, or from information in the R&Es for BHOs that did not provide information, may result in changes to the calculated reserve levels.

Appendix A: BHO Reserve Requirements

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Results

The percentages in the table are represented as a percentage of a 12 month revenue figure. The resulting Inpatient Reserve percentage recommendations are fairly consistent across all BHOs, ranging from 0.4% for Thurston Mason to 5.9% for King. The variations in the reserve percentages are influenced by the proportion of non-Inpatient BHO expenses related to Inpatient services. A higher proportion of Inpatient spending indicates a higher portion of revenue is needed to cover the Inpatient Reserve. The Operating Reserve percentage recommendations have wider variation, from 5.8% for North Central and Salish to 13.3% for North Sound and Spokane. As noted above, this variation is driven by assumed sub-capitated versus FFS arrangements.

BHO	Inpatient	Operating
North Central	2.2%	5.8%
Greater Columbia	1.4%	8.1%
King	5.9%	10.6%
North Sound	2.3%	13.3%
Salish	1.0%	5.8%
Pierce	0.8%	13.1%
Southwest	0.8%	12.4%
Spokane	0.9%	13.3%
Thurston Mason	0.4%	12.7%
Great Rivers	5.1%	6.6%

Combined Results

Based on the completed analysis, Mercer's recommended range of appropriate combined risk and Inpatient and Operating non-Medicaid Reserve levels are summarized in the below table.
As both the Inpatient and Outpatient reserves are provisions for outstanding claim liability, Mercer recommends the Operating Reserve be mandatory as well. The considerations for provider contracting reflect the lesser reserve implications for BHOs with provider sub-capitation.

BHO	100.0% RBC (200.0% ACL)	200.0% RBC (400.0% ACL)
North Central	11.6%	15.1%
Greater Columbia	12.1%	14.6%
King	20.9%	25.3%

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Appendix A: BHO Reserve Requirements

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BHO	100.0% RBC (200.0% ACL)	200.0% RBC (400.0% ACL)
North Sound	19.1%	22.6%
Salish	7.9%	9.0%
Pierce	16.3%	18.7%
Southwest	15.2%	17.3%
Spokane	17.1%	20.0%
Thurston Mason	15.6%	18.1%
Great Rivers	14.4%	17.0%

At both ends of the range, King has the highest overall reserve level requirement, driven by high risk, Inpatient and Operating Reserves. Conversely, Salish has the lowest overall reserve level requirement at both ends of the range driven by low risk and Inpatient Reserves. As noted throughout this letter, the variation in reserve calculation across the BHOs is driven by the sub-capitation classification related to provider contracting, which transfers financial risk from the BHO to providers and results in lesser reserve considerations.

Additional detail on the development of the non-Medicaid reserves can be found in Appendix B.

Caveats and Limitations

This analysis and these recommendations were based on projected SFY 2017 capitation rates as of December 28, 2015. Subsequent changes to the SFY 2017 rate ranges or structure of the BHO program may impact the results of this analysis.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness or attainability of the results for the Medicaid program. These assumptions may also be changed from one analysis to the next because of changes in mandated requirements, program experience, changes in expectations about the future and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate or unattainable when they were made.

All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a

Appendix A: BHO Reserve Requirements

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likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

If you have any questions on any of the information provided, please feel free to call Jon Marsden at 612 642 8940, Brad Diaz at 612 642 8756 or Angela Ugstad at 612 642 8927.

Sincerely,

Angela Ugstad
Brad Diaz, FSA, MAAA
Jonathan C. Marsden, FSA, MAAA

Copy:
Melena Thompson — Division of Behavioral Health and Recovery
Scott Banken, CPA and Denise Podeschi — Mercer

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Historical Medicaid Reserve Levels and SFY 2015 Contracted and Reported R&E Reserve Levels

BHO	Reserve from 2007[1]				DSHS/HRSA DRF/Mental Health Fiscal Reserve from 2007			
	Operating Percent	Risk Reserve Percent	IP Percent	Total Percent	Operating Percent	Risk Reserve Percent	IP Percent	Total Percent
North Central	14.6%	11.7%	3.2%	29.5%	14.6%	11.7%	3.2%	29.5%
Greater Columbia	14.2%	4.5%	3.9%	22.6%	5.0%	4.5%	3.9%	13.4%
King	14.2%	3.5%	3.9%	21.6%	14.2%	3.5%	3.9%	21.6%
North Sound	13.0%	4.5%	5.7%	23.2%	5.0%	4.5%	5.7%	15.2%
Salish	16.1%	10.0%	0.9%	27.0%	5.0%	10.0%	0.9%	15.9%
Pierce	15.2%	5.0%	2.3%	22.5%	15.2%	5.0%	2.3%	22.5%
Southwest	13.8%	9.7%	4.4%	27.9%	13.8%	9.7%	4.4%	27.9%
Spokane	13.9%	7.1%	4.2%	25.2%	13.9%	7.1%	4.2%	25.2%
Thurston Mason	13.3%	10.0%	5.2%	28.5%	13.3%	10.0%	5.2%	28.5%
Great Rivers	14.8%	14.3%	2.9%	32.0%	5.7%	14.3%	2.9%	22.9%
Total	14.2%	6.1%	3.9%	24.2%	11.1%	6.1%	3.9%	21.1%

[1] As calculated by Milliman

BHO	SFY 2015 R&E Reported Reserves				Total SFY 2015 Reported	Total Contractual
	Operating	Risk Reserve	IP	Total		
North Central	$ 2,957,881	$ 1,967,042	$ 717,294	$ 5,642,217	28.2%	28.1%
Greater Columbia	$ -	$ 3,271,516	$ 2,828,484	$ 6,100,000	7.8%	12.8%
King	$ 21,271,817	$ 6,034,923	$ 6,716,070	$ 34,022,810	20.0%	21.6%
North Sound	$ 10,097,285	$ 3,504,121	$ 4,462,754	$ 18,064,160	20.0%	15.2%
Salish	$ 444,233	$ 2,873,327	$ 269,423	$ 3,586,983	11.0%	14.4%
Pierce	$ 4,699,693	$ 4,157,232	$ 1,919,365	$ 10,776,289	13.4%	22.5%
Southwest	$ 8,049,522	$ 5,140,528	$ 2,334,028	$ 15,524,078	26.9%	27.0%
Spokane	$ 11,995,380	$ 5,721,730	$ 3,425,825	$ 21,142,935	24.7%	24.5%
Thurston Mason	$ 12,858,382	$ 3,238,723	$ 1,675,251	$ 17,772,356	57.5%	28.5%
Great Rivers	$ 5,715,990	$ 3,332,801	$ 747,141	$ 9,795,931	41.7%	22.7%
Total	$ 78,090,182	$ 39,241,943	$ 25,095,634	$ 142,427,759		

2016 Mercer Medicaid Reserves Analysis

Medicaid Risk Reserve

	A	B	C	D	E	F	G	H	I	J
									(B x D + F x H) / (D + H)	(C x D + G x H) / (D + H)
	E&T Managed Care Discount Development									
	Mental Health				Chemical Dependency				Blended Assumption	
BHO	Provider Contracting Arrangement	Managed Care Discount	Portion of Payments based on Arrangement	SFY 2017 Medical Capitation Revenue	Provider Contracting Arrangement	Managed Care Discount	Portion of Payments based on Arrangement	SFY 2017 Medical Capitation Revenue	Managed Care Discount	Portion of Payments based on Arrangement
North Central	FFS	15%	90%	$ 276,931	FFS	15%	90%	$ 1,742,907	15%	90%
Greater Columbia	FFS	15%	90%	$ 10,337,897	FFS	15%	90%	$ 7,720,635	15%	90%
King	FFS	15%	90%	$ 27,330,685	FFS	15%	90%	$ 11,962,379	15%	90%
North Sound	FFS	15%	90%	$ 16,570,539	FFS	15%	90%	$ 10,473,042	15%	90%
Salish	Sub-capitation	60%	90%	$ 7,209,149	FFS	15%	90%	$ 4,425,927	43%	90%
Pierce	FFS	15%	90%	$ 31,290,337	FFS	15%	90%	$ 4,800,625	15%	90%
Southwest	FFS	15%	90%	$ 4,122,292	FFS	15%	90%	$ 3,395,757	15%	90%
Spokane	FFS	15%	90%	$ 6,389,839	FFS	15%	90%	$ 7,663,215	15%	90%
Thurston Mason	FFS	15%	60%	$ 6,166,760	50% FFS 50% Sub-Capitation	38%	90%	$ 3,008,622	22%	70%
Great Rivers[1]	FFS	15%	90%	$ 2,673,456	FFS	15%	90%	$ 4,164,070	15%	90%

[1]Reflects a blend of assumptions for Cowlitz County from Southwest, Grays Harbor and Timberlands.

	A	B	C	D	E	F	G	H	I	J
									(B x D + F x H) / (D + H)	(C x D + G x H) / (D + H)
	Outpatient Managed Care Discount Development									
	Mental Health				Chemical Dependency				Blended Assumption	
BHO	Provider Contracting Arrangement	Managed Care Discount	Portion of Payments based on Arrangement	SFY 2017 Medical Capitation Revenue	Provider Contracting Arrangement	Managed Care Discount	Portion of Payments based on Arrangement	SFY 2017 Medical Capitation Revenue	Managed Care Discount	Portion of Payments based on Arrangement
North Central	25% FFS 75% Sub-Capitation	49%	90%	$ 11,061,696	Sub-Capitation	60%	90%	$ 2,912,240	51%	90%
Greater Columbia	Sub-Capitation	60%	90%	$ 41,073,800	FFS	15%	90%	$ 12,812,166	49%	90%
King	FFS	15%	90%	$ 107,398,445	FFS	15%	90%	$ 34,855,760	15%	90%
North Sound	FFS	15%	90%	$ 49,164,633	FFS	15%	90%	$ 23,399,059	15%	90%
Salish	Sub-capitation	60%	90%	$ 16,403,092	FFS	15%	90%	$ 8,347,301	45%	90%
Pierce	FFS	15%	90%	$ 34,350,707	FFS	15%	90%	$ 16,489,127	15%	90%
Southwest	FFS	15%	90%	$ 29,286,926	FFS	15%	90%	$ 7,516,460	15%	90%
Spokane	85% FFS 15% Sub-Capitation	22%	90%	$ 45,489,675	FFS	15%	90%	$ 15,883,976	20%	90%
Thurston Mason	FFS	15%	60%	$ 17,415,370	FFS	15%	88%	$ 7,052,426	15%	68%
Great Rivers[1]	Sub-Capitation	49%	90%	$ 24,548,937	FFS	15%	90%	$ 10,894,778	39%	90%

[1]Reflects a blend of sub-capitation assumptions for Grays Harbor and Timberlands and a FFS assumption for Cowlitz County from Southwest.

	Managed Care Discount			
BHO	Inpatient	E&T	Outpatient	Total
North Central	$ 21,000	$ 40,902	$ 963,889	$ 1,025,792
Greater Columbia	$ 73,283	$ 267,275	$ 2,621,277	$ 2,961,836
King	$ 460,256	$ 514,737	$ 1,863,524	$ 2,838,517
North Sound	$ 179,547	$ 377,839	$ 1,013,822	$ 1,571,208
Salish	$ 17,163	$ 584,895	$ 1,300,523	$ 1,902,581
Pierce	$ 41,325	$ 520,153	$ 732,718	$ 1,294,196
Southwest	$ 66,485	$ 123,077	$ 602,502	$ 792,063
Spokane	$ 152,829	$ 204,268	$ 1,189,640	$ 1,546,736
Thurston Mason	$ 49,987	$ 188,506	$ 328,431	$ 566,924
Great Rivers	$ 46,084	$ 114,004	$ 1,530,785	$ 1,690,873
Total	**$ 1,107,959**	**$ 2,935,656**	**$ 12,147,110**	**$ 16,190,725**

		100% RBC (200% ACL)				200% RBC (400% ACL)			
BHO	Projected SFY 2017 Revenue	Gross RBC	Managed Care Discount	Net RBC (100%)	Percent of Cap	Gross RBC	Managed Care Discount	Net RBC (200%)	Percent of Cap
North Central	$ 19,456,469	$ 2,539,069	$ 1,025,792	$ 1,513,278	7.8%	$ 2,539,069	$ 1,025,792	$ 3,026,555	15.6%
Greater Columbia	$ 85,843,562	$ 8,376,069	$ 2,961,836	$ 5,414,234	6.3%	$ 8,376,069	$ 2,961,836	$ 10,828,467	12.6%
King	$ 227,987,189	$ 20,685,122	$ 2,838,517	$ 17,846,605	7.8%	$ 20,685,122	$ 2,838,517	$ 35,693,210	15.7%
North Sound	$ 122,168,284	$ 11,505,582	$ 1,571,208	$ 9,934,374	8.1%	$ 11,505,582	$ 1,571,208	$ 19,868,748	16.3%
Salish	$ 42,106,093	$ 4,853,750	$ 1,902,581	$ 2,951,170	7.0%	$ 4,853,750	$ 1,902,581	$ 5,902,339	14.0%
Pierce	$ 98,364,204	$ 9,556,028	$ 1,294,196	$ 8,261,832	8.4%	$ 9,556,028	$ 1,294,196	$ 16,523,664	16.8%
Southwest	$ 53,012,691	$ 5,817,884	$ 792,063	$ 5,025,821	9.5%	$ 5,817,884	$ 792,063	$ 10,051,642	19.0%
Spokane	$ 95,381,485	$ 9,140,057	$ 1,546,736	$ 7,593,320	8.0%	$ 9,140,057	$ 1,546,736	$ 15,186,641	15.9%
Thurston Mason	$ 39,538,897	$ 4,756,028	$ 566,924	$ 4,189,104	10.6%	$ 4,756,028	$ 566,924	$ 8,378,209	21.2%
Great Rivers	$ 50,302,008	$ 5,529,191	$ 1,690,873	$ 3,838,318	7.6%	$ 5,529,191	$ 1,690,873	$ 7,676,636	15.3%
Total	**$ 834,160,881**	**$ 82,758,781**	**$ 16,190,725**	**$ 66,568,056**	**8.0%**	**$ 82,758,781**	**$ 16,190,725**	**$ 133,136,112**	**16.0%**

Appendix A: BHO Reserve Requirements

Medicaid IP and Operating Reserves

A	B	C	D	E	F	G	H	I	J	K
									A x E	MAX(5%,(C x (1-I) x H) + (B x (1-G) x F))

April 1, 2016 - June 30, 2017 Mental Health/Chemical Dependency Service

BHO	Cost as Percent of Total PMPM				Assumptions						Resulting Inpatient and Operating Reserves	
						E&T		Outpatient				
	Inpatient	*E&T (including Residential)*	*Outpatient*	*Administrative*	*Inpatient IBNR*	*IBNR*	*Sub-Capitation Assumption*[1]	*IBNR*	*Sub-Capitation Assumption*[1]		*Inpatient*	*Operating*[2]
North Central	4.9%	10.4%	71.6%	13.0%	25%	15%	0%	15%	72%		1.2%	5.0%
Greater Columbia	5.2%	21.0%	62.8%	11.0%	25%	15%	0%	15%	69%		1.3%	6.1%
King	13.9%	17.2%	62.4%	6.5%	25%	15%	0%	15%	0%		3.5%	11.9%
North Sound	9.6%	21.4%	60.0%	9.0%	25%	15%	0%	15%	0%		2.4%	12.2%
Salish	2.1%	27.6%	56.8%	11.5%	25%	15%	66%	15%	60%		0.5%	5.4%
Pierce	2.6%	36.7%	51.7%	9.0%	25%	15%	0%	15%	0%		0.7%	13.3%
Southwest	6.9%	14.2%	69.4%	9.5%	25%	15%	0%	15%	0%		1.7%	12.5%
Spokane	9.9%	14.7%	64.3%	11.0%	25%	15%	0%	15%	10%		2.5%	10.9%
Thurston Mason	6.4%	23.2%	61.9%	8.5%	25%	15%	15%	15%	0%		1.6%	12.2%
Great Rivers	4.9%	13.8%	70.5%	11.0%	25%	15%	0%	15%	46%		1.2%	7.6%
Total	**8.4%**	**20.5%**	**62.0%**	**9.1%**	**25%**	**15%**		**15%**			**2.1%**	**10.8%**

[1]Reflects the portion of Mental Health and Chemical Dependency E&T (including Residential) and Outpatient claims subject to claims runout based on review of BHO provided information and information reported in the R&Es. For example, an assumption of 90% indicates that 90% of claims are not subject to claims runout and, as such, only 10% of claims are considered in the development of the reserve level.
[2]Due to the potential for variation in provider contracting arrangements, Mercer applied a minimum Operating (E&T and Outpatient combined) reserve requirement of 5% for all BHOs.

Final Medicaid Inpatient, Operating and Risk Reserves

BHO	Risk Reserve		Inpatient Reserve	Operating Reserve	Total Reserve	
	100% RBC/200% ACL)	*200% RBC (400% ACL)*			*100% RBC/200% ACL)*	*200% RBC (400% ACL)*
North Central	7.8%	15.6%	1.2%	5.0%	14.0%	21.8%
Greater Columbia	6.3%	12.6%	1.3%	6.1%	13.7%	20.0%
King	7.6%	15.7%	3.5%	11.9%	23.2%	31.1%
North Sound	8.1%	16.3%	2.4%	12.2%	22.7%	30.9%
Salish	7.0%	14.0%	0.5%	5.4%	12.9%	19.9%
Pierce	8.4%	16.8%	0.7%	13.3%	22.5%	30.7%
Southwest	9.5%	19.0%	1.7%	12.5%	23.7%	33.2%
Spokane	8.0%	15.9%	2.5%	10.9%	21.3%	29.3%
Thurston Mason	10.6%	21.2%	1.6%	12.2%	24.4%	35.0%
Great Rivers	7.6%	15.3%	1.2%	7.6%	16.4%	24.1%
Total	**8.0%**	**16.0%**	**2.1%**	**10.8%**	**20.5%**	**28.5%**

Appendix A: BHO Reserve Requirements

2016 Mercer Non-Medicaid Reserves Analysis

Non-Medicaid Risk Reserve

BHO	Non-Medicaid Service Cost Subject to Risk Reserve[1]	Total Non-Medicaid Costs	Portion of Non-Medicaid Costs Subject to Risk Reserve
North Central	$ 1,458,679	$ 3,197,103	45.6%
Greater Columbia	$ 5,109,815	$ 12,607,906	40.5%
King	$ 18,407,741	$ 32,782,981	56.2%
North Sound	$ 7,447,814	$ 17,342,140	42.9%
Salish	$ 958,064	$ 6,102,164	15.7%
Pierce	$ 4,261,968	$ 14,945,452	28.5%
Southwest	$ 1,721,559	$ 7,908,957	21.8%
Spokane	$ 5,089,423	$ 14,146,038	36.0%
Thurston Mason	$ 1,968,782	$ 8,241,350	23.9%
Great Rivers	$ 1,179,975	$ 3,420,405	34.5%
Total	**$ 47,603,820**	**$ 120,694,497**	**39.4%**

[1]Includes Crisis, Inpatient and Involuntary Treatment Act (ITA) service costs.

BHO	Medicaid RBC Reserves		Non-Medicaid Portion of Service Cost Subject to Risk Reserve	Non-Medicaid RBC Reserves	
	100% RBC (200% ACL)	*200% RBC (400% ACL)*		*100% RBC (200% ACL)*	*200% RBC (400% ACL)*
North Central	7.8%	15.6%	45.6%	3.5%	7.1%
Greater Columbia	6.3%	12.6%	40.5%	2.8%	5.1%
King	7.8%	15.7%	56.2%	4.4%	8.8%
North Sound	8.1%	16.3%	42.9%	3.5%	7.0%
Salish	7.0%	14.0%	15.7%	1.1%	2.2%
Pierce	8.4%	16.8%	28.5%	2.4%	4.8%
Southwest	9.5%	19.0%	21.8%	2.1%	4.1%
Spokane	8.0%	15.9%	36.0%	2.9%	5.7%
Thurston Mason	10.6%	21.2%	23.9%	2.5%	5.1%
Great Rivers	7.6%	15.3%	34.5%	2.6%	5.3%
Total	**8.0%**	**16.0%**	**39.4%**	**3.1%**	**6.3%**

Non-Medicaid IP and Operating Reserves

	A	B	C	D	E	F	G	H	I	J	K
										A x E	MAX(5%,(C x (1-I) x H) + (B x (1-G) x F))
	SFY 2015 Non-Medicaid R&E Service Cost as Percent of Total				Assumptions					Resulting Inpatient and Operating Non-Medicaid Reserves	
						E&T		Outpatient			
BHO	*Inpatient*	*E&T (including Residential)*	*Outpatient*	*Administrative*	*Inpatient IBNR*	*IBNR*	*Sub-Capitation Assumption*[1]	*IBNR*	*Sub-Capitation Assumption*[1]	*Inpatient*	*Operating*
North Central	8.9%	21.9%	60.3%	8.9%	25%	15%	0%	15%	72%	2.2%	5.8%
Greater Columbia	5.5%	36.4%	56.4%	1.7%	25%	15%	0%	15%	69%	1.4%	8.1%
King	23.6%	36.6%	34.1%	5.7%	25%	15%	0%	15%	0%	5.9%	10.6%
North Sound	9.0%	30.5%	58.2%	2.3%	25%	15%	0%	15%	0%	2.3%	13.3%
Salish	4.2%	26.4%	66.1%	3.3%	25%	15%	56%	15%	60%	1.0%	5.8%
Pierce	3.2%	36.0%	51.1%	9.7%	25%	15%	0%	15%	0%	0.8%	13.1%
Southwest	3.1%	21.4%	61.2%	14.4%	25%	15%	0%	15%	0%	0.8%	12.4%
Spokane	3.6%	39.6%	54.9%	1.9%	25%	15%	0%	15%	10%	0.9%	13.3%
Thurston Mason	1.5%	53.1%	39.5%	5.9%	25%	15%	15%	15%	0%	0.4%	12.7%
Great Rivers	20.6%	12.2%	61.0%	6.3%	25%	15%	0%	15%	48%	5.1%	6.6%
Total	**10.4%**	**34.5%**	**49.6%**	**5.4%**	**25%**	**15%**		**15%**		**2.6%**	**11.0%**

[1]Reflects the portion of E&T (including Residential) and Outpatient claims subject to claims runout based on review of BHO provided information and information reported in the R&Es. For example, an assumption of 90% indicates that 90% of claims are not subject to claims runout and, as such, only 10% of claims are considered in the development of the reserve level.

Final Non-Medicaid Inpatient, Operating and Risk Reserves

BHO	Risk Reserve		Inpatient Reserve	Operating Reserve	Total Reserve	
	100% RBC (200% ACL)	*200% RBC (400% ACL)*			*100% RBC (200% ACL)*	*200% RBC (400% ACL)*
North Central	3.5%	7.1%	2.2%	5.8%	11.6%	15.1%
Greater Columbia	2.8%	5.1%	1.4%	8.1%	12.1%	14.8%
King	4.4%	8.8%	5.9%	10.6%	20.9%	25.3%
North Sound	3.5%	7.0%	2.3%	13.3%	18.1%	22.6%
Salish	1.1%	2.2%	1.0%	5.8%	7.9%	9.0%
Pierce	2.4%	4.8%	0.8%	13.1%	16.3%	18.7%
Southwest	2.1%	4.1%	0.8%	12.4%	15.2%	17.3%
Spokane	2.9%	5.7%	0.9%	13.3%	17.1%	20.0%
Thurston Mason	2.5%	5.1%	0.4%	12.7%	15.6%	18.1%
Great Rivers	2.6%	5.3%	5.1%	6.6%	14.4%	17.0%
Total	**3.1%**	**6.3%**	**2.6%**	**11.0%**	**16.7%**	**19.9%**

Appendix B: Encumbrance Guidance

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ENCUMBRANCE RESERVE FUNDS

Background

Mercer was contracted by the State of Washington (State) to provide information regarding the use of encumbrance reserve funds in other state programs. This information will be used by the State in determining appropriate uses for encumbrance reserve funds currently held by regional support networks (RSNs). Encumbrance reserves are allowed per the current (RSN) contract and provide an assurance of solvency for the RSNs. Certain levels of unobligated funds are necessary for growth, start-up initiatives, replenishing capital assets and for services not normally covered by Medicaid.

Per the current Revenue and Expenditures Report Instructions provided by the State, the use of encumbrance reserve funds includes the following limitations.

Use encumbrance reserve:

- At year end if prior year appropriation authority is being carried forward to pay for a future service
- For estimated and/or known litigation amounts
- Unspent proviso funds expected to be recovered by the Division of Behavioral Health and Recovery

Do not use encumbrance reserve:

- If service has been provided and not yet paid for — this is considered an accrual
- For routine contracts — this amount is expected to be paid from current revenue
- For contracts to be paid from future revenues

State/Regulatory Environment

Under managed care, encumbrance reserve funds are primarily the result of lower than projected medical and administrative expenses when compared to capitation funding. Some states limit excess capitation through the use of risk corridors, such as Minnesota in 2010 and 2011 capping managed care organization profit on Medicaid at 1% of capitation revenue. Other states, such as Pennsylvania, require profit greater than 3% of capitation to be paid back to the state (and subsequently the Centers for Medicare and Medicaid Services (CMS)).

There are no federal regulations restricting the use of Medicaid managed care profit. As the RSNs are a third-party subcontractor to the federal government, they are not subject to limitations outlined in OMB Circular A-87, A-122 or A-133 as those regulations only apply to the Medicaid agency receiving the Federal funds directly. Funds designated to the encumbrance reserve can only be restricted through contractual obligations.

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Appendix B: Encumbrance Guidance

Funding Medical Expenses

Since states are required to pay actuarially sound capitation rates and the capitation includes both state and federal funds, the use of the encumbrance is not allowed as a source of paying Medical expenses when calculating capitation rates. Encumbrance reserve funds should only be used to pay for medical expenses covered by Medicaid, or for administrative expenses expended in the normal course of business after capitation funding, the risk reserve, the Inpatient reserve and any medical expense accruals are exhausted. The fund should not be used for payment of covered Medical services that were provided but not paid. The RSN should have accrued those expenses using an incurred but not reported (IBNR) fund. The encumbrance fund should not be used for routine contracts for providing or supporting Medicaid-covered medical expenses, or to prepay for future expenses. These types of expenses are included in capitation rates and costs incurred are built into the rate-setting process.

Certain financing arrangements (for example, the use of intergovernmental transfers (IGTs) can further limit the use of encumbrance reserve funds. First, only those RSNs that qualify as a unit of government could provide IGTs to the State. CMS policy is that providers must retain the total computable payment and the State may not require any portion of a payment be returned to the State. Additionally, if these funds are restricted for specific uses other than funding Medicaid payments (such as future payments or statutory reserves) they would not be considered available as government funding for Medicaid payments.

Acceptable Uses

An encumbrance should be reserved to cover one-time or rare cash expenditures, such as litigation, purchases of real property or purchases of depreciable expenses, such as system upgrades, when cash outlays exceed amounts included as depreciation in the rate-setting process. Funds may also be used to cover new initiatives or services not covered by Medicaid, or to enhance quality or access to care. The following list of acceptable expenditures is not exhaustive, but should be a reasonable indicator of allowable uses for encumbrance reserve funds.

Capitation Shortfalls

Capitation shortfalls are typically due to high utilization or high expenses due to unanticipated rises in pricing or cost. If medical expenses exceed capitation, risk reserve or Inpatient reserve funds due to an unforeseen event, such as an epidemic or steep rises in pricing, encumbrance reserves may be redirected to cover shortfalls in IBNR on an annual basis.

Litigation and Non-Operating Expenditures

Expenses incurred for litigation should be rare or one-time expenditures, and therefore would not be built into the rate-setting process or covered through normal capitation. Non-operating expenses, such as the cost of moving an office or costs to shut down an operation, are also excluded from the rate-setting process, but may be necessary to increase the efficiency or effectiveness of an RSN operation.

Appendix B: Encumbrance Guidance

Real Property and Depreciable Assets
Buildings, leasehold improvements, equipment, furniture and other capital assets are expenditures necessary for sustaining the RSN, but are only allowed as depreciation in the rate-setting process. Expenditures for real property and depreciable assets should be used for efficient and effective administration of Medicaid through sound business practices. System conversion or development costs intended to maintain or improve the efficiency of the RSN are allowable to the extent they are capitalized. Repairs to existing equipment or capital assets are allowable if they are capitalized and exceed $5,000 or the amount established by the Internal Revenue Service.

New (Start-Up) Initiatives or Closeout Initiatives
While organization costs require prior approval from the State and CMS, outreach programs used to establish new initiatives that improve the quality of care or access to care for Medicaid recipients are allowable to the extent they are not normally expensed as administrative costs. For example, the first and last year that an RSN operates to manage Medicaid recipients, costs may be higher due to start-up or closeout of program activities and staff. The costs that exceed normal operating costs should be excluded from the rate-setting process, and are therefore acceptable as expenditures from encumbrance reserve funds.

Enhanced Services
Excess encumbrances may be used to fund additional services to Medicaid enrollees beyond those covered under the Medicaid contract. These expenditures are not considered in subsequent Medicaid rate periods, which may lead to a natural reduction in the reserve levels over time.

Conclusion
Expenditures from the encumbrance reserve fund should be utilized timely and appropriately to ensure RSNs are able to maintain or improve access to care and the quality of care provided to eligible Medicaid recipients. Expenditures must follow acceptable use guidelines from both state and federal statutes. Expenditures should be legal, necessary, reasonable, allocable to Medicaid and not funded through other means, including capitation or other programs, including federal grants or state-funded services. They are generally one-time or rare expenditures or used to build or buy depreciable assets or real property that should enhance quality and access to care for Medicaid recipients. Expenditures from encumbrance reserve funds of governmental managed care plans have drawn increased attention and federal concern about profit and reserve expenditures. The level of accountability for these expenditures will be higher.

If there are any questions, please contact Scott Banken at 612 642 8722 or Brad Diaz at 612 642 8756.

Sincerely,

Scott Banken, CPA
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