Acute Care Updated Actuarial Memorandum for CYE 2015

I. Purpose

This memorandum presents a discussion of the revision to the already approved Contract Year Ending 2015 (CYE 15) Acute Care capitation rates. Please see Attachment A for the actuarial memorandum and other supplemental information for the already-approved Acute Care capitation rates which detail the original rate build up.

This update to the capitation rates is required as a result of a new contract mandate requiring Contractors to pay the all-inclusive per visit Prospective Payment System (PPS) rates for Federally Qualified Health Centers/Rural Health Clinics (FQHCs/RHCs) and clarification of responsible party payer when both physical and behavioral health services are included on the same inpatient claim.

The purpose of this actuarial memorandum is to demonstrate that the updated capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

II. Overview of Changes

Under federal law, the Arizona Health Care Cost Containment System (AHCCCS) is required to reimburse FQHCs and RHCs all-inclusive per visit PPS rates for FQHC/RHC services. Historically, this has been accomplished by a combination of Contractor and AHCCCS Administration fee-for-service claims' payments, quarterly supplemental payments made by the Administration, and an annual reconciliation also performed by the Administration to the PPS rate. Effective April 1, 2015, AHCCCS and its Contractors will begin reimbursing FQHCs and RHCs at the all-inclusive per visit rates on a per claim basis.

AHCCCS has proposed a rulemaking and is updating existing policy to clarify an issue that has been identified through the administrative hearing process regarding Contractor responsibility for covering inpatient hospital services when both medical and behavioral health services are provided during the same hospital stay. Both the rule and policy amendment clarify that the Contractor responsible for the provision of behavioral health services is responsible for payment of all inpatient hospital services if the principal diagnosis on the hospital claim is a behavioral health diagnosis. Hospital claims that do not have a behavioral health diagnosis as the principal diagnosis will be paid by the Contractor responsible for the provision of acute care services.

III. Methodology for Calculating Capitation Adjustments

FQHC/RHC All-Inclusive PPS Rates

AHCCCS will shift payment responsibility for FQHC/RHC PPS rates to the Contractors in order to properly account for FQHC/RHC expenditures for managed care enrollees. To identify the amount of full-funding needed for Contractors to pay the PPS rates on a per visit basis, it was necessary to identify the historical FQHC/RHC visits in order to distribute the quarterly supplemental and annual reconciliation payments made by the Administration.

The historical encounter data for FQHC/RHC expenditures was paid on a per service basis while the new mandate requires payment on a per visit basis, thus AHCCCS had to group the encounter service data to represent visits. A visit is defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

The visits from the historical encounter data were then used to develop the distribution of FQHC/RHC utilization by AHCCCS line of business (or program), Geographical Service Area (GSA) and risk group. Capitation rates were increased by the amount of the quarterly supplemental and annual reconciliation payments made by the Administration for managed care program visits, trended forward to federal fiscal year 2015. The trended Administration payment amounts were then multiplied by the visit distribution percentages by FQHC/RHC to determine the impact by program, GSA and risk group.

Additional adjustments were made to the data due to:

- The introduction of three new FQHCs/RHCs - historical encounter data is available since these providers were in place during the data period, but they did not have historical supplemental or reconciliation payments since they were not designated as FQHCs/RHCs until after the data period
- The integration of services in the Children Rehabilitative Services (CRS) program
- The integration of services for members with Serious Mental Illness (SMI) in Maricopa County
- The addition of Adults > 106% because this risk group was not in place during the data period
- Outlier utilization data for one contractor unrelated to data accuracy

The adjustments made to account for each of these unique situations are described below:

- The adjustment for the new FQHCs/RHCs involved projecting the reconciliation and quarterly supplemental payments from historical visits multiplied by the PPS rates and subtracting historical encounter payments
- The two integration models necessitated a reassignment of historical encounter and member month data for members moved to the integrated programs
- The computation of the Adults > 106% FPL impact followed the same process as building the Adults > 106% FPL base capitation rate, which involved taking the weights assumed in the Adults > 106% FPL capitation rates and multiplying those weights by the respective FQHC/RHC per member per month (PMPM) add-in impact
- A budget neutral adjustment was made in the GSA where one Contractor qualified as an outlier based on FQHC/RHC utilization data

The estimated impact of shifting payment responsibility from the Administration to the Contractors across all AHCCCS lines of business combined is budget neutral, but the estimated six month impact to the Acute program is an increase of approximately $69.8 million.

Physical Health/Behavioral Health Payment Responsibility
AHCCCS policy dictates that the principal diagnosis on an inpatient hospital claim determines the appropriate party payer: a claim with a physical health principal diagnosis code is paid by the Acute Care Contractor, and a claim with a behavioral health principal diagnosis code is paid by the Behavioral Health Contractor (the Regional Behavioral Health Authority – RBHA). Under certain circumstances however, when both physical and behavioral health services were provided during the same inpatient stay, Acute Care Contractors sometimes paid claims even when the principal diagnoses were for behavioral health.

AHCCCS policy and administrative rule are currently being amended to emphasize that inpatient hospital claims' payments shall be based on the principal diagnosis, even when both physical and behavioral services are found on the claim. For this reason, funding included in the Acute Care capitation rates, based on historical inpatient hospital expenditures for claims with principal behavioral health diagnoses, must be removed from the rates and added to the RBHA capitation rates. AHCCCS used FFY 13 encounter and member month data for Acute Care Contractors to determine the amount to shift. This was done at a GSA and risk group level.

Additional adjustments were made to the data due to:

- The rates that RBHAs will pay versus the rates that Acute Care Contractors pay
- The integration of services in the CRS program
- The integration of services for members with SMI in Maricopa County
- The addition of Adults > 106% because this risk group was not in place during the data period

The adjustments made to account for each of these unique situations are described below:

- For rate differences between RBHAs and Acute Care Contractors, historical visits were re-priced at the appropriate payment rates to determine the amount to add into the RBHA capitation rates
- The two integration models necessitated a reassignment of historical encounter and member month data for members moved to the integrated programs
- The computation of the Adults > 106% FPL impact followed the same process as building the Adults > 106% FPL base capitation rate, which involved taking the weights assumed in the Adults > 106% FPL capitation rates and multiplying those weights by the respective behavioral health/physical health PMPM impact

The estimated six month impact to the Acute program is a decrease of approximately $3.2 million.

IV. Proposed Revised Capitation Rates and Their Impacts

Table I below summarizes the changes from the current approved CYE 15 capitation rates and the estimated budget impact, effective for the period April 1, 2015 through September 30, 2015 on a statewide basis. The impact to Contractors ranges from 0.8% to 5.1%. Individual Contractor capitation rates will be impacted as shown in Section B of the Contracts.

Table I. Statewide Budget Impact

	Risk Group	Projected CYE 15 MMs (04/01/15 - 09/30/15) [1]	Current Cap Rate based on Proj CYE 15 MMs [3]	Total Dollars Current CYE 15 Cap Rates	Upd CYE 15 Cap Rate based on Proj CYE 15 MMs [3]	Total Dollars Upd CYE 15 Cap Rates	Difference Upd CYE 15 Dollars and Current CYE 15 Dollars	% Increase Upd CYE 15 over Current CYE 15
TXIX								
	Prospective							
	TANF < 1 [2]	284,414	$ 479.97	$ 136,510,560	$ 506.32	$ 144,004,330	$ 7,493,770	5.5%
	TANF 1-13 [2]	2,661,649	$ 102.78	$ 273,559,070	$ 110.19	$ 293,278,542	$ 19,719,472	7.2%
	TANF 14-44F [2]	1,422,663	$ 241.27	$ 343,241,552	$ 249.34	$ 354,730,557	$ 11,489,005	3.3%
	TANF 14-44M [2]	704,823	$ 151.89	$ 107,054,628	$ 156.88	$ 110,574,448	$ 3,519,820	3.3%
	TANF 45+ [2]	270,329	$ 405.87	$ 109,719,503	$ 417.42	$ 112,841,249	$ 3,121,746	2.8%
	SSI w/ Medicare	524,223	$ 142.43	$ 74,665,726	$ 151.81	$ 79,583,950	$ 4,918,224	6.6%
	SSI w/o Medicare	339,945	$ 802.43	$ 272,782,192	$ 813.84	$ 276,659,890	$ 3,877,698	1.4%
	Adults < 106% of FPL	1,531,816	$ 411.84	$ 630,869,707	$ 419.82	$ 643,082,515	$ 12,212,808	1.9%
	Adults > 106% of FPL	270,699	$ 303.32	$ 82,107,075	$ 310.98	$ 84,181,508	$ 2,074,433	2.5%
	Delivery Supplemental Payment	17,385	$ 6,079.39	$ 105,689,130	$ 6,079.39	$ 105,689,130	$ -	0.0%
	Total Prospective TXIX	8,027,947		$ 2,136,199,143		$ 2,204,626,118	$ 68,426,975	3.2%
	PPC							
	TANF < 1 [2]	5,993	$ 1,121.09	$ 6,718,497	$ 1,128.50	$ 6,762,922	$ 44,426	0.7%
	TANF 1-13 [2]	90,472	$ 59.36	$ 5,370,777	$ 60.42	$ 5,466,622	$ 95,845	1.8%
	TANF 14-44F [2]	71,132	$ 199.67	$ 14,202,799	$ 200.96	$ 14,294,554	$ 91,755	0.6%
	TANF 14-44M [2]	34,073	$ 166.39	$ 5,669,295	$ 166.30	$ 5,666,255	$ (3,040)	-0.1%
	TANF 45+ [2]	18,570	$ 421.90	$ 7,834,733	$ 423.22	$ 7,859,281	$ 24,548	0.3%
	SSI w/ Medicare	12,400	$ 92.10	$ 1,142,071	$ 93.34	$ 1,157,484	$ 15,413	1.3%
	SSI w/o Medicare	16,846	$ 506.38	$ 8,530,413	$ 505.10	$ 8,508,942	$ (21,471)	-0.3%
	Adults < 106% of FPL	153,182	$ 667.13	$ 102,192,330	$ 666.48	$ 102,092,897	$ (99,433)	-0.1%
	Adults > 106% of FPL	27,070	$ 332.36	$ 8,997,032	$ 332.76	$ 9,007,785	$ 10,753	0.1%
	Total PPC TXIX	429,738		$ 160,657,947		$ 160,816,743	$ 158,796	0.1%
	Total Title XIX	8,457,685		$ 2,296,857,090		$ 2,365,442,861	$ 68,585,771	3.0%
TXXI								
	Kidscare <1	79	$ 479.97	$ 38,103	$ 506.32	$ 40,195	$ 2,092	5.5%
	Kidscare 1-13	5,816	$ 102.78	$ 597,796	$ 110.19	$ 640,888	$ 43,092	7.2%
	Kidscare 14-18 F	2,382	$ 241.27	$ 574,600	$ 249.34	$ 593,833	$ 19,233	3.3%
	Kidscare 14-18 M	2,170	$ 151.89	$ 329,575	$ 156.88	$ 340,411	$ 10,836	3.3%
	Total TXXI	10,447		$ 1,540,074		$ 1,615,327	$ 75,253	4.9%
State Only								
	Transplants	24	$ 16.50	$ 396	$ 16.50	$ 396	$ -	0.0%
Grand Total Capitation				**$ 2,298,397,560**		**$ 2,367,058,584**	**$ 68,661,023**	3.0%

Notes

[1] Population estimates for CYE 15 are taken from Davison of Budget and Finance (DBF) projections.

[2] TANF rate cells include SOBRA and Child Expansion groups. Child Expansion are only for those children ages 6-18.

[3] Reinsurance levels are at a $25,000 deductible level.

V. Actuarial Certification of the Capitation Rates

I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The capitation rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The capitation rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The capitation rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The capitation rates may not be appropriate for any other purpose. The documentation has been included with this certification. The proposed actuarially sound capitation rates that are associated with this certification are effective for the six-month period beginning April 1, 2015.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the Contractors and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the health plan auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations and analyses promulgated from time-to-time through the Actuarial Standards of Practice by the Actuarial Standards Board.

This certification letter assumes the reader is familiar with the Acute Care program, Medicare and Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS 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.

SIGNATURE ON FILE	*02/12/2015*
Windy J. Marks	Date

Fellow of the Society of Actuaries
Member, American Academy of Actuaries

ATTACHMENT A

Acute Care Actuarial Memorandum

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Acute Care capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

Arizona Health Cost Containment System (AHCCCS) intends to update these capitation rates for January 1, 2015 to include changes in cost sharing and a shift in payment responsibility for services provided at Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as well as any other necessary changes.

AHCCCS will be applying revised risk adjustment factors with an anticipated implementation date of April 1, 2015 retroactive to October 1, 2014. This adjustment will be budget neutral to AHCCCS and will also require a rate update.

The Affordable Care Act (ACA) places an annual fee on the health insurance industry nationwide including most Medicaid health plans effective January 1, 2014. The fee will be allocated to health insurers based on their respective market share of premium revenue in the previous year. Due to the uncertainty of the actual fees and other unknowns, AHCCCS will not be adjusting the capitation rates for this fee at this time, but intends to make retroactive capitation rate revision once the impacts are known.

II. Overview of Rate Setting Methodology

Contract year ending 2015 (CYE 15) capitation rates were developed as a rate update from the previously approved contract year ending 2014 (CYE 14) capitation rates. The CYE 15 capitation rates represent the twelve month contract period from October 1, 2014 through September 30, 2015.

The Acute Care capitation rates were developed from historical Acute Care data primarily using Arizona Medicaid managed care encounter data (via an extract that provides utilization and cost data, referred to as the "databook"). Other data sources include Contractors' financial statements, programmatic changes, anticipated AHCCCS Fee-For-Service (FFS) rate changes, anticipated Arizona Department of Health Services (ADHS) transportation increases, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information.

The contract between AHCCCS and the Contractors specifies that the Contractors may cover additional services not covered by Medicaid. All non-covered services were removed from the databook and excluded from rate development.

Trend rates were calculated from the databook and other sources on a unit cost and/or utilization basis by category of service (COS) and a cap was applied to limit the negative and positive trends to a reasonable level. Unit cost trends were further refined by actual changes in AHCCCS FFS provider rates. These adjustments also include state mandates, court ordered programs and other programmatic changes, if necessary. For more information on trends see Section III Projected Trend Adjustments.

The Acute Care program has a large membership base, which allows for the experience data to be analyzed by different rate cells. These rate cells are comprised of members with similar risk characteristics. The rate cells were analyzed by major categories of aid (COA), i.e. risk groups, and COS. In addition, AHCCCS develops capitation rates by Geographic Service Area (GSA).

The experience data includes only Acute Care Medicaid eligible expenses for Acute Care Medicaid eligible individuals, as well as reinsurance amounts. The Adults Group above 106% Federal Poverty Level (Adults > 106%) capitation rates are reconciled to a maximum 1% profit or loss. The Prior Period Coverage (PPC) capitation rates, excluding Adults > 106%, are reconciled to a maximum 2% profit or loss. The prospective risk group capitation rates, excluding Adults > 106%, are reconciled based on a tiered methodology (see Section XVI CMS Rate Setting Checklist for additional information). Additional payments are made for members giving birth via a Delivery Supplemental Payment.

The general process in developing the capitation rates involves trending the CYE 14 capitation rates to the midpoint of the effective period, which is April 1, 2015. The next step involves applying programmatic changes which creates the CYE 15 medical per member per month (PMPM) rate from which the reinsurance offsets are deducted. Following this calculation, the projected administrative expenses, risk/contingency margin and premium tax are added to the projected claim PMPMs to obtain the capitation rates. The payment reform initiative (PRI) will continue for CYE 15; however instead of withholding 1% of the Contractors' capitation rate, AHCCCS will perform a reconciliation to distribute the Contractors' earned contribution. Each step is described in the sections below.

In addition there are sections dedicated to the development of other capitation rates including, but not limited to, Delivery Supplemental Payment and PPC capitation rates.

III. Projected Trend Adjustments

The trend analysis used historical yearly encounter data for the time period from October 1, 2010 through September 30, 2013. The data was reviewed for accuracy, timeliness and completeness through encounter validation studies as well as studies comparing the encounter data to the Contractors' financial statements. The encounter

data was adjusted to include, but not limited to, the following: completion factors, historical programmatic changes and historical AHCCCS FFS provider rate changes.

Historical trend rates were developed from the adjusted encounter data. These trends were developed by major COA and COS, with a cap on the percentage increase and decrease to smooth out exceptional trends. Once these trends were developed they were analyzed by comparing the results to Contractor financial statements and data and trends in the marketplace such as NHEs.

Effective October 1, 2014, AHCCCS is changing FFS provider rates for certain providers based either on access to care needs, Medicare or ADHS fee schedule rates, and/or legislative mandates. The unit cost (inflation) trends were adjusted appropriately for these changes. The estimated impact is an increase of approximately $2.9 million.

The utilization and unit cost trend rates used in projecting the claim costs are summarized in Appendix I. The prospective PMPM trends are shown below in Table I. These trends do not reflect the impact of any programmatic changes or AHCCCS FFS provider rate changes.

Table I: Prospective Average Annual PMPM Trends

	PMPM Trends					
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Adults </= 106%	Adults > 106%	Total
Hospital Inpatient	0.3%	0.1%	0.0%	0.0%	0.3%	0.1%
Outpatient Facility	8.6%	6.9%	9.3%	9.4%	9.5%	8.9%
Emergency Room	3.8%	6.5%	5.5%	-2.6%	1.5%	2.2%
Physician	3.4%	-6.6%	3.7%	-0.8%	1.2%	1.8%
Other Professional	8.2%	-1.6%	4.6%	4.2%	6.9%	6.4%
Pharmacy	2.3%	4.8%	1.7%	9.9%	5.9%	5.0%
Other	-3.2%	-6.3%	-2.3%	-2.2%	-2.6%	-3.0%

IV. State Mandates, Court Ordered Programs, Programmatic Changes and Other Changes

Prior Program Changes

Several program changes (dental homes, dental varnish and physical therapy benefits to get and keep a level of function) were described in the prior approved Acute Actuarial Certification dated March 11, 2014. At the time of the certification the capitation rates were not adjusted for these program changes and it was noted that AHCCCS would monitor utilization and ramp-up of these initiatives with a possible adjustment to future capitation rates. AHCCCS is now adjusting the capitation rates

for these program changes. The estimated impact to the Acute Care program is an increase of approximately $2.2 million.

Newborn Screening
Effective April 1, 2014, per Arizona Revised Statutes (A.R.S.) §41-1032, the newborn screening fee increased from $40.00 to $65.00. This increase in fee will allow for more accurate testing with fewer false positives, more thorough follow-up on abnormal results, more extensive provider education to reduce time from specimen collection to submission and testing and more comprehensive quality assurance activities. The estimated impact to the Acute Care program is an increase of approximately $1.4 million.

ADHS Ambulance Rates
In accordance with A.R.S. §36-2239, AHCCCS is required to pay ambulance providers rates equal to a prescribed percentage of the amounts approved by ADHS. Currently AHCCCS' rates are equal to 68.59% of the ADHS rates per Laws 2013, First Special Session, Chapter 10. However, AHCCCS is required by this same section of law to increase this percentage to 74.74% of the ADHS rates for rates effective October 1, 2014. This mandated adjustment results in a 9% increase in payments, assuming all utilization stays the same. The legislation also updates the base ADHS rates that are used to calculate the payments, which will result in further increases greater than 9%. The estimated impact to the Acute Care program is an increase of approximately $10.8 million.

Diagnosis Related Group (DRG) Impacts
Acute hospital inpatient stays with dates of discharge on and after October 1, 2014 will be paid using an All Patient Refined Diagnosis Related Group (APR-DRG) payment system (with certain exclusions). This payment system replaces the 20+ year tiered per diem inpatient reimbursement system in accordance with A.R.S. § 36-2903.01 and Arizona Administrative Code (A.A.C.) R9-22-712.60 through 712.81. The impact of this move to APR-DRG is budget neutral to the state, but does vary by Program. In addition to the methodological change there are impacts to what qualifies for reinsurance (see section VI for additional information on those changes). The estimated, combined impact to the Acute Care program of both the methodological and reinsurance changes is a decrease of approximately $2.2 million

Insulin Pumps
Effective October 1, 2014, the State of Arizona's 2014 Health and Welfare Budget Reconciliation Bill (BRB) reinstated insulin pumps, which were previously eliminated October 1, 2010, as a covered service for enrolled adults. The estimated impact to the Acute Care program is an increase of approximately $1.1 million.

Hepatitis C – Sovaldi and New Hepatitis C Drugs
The Food and Drug Administration (FDA) approved Sovaldi, a treatment option for hepatitis C, in December 2013. Sovaldi has the potential to positively impact the care and outcomes for certain Hepatitis C-positive individuals, but it also has significant

financial implications. New Hepatitis C drugs are anticipated to be released in the fall of 2014. The estimated impact to the Acute Care program is an increase of approximately $26.8 million, which includes an offset for prior Hepatitis C drugs that were included in the base data.

Automated Visual Screenings
Effective October 1, 2014, AHCCCS is providing coverage for automated visual screenings for children aged one to three years of age. Children ages four to five years of age may have a second screening if shown to be developmentally disabled or otherwise incapable of cooperating with traditional visual screening techniques. The estimated impact to the Acute Care program is an increase of approximately $470,000.

Medically Preferred Treatment Options
Effective October 1, 2014, AHCCCS will provide medically necessary orthotics services that are recognized as a preferred treatment option and are less expensive than other treatment or surgical options. More specifically, AHCCCS will reinstate orthotics instead of imminent surgery, or as necessary as a result of surgery, with prescribed criteria. There is no impact to rates as these orthotics are offered in place of more costly interventions.

In-Lieu of Services
Included in the base capitation rates is funding for "in lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. State approved FFS rates at inpatient non-specialty hospitals are approximately 93.5% more expensive than those provided in alternative inpatient settings. The proposed capitation rates allow for the provision of services in alternative inpatient settings that are licensed by ADHS/Arizona Licensing Services/Office of Behavioral Health License, in lieu of services in an inpatient non-specialty hospital, thus no impact to capitation rates is included.

Primary Care Provider (PCP) Payment Increase
Section 1902(a)(13)(C) of the Social Security Act, as amended by the ACA, requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. The AHCCCS managed care model, with strict requirements regarding actuarially-sound capitation rates, necessitates that Contractors be funded for expected cost increases due to primary care rate parity. AHCCCS reimburses Contractors with the necessary funds to increase primary care payments by using Model 3: Non-risk Reconciled Payments for Enhanced Rates as referenced in the *Medicaid Managed Care Payment for PCP Services in 2013 and 2014, Technical Guidance and Rate Setting Practices* (Technical Guidance) document released by CMS.

In summary, under Model 3, prospective capitation rates are not adjusted for the enhanced primary care payments. Rather, AHCCCS queries actual encounter data to calculate the total payments that eligible providers were paid for eligible services in

order to reach the mandated enhanced payment rates. Once the data on these reports are verified, AHCCCS pays the Contractors the calculated additional payment amounts. A more detail explanation of the process and methodology can be found in the Actuarial Certification submitted March 2013 to CMS for approval of AHCCCS methodology. There is no impact to the CYE 15 capitation rates.

V. Prospective Projected Net Claim PMPM

The CYE 14 utilization, unit costs and net claims PMPMs are trended forward and adjusted for state mandates, court ordered programs and programmatic changes to arrive at the CYE 15 utilization, unit costs and net claims PMPMs for each COS and COA.

VI. Prospective Reinsurance Offsets

The reinsurance offsets were reviewed by AHCCCS for appropriateness and reasonableness using reinsurance encounter and payment information. Due to the change in the DRG method of payment which will no longer allow Contractors to split inpatient encounters in most cases, the reinsurance offsets had to not only be reviewed for impact of the move to the DRG method, but also for this change. Appropriate adjustments were made to the reinsurance offsets based upon this review. In addition, transplant evaluations will be eliminated from transplant contracts effective October 1, 2014, thus removing this contract component from reinsurance coverage. The reinsurance offset is adjusted to reflect this modification. The total estimated impact, for the transplant evaluations, to the Acute Care program is an increase of approximately $720,000.

VII. Coordination of Benefits

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 to SFY 2014, encounter-reported COB cost avoidance grew by greater than 63%, from $391 million to $637 million. Additionally, Acute Contractors cost-avoided $193 million in additional claims in the nine months ending March 31, 2014 for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and therefore those services are excluded completely from capitation expenditure projections. AHCCCS continues to emphasize the importance of COB activities with the Acute Contractors.

VIII. Prospective Administrative Expenses and Risk Contingency

The administrative PMPM for the majority of risk groups, and the administrative percentage for another risk group, remain the same as CYE 14 which was determined appropriate to cover the Contractors' average expenses. The risk contingency load remains the same for all risk groups at 1%.

IX. Payment Reform Initiative

AHCCCS has continued the PRI implemented October 1, 2013 with slight modifications. The purpose of this initiative is to improve members' health outcomes while reducing costs. Effective October 1, 2014, instead of withholding 1% of the Contractors' capitation rate, AHCCCS will perform a reconciliation to distribute the Contractors' earned contribution. A contribution pool will be established by assessing 1% of prospective capitation rates excluding Delivery Supplement, KidsCare and State Only Transplant capitation rates. Quality improvement metrics have been established and Contractors' performance will be measured against these measures. The entire contribution pool amount will be distributed back to the Contractors based on the results of these performance measurements. While the entire contribution pool will be distributed, some Contractors may receive distributions back from the reconciliation and some may not.

X. Prospective Proposed Capitation Rates and Their Impacts

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section V) less the reinsurance offsets (in Section VI) and the projected administrative expenses and risk contingency PMPM (in Section VIII), divided by 1 minus the 2% premium tax. Appendix II contains the proposed capitation rates and the budget impact for all capitation rates using projected CYE 15 member months and actual Contractor reinsurance deductible levels.

XI. Risk Adjustment Factor

AHCCCS will be recalculating the risk factors to apply to the CYE 15 capitation rates once the appropriate data is available. It is expected that the adjustment will be applied to the rates on or around April 1, 2015 along with a retroactive adjustment to the capitation rates effective October 1, 2014. Until that time the CYE 15 capitation rates will use the CYE 14 risk adjustment factors.

XII. Delivery Supplemental Payment

The methodology followed in developing the Delivery Supplemental Payment is similar to the methodology used in the development of the prospective capitation rates discussed above. When developing this PMPM, the number of Delivery Supplement payments becomes the denominator rather than total member months. No reinsurance offset applies to this rate. The impact is a 3.0% increase over the CYE 14 Delivery Supplemental Payment.

XIII. KidsCare Capitation Rates

Continuing with the methodology of previous years, Contractors will be paid one blended capitation rate that includes experience from the traditional TANF Medicaid population, the Child Expansion population, and the Title XXI SCHIP population. For CYE 15, the Title XXI (KidsCare) population includes those children whose household has income levels between 133-200% of the FPL. This program is frozen to new enrollment. However if a child loses Medicaid as a result of modified adjusted gross income (MAGI) determination they can enroll in KidsCare.

The rate cohorts whose experience is blended together are detailed as follows:

- TANF < 1 and KidsCare < 1
- TANF 1– 13 M&F, KidsCare 1 – 13 M&F, and Child Expansion 6-13 M&F
- TANF 14 – 44 F, KidsCare 14 – 18 F, and Child Expansion 14-18 F
- TANF 14 – 44 M, KidsCare 14 – 18 M, and Child Expansion 14-18 M

The related member month, capitation rate and dollar information is as follows:

KidsCare Info	CYE 15 Projected Member Months	CYE 15 Proj Cap Rate	Total Annual Dollars CYE 15 based on CYE 15 Proj MMs
KC <1	164	$ 479.97	$ 78,575
KC 1-13	11,994	$ 102.78	$ 1,232,750
KC 14-18F	4,911	$ 241.27	$ 1,184,915
KC 14-18M	4,475	$ 151.89	$ 679,635

XIV. Prior Period Coverage Capitation Rates

PPC capitation rates cover the period of time from the effective date of eligibility to the day a member is enrolled with the Contractor. There is no PPC capitation for members enrolled with the Contractor who are initially found eligible for AHCCCS through hospital presumptive eligibility. These members will receive coverage of services during the PPC period through AHCCCS fee for service. PPC capitation

rates are established using a similar methodology that was followed in developing the prospective capitation rates. The administrative expense was set at the same percent as the CYE 14 capitation rates which was 8% of medical expense. Risk contingency also remains unchanged at 1%. The PPC capitation rates do not qualify for reinsurance and thus will not have a reinsurance offset. The overall statewide impact is an increase of 1.3%. The PPC capitation rates are reconciled to a maximum 2.0% profit or loss in CYE 15.

XV. Final Capitation Rates and Their Impact

Table II below summarizes overall statewide changes from the CYE 14 capitation rates. Because the CYE 14 capitation rates included a 1% withhold that is being eliminated in CYE 15, the changes are displayed two ways. Presenting the CYE 14 capitation rates before withhold provides a consistent comparison to the complete capitation rates. However, the CYE 14 capitation rates post withhold are also provided as these were the approved rates. The impacts to Contractors range from 2.3% to 3.7% (before withhold) or 3.0% to 4.9% (post withhold). Individual Contractor capitation rates are provided in Section B of each contract.

Table II: Changes from the CYE 14 Capitation Rates

AHCCCS Medicaid Managed Care Summary			
	Prospective	PPC	Weighted Average
Trend:			
1. Utilization	0.24%	1.37%	0.32%
2. Inflation	1.65%	0.48%	1.57%
Program Changes			
1. DRG Adjustments Including RI Impact	0.01%	-0.81%	-0.05%
2. ADHS Ambulance Rates	0.24%	0.18%	0.24%
3. Insulin Pumps	0.03%	0.00%	0.02%
4. Hepatitis C New Drugs	0.62%	0.00%	0.58%
5. Automated Visual Screening	0.01%	0.00%	0.01%
6. Physical Therapy (To Get and Keep Level of Care)	0.02%	0.00%	0.02%
7. Newborn Screening	0.03%	0.00%	0.03%
8. Dental Varnish	0.01%	0.00%	0.01%
9. Dental Homes	0.03%	0.00%	0.03%
10. Other Provider Rates	0.07%	-0.02%	0.06%
11. Evaluation Component of Transplants	0.02%	0.00%	0.02%
Misc			
1. Reinsurance Offset Change	0.00%	0.00%	0.00%
2. Other Changes (ie Admin, Risk, Prem Tax)	0.09%	0.13%	0.09%
Total Percentage Change Before 14 Withhold	3.05%	1.33%	2.93%
Withhold Impact	0.99%	0.00%	0.92%
Total Percentage Change Post 14 Withhold	4.04%	1.33%	3.85%

XVI. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.1.0: Overview of rate setting methodology

AHCCCS is performing a rate update from the previously approved CYE 14 capitation rates as adjusted April 1, 2014 under 42 CFR 438.6(c). Please refer to Section II.

AA.1.1: Actuarial certification

Please refer to Section XVII.

AA.1.2: Projection of expenditure

Please refer to Appendix II.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

AA.1.5: Risk contract

AHCCCS limits risk for the Adults > 106% to 1% profit or loss. AHCCCS limits risk for the PPC risk groups, excluding Adults > 106%, to 2% profit or loss. The prospective risk groups, excluding Adults > 106%, are reconciled as follows:

Profit	MCO Share	State Share	Maximum Contractor Profit
<=3%	100%	0%	3.0%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%
Total			4.5%

Loss	MCO Share	State Share	Maximum Contractor Loss
<=3%	100%	0%	3.0%
>3%	0%	100%	0%
Total			3.0%

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Critical Access Hospitals (CAH). GME is paid in accordance with state plan. DSH and CAH payments are paid in accordance with the Waiver Special Terms and Conditions.

None of the additional payments to providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Sections II through XIV.

XVII. Actuarial Certification of the Capitation Rates

I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time to time by the Actuarial Standards Board.

The capitation rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The capitation rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The capitation rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The capitation rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the twelve-month period beginning October 1, 2014.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the capitation rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the Contractors and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the Contractor's auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

This certification letter assumes the reader is familiar with the Acute program, Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS 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.

SIGNATURE ON FILE	*08/29/2014*
Windy J. Marks	Date

Fellow of the Society of Actuaries
Member, American Academy of Actuaries

Appendix I

Prospective Trends

Utilization per 1,000 trends						
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Adults </= 106%	Adults > 106%	Total
Hospital Inpatient	0.4%	0.0%	0.0%	0.0%	0.4%	0.2%
Outpatient Facility	5.6%	-4.3%	6.5%	3.7%	4.3%	4.0%
Emergency Room	2.0%	5.1%	2.7%	-6.6%	-0.9%	0.2%
Physician	-4.9%	-5.5%	-1.0%	-2.3%	-1.9%	-4.0%
Other Professional	7.7%	8.7%	9.3%	4.7%	7.4%	7.2%
Pharmacy	0.5%	-3.5%	-0.5%	8.7%	3.6%	2.9%
Other	n/a	n/a	n/a	n/a	n/a	n/a

Unit Cost Trends						
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Adults </= 106%	Adults > 106%	Total
Hospital Inpatient	-0.1%	0.1%	0.0%	0.0%	-0.1%	-0.1%
Outpatient Facility	2.8%	11.8%	2.6%	5.4%	4.9%	4.7%
Emergency Room	1.8%	1.3%	2.7%	4.3%	2.4%	2.1%
Physician	8.7%	-1.2%	4.7%	1.5%	3.2%	6.1%
Other Professional	0.4%	-9.4%	-4.3%	-0.5%	-0.4%	-0.7%
Pharmacy	1.7%	8.6%	2.2%	1.1%	2.2%	2.1%
Other	n/a	n/a	n/a	n/a	n/a	n/a

PMPM Trends						
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Adults </= 106%	Adults > 106%	Total
Hospital Inpatient	0.3%	0.1%	0.0%	0.0%	0.3%	0.1%
Outpatient Facility	8.6%	6.9%	9.3%	9.4%	9.5%	8.9%
Emergency Room	3.8%	6.5%	5.5%	-2.6%	1.5%	2.2%
Physician	3.4%	-6.6%	3.7%	-0.8%	1.2%	1.8%
Other Professional	8.2%	-1.6%	4.6%	4.2%	6.9%	6.4%
Pharmacy	2.3%	4.8%	1.7%	9.9%	5.9%	5.0%
Other	-3.2%	-6.3%	-2.3%	-2.2%	-2.6%	-3.0%