Contract Year Ending 2018 Comprehensive Medical and Dental Program Capitation Rate Certification

January 1, 2018 through June 30, 2018

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

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AHCCCS
Arizona Health Care Cost Containment System

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Introduction and Limitations

The purpose of this rate certification is to provide documentation, including the data, assumptions, and methodologies, used to develop the amendment for the July 1, 2017 through June 30, 2018 (Contract Year Ending 2018 or CYE 18) actuarially sound capitation rates for the period January 1, 2018 through June 30, 2018 for Arizona's Comprehensive Medical and Dental Program (CMDP) for compliance with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 of 81 FR 27497 applicable to this rate certification, the 2018 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2018 Medicaid Managed Care Rate Development Guide (2018 Guide) describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2018 Guide to help facilitate the review of this rate certification by CMS. Sections of the 2018 Guide that do not apply will be marked as "Not Applicable" and will be included in this rate certification as requested by CMS.

This certification is an amendment to a previously submitted CYE 18 certification that was filed on March 31, 2017, before the 2018 Guide was available. The structure and contents of that certification were therefore aligned with the 2017 Guide. As such, references to the March 31 certification may not correspond directly to the same part or subpart as this certification.

Section I Medicaid Managed Care Rates

The capitation rates included with this rate certification are considered actuarially sound according to the following criteria from 42 CFR § 438.4 at 81 FR 27858:

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.

Additionally, the term actuarially sound is defined in Actuarial Standard of Practice (ASOP) 49, "Medicaid Managed Care Capitation Rate Development and Certification," as:

> "Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

As stated on page 2 of the 2018 Guide, CMS will also use these three principles in applying the regulation standards:

- the capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;

- the rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- the documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR Part 438 and generally accepted actuarial principles and practices.

1. General Information

This section provides documentation for the General Information section of the 2018 Guide.

A. Rate Development Standards

i. Rating Period

The amended CYE 18 capitation rates for the CMDP are effective for the six month time period from January 1, 2018 through June 30, 2018.

ii. Rate Certification Documentation

This rate certification includes the following items and information:

(a) Letter from Certifying Actuary

The actuarial certification letter for the amended CYE 18 capitation rates for the CMDP, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854, provided below for reference.

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Mr. Varitek certifies that the amended CYE 18 capitation rates for the CMDP contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 of 81 FR 27497.

(b) Final and Certified Capitation Rates

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the CMDP contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856. The CMDP contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 and the 2018 Guide.

(c) Final and Certified Capitation Rate Ranges

Not Applicable. Rate ranges were not developed for the amended CYE18 capitation rates for the CMDP.

(d) Program Information

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

iii. Rate Development Standards and Federal Financial Participation

Proposed differences among the amended CYE 18 capitation rates for the CMDP are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the CMDP.

iv. Rate Cell Cross-subsidization

The amended CYE 18 capitation rates were developed at the rate cell level. Payments from rate cells do not cross-subsidize payments of other rate cells.

v. Effective Dates of Changes

The effective dates of changes to the CMDP are consistent with the assumptions used to develop the amended CYE 18 capitation rates for the CMDP.

vi. Generally Accepted Actuarial Principles and Practices

(a) Reasonable, Appropriate, and Attainable Costs

In the actuary's judgement, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate and attainable costs. To the actuary's knowledge, all reasonable, appropriate and attainable costs have been included in the rate certification.

(b) Rate Setting Process

Adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. There are no adjustments to the rates performed outside of the rate setting process.

(c) Contracted Rates

Consistent with 42 CFR §438.7(c), the final contracted rates in each cell must either match the capitation rates or be within the rate ranges in the rate certification. This is required in total and for each and every rate cell. The CYE 18 capitation rates certified in this report represent the final contracted rates by rate cell.

vii. Rates from Previous Rating Periods

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

viii. Rate Certification Procedures

(a) CMS Rate Certification Requirement for Rate Change

This is a new rate certification that documents the CMDP capitation rates that will be changing effective January 1, 2018.

(b) CMS Rate Certification Requirement for No Rate Change

Not Applicable. This rate certification will change the CMDP capitation rates effective January 1, 2018.

(c) CMS Rate Certification Circumstances

This section of the 2018 Guide provides information on when CMS would not require a new rate certification, and is not applicable to this certification.

(d) CMS Contract Amendment Requirement

CMS requires a contract amendment be submitted whenever capitation rates change for any reason other than application of an approved payment term (e.g. risk adjustment methodology) which was included in the initial managed care contract. The capitation rates are changing due to prospective program changes effective January 1, 2018, and thus a contract amendment is required to be submitted.

B. Appropriate Documentation

i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the amended CYE 18 capitation rates for the CMDP.

ii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2018 Guide. Sections of the 2018 Guide that do not apply will be marked as "Not Applicable" and will be included in this rate certification as requested by CMS.

iii. Differences in Federal Medical Assistance Percentage

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

iv. Rate Ranges

Not Applicable. Rate ranges were not developed for the amended CYE 18 capitation rates for the CMDP.

v. Rate Range Development

Not Applicable. Rate ranges were not developed for the amended CYE 18 capitation rates for the CMDP.

2. Data

For more information regarding base data, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2018 Guide.

A. Rate Development Standards

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

B. Appropriate Documentation

i. Projected Benefit Costs

The projected CYE 18 gross medical expenses by rate cell and COS can be found in Appendix 4.

ii. Projected Benefit Cost Development

The section provides information on the projected benefit costs include in the amended CYE 18 capitation rates for the CMDP.

(a) Description of the Data, Assumptions, and Methodologies

DRG Reimbursement Rate Changes

AHCCCS will transition from version 31 to version 34 of the All Patient Refined Diagnostic Related Groups (APR-DRG) payment classification system on January 1, 2018. AHCCCS has used v31 APR-DRG national weights published by 3M since the initial implementation of the system on October 1, 2014 until present. To make the APR-DRG grouper fully ICD-10 code compliant, AHCCCS will rebase the inpatient system and update to APR-DRG v34 effective January 1, 2018. Rebasing involves updating the DRG grouper version, relative weights and DRG base rates via payment simulation modeling using more recent data.

Navigant Consulting did the rebase of AHCCCS' DRG system. Their modeling approach: "Rebasing calculations included updated base rates (both standardized amounts and wage indices), relative weights, and addition and change of policy adjusters. Outlier identification and payment methodology has not changed nor has any other underlying claim pricing calculation (notwithstanding the above noted changes to factors, indices, and statewide standardized base rate).

To affect a budget neutral payment system change, Navigant first repriced the FFY 2016 claims under current APR-DRG v31 FFS rates, including changes to the payment system which have occurred since the FFY 2016 claims period (such as the removal of the transition factor, coding improvement factor, and the increase of the high acuity pediatric adjuster to 1.945). Navigant then repriced the same claims set using the APR-DRG v34 grouper and weights and calculated a statewide standardized amount

(adjusted to each facility's labor cost using CMS's published FFY 2017 Final Rule Wage Indices). The statewide standardized amount was calculated to result in total simulated rebased payments equal to current system payments.

The next modeling step was to increase select policy adjusters to meet program funding goals, as determined by AHCCCS. These adjustments included an increase of the high acuity pediatric policy adjuster to 2.30, the addition of a service policy adjuster for burn cases (as identified by APR-DRG groups 841-844) of 2.70, the increase of the policy adjuster for other adult services to 1.025, and the increase of the existing High Volume Hold Harmless adjuster to 1.11."

The PMPM adjustments to apply to each rate cell were then developed as the total simulated APR-DRG rebased payments with the new policy adjuster factors applied to each inpatient hospital admission during FFY 16 by members in each rate cell, minus the total actual payments associated with those admissions, divided by the FFY 16 member months for each rate cell.

The AHCCCS Division of HealthCare Management (DHCM) Actuarial Team relied upon Navigant and AHCCCS DHCM Rates & Reimbursement Team for the reasonableness of these assumptions. The estimated six month impact to inpatient medical expenditures is approximately $136,000, and the impact to reinsurance payments approximately $42,000 (see section I.4.C.ii.(c) for additional information), for a combined impact of $94,000 to medical expenditures net of reinsurance. Table 1 below provides the PMPM impact to the Prospective rate cell of increases to inpatient expenditures, increases to the reinsurance offsets, and net impact to medical expenditures. Reinsurance is not applicable to PPC.

Table 1: PMPM Impacts (1/1/18 – 6/30/18) to Inpatient (IP) Expenditures and Reinsurance (RI) Offsets

Rate Cell	Projected SFY 18 (Jan-Jun) Member Months	Increase to IP Expenses PMPM	Increase to RI Offset PMPM	Net Impact to Medical Expenses PMPM
Prior Period Coverage	2,745	$4.95	NA	$4.95
Prospective	107,746	$1.14	-$0.39	$0.75

Severe Combined Immunodeficiency (SCID)

Arizona Revised Statutes (A.R.S.) § 36-694 establishes a newborn screening program within the Arizona Department of Health Services (ADHS) which contains requirements for ordering tests for certain congenital disorders and for reporting congenital disorder test results and hearing test results to the ADHS. The ADHS has implemented this statute in Arizona Administrative Code (A.A.C.) Title 9, Chapter 13,

Article 2. As part of a 2015 exempt rulemaking, the ADHS included in the rules in 9 A.A.C. 13, Article 2, notice that the ADHS may include screening for severe combined immunodeficiency (SCID) as part of a newborn bloodspot test when the ADHS has funding available to cover the costs for activities related to screening for SCID. Laws 2017, Ch. 339 increases the fee cap for the first newborn screening test from $30.00 to $36.00, which will allow the ADHS to test for SCID as part of newborn screening. This increase in fee is effective January 1, 2018.

To estimate the impact of the increase in the first newborn screening test the AHCCCS DHCM Actuarial Team used encounter data for the time frame October 1, 2014 to current for HCPCS code S3620 (Newborn Metabolic Screening Panel). This is the code that will be seeing the increase in fee to account for the SCID screening.

To develop the projected costs of this increase, the historical units for HCPCS Code S3620 were multiplied by the $6 increase. This method was followed for all programs to which this benefit change was applicable. The encounter data included a trivial amount of utilization by CMDP members, for which the calculated impact of the fee increase was immaterial at less than $0.01 PMPM. As such, no adjustment was made to CMDP capitation for this benefit.

Differential Adjusted Payments (DAP)

AHCCCS has implemented DAP to distinguish providers who have committed to supporting designated actions that improve the patient care experience, improve member health and reduce cost of care growth. Most of the providers eligible for DAP had an effective implementation date of October 1, 2017. Qualifying providers for other hospitals and inpatient services (hospitals not subject to APR-DRG reimbursement) have a January 1, 2018 effective implementation date.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP was the CYE 16 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 18 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program when material.

For the DAP providers with a January 1, 2018 implementation date, the calculated impact to the CMDP of the DAP increase was immaterial at less than $0.01 PMPM. As such, no adjustment was made to CMDP capitation for this benefit.

(b) Material Changes to the Data, Assumptions, and Methodologies

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

iii. Projected Benefit Cost Trends

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

iv. Mental Health Parity and Addiction Equity Act Compliance

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

v. In-Lieu-Of Services

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

vi. Retrospective Eligibility Periods

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

vii. Impact of All Material Changes

This section of the 2018 Guide provides information on what must be documented for all material changes to covered benefits or services since the last rate certification.

(a) Covered Benefits

Material adjustments related to covered benefits are discussed in Section I.3.B.ii of this rate certification.

(b) Recoveries of Overpayments

There were no adjustments made to reflect recoveries of overpayments made to providers by health plans in accordance with 42 CFR at §438.608(d) at 27892. The AHCCCS DHCM Actuarial Team will be working with the AHCCCS Office of Inspector General (OIG) Team to collect historical and current recoveries of overpayments to determine if adjustments will need to be included in future rate development processes.

(c) Provider Payment Requirements

Adjustments related to provider reimbursement changes are discussed in Section I.3.B.ii.(a).

(d) Applicable Waivers

There were no material changes since the last rate certification related to waiver requirements or conditions.

(e) Applicable Litigation

There were no material changes since the last rate certification related to litigation.

viii. Impact of All Material and Non-Material Changes

Documentation regarding all changes for this rate revision, whether material or non-material, has been provided above in Section I.3.B.ii. The aggregate impact of all non-material items not included as an adjustment to the capitation rates is 0.0035% of capitation.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

B. Withhold Arrangements

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

C. Risk-Sharing Mechanisms

i. Rate Development Standards

This section of the 2018 Guide provides information on the requirements for risk-sharing mechanisms.

ii. Appropriate Documentation

(a) Description of Risk-Sharing Mechanisms

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

(b) Description of Medical Loss Ratio

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

(c) Description of Reinsurance Requirements

(i) Reinsurance Requirements

AHCCCS provides a reinsurance program to the CMDP for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than the CMDP paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical. One could view the reinsurance offset as a premium. Historical reinsurance experience is the basis of the reinsurance offset.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with General Fund for State Match and Federal Matching

authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the CMDP for covered services incurred above the deductible. The deductible is the responsibility of the CMDP. There has been no change to the deductible or coinsurance factors since the last rate setting period.

The actual reinsurance case amounts are paid to the CMDP whether the actual amount is above or below the reinsurance offset in the capitation rates. This can result in a loss or gain by the CMDP based on actual reinsurance payments versus expected reinsurance payments.

The projected reinsurance offset PMPM assumed in the CYE 18 capitation rates varies by rate cell. Table 2 below includes the projected reinsurance offsets assumed in the amended CYE 18 capitation rates and the percentage that these reinsurance offsets represent of the capitation rate from Appendix 2 for the Prospective rate cell. These reinsurance offsets were revised due to the DRG reimbursement rebase effective January 1, 2018.

For additional information, including all deductibles and coinsurance amounts, on the reinsurance program refer to the Reinsurance section of the CMDP contract.

Table 2: CYE 18 (1/1/18 - 6/30/18) Projected Reinsurance Offsets

Rate Cell	RI Offset PMPM	Percent of Total Capitation for Rate Cell
Prior Period Coverage	$0.00	0.0%
Prospective	-$7.40	3.3%

(ii) Effect on Development of Capitation Rates

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical expense PMPM calculated for the rate setting period. It is a separate calculation and does not affect the methodologies for development of the gross medical capitation PMPM rate.

(iii) Development in Accordance with Generally Accepted Actuarial Principles and Practices

Projected reinsurance offsets are developed in accordance with generally accepted actuarial principles and practices.

(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset

The data used to develop the adjustment to the previously submitted CYE 18 reinsurance offset are the repriced FFY 16 inpatient admissions as described in Section 3.B.(ii).(a). The actuary calculated expected reinsurance payments associated with the actual health plan paid amount for each admission, and expected reinsurance payments associated with the repriced amount for each admission. The sums of the expected and repriced payments by rate cell were converted into PMPMs using FFY 16 member months by rate cell, and the arithmetic differences in the PMPMs represent the adjustments applied to the previously submitted reinsurance offsets PMPM by rate cell. The previously submitted and revised reinsurance offsets PMPM by rate cell are shown in Appendix 4.

D. Delivery System and Provider Payment Initiatives

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

E. Pass-Through Payments

Not applicable. There are no pass-through payments in the CYE 18 capitation rates for the CMDP.

5. Projected Non-Benefit Costs

A. Rate Development Standards

This section of the 2018 Guide provides information on the non-benefit component of the capitation rates.

B. Appropriate Documentation

i. Description of the Development of Projected Non-Benefit Costs

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

ii. Projected Non-Benefit Costs by Category

(a) Administrative Costs

For more information, please refer to the Contract Year Ending 2018 CMDP Rate Certification dated March 31, 2017.

(b) Taxes and Other Fees

The amended CYE 18 capitation rates for the CMDP include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation.

(c) Contribution to Reserves, Risk Margin, and Cost of Capital

The amended CYE 18 capitation rates for the CMDP include a provision of 1% for risk margin (i.e. underwriting gain).

(d) Other Material Non-Benefit Costs

No other material or non-material non-benefit costs are reflected in the amended CYE 18 capitation rates for the CMDP.

iii. Health Insurance Provider's Fee

This is not applicable because the CMDP is a governmental entity and thus excluded from the Health Insurance Provider's Fee.

6. Risk Adjustment and Acuity Adjustments

This section of the 2018 Guide is not applicable to the CMDP. The CMDP does not utilize risk adjustments or acuity adjustments. This is not anticipated to change.

Section II Medicaid Managed Care Rates with Long-Term Services and Supports

Section II of the 2018 Guide is not applicable to the CMDP. Managed long-term services and supports, as defined at 42 CFR § 438.2 at 81 FR 27855, are not covered services under the CMDP. The CMDP does cover nursing facility services, and related home and community based services, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates

Section III of the 2018 Guide is not applicable to the CMDP.

Appendix 1: Actuarial Certification

I, Matthew C. Varitek, 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 by the Actuarial Standards Board.

The capitation rates included with this rate certification are considered "actuarially sound" according to the following criteria from 42 CFR § 438.4 of 81 FR 27497:

- § 438.4 (a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4 (b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4 (b) (1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- § 438.4 (b) (2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4 (b) (5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4 (b) (6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4 (b) (7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b) (8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.

Additionally, the term "actuarially sound" is defined in Actuarial Standard of Practice (ASOP) 49, "Medicaid Managed Care Capitation Rate Development and Certification," as:

> "Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

The data, assumptions, and methodologies used to develop the amended CYE 18 capitation rates for the CMDP have been documented according to the guidelines established by CMS in the 2018 Guide. The amended CYE 18 capitation rates for the CMDP are effective for the six month time period from January 1, 2018 through June 30, 2018.

The "actuarially sound" capitation rates are based on projections of future events. Actual results may vary from the projections. In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by AHCCCS and CMDP. I have relied upon AHCCCS and the CMDP for the accuracy of the data and I have accepted the data without audit, after checking the data for reasonableness and consistency.

SIGNATURE ON FILE	January 1, 2018
Matthew C. Varitek	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Rate Cell	Projected SFY 18 (Jan-Jun) Member Months	Submitted SFY 18 Capitation Rate	Revised SFY 18 Capitation Rate	Percentage Impact
Prior Period Coverage	2,745	$234.29	$239.39	2.2%
Prospective	107,746	$225.52	$226.30	0.3%

Notes:

1. The Submitted SFY 18 Capitation Rate represents the most recently submitted rates effective from July 1, 2017.

Appendix 3: Fiscal Impact Summary

Rate Cell	Projected SFY 18 (Jan-Jun) Member Months	Submitted SFY 18 Capitation Rate	Revised SFY 18 Capitation Rate	PMPM Change
Prior Period Coverage	2,745	$234.29	$239.39	$5.10
Prospective	107,746	$225.52	$226.30	$0.78
Total	**110,491**	**$225.74**	**$226.63**	**$0.89**

Rate Cell	Submitted 6-Month Projected Expenditures	Revised 6-Month Projected Expenditures	Dollar Impact	Percentage Impact
Prior Period Coverage	$643,233	$657,235	$14,002	2.2%
Prospective	$24,298,798	$24,382,840	$84,042	0.3%
Total	**$24,942,031**	**$25,040,074**	**$98,043**	**0.4%**

Notes:

1. The Submitted SFY 18 Capitation Rate represents the most recently submitted rates effective from July 1, 2017.

Appendix 4: Submitted and Revised CYE 18 Capitation Rates

Prospective			
Service Category	**Submitted SFY 18 Proj PMPM**	**Program Changes PMPM Effective 1/1/18**	**Revised SFY 18 Proj PMPM**
Hospital Inpatient	$20.83	$1.14	$21.97
Physician	$40.97	$0.00	$40.97
Emergency Services	$9.99	$0.00	$9.99
Pharmacy	$30.14	$0.00	$30.14
Lab, X-ray, & med image	$5.32	$0.00	$5.32
Outpatient Facility	$26.73	$0.00	$26.73
Durable Med Equip	$13.80	$0.00	$13.80
Dental	$30.15	$0.00	$30.15
FQHC/RHC	$10.17	$0.00	$10.17
Transportation	$2.78	$0.00	$2.78
NF, Home HC	$0.21	$0.00	$0.21
PT, Other Prof, Misc Med	$0.80	$0.00	$0.80
Total Gross Claim Cost PMPM	**$191.90**		**$193.04**
Less Reinsurance PMPM	-$7.01	-$0.39	-$7.40
Net Claim Cost PMPM	**$184.88**		**$185.63**
Admin Expenses PMPM	$33.87		$33.87
Underwriting Gain PMPM	$2.26		$2.27
Premium Tax Rate	2.0%		2.0%
Effective Capitation PMPM	**$225.52**		**$226.30**

Prior Period Coverage			
Service Category	**Submitted SFY 18 Proj PMPM**	**Program Changes PMPM Effective 1/1/18**	**Revised SFY 18 Proj PMPM**
Hospital Inpatient	$95.96	$4.95	$100.91
Physician	$44.24	$0.00	$44.24
All Other Service Categories	$53.26	$0.00	$53.26
Total Gross Claim Cost PMPM	**$193.46**		**$198.41**
Less Reinsurance PMPM	$0.00		$0.00
Net Claim Cost PMPM	**$193.46**		**$198.41**
Admin Expenses PMPM	$33.87		$33.87
Underwriting Gain PMPM	$2.27		$2.32
Premium Tax Rate	2.0%		2.0%
Effective Capitation PMPM	**$234.29**		**$239.39**