Contract Year Ending 2018 Acute Care Program Capitation Rate Certification

October 1, 2017 through September 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 in the development of the October 1, 2017 through September 30, 2018 (Contract Year Ending 2018 or CYE 18) actuarially sound capitation rates for the Acute Care Program 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.

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 CYE 18 capitation rates for the Acute Care Program are effective for the twelve month time period from October 1, 2017 through September 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 CYE 18 capitation rates for the Acute Care Program, 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 and is 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 CYE 18 capitation rates for the Acute Care Program 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 Appendices 2a, 2b, 2c and 2d. Appendices 2a and 2c contain the Prospective and PPC rates without the Access to Professional Services Initiative (APSI), identified below in Section I.1.A.ii.(d)(i)(C)(v). Appendices 2b and 2d contain the rates including the APSI. The capitation rates are separated in that manner because the funding requires an intergovernmental transfer that has not occurred as of the date of this filing. The capitation rates in Appendices 2a and 2c will be paid to the Contractor if funding is not secured by October 1, 2017. When funding is secured, a mass adjustment will take place to pay the capitation rates in Appendices 2b and 2d retroactive to October 1, 2017. Additionally, the Acute Care Program 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 Acute Care 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 CYE18 capitation rates for the Acute Care Program.

(d) Program Information

(i) Summary of Program

(A) Type and Number of Managed Care Plans

The Acute Care Program contracts with six managed care plans. The number of managed care plans contracted with the Program varies by Geographical Service Area (GSA). The GSAs, along with the managed care plans within the GSAs and the counties are listed in Table 1 below.

Table 1: Managed Care Plan(s) by GSA and Counties

GSA	Counties	Managed Care Plan(s)
02	LaPaz and Yuma	University Family Care United Health Care
04	Apache, Coconino, Mohave and Navajo	Health Choice Arizona United Health Care
06	Yavapai	University Family Care United Health Care
08	Gila and Pinal	Health Choice Arizona University Family Care
10	Pima and Santa Cruz	Care 1st (Pima County Only) Health Choice Arizona (Pima County Only) Mercy Care Plan (Pima County Only) University Family Care United Health Care
12	Maricopa	Care 1st Health Choice Arizona Health Net Mercy Care Plan United Health Care
14	Cochise, Graham and Greenlee	University Family Care United Health Care

(B) Covered Services

This certification covers the Acute Care program which offers acute care medical services to AHCCCS members who are Title XIX or Title XXI eligible, and who do not qualify for another AHCCCS program. Most behavioral health services are carved out and provided through Regional Behavioral Health Authorities (RBHAs) for all Acute Care

Program members except those who are concurrently eligible for Medicare.

Additional information regarding covered services can be found in the Acute Care contract.

(C) Areas of State Covered and Length of Time of Operation

The Acute Care Program has operated on a statewide basis in the State of Arizona since 1982.

(ii) Rating Period Covered

The rate certification for the CYE 18 capitation rates for the Acute Care Program is effective for the twelve month time period from October 1, 2017 through September 30, 2018.

(iii) Covered Populations

The populations covered under Acute Care are AHCCCS members who are Title XIX or Title XXI eligible, and who do not qualify for another AHCCCS Program.

Additional information regarding covered populations can be found in the Enrollment and Disenrollment section of the Acute Care contract.

(iv) Eligibility or Enrollment Criteria Impacts

AHCCCS operates as a mandatory managed care program. Information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the Acute Care Program Contract.

There are no expected changes to the eligibility and enrollment criteria during CYE18 that could have an impact on the populations to be covered under the Acute Care Program.

(v) Summary of Special Contract Provisions Related to Payment

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE18 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Alternative Payment Model (APM) Initiative – Quality Measure Performance (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- APM Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- APM Initiative – Quality Measure Performance (Withhold Arrangement) (42 CFR § 438.6(b)(3) at 81 FR 27859)

- AHCCCS Targeted Investments Program (42 CFR § 438.6(c)(1)(ii) at 81 FR 27860)
- AHCCCS Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Rural Hospital Payments (42 CFR § 438.6(d) at 81 FR 27860)

Documentation on these special contract provisions related to payment can be found in Section I.4 of this rate certification.

(vi) Retroactive Capitation Rate Adjustments

Not Applicable. This rate certification does not cover retroactive adjustments for previous capitation rates.

iii. Rate Development Standards and Federal Financial Participation

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

iv. Rate Cell Cross-subsidization

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

v. Effective Dates of Changes

The effective dates of changes to the Acute Care Program are consistent with the assumptions used to develop the CYE 18 capitation rates for the Acute Care Program.

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, there are no reasonable, appropriate and attainable costs which have not 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 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 contracted rates by rate cell.

vii. Rates from Previous Rating Periods

Not Applicable. Capitation rates from previous rating periods are not used in the development of the CYE 18 capitation rates for the Acute Care Program.

viii. Rate Certification Procedures

(a) CMS Rate Certification Requirement for Rate Change

This is a new rate certification that documents the Acute Care Program capitation rates are changing effective October 1, 2017.

(b) CMS Rate Certification Requirement for No Rate Change

Not Applicable. This rate certification will change the Acute Care Program capitation rates effective October 1, 2017.

(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 the annual rate development cycle, 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 CYE 18 capitation rates for the Acute Care Program.

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 section numbers from the 2018 Guide relevant to the Acute Care Program

iii. Differences in Federal Medical Assistance Percentage

The Acute Care Program includes populations for which the State receives a different Federal Medical Assistance Percentage (FMAP). The populations, FMAPs, and the percentage of costs for October 1, 2015 through September 30, 2016 (CYE 16) are provided below in Table 2. The FMAPs shown below are for the time period of January 1, 2017 through September 30, 2017.

Table 2: FMAP and Percentage of Costs by Population

Population	FMAP	CYE 16 Percentage of Costs
Adult Expansion	95.00%	6.59%
Child Expansion	100.00%	1.95%
Childless Adult Restoration	89.85%	31.26%
KidsCare (Title XXI)	100.00%	0.04%
Populations not listed above	69.24%	60.16%

iv. Rate Ranges

Not Applicable. Rate ranges were not developed for the CYE 18 capitation rates for the Acute Care Program.

v. Rate Range Development

Not Applicable. Rate ranges were not developed for the CYE 18 capitation rates for the Acute Care Program.

2. Data

This section provides documentation for the Data section of the 2018 Guide.

A. Rate Development Standards

i. Compliance with 42 CFR § 438.5(c)

This section of the 2018 Guide provides information related to base data.

B. Appropriate Documentation

i. Data Request

Since AHCCCS employs their own actuaries, a formal data request was not needed between the AHCCCS Division of Health Care Management (DHCM) Actuarial Team and the State. The AHCCCS DHCM Actuarial Team worked with the appropriate teams at AHCCCS to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) at 81 FR 27858.

ii. Data Used for Rate Development

(a) Description of Data

(i) Types of Data Used

The types of data that AHCCCS relied upon for developing the CYE 18 capitation rates for the Acute Care Program were:

- Adjudicated and approved encounter data submitted by the Acute Care Contractors;
- Reinsurance payments made to the Acute Care Contractors for services incurred during FFY 16;
- Historical and projected enrollment data for Acute Care members;
- Projected enrollment data;
- Annual financial statements submitted by the Acute Care Contractors;
- Historical and Future Fee For Service (FFS) schedules developed by DHCM Rates & Reimbursement Team; and
- Data from DHCM Rates & Reimbursement Team related to DAP, see section I.4.D.

(ii) Age of Data

The encounter data serving as the base experience in the capitation rate development process was incurred during federal fiscal year 2016 (October 1, 2015 to September 30, 2016) (FFY 16) and paid through July 2017. For the purposes of trend development and analyzing historical experience, AHCCCS also reviewed encounter data incurred during FFY 14 (October 1, 2014 through September 30, 2015, paid through July 2017), FFY 15 (October 1, 2014 through September 30, 2015, paid through July 2017) and the 1st half of FFY 17 (October 1, 2016 through March 31, 2017, paid through July 2017).

The historical enrollment data for Acute Care members aligned with the encounter data time periods of FFY 14, FFY 15, FFY 16, and the 1st half of FFY 17.

The financial statement data reviewed as part of the rate development process included financial statements for the FFY 14, FFY 15, FFY 16, and the 1st half of FFY 17.

(iii) Sources of Data

The enrollment, encounter, and reinsurance payment data were provided from the AHCCCS PMMIS mainframe. The financial statement data were provided by the AHCCCS DHCM Finance & Reimbursement Team. The

projected enrollment data for CYE 18 was provided by the AHCCCS Division of Business and Finance (DBF) Budget Team.

(iv) Sub-capitated Arrangements

The Acute Care Contractors use sub-capitated/block purchasing arrangements for some professional and dental services. During FFY 16, the Contractors paid approximately 5.6% of total medical expenditures through sub-capitated arrangements. The sub-capitated arrangements between the Contractors and their providers still require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for subcapitated encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05, and health plan paid of zero (i.e. subcapitated)) encounters to estimate a health plan valued amount for these encounters. The units of service data from the encounters and the estimated health plan valued amounts were used for the basis of calculating utilization and unit cost.

(b) Availability and Quality of the Data

(i) Data Validation Steps

Guidelines and formats for submitting individual encounters generally follow health insurance industry standards used by commercial insurance companies and Medicare; however some requirements are specific to the AHCCCS program. All encounter submissions are subject to translation and validation using standards and custom business rules (guidelines). Once translation has occurred and the encounters pass validation, they are passed to the AHCCCS PMMIS mainframe and are subject to approximately 500 claims type edits resulting in the approval, denial or pend of each encounter.

Additionally, the AHCCCS DHCM Actuarial Team compared the encounter data to the financial statements for CYE 14, CYE 15 and CYE 16 as well as reviewing encounter data on a monthly basis throughout the year to be aware of any potential encounter issues.

(A) Completeness of the Data

The AHCCCS DHCM Data & Research Team performs encounter data validation studies to evaluate the completeness, accuracy, and timeliness of the collected encounter data.

(B) Accuracy of the Data

AHCCCS has an additional encounter process which ensures that each adjudicated and approved encounter contains a valid AHCCCS member ID for an individual who was enrolled on the date that the service was provided. The process also checks to ensure that each adjudicated and approved encounter is for a covered service under the state plan and contains the codes necessary to map it into one of the categories of service used in the rate development process.

Through the DHCM Actuarial team review of the encounter data provided from the AHCCCS PMMIS mainframe, we ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 18 capitation rates for the Acute Care Program. Additionally, we ensured that only services covered under the state plan were included.

(C) Consistency of the Data

The AHCCCS DHCM Actuarial Team reviewed the encounter data for consistency by viewing month over month, year over year as well as encounter data versus financial statements. The encounter data was deemed to be consistent for capitation rate setting.

(ii) Actuary's Assessment of the Data

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon encounter data submitted by the Acute Contractors and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the Acute Contractors and reviewed by the AHCCCS Rates & Reimbursement Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP and fee schedule impacts, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

AHCCCS has determined the FFY 16 encounter data to be appropriate for the purposes of developing the CYE 18 capitation rates for the Acute Care Program. Additionally, the FFY 14 and FFY 15 encounter data was deemed appropriate for use in trends.

(iii) Data Concerns

There are no concerns with the data used.

(c) Appropriate Data for Rate Development

The FFY 16 encounter data was appropriate to use as the base data for developing the CYE 18 capitation rates for the Acute Care Program.

(i) Not using Encounter or Fee-for-Service Data

As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 18 capitation rates for the Acute Care Program.

(ii) Not using Managed Care Encounter Data

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 18 capitation rates for the Acute Care Program.

(d) Use of a Data Book

The rate development process of the capitation rates relied primarily on data extracted from the AHCCCS PMMIS mainframe and provided to the AHCCCS DHCM Actuarial Team via a data book. The data book contained summarized enrollment data by rate cell, county, GSA and FFY, and encounter data by rate cell, county, GSA, FFY and COS.

iii. Adjustments to the Data

The encounter data was adjusted as described in Section I.2.B.ii.(a).(iv) for sub-capitated arrangements for categories of service, Professional and Dental. Completion factors, adjustments for PCP Parity payments in prior years, and program and fee schedule changes were applied to bring the historical data to current program and reimbursement levels.

(a) Credibility of the Data

No credibility adjustment was necessary.

(b) Completion Factors

Adjustments to the encounter data were made to reflect the level of completion. AHCCCS calculated completion factors using the development method with monthly encounter data from October 1, 2013 through September 30, 2016, paid through March 2017. The monthly completion factors were rolled up into annualized factors by FFY to be applied to the encounter data in the data book. The aggregated FFY 14, FFY 15, and FFY 16 completion factors applied to each category of service are shown in Appendix 4a.

(c) Errors Found in the Data

No errors were found in the data. Thus, no data adjustments were made for errors.

(d) Changes in the Program

All historical changes applied to the base data period are provided in Appendix 5.

(e) Exclusions of Payments or Services

The data book ensured that all non-covered services were excluded from the encounter data used for developing the CYE 18 capitation rates.

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

i. Compliance with 42 CFR § 438.3(c)(1)(ii) and § 438.3(e)

The final capitation rates are based only upon services allowed under 42 CFR § 438.3(c)(1)(ii) at 81 FR 27856 and 42 CFR § 438.3(e) at 81 FR 27861.

ii. Variations in Assumptions

Any variation in assumptions for covered populations is based upon valid rate development standards and is not based upon the rate of federal financial participation associated with the covered populations.

iii. Projected Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The actual experience of the covered populations was the primary data source used to develop the projected benefit cost trend assumptions.

iv. In-Lieu-Of Services

This is not applicable because in-lieu-of services, as defined in 42 CFR § 438.3(e)(2) of 81 FR 27497, were not used in developing the CYE 18 capitation rates for the Acute Care Program. The Acute Care Program does not have in-lieu-of services. All services provided are covered under the 1115 Waiver, and thus are considered State Plan Services.

v. Institution for Mental Disease

Institution for mental disease (IMD) payments in accordance with 42 CFR § 438.6(e) of 81 FR 27497 are for enrollees aged 21 to 64. No adjustment was made to encounter data or capitation rates for the Acute Care Program, since there was immaterial utilization of IMDs for enrollees aged 21 to 64 in the encounter data used for the development of the capitation rate.

vi. Section 12002 of the 21st Century Cures Act (P.L. 114-255)

As requested by CMS, this section provides information in connection with Section 12002 of the 21st Century Cures Act (P.L. 114-255).

(a) Number of Enrollees

There were 330 Acute members between the ages of 21 to 64 who received treatment in an IMD during FFY 16.

(b) Length of Stay

The 330 enrollees received a combined 2,310 days of care in an IMD during FFY 16, for an average length of stay of 7 days.

(c) Impact on Rates

No adjustment was made to the encounter data or CYE 18 capitation rates for repricing of these stays, as virtually all of the utilization was incurred by members who were Medicare eligible. Thus the impact of repricing only the stays for members who weren't Medicare eligible was judged to be immaterial (PMPM impact of less than $0.01).

B. Appropriate Documentation

i. Projected Benefit Costs

Appendix 7a contains the projected gross medical expenses PMPM by rate cell, Contractor, and GSA.

ii. Projected Benefit Cost Development

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

The data described in Section I.2.B.ii.(a) was adjusted to reflect assumed completion, benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The per-member-per-month (PMPM) expenditures for each COS in the base year are trended forward to the midpoint of the effective period of the capitation rates by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a).

As noted in Section I.2.B.ii.(a).(ii), data from FFY 16 served as the base for projections to CYE 18 for the capitation rate, while data from FFY 14, FFY 15, and FFY 16 was used in development of trends and completion factors. The historical encounter data was summarized by FFY and COS.

Prospective Program Changes

Adult ER Dental

As part of the 2017 Legislative session, the Arizona Legislature passed SB 1527, reinstating emergency adult dental services and extractions up to a limit of $1,000 annually, a covered service prior to October 1, 2010. AHCCCS will restore this as a covered service effective October 1, 2017.

To estimate the impact of restoring emergency adult dental services, the AHCCCS DHCM Actuarial Team used historical adult (21 and over) dental encounter data and member month data for the time frame October 1, 2009 through September 2011. While this data is outside of the requirement under §438.5(c) to use data from the most recent three years of the rating period to develop capitation rates, the AHCCCS DHCM Actuarial Team determined that this data was reasonable to use to estimate the impact of restoring the benefit. The time frame of October 1, 2009 through September 2011 includes the final year (FFY 10 (10/1/09 – 09/30/10)) AHCCCS covered emergency adult dental services and the first year (FFY 11 (10/1/10 – 09/30/11)) AHCCCS did not cover emergency adult dental services.

The AHCCCS DHCM Actuarial Team developed dental PMPMs by rate cell and GSA for both the FFY10 and FFY11 time frames. The difference between FFY 10 PMPMs and FFY 11 PMPMs was assumed to be the impact of removing the emergency adult dental services. This difference between the FFY 10 PMPMs and FFY 11 PMPMs was trended forwarded to FFY 18 using an annualized trend of 2.0%. The 2.0% trend was derived using actuarial judgement with consideration of the following information:

- Consumer Price Index - data from IHS Global Insight that was provided to the AHCCCS DHCM Rates & Reimbursement Team;
- National Health Expenditures;
- Encounter data for children dental; and
- AHCCCS FFS fee schedule changes.

The FFY 18 emergency adult dental services PMPMs were then added to the capitation rates. The estimated impact is an increase of approximately $26.8 million.

Occupational Therapy in an Outpatient Setting for Adults (Aged 21 and Over)

As part of the 2017 Legislative session, the Arizona Legislature passed SB 1527 which added occupational therapy in an outpatient setting for adults aged 21 and over (OT for Adults). AHCCCS will begin coverage for this service effective October 1, 2017. This program change will only impact the Integrated SMI rate cell because OT for Adults is a physical health service.

To estimate the impact of adding OT for Adults, the AHCCCS DHCM Actuarial Team first developed an assumption for the expected number of members that would utilize the OT for Adults services. This was completed by using the projected FFY 18 member months for Integrated SMI members. The average annual members for FFY 18 were calculated by using the projected FFY 18 member months and dividing by twelve. It was assumed that 0.6% of the average annual members would utilize these OT for Adults services.

To develop the FFY 18 projected costs, the expected utilizing members were multiplied by the assumed cost amount of $339.48 per utilizing member. Then the FFY 18 projected costs were divided by FFY 18 projected members months to develop the FFY 18 PMPMs. The projected member months were derived by the AHCCCS DBF Budget Team. The utilization assumption and cost of utilizing members were derived by the AHCCCS Clinical Quality Management Team. These utilization and cost assumptions were derived from the professional clinical judgment and informed by historical occupational therapy experience from the Arizona Long Term Care Services Program. The AHCCCS DHCM Actuarial Team was unable to determine the reasonableness of these assumptions without performing a substantial amount of work and relied upon the AHCCCS Clinical Quality Management Team for the reasonableness for these assumptions.

The FFY 18 occupational therapy PMPMs were then added to the capitation rates. The estimated impact is an increase of approximately $1.5 million.

High-Cost Biologics Eligible for Reinsurance

The AHCCCS Pharmacy and Therapeutics Committee, on recommendation from AHCCCS Medical Management Unit, determined that five high-cost biologics (Syprine, Cuprimine, Firazyr, Berinert, and Zavesca) will be deemed eligible for reinsurance effective October 1, 2017. The AHCCCS DHCM Actuarial Team used enrollment counts and encounter data from the first half of FFY 17 to estimate the projected CYE 18 utilization of these biologics by rate cell and GSA. Then the amount to add into the RI offset by rate cell and GSA was 85% of the projected total CYE 18 expenditure by rate cell and GSA for these biologics, since biologics are included in the Non-Regular Reinsurance case type as defined in the Reinsurance section of the Acute Care Program contract. The estimated impact to net medical expenses is a decrease of $2.5 million.

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically

determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known though health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding their fee schedules.

Additionally, the Acute Contracts have requirements that the Contractors reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. This contract requirement was effective April 1, 2015. The AHCCCS Fee-for-Service Fee Schedule Updates program change includes a fee schedule adjustment to bring the encounter base data from CYE 16 FQHC PPS rates up to projected CYE 18 FQHC PPS rates.

Effective October 1, 2017, AHCCCS will be updating provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 18 capitation rates have been adjusted to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to the CYE 18 capitation rates was the CYE 16 encounter data across all programs. The AHCCCS DHCM Rates & Reimbursement Team applied the AHCCCS provider fee schedule changes as a unit cost change 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. The annualized impact to the Acute Care Program before administrative load, premium tax and underwriting gain is approximately $13.5 million.

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

The CYE 18 capitation rates are developed as a rebase, where the CYE 17 capitation rates were developed as a trend update to the CYE 16 rates. There were no other material changes to the components of the capitation rates or the process of their development.

iii. Projected Benefit Cost Trends

In accordance with 42 CFR § 438.7(b)(2) at 81 FR 27861, this section provides documentation on the projected benefit cost trends.

(a) Requirements

(i) Projected Benefit Cost Trends Data

Please see Section I.2.B.ii.(a) for the types of data that AHCCCS relied upon for developing the projected benefit cost trends for the Acute Care Program.

All data used was specific to the Acute Care population, but comparisons were made to other AHCCCS populations for reasonability of observed trends.

(ii) Projected Benefit Cost Trends Methodologies

Historical utilization, unit cost and PMPM data from FFY 14, FFY 15, and FFY 16 was organized by rate cell, GSA, incurred FFY, and category of service (COS). The three federal fiscal years of data were adjusted for completion and normalized for historical program and fee schedule changes. Trend rates were developed to adjust the base data (midpoint of April 1, 2016) forward 24 months to the midpoint of the contract period (April 1, 2018). Utilization and/or unit cost trends were limited such that the PMPM trend for any combination of rate cell, GSA, and COS would fall between -5.0% and +5.0%. No simple formulaic solution exists to determine future trend; actuarial judgement is required. Each category of service was analyzed in the same manner, but different trend decisions were made for each based off additional knowledge of the actuary with regards to the Acute Care Program, as well as in conjunction with knowledge of other AHCCCS programs.

(iii) Projected Benefit Cost Trends Comparisons

The PMPM trend assumptions were compared to similar assumptions made in prior years for Acute Care Program capitation rates and judged reasonable to assume for projection to CYE 18..

(b) Projected Benefit Cost Trends by Component

(i) Changes in Price and Utilization

The trend assumptions were developed by unit cost and utilization. Appendix 4a and Appendix 4b contain the components of the projected benefit cost trend, aggregated across all COS, by rate cell and GSA for Prospective and PPC capitation rates.

(ii) Alternative Methods

Not applicable.

(iii) Other Components

No other components were used in the development of the annualized trend assumptions summarized in Appendix 4a.

(c) Variation in Trend

Projected benefit cost trends vary by rate cell, GSA, and category of service.

(d) Any Other Material Adjustments

No other material adjustments were made to the trend assumptions.

(e) Any Other Adjustments

No other adjustments were made to the trend assumptions.

iv. Mental Health Parity and Addiction Equity Act Compliance

The AHCCCS DHCM Medical Management Team, the AHCCCS Office of Administrative Legal Services (OALS) Legal Counsel Team, and the AHCCCS Office of the Director, are currently working on a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis to determine if additional services are necessary to comply with parity standards. Although the analysis is not yet complete, at this time no additional services have been identified as necessary services to comply with MHPAEA.

v. In-Lieu-Of Services

This is not applicable because in-lieu-of services, as defined in 42 CFR § 438.3(e)(2) of 81 FR 27497, were not used in developing the CYE 18 capitation rates for the Acute Care Program. The Acute Care Program does not have in-lieu-of services. All services provided are covered under the 1115 Waiver, and thus are considered State Plan Services.

vi. Retrospective Eligibility Periods

(a) Managed Care Plan Responsibility

AHCCCS provides prior period coverage for the period of time prior to the member's enrollment during which the member is eligible for covered services. Prior period coverage refers to the time frame from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the Acute Care Contractor. The Acute Care Contractor receives notification from AHCCCS of the member's enrollment. The Acute Care Contractor is responsible for payment of all claims for medically necessary services covered by the Acute Care Program and provided to members during prior period coverage.

(b) Claims Data Included in Base Data

Encounters delivered during the prior period coverage (PPC) timeframe for each member are included in the base encounter data used for setting PPC capitation rates.

(c) Enrollment Data Included in Base Data

Member months during the PPC timeframe are included in the base enrollment data used for setting PPC capitation rates.

(d) Adjustments, Assumptions, and Methodology

A separate PPC capitation rate was developed and all covered expenses and member months are included in the PPC capitation rate cells.

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

The newly covered benefits effective October 1, 2017 are described in Section I.3.B.ii.

(b) Recoveries of Overpayments

There were no adjustments were made to reflect recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d). 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). Adjustments related to provider payment requirements are discussed in Section I.4.D of this rate certification.

(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 material and non-material changes has been provided above in Section I.3.B.vii.

(a) Non-Material Changes

Per 42 CFR § 438.7(b)(4) of 81 FR 27497, all material and non-material adjustments related to the projected benefit costs and trends have been described.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

This section of the 2018 Guide provides information on the definition and requirements of an incentive arrangement.

ii. Appropriate Documentation

(a) Description of Any Incentive Arrangements

Per section 42 CFR § 438.6(b)(2) at 81 FR 27859 the capitation payments including all incentive arrangements will not exceed 105 percent of the capitation payments prior to any incentive payments.

Alternative Payment Model (APM) Initiative – Quality Measure Performance

The incentive arrangement for the Alternative Payment Model (APM) Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of AHCCCS quality measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement. The maximum incentive pool possible is approximately $50.5 million, which is the amount that would be available if every Contractor earned exactly 0% of the withhold described below. This is not anticipated to happen, and thus the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors. The incentive arrangement will not exceed 105% of the capitation payments.

APM Initiative – Performance Based Payments

The CYE 18 capitation rates for the Acute Care Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2) at 81 FR 27589, called the Alternative Payment Model (APM) Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a

special provision for payment where the Acute Care Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by Acute Care Contractors that are aimed at quality improvement, such as reducing costs, improving health outcomes or improving access to care. The incentive arrangement will not exceed 105% of the capitation payments. It is anticipated that the APM Initiative – Performance Based Payment amounts for CYE 18 will be at least $13.8 million, or approximately 0.26% of projected CYE 18 capitation payments, based upon current CYE 17 APM Initiative – Performance Based Payment amounts.

(i) Time Period

The time period of the incentive arrangements described herein coincides with the rating period.

(ii) Enrollees, Services, and Providers Covered

APM Initiative – Quality Measure Performance

The incentive arrangement includes quality measures impacting emergency department and inpatient hospital services, well visits for children and dental visits for children. All adult and child enrollees and providers utilizing/providing these services, respectively, are covered by the incentive arrangement, unless specifically stated otherwise.

APM Initiative – Performance Based Payments

All enrollees, children and adults, may be covered by this incentive arrangement. Likewise, all network providers have the opportunity to participate in the APM arrangements and all covered services are eligible for inclusion. The Acute Care Contractors are mandated to utilize the APM strategies in the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 as defined at https://hcp-lan.org/workproducts/apm-whitepaper.pdf.

The Acute Care Contractors provider contracts must include performance measures for quality and/or cost efficiency.

(iii) Purpose

APM Initiative – Quality Measure Performance

The purpose of the APM Initiative – Quality Measure Performance incentive arrangement is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings. Contractors are required to meet a targeted percentage of total expenses under an APM contract arrangement in order to participate in the APM Initiative incentive.

APM Initiative – Performance Based Payments

The purpose of the APM Initiative – Performance Based Payments incentive arrangement is to align incentives between the Contractor and providers to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality to achieve cost savings and quantifiable improved outcomes.

(iv) Effect on Capitation Rate Development

APM Initiative – Quality Measure Performance

Incentive payments are not included in the certified capitation rates and had no effect on the development of the capitation rates. AHCCCS does not have analysis on the amount of the anticipated incentive payment, since it is dependent on the amount of unearned withhold across all Contractors, and that has yet to be determined. Incentive payments for the APM Initiative will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the contract year and the computation of the quality measures, and after the withhold payments are distributed and the value of the incentive pool determined.

APM Initiative – Performance Based Payments

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 18 capitation rates for the Acute Care Program. Additionally, incentive payments for the APM Initiative – Performance Based Payments incentive arrangement had no impact on the development of the CYE 18 capitation rates for the Acute Care Program. The anticipated incentive payment amount will be paid by AHCCCS to the Acute Care Contractors through lump sum payments after the completion of the CYE 18 contract year.

B. Withhold Arrangements

i. Rate Development Standards

This section of the 2018 Guide provides information on the definition and requirements of a withhold arrangement.

ii. Appropriate Documentation

(a) Description of Any Withhold Arrangements

The purpose of the Acute Care Program withhold is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health. Contractors are required to engage in a minimally-set targeted percentage of total expenses under an APM purchasing arrangement in order to receive any payment from the APM payment withhold.

(i) Time Period

The time period of the withhold arrangements coincides with the rating period.

(ii) Description of Percentage of Capitation Rates Withheld

AHCCCS has established a quality withhold of 1% of the Contractor's capitation and a percentage (up to 100%) of the withheld amount will be paid to the Contractor for performance on select quality measures including emergency department utilization, hospital readmissions, well-child visits (age 15 month, age 3-6 and age 12-21) and dental visits (age 2-21). AHCCCS will determine the portion of the withheld amount to be returned based on a review of each Contractor's Healthcare Effectiveness Data and Information Set (HEDIS) data and the Contractor's compliance with these quality measures.

(iii) Percentage of the Withheld Amount Not Reasonably Achievable

It is highly unlikely that a Contractor will not receive some portion of the withhold back. The only scenario where a Contractor would earn none of the withhold back is if they failed to meet the targeted percentage of total expenses under an APM purchasing arrangement. However, the AHCCCS DHCM Actuarial Team does not have the information they need to develop an estimate of the withheld amount that is not reasonably achievable.

(iv) Description of Reasonableness of Withhold Arrangement

The actuary relied upon the AHCCCS DHCM Finance & Reinsurance Team's review. That review of the total withhold percentage of 1% of capitation revenue indicated that it is reasonable within the context of the capitation rate development, and that the magnitude of the withhold does not have a detrimental impact on the Contractors' financial operation needs and capital reserves. The AHCCCS DHCM Finance & Reinsurance Team's interpretation of financial operating needs relates to cash flow needs for the Contractors to pay claims and administer benefits for its covered populations. The AHCCCS DHCM Finance & Reinsurance Team evaluated the reasonableness of the withhold within this context by reviewing the Contractors' cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by AHCCCS. To evaluate the reasonableness of the withhold in relation to capitalization levels, the AHCCCS DHCM Finance & Reinsurance Team reviewed the surplus above the equity per member requirement, the performance bond amounts, and financial stability of each Contractor to pay all obligations. The AHCCCS DHCM Finance & Reinsurance Team reviewed cash and cash equivalent

levels in relation to the withhold arrangement and has indicated the withhold arrangement is reasonable based on current cash levels.

(v) Effect on Capitation Rate Development

The capitation rates shown in this rate certification are illustrated before offset for the withhold amount; however the CYE18 capitation rates documented in this report are actuarially sound even if none of the withhold is earned back.

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

The CYE 18 capitation rates for the Acute Care Program will include a risk corridor.

(i) Rationale for Risk-Sharing Mechanisms

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 18 capitation rates will continue AHCCCS' long-standing program policy and will include a risk corridor. This rate certification will use the term risk corridor to be consistent with the 2018 Guide. The Acute Care Contract refers to the risk corridor as reconciliation.

(ii) Description of Risk-Sharing Mechanisms

The risk corridor will reconcile each Contractor's medical cost expenses to the net capitation paid to each Contractor. Net capitation is equal to the capitation rates paid less the premium tax, the health insurer fee (if applicable) and the administrative component plus the Reinsurance payments. Each Contractor's medical cost expenses are equal to the Contractor's fully adjudicated encounters and subcapitated/block purchase expenses as reported by the Contractor with dates of service during the contract year.

Initial Reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically

computed no sooner than 12 or 15 months after the contract year. The difference between the 12 and 15 months depends on whether reinsurance is offered for the risk groups being reconciled.

Additional information regarding the risk corridor can be found in the Compensation section of the Acute Care Program Contract.

(iii) Effect of Risk-Sharing Mechanisms on Capitation Rates

The risk corridor did not have any effect on the development of the CYE 18 capitation rates for the Acute Care Program.

(iv) Risk-Sharing Mechanisms Documentation

The predetermined threshold amount for the risk corridor was set using actuarial judgment with consideration of conversations between the AHCCCS DHCM Actuarial Team, the AHCCCS DHCM Finance & Reinsurance Team and the AHCCCS Office of the Director.

(b) Description of Medical Loss Ratio

The contract does not include a remittance/payment requirement for being above/below a specified medical loss ratio (MLR). This section is not applicable.

(c) Description of Reinsurance Requirements

(i) Reinsurance Requirements

AHCCCS provides a reinsurance program to the Acute Care Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what you would see 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 (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than the Contractors 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 Acute Care Contractors for covered services incurred above the deductible. The deductible is the responsibility of the Acute Care

Contractors. 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 Acute Care Contractors whether the actual amount is above or below the reinsurance offset in the capitation rates. This can result in a loss or gain by an Acute Care Contractor 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 and GSA. The tables in Appendix 7c and Appendix 7q include the projected reinsurance payments assumed in the CYE 18 capitation rates and the percentage of the total capitation rate for each rate cell.

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

(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 reinsurance offset are historical reinsurance payments to Acute Care Contractors for services incurred during FFY 16. The historical payments were expressed as PMPMs using FFY 16 member months, and then adjusted for completion (FFY 16 factors provided in Section I.2.B.iii.(b)), historical programmatic and reimbursement changes, and trended to midpoint of the rating period using the same trend factors applied to the gross medical capitation rates by category of service (provided in Section I.3.B.iii.(b).(i)).

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

This section of the 2018 Guide provides information on delivery system and provider payment initiatives.

ii. Appropriate Documentation

(a) Description of Delivery System and Provider Payment Initiatives

(i) Description

AHCCCS Targeted Investments Program

The Targeted Investments Program is designed to provide a uniform dollar increase to eligible AHCCCS providers to develop systems for integrated care and support ongoing efforts to improve care coordination, increase efficiencies in service delivery, and reduce fragmentation between behavioral health and physical health care.

AHCCCS Differential Adjusted Payments

The Differential Adjusted Payment (DAP) initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 10%, depending on the provider type.

Access to Professional Services Initiative

The Access to Professional Services Initiative (APSI) seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the Contractors' rates for professional services provided by qualified physicians and non-physician professionals affiliated with designated hospitals who meet the following definition:

- A hospital facility with an ACGME-accredited teaching program and which is operated pursuant to the authority in Arizona Statute Title 48, Chapter 31; or,
- A hospital facility with:

- An ACGME-accredited teaching program with a state university, and
- AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2014; or,

- A freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than one hundred (100) licensed pediatric beds, excluding nursery beds.

The APSI provides a uniform percentage increase of 40% to otherwise contracted rates for qualified practitioners-for all claims for which AHCCCS is the primary payer. The rate increase is intended to supplement, not supplant, payments to eligible providers.

(ii) Amount

AHCCCS Targeted Investments Program

Anticipated payments for Targeted Investments are approximately $33.8 million. AHCCCS will adjust capitation rates in the form of an annual lump sum payment to the Contractors after the completion of the contract year.

AHCCCS Differential Adjusted Payment

The total amount of DAP payments before premium tax, admin or underwriting gain included as an adjustment to the capitation rates is approximately $11.2 million or $0.60 PMPM.

Access to Professional Services Initiative

The total amount of APSI payments before premium tax, admin or underwriting gain included as an adjustment to the capitation rates is approximately $38.7 million or $2.04 PMPM.

(iii) Providers Receiving Payment

AHCCCS Targeted Investments Program

The providers receiving the payments include primary care physicians, Integrated Clinic providers, Behavioral Health Outpatient Clinics, and hospitals which qualify for the Targeted Investments Program and who demonstrate performance improvement by meeting certain benchmarks for integrating and coordinating physical and behavioral health care.

AHCCCS Differential Adjusted Payments

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for a 0.5% increase), other hospitals and inpatient facilities (eligible for a 0.5% increase), nursing facilities

(eligible for up to 2% increase), integrated clinics (eligible for a 10% increase on a limited set of codes), physicians, physician assistants, and registered nurse practitioners (all eligible for a 1% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

Access to Professional Services Initiative

The qualifying providers receiving the payment increase include physicians, including doctors of medicine and doctors of osteopathic medicine; certified registered nurse anesthetists; certified registered nurse practitioners; physician assistants; certified nurse midwives; clinical social workers; clinical psychologists; dentists; and optometrists.

(iv) Effect on Capitation Rate Development

AHCCCS Targeted Investments Program

Funding for Targeted Investments is not included in the certified capitation rates. AHCCCS describes the methodology, data and assumptions related the Targeted Investment Program within the 438.6(c) pre-print.

AHCCCS Differential Adjusted Payments (DAP)

Funding for DAP is included in the certified capitation rates. 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. AHCCCS describes the methodology, data and assumptions related the DAP within the approved 438.6(c) pre-print.

Access to Professional Services Initiative

Funding for the APSI is included in the certified capitation rates. The AHCCCS DHCM Actuarial Team relied upon information provided by the APSI Hospital Coalition and their consultants. The information provided by the APSI Hospital Coalition and their consultants was the Billing Provider Tax IDs, which were used to identify the hospital provider groups within the CYE 16 encounter data, and also with the Average Commercial Rates (ACR) for these hospital provider groups. The AHCCCS DHCM Actuarial Team was unable to determine the reasonableness of the ACR data provided without

performing a substantial amount of work and has relied upon the APSI Hospital Coalition and their consultants for the reasonability of the ACR data.

The methodology to determine the 40% fee schedule increase followed the upper payment limit calculation using an ACR. The data used for this analysis was the CYE 16 encounter data for the hospital provider groups to be included in the initiative. The CYE 16 encounter data was repriced with both the ACRs and with the AHCCCS fee schedule. Under this repriced comparison, the ACR amounts were approximately 53% higher than the AHCCCS fee schedule amounts. The 40% increase for the APSI was then determined through collaborative meetings with the AHCCCS Office of the Director and subsequent meetings with the Hospital Coalition. This 40% increase was then applied to the CYE 16 encounter data for rate setting and was applied to the amounts the health plans had paid. AHCCCS describes the methodology, data and assumptions related the APSI within the 438.6(c) pre-print.

E. Pass-Through Payments

i. Rate Development Standards

This section of the 2018 Guide provides information on the pass-through payments.

ii. Appropriate Documentation

(a) Existing Pass-Through Payments

The Acute Care Program includes an existing pass-through payment for rural hospitals.

(i) Description of Pass-Through Payments

The Rural Hospital Inpatient Fund was established in Arizona Revised Statute (A.R.S.) § 36-2905.02 by the Arizona State Legislature in 2005 in response to a 2002 hospital inpatient study that showed rural hospital inpatient cost structures were higher than urban hospital cost structures for inpatient services. The Rural Hospital Inpatient Fund was designed to supplement rural hospital inpatient payments and is paid out by the Contractors to the rural hospitals as a pass-through payment. Additional information regarding the pass-through payment for rural hospitals can be found in the A.R.S. § 36-2905.02 and in the Arizona Administrative Code (A.A.C.) R9-22-712.07.

- A.R.S.§36-2905.02: http://www.azleg.gov/viewdocument/?docName=http://www.azleg.gov/ars/36/02905-02.htm

- A.A.C. R9-22-712.07: http://apps.azsos.gov/public_services/Title_09/9-22.pdf

(ii) Amount of Pass-Through Payments

The total amount before premium tax of the pass-through payment for rural hospitals in the CYE 18 capitation rates is $12,158,100.The total amount with 2% premium tax is $12,406,224.

(iii) Providers Receiving Pass-Through Payments

The providers receiving the pass-through payment are the rural hospitals that meet the state regulatory definition of a rural hospital. For the purpose of this payment, a rural hospital is defined in the A.A.C. R9-22-712.07 as, *"A health care institution that is licensed as an acute care hospital by the Arizona Department of Health Services for the previous state fiscal year and is not an IHS hospital or a tribally owned or operated facility and: a. Has 100 or fewer PPS beds, not including beds reported as sub provider beds on the hospital's Medicare Cost Report, and is located in a county with a population of less than 500,000 persons, or b. Is designated as a critical access hospital for the majority of the previous state fiscal year."*

(iv) Financing Mechanism Pass-Through Payments

The rural hospital supplemental payments are financed through a state General Fund appropriation as specified in A.R.S. § 36-2905.02 and the annual appropriation bill.

(v) Amount of Pass-Through Payments in Previous Rating Period

The total amount before premium tax of the pass-through payment for rural hospitals in the previous CYE 17 capitation rates was $12,158,100. The total amount with 2% premium tax was $12,406,224.49.

(vi) Amount of Pass-Through Payments in Rating Period with July 5, 2016

The total amount before premium tax of the pass-through payment for rural hospitals in the previous CYE 16 capitation rates was $12,158,100. The CYE 16 capitation rates covered the October 1, 2015 through September 30, 2016 and therefore included the date of July 5, 2016 as required by 42 CFR § 438.6(d) at 81 FR 27860 and later amended by 42 CFR Part 438 of 82 FR 5415 (published January 18, 2017 and effective March 20, 2017).

(b) Base Amount Information

This section documents the data, assumptions, and methodology to calculate the base amount. All amounts listed in this section are before premium tax.

(i) Base Amount Data, Assumptions, Methodology

The data, assumptions, and methodology align with the requirements of 42 CFR § 438.6(d) at 81 FR 27860 and later amended at 42 CFR § 438.6(d) at 82 FR 5428. The CYE 16 encounter and Fee-for-Service (FFS) claims data for inpatient services incurred at the rural hospitals was used for the base amount calculation. The AHCCCS DHCM Actuarial Team also used CMS 2552 Hospital Cost Reports provided by the AHCCCS DHCM Rate & Reimbursement Team. The CMS 2552 Hospital Cost Reports were used to get the Medicare FFS inpatient charge and payment amounts to calculate a Medicare FFS payment-to-charge ratio for each rural hospital.

The Medicare FFS inpatient charge amounts were from Worksheet D, Part IV, Line 200, Column 10 of the CMS 2552 Hospital Cost Reports. The Medicare FFS inpatient payment amounts were from Worksheet E, Part A, Lines 1.00 through 2.02, Column 1 and Worksheet E-3, Part V, Line 4, Column 1 of the CMS 2552 Hospital Cost Reports. The Medicare FFS payment-to-charge ratios were applied to the CYE 16 inpatient encounter data and the CYE 16 inpatient FFS claims data for each rural hospital to get estimates of what would had been paid, had Medicare FFS paid for the inpatient services.

The resulting base amount was estimated to be $33,457,574. As described at 42 CFR § 438.6(d) at 82 FR 5428, the total dollar amount of the pass-through payment for rural hospitals for the CYE 18 capitation rates may not exceed the lesser of 100% of the base amount and the pass-through payment for rural hospitals in the CYE 16 capitation rates. The result from this lesser of calculation is that pass-through payment for rural hospitals may not exceed $12,158,100 for the CYE 18 capitation rates. The aggregate amounts calculated for the base amount calculation are provided below in Section I.4.E.ii.(b).(ii).

(ii) Base Amount Aggregate Components

The aggregate amounts for the base amount calculation are provided below.

- For Section I.4.E.i.(c).(i).(A) of the 2018 Guide - $55,855,269 (this section of the 2018 Guide aligns with 42 CFR § 438.6(d)(2)(i)(A) at 81 FR 27860).
- For Section I.4.E.i.(c).(i).(B) of the 2018 Guide - $33,712,037 (this section of the 2018 Guide aligns with 42 CFR § 438.6(d)(2)(i)(B) at 81 FR 27860).

- For Section I.4.E.i.(c).(ii).(A) of the 2018 Guide - $19,626,985 (this section of the 2018 Guide aligns with 42 CFR § 438.6(d)(2)(ii)(A) at 81 FR 27860).
- For Section I.4.E.i.(c).(ii).(B) of the 2018 Guide - $8,312,642 (this section of the 2018 Guide aligns with 42 CFR § 438.6(d)(2)(ii)(B) at 81 FR 27860).

The difference between $55,855,269 and $33,712,037 is $22,143,232. The difference between $19,626,985 and $8,312,642 is $11,314,342. The base amount is the sum of these differences and is $33,457,574.

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

(a) Data, Assumptions, Methodology

The administrative expense PMPM by rate cell and GSA assumed in the CYE 18 capitation rates is equal to the PMPM amount assumed in the CYE 17 capitation rates.

(b) Material Changes

There were no material changes since the last rate certification and no other material changes.

(c) Description of Other Material Adjustments

There were no other adjustments (material or non-material) to the projected non-benefit expenses included in the capitation rate.

ii. Projected Non-Benefit Costs by Category

(a) Administrative Costs

The administrative component of the CYE 18 capitation rates for the Acute Care Program is described above in Section I.5.B.i.(a). The PMPM amounts assumed can be found in Appendix 7e for Prospective rates and Appendix 7l for PPC rates.

(b) Taxes and Other Fees

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

capitation. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 18 capitation rate for the Acute Care Program includes a provision of 1% for margin (i.e. underwriting gain).

(d) Other Material Non-Benefit Costs

No other material or non-material non-benefit costs are reflected in the CYE 18 capitation rates for the Acute Care Program.

iii. Health Insurance Provider's Fee

(a) Address if in Rates

The CYE 18 capitation rates for the Acute Care Program reflected in this rate certification do not incorporate the Health Insurance Providers Fee (HIPF). AHCCCS will follow previous Acute Care Program capitation rate methodologies for the HIPF, in which capitation rates are amended to reflect the calculated HIPF and related tax impacts. AHCCCS does not intend to submit a new actuarial certification due to this update since the documentation below describes the process. A letter to CMS with the impact to the Acute Care Program will be submitted once it is known, anticipated late 2018.

(b) Data Year or Fee Year

Not applicable. The HIPF is not incorporated into the CYE 18 capitation rates for the Acute Care Program.

(c) Description of how Fee was Determined

Not applicable. The HIPF is not incorporated into the CYE 18 capitation rates for the Acute Care Program.

(d) Address if not in Rates

The CYE 18 Acute Care capitation rates do not include the fee at this time; the impact to the Acute Care Program will be addressed in a letter to CMS once the fees are known.

The PMPM capitation adjustments will be developed based on the fee liability reported to AHCCCS. Each Acute Care Contractor subject to the HIPF is notified of the fee liability for the entire entity by the Treasury Department. Contractors who receive multiple streams of revenue applicable to the HIPF calculation will be responsible for allocating an appropriate portion of their fee liability to AHCCCS, which will be verified by AHCCCS for reasonableness and appropriateness. To determine if the reported revenue and the HIPF liability allocations to AHCCCS from the Contractors is reasonable and appropriate, AHCCCS will review for each Contractor the HIPF liability allocated to AHCCCS as a percentage of the total HIPF liability from the IRS, and the revenue allocated

to AHCCCS as a percentage of the total revenue reported to the IRS. Additionally, AHCCCS will compare the revenue allocated to each AHCCCS program from each Contractor against paid capitation data and determine if the revenue allocated by Contractor to each AHCCCS program is reasonable and appropriate.

As in previous years, the PMPM adjustments will be developed based on each entity's actual member months within each applicable rate cell. This adjustment is expected to be calculated in late 2018. The estimated impact to the Acute Care Program of this adjustment is a statewide increase of approximately $112.3 million.

(e) Summary of Benefits Under 26 CFR § 57.2(h)(2)(ix)

Table 3 provides the portion of the CYE 18 Prospective capitation rates for the Acute Care Program attributable to nursing facility services, and related home and community based services, for 90 days of short-term convalescent care.

Table 3: Percentage of Prospective Capitation Attributable to NF & HCBS Services

Rate Cell	CYE 18 MMs	LTC Total (NF+HCBS) PMPM	LTC Total (NF+HCBS) as % of Medical
TANF/Kidscare <1, M/F	576,065	$0.54	0.13%
TANF/Kidscare 1-13, M/F	6,249,395	$0.05	0.05%
TANF/Kidscare 14-44, F	3,201,645	$0.64	0.28%
TANF/Kidscare 14-44, M	1,711,573	$0.54	0.36%
TANF 45+, M/F	648,478	$2.91	0.72%
SSI w/ Med	1,110,736	$4.69	3.59%
SSI w/o Med	594,666	$20.44	1.94%
Adults <= 106% FPL	3,386,913	$7.05	1.54%
Adults > 106% FPL	954,301	$2.99	0.96%
Total	18,433,773	$2.69	1.04%

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Risk Adjustment

AHCCCS contracts with Wakely Consulting Group to assist in the development of the AHCCCS risk adjustment model. AHCCCS relies on Wakely Consulting Group to maintain and recalibrate the AHCCCS risk adjustment model. The DHCM Actuarial Team reviews the results from the AHCCCS risk adjustment model and provides contractor specific files to each of the Contractors.

The CYE 18 capitation rates have risk adjustment factors applied to them. The risk adjustment factors applied to the CYE 18 rates were developed for the CYE 16 capitation rates with an experience period of October 1, 2014 through September 20, 2015. AHCCCS anticipates before the end of the first calendar year quarter of 2018, the CYE 18 capitation rates will be updated with new risk adjustment factors. The development of these new risk adjustment factors will follow the same methodology as in historical years and as described below, but will use a more recent time frame for the experience period. AHCCCS anticipates using an experience period of June 1, 2016 through May 31, 2017 to develop the revised factors for all risk group models (i.e. TANF < 1 model and all other risk group model). AHCCCS will apply 100% of the risk adjustment factors for CYE 18 to the previously approved capitation rates to develop the revised capitation rates. When this adjustment happens it will be retroactive to the start of the contract year (October 1, 2017). AHCCCS does not intend to submit a revised rate certification as referenced in 438.7(b)(5)(iii) due to this update to use more recent encounter data for the experience period since the documentation below describes the risk adjustment process. A new contract with the revised capitation rates will be submitted as required under 438.7(b)(5)(iii).

ii. Budget Neutrality

In accordance with 42 CFR §438.5(g), risk adjustment will be applied in a budget neutral manner.

iii. Acuity Adjustment

This is not applicable because an acuity adjustment was not developed for the CYE 18 capitation rates for the Acute Program.

B. Appropriate Documentation

i. Prospective Risk Adjustment

(a) Data and Data Adjustments

Encounter and member data is used for the risk adjustment factors. AHCCCS regularly performs testing on encounters to identify any potential areas of concern. If AHCCCS identifies any encounter gaps, AHCCCS contacts the Contractor and works with them to improve encounter submissions. AHCCCS monitors the encounters by reviewing encounter data by date of service and form type to identify potential issues.

In addition, AHCCCS intends to compare the Contractor's encounter data to their financials and compare how the Contractors look relative to one another. Additional testing is anticipated to include the following: reviewing the average number of encounters per member per month, the encounter diagnosis information by Contractor, the portion of a Contractor's population that has

zero encounters and the portion of the population scored. These results will be compared across the Contractors. The results of these analyses will assist in determining if any encounter data is deemed unusable for the risk adjustment process and if any adjustments to the encounter data will be required.

(b) Model and Model Adjustments

AHCCCS uses risk scores resulting from the Optum (formerly Ingenix) Symmetry Episode Risk Group (ERG) Model Version 9.1.

The ERG model assigns each member to one or more of the 237 ERGs (i.e. risk markers) based on diagnostic and procedural information available on medical and pharmacy encounters. An ERG profile for each member is created by considering age, gender and the ERGs to which they have been assigned. A relative health status weight is associated with each age, gender and ERG category.

Wakely Consulting Group developed and produces the AHCCCS risk adjustment model which uses the risk markers from the ERG model. AHCCCS provides all encounters, ERG risk markers, membership and capitation rates data for the appropriate time frames to Wakely Consulting Group for them to perform the analysis. The AHCCCS risk adjustment model was calibrated by Wakely Consulting Group in 2017 for the Acute Care Program.

The following costs were not reflected in the condition or demographic weights in the calibrated AHCCCS risk adjustment model:

1. PPC
2. Costs above reinsurance thresholds for which the Contractors were not at risk
3. Maternity costs covered by the Delivery Supplement

The diagnosis codes on all encounters are used for purposes of identifying conditions, but the costs not at risk (identified above) were excluded for purposes of determining the risk weights. This process captures the additional complexity/cost for at-risk conditions due to the presence of an underlying not-at-risk condition.

Risk weights were developed by age and gender category and for all of the 237 ERG condition categories. Four sets of risk weights were developed for the 237 ERG condition categories (TANF <1 was modeled differently – see section below): 1) TANF and Adults <= 106% FPL, 2) Adults > 106%, 3) SSI without Medicare, and 4) SSI with Medicare. Only members with at least six months of experience in the base period and at least one month of experience in the

projection period were used in the calibration. Each member's contribution to the regression model and therefore the risk weights, was weighted according to the number of months that member was enrolled during the prospective period. The AHCCCS risk adjustment model weights were based on statewide data.

Risk scores calculated during the experience period will follow the individual during the rating period.

(c) Relative Risk Factor Methodology

The risk adjustment method described below is reasonable and appropriate in measuring the risk factors of the respective population.

AHCCCS will risk adjust most of the prospective rate cells which include: SSI with and without Medicare, TANF, Adults <= 106% FPL and Adults > 106% FPL. The following rates will not have an encounter based risk adjustment model applied:

1. Delivery Supplemental Payment Capitation Rates
2. Option 1 & 2 Transplant (State Only Transplants) Capitation Rates
3. All Prior Period Coverage (PPC) Capitation Rates

Risk Adjustment for All Rate Cells, except TANF < 1

Only members with at least six months of enrollment during the experience period ('long' cohort) will be given an encounters based risk adjustment factor (average ERG risk score). Members with less than six months of enrollment during the experience period ('short' cohort) will be given a risk factor that is equal to 50% of their average age and gender factor plus 50% of an adjusted plan factor. The adjusted plan factor is calculated by taking the average ERG risk score of the long cohort and dividing by the average age and gender factor of the long cohort (relative health factor) and then multiplying by the average age and gender factor of the short cohort. The weighted average of the long cohort and the short cohort results in the average risk score for each Contractor, which will then be divided by the GSA average risk score to calculate the relative risk score. The relative risk score is adjusted for budget neutrality to calculate the risk score used to adjust the capitation rates.

(d) Magnitude of Adjustment by MCO

See table below for the magnitude of risk adjustment (CYE 16 factors) on the CYE 18 capitation rates. These values will change once the new risk adjustment factors (CYE 18 factors) are calculated. Since the CYE 18 factors have not been developed, the magnitude by Contractor is currently not known. AHCCCS can provide the magnitude by Contractor in a letter to CMS when submitting the revised rates and contracts.

Contractor	Magnitude of Risk Adjustment [1]
Care 1st	-5.69%
Health Net	-11.32%
Health Choice	-0.01%
Mercy Care	3.73%
UHC	1.34%
UFC	-0.04%

1) Magnitude of risk adjustment is in aggregate including TANF < 1 risk group

(e) Predictive Value Assessment

Wakely Consulting Group used r-squared statistic to evaluate the predictive value of the model. The r-squared statistic by model is shown below along with a comparison for prior models.

Regression Summary		
Rate Cell Grouping	R-Squared 2009	R-Squared 2017
TANF and Adults <= 106% FPL	0.2550	0.2382
Adults > 106% FPL	N/A	0.2670
SSIW	0.1416	0.2253
SSIWO	0.3149	0.2479

The r-squared statistics presented above are considered good for such types of models and consistent with similar models in the industry.

The r-squared for TANF and Adults <=106% FPL is very consistent between the two models. Wakely Consulting Group did observe some variability in the SSI models but that variability is expected given the gap in the population and relatively fewer members in the SSI risk groups. The Adults > 106% FPL risk group did not exist in 2009 and the r-squared evaluation in 2017 was the first such evaluation. Wakely Consulting Group noted the r-squared statistic for Adults > 106% FPL is consistent with that of other risk groups.

(f) Actuarial Concerns

The actuary has no concerns with the risk adjustment process.

ii. Retrospective Risk Adjustment

(a) The Party Calculating

Wakely Consulting Group developed and produces the AHCCCS risk adjustment model for the TANF < 1 rate cell.

(b) Data and Data Adjustments

Encounter and member data is used for the risk adjustment factors. AHCCCS regularly performs testing on encounters to identify any potential areas of concern. If AHCCCS identifies any encounter gaps, AHCCCS contacts the Contractor and works with them to improve encounter submissions. AHCCCS monitors the encounters by reviewing encounter data by date of service and form type to identify potential issues.

In addition, AHCCCS intends to compare the Contractor's encounter data to their financials and compare how the Contractors look relative to one another. Additional testing is anticipated to include the following: reviewing the average number of encounters per member per month, the encounter diagnosis information by Contractor, the portion of a Contractor's population that has zero encounters and the portion of the population scored. These results will be compared across the Contractors. The results of these analyses will assist in determining if any encounter data is deemed unusable for the risk adjustment process and if any adjustments to the encounter data will be required.

(c) Model and Model Adjustments

Risk adjustment for TANF under age one (newborns) is necessarily different than risk adjustment for other rate cells. Instead of an individual approach where risk adjustment factors follow individual members, an aggregate, concurrent approach is used. This approach assumes that historic relationships in newborn risk will continue into the future. While the specific newborns in any Contractor will change from the experience period to the rating period, this approach assumes that Contractors attract newborns with a consistent health status mix.

Based on encounter data provided by AHCCCS to Wakely Consulting Group for the newborn Medicaid populations, a series of conditions that resulted in material variations among newborns due to the frequency, cost and nature of those conditions were identified. This analysis resulted in eleven general risk marker categories that will be used to differentiate the health status and therefore risk of newborns. Calibration of the weights for the eleven selected newborn risk markers was based on a concurrent, rather than prospective, methodology.

Newborns with sufficient experience are identified during the experience period (June 1, 2016 through May 31, 2017). Sufficient experience is defined as being born in the experience period, with at least three months of enrollment during the experience period or enrolled at the time of death. Newborns with sufficient experience are assigned a risk score.

Newborns not meeting the enrollment criteria described above are assigned 50% of the average relative risk adjustment for those meeting the eligibility criteria and 50% of a 1.00 factor. Each Contractor's risk score for newborns within a GSA will be calculated as the weighted average of the risk scores for newborns who met the above eligibility criteria during the experience period and those who did not to develop the relative risk score. The relative risk score is adjusted for budget neutrality to calculate the risk score used to adjust the capitation rates.

(d) Timing and Frequency

The CYE 18 capitation rates have risk adjustment factors applied to them. The risk adjustment factors applied to the CYE 18 rates were developed for the CYE 16 capitation rates with an experience period of October 1, 2014 through September 20, 2015. AHCCCS anticipates before the end of the first calendar year quarter of 2018, the CYE 18 capitation rates will be updated with new risk adjustment factors. The development of these new risk adjustment factors will follow the same methodology as in historical years and as described above, but will use a more recent time frame for the experience period. The experience period that is anticipated to be used to develop the revised factors is the period of June 1, 2016 through May 31, 2017. AHCCCS will apply 100% of the risk adjustment factors for CYE 18 to the previously approved capitation rates to develop the revised capitation rates. When this adjustment happens it will be retroactive to the start of the contract year (October 1, 2017). AHCCCS does not intend to submit a revised rate certification as referenced in 438.7(b)(5)(iii) due to this update to use more recent encounter data for the experience period since the documentation below describes the risk adjustment process. A new contract with the revised capitation rates will be submitted as required under 438.7(b)(5)(iii).

(e) Actuarial Concerns

The actuary has no concerns with the risk adjustment process..

iii. Additional Items on Risk Adjustment

(a) Model Changes since Last Rating Period

No changes in the model since the last rating period.

(b) Budget Neutrality

The model is budget neutral in accordance with 42 CFR §438.5(g). The budget neutrality adjustment is the last step to calculate the final risk adjustment factor. To calculate the final risk adjustment factor the relative risk score is divided by the budget neutrality adjustment. The budget neutrality adjustment is calculated by taking the rating period capitation rates before risk adjustment times the rating period member months and dividing by the rating period capitation rates times the relative risk score times the rating period member months.

iv. Acuity Adjustment Description

This is not applicable because an acuity adjustment was not developed for the CYE 18 capitation rates for the Acute Program.

(a) Reason for Uncertainty

This is not applicable because an acuity adjustment was not developed for the CYE 18 capitation rates for the Acute Program.

(b) Acuity Adjustment Model

This is not applicable because an acuity adjustment was not developed for the CYE 18 capitation rates for the Acute Program.

(c) Acuity Adjustment Data

This is not applicable because an acuity adjustment was not developed for the CYE 18 capitation rates for the Acute Program.

(d) Relationship and Potential Interactions

This is not applicable because an acuity adjustment was not developed for the CYE 18 capitation rates for the Acute Program.

(e) Application of Acuity Scores

This is not applicable because an acuity adjustment was not developed for the CYE 18 capitation rates for the Acute Program.

(f) Acuity Score Documentation

This is not applicable because an acuity adjustment was not developed for the CYE 18 capitation rates for the Acute Program.

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

Section II of the 2018 Medicaid Managed Care Rate Development Guide is not applicable to the Acute Care Program. Managed long-term services and supports, as defined at 42 CFR § 438.2(a) at 81 FR 27855, are not covered services under the Acute Care Program. The Acute Care Program 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 Medicaid Managed Care Rate Development Guide is applicable to the Acute Care Program.

AHCCCS expanded coverage for childless adults up to 100% of the federal poverty level (FPL) in 2000 under Proposition 204. In January 2011, this population was subject to an enrollment freeze. Effective January 1, 2014, AHCCCS opted to expand Medicaid eligibility for all adults up to 133% FPL (Adult Expansion) and restored coverage for the childless adults up to 100% FPL population (Childless Adult Restoration). Collectively, these two populations will be referred to as the new adult group.

The Acute Care Program capitation rates include separate rate cells for the Adult Expansion and Childless Adult Restoration populations, which are labeled throughout this certification as "Adults <= 106% FPL" and "Adults > 106% FPL" respectively. The capitation rates for these rate cells are developed the same way as the rates for the TANF/Kidscare and SSI rate cells. The new adult group represents approximately 37.85% of expenditures for the Acute Care Program. See Section I for the rate development of the Acute Care Program capitation rates. The new adult group would be treated as any other Acute Care Program rate cell.

1. Data

A. Description of Data for Rate Development

The CYE 18 capitation rates for the new adult group rely on the same types and sources of data used for the other rate cells and described in Section I.2.

B. Documentation

i. New Data

The previous Acute Care Program capitation rates for CYE 17 were developed as a rate update from the CYE 16 rates. The CYE 18 capitation rate development process used more recent data that was available. All data related to the CYE 18 capitation rates for the Acute Care Program is described in Section I.2.

ii. Monitoring of Costs and Experience

The AHCCCS DHCM Actuarial Team, along with the AHCCCS DHCM Finance & Reinsurance Team, monitors the costs and experience for all rate cells for the Acute Care Program. AHCCCS did not develop plans to monitor costs and experience specifically for the new adult group beyond the monitoring done for all rate cells of the Acute Care Program.

iii. Actual Experience vs. Projected Experience

Tables 4a and 4b contain the statewide average projected gross medical expense PMPM by contract year from the capitation rate development for FFY 14, 15, and 16, and the statewide average gross medical expense PMPM by contract year for those

years from encounter data used in CYE 18 rate setting, for the Prospective Adults > 106% FPL and Adults <= 106% FPL populations.

Table 4a: Projected and Actual Gross Medical Expense PMPM by Year, Adults > 106% FPL

Contract Year	Projected GME in Cap Rates	Actual GME from Completed Encounter Data	Pct Diff
CYE 14	$273.08	$336.16	23.1%
CYE 15	$281.52	$312.05	10.8%
CYE 16	$338.84	$304.34	-10.2%

Table 4b: Projected and Actual Gross Medical Expense PMPM by Year, Adults <= 106% FPL

Contract Year	Projected GME in Cap Rates	Actual GME from Completed Encounter Data	Pct Diff
CYE 14	$380.88	$389.62	2.3%
CYE 15	$387.13	$377.47	-2.5%
CYE 16	$405.89	$416.74	2.7%

iv. Adjustments Based Upon Actual Experience vs. Projected Experience

As described throughout Section I, the CYE 18 capitation rates were developed as a rebase using CYE 16 as the starting point for projections to CYE 18. No other adjustments were made to the CYE 18 capitation rates for the Acute Care Program to reflect differences between projected and actual experience from previous rating periods.

2. Projected Benefit Costs

A. Description of Projected Benefit Costs

i. Documentation

(a) Previous Data and Experience Used

The projected benefit costs for the CYE 18 capitation rates for the Acute Care Program are described in Section I.3. The capitation rates for each rate cell were developed using the CYE 16 encounter data specific to each rate cell as the base. All data specific to the new adult group would be captured to develop the rates for the new adult group rate cells.

(b) Changes in Data Sources, Assumptions, Methodologies

The projected benefit costs for the CYE 18 capitation rates for the Acute Care Program are described in Section I.3. The data and assumptions for each rate cell were specific to each rate cell, and the same methodology was used to develop projected benefit costs for each rate cell. All data specific to the new adult group would be captured to develop the rates for the new adult group rate cells.

(c) Change in Key Assumptions

(i) Acuity or Health Status

Acuity or health status adjustments were not used in previous capitation rates for the Acute Care Program to specifically address the new adult group population.

(ii) Pent-up Demand

Pent-up demand adjustments were not used in previous capitation rates for the Acute Care Program to specifically address the new adult group population.

(iii) Adverse Selection

Adverse selection adjustments were not used in previous capitation rates for the Acute Care Program to specifically address the new adult group population.

(iv) Demographics

Demographic adjustments were not used in previous capitation rates for the Acute Care Program to specifically address the new adult group population.

(v) Provider Reimbursement Rates

Provider reimbursement rate adjustments were not used in previous capitation rates for the Acute Care Program to specifically address the new adult group population.

(A) Variations in Assumptions

For the previous capitation rates for the Acute Care Program, any variation in the assumptions used to develop the projected benefit costs for the covered populations would have been based upon valid rate development standards and not based on the rate of federal financial participation for the covered populations.

(vi) Other Material Adjustments

No other material adjustments were used in previous capitation rates for the Acute Care Program to specifically address the new adult group population.

B. Key Assumptions

The CYE 18 capitation rates for the Acute Care Program used a base data time period of CYE 16. This time period has twelve months of actual experience for the new adult group. Additionally, the CYE 16 time period is 21 to 33 months past the effective date of the Adult Expansion population. Therefore, the CYE 18 capitation rates for the Acute Care Program do not include assumptions for the following adjustments to specifically address the new adult group population: acuity or health status, pent-up demand, adverse selection, demographics, provider reimbursement rates, and any other material adjustments to specifically address the new adult group population.

i. Acuity Adjustment

Not applicable as described in Section III.2.B.

ii. Pent-up Demand Adjustment

Not applicable as described in Section III.2.B.

iii. Adverse Selection Adjustment

Not applicable as described in Section III.2.B.

iv. Demographics Adjustment

Not applicable as described in Section III.2.B.

v. Provider Reimbursement Adjustments

Not applicable as described in Section III.2.B.

vi. Other Material Adjustments

Not applicable as described in Section III.2.B.

C. Benefit Plan Changes

Not applicable. The Acute Care Program does not have separate benefit plans for the new adult group.

D. Any Other Material Changes

For the Adults <= 106% FPL rate cell, a population which has been covered by AHCCCS since 2000, historical encounter data relevant to the emergency adult dental benefit was used as described in Section I.3.B.(ii) to project benefit costs. The same methodology was used for this population as for the TANF and SSI rate cells.

For the Adults > 106% FPL rate cell, historical encounter data relevant to the emergency adult dental benefit was not available since this population was not effective until January 1, 2014. For this population, the AHCCCS DHCM Actuarial Team used the Adults <= 106% rate cell projected FFY 18 Adult emergency adult dental services PMPMs and applied a factor. The factor was developed based on the actual historical FFY 16 encounter data PMPM relationship between Adults <= 106% FPL and Adults > 106% FPL to develop the projected FFY 18 emergency adult dental services PMPM for Adults > 106% FPL. This was determined to be a reasonable approach, given similarities of these two populations in service levels and utilization patterns.

There are no other material changes to specifically address the new adult group population in the CYE 18 capitation rates for the Acute Care Program.

3. Projected Non-Benefit Costs

A. Description of Issues

i. Changes in Data Sources, Assumptions, Methodologies

The projected non-benefit costs for the CYE 18 capitation rates for the Acute Care Program are described in Section I.5.

ii. Changes in Assumptions from Previous Rating Period

(a) Administrative Costs

There were no changes to the assumptions for administrative costs PMPM from the previous capitation rates for the Acute Care Program.

(b) Care Coordination and care management

There were no changes to the assumptions for care coordination and care management costs PMPM from the previous capitation rates for the Acute Care Program.

(c) Provision for Underwriting Gain

There was no change to the provision of underwriting gain assumption from the previous capitation rates for the Acute Care Program.

(d) Taxes, Fees, and Assessments

There were no changes to the premium tax assumptions from the previous capitation rates for the Acute Care Program.

(e) Other Material Non-Benefit Costs

There were no changes to other material non-benefit cost assumptions from the previous capitation rates for the Acute Care Program.

B. Differences between Populations

i. Administrative Costs

The administrative cost assumptions PMPM vary between populations for the CYE 18 capitation rates for the Acute Care Program. For the Prospective Adults > 106% rate cell and for all PPC rate cells, the administrative cost assumptions were developed as a percentage of gross medical expense PMPM. For all other Prospective rate cells, including the Adults <= 106% FPL rate cell, the PMPM cost assumptions are based on the amount bid by each Contractor in each GSA during RFP #YH14-0001.

ii. Care Coordination and care management

Not applicable. There are no differences in care coordination and care management assumptions between populations for the CYE 18 capitation rates for the Acute Care Program.

iii. Provision for Underwriting Gain

Not applicable. There are no differences in underwriting gain assumptions between the new adult group and other populations for the CYE 18 capitation rates for the Acute Care Program.

iv. Taxes, Fees, and Assessments

Not applicable. There are no differences in premium tax assumptions between populations for the CYE 18 capitation rates for the Acute Care Program.

v. Other Material Non-Benefit Costs

There are no other material non-benefit costs to specifically address the new adult group population in the CYE 18 capitation rates for the Acute Care Program.

4. Final Certified Rates

A. Documentation

i. Comparison of Rates

The final and certified CYE 18 capitation rates by Contractor, GSA, and rate cell are located in Appendix 2. Appendix 2a contains the capitation rates without the APSI payments described in Section I.4.D. Appendix 2b contains the capitation rates when APSI payments are included.

ii. Description of Material Changes

There are no other material changes to specifically address the new adult group population in the CYE 18 capitation rates for the Acute Care Program.

5. Risk Mitigation Strategies

A. New Adult Rates Risk Mitigation

Not applicable. The CYE 18 capitation rates for the Acute Care Program do not include any risk mitigation strategies specific to the new adult group population. The CYE 18 capitation rates do include a risk corridor for the new adult group population that is equivalent to all other rate cells.

B. Documentation

i. Changes in Risk Mitigation Strategies

Beginning in CYE 14, the Acute Care Program applied a distinct risk corridor specific to the Adults > 106% FPL population for contract years prior to CYE 18. As noted in Section III.5.A, the Adults > 106% FPL population is now subject to the same risk corridor as the other rate cells.

ii. Rationale

Coverage for the Adults > 106% FPL population, and restoration of new enrollment in the Adults <=106% FPL population, went into effect on January 1, 2014. Due to the initial uncertainty around the health care needs of the Adults > 106% FPL population, AHCCCS believed it was prudent to apply a narrower risk corridor to the Adults > 106% FPL population that would be calculated and reconciled separately from the other rate cells of the Acute Care Program, which are reconciled in aggregate by Contractor. Prior to CYE 18, AHCCCS therefore ran three different reconciliations for each Contractor with the Acute Care Program:

- Prospective, all rate cells combined except Adults > 106% FPL
- PPC, all rate cells combined except Adults > 106% FPL
- Adults > 106% FPL, Prospective and PPC combined

The narrow risk band reduced the financial risk of the capitation rates for the Adults > 106% FPL rate cell being either substantially inadequate or overly conservative. Now that sufficient historical experience exists to improve the predictability of medical expenses PMPM for the Adults > 106% FPL population, it is no longer necessary to reconcile that population under different terms than the rest of the Acute Care Program.

iii. Prior Results

The application of the risk corridor for the Adults > 106% FPL population resulted in an aggregate recoupment from the Acute Care Program Contractors of approximately $8.2 million for FFY 14 and an aggregate payment to the Contractors of $5.8 million for FFY 15. As noted in Section III.5.B.(ii), the Adults <= 106% FPL population is combined with the TANF/Kidscare and SSI populations to perform the Prospective and PPC reconciliations.

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 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 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 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 CYE 18 capitation rates for the Acute Care Program have been documented according to the guidelines established by CMS in the 2018 Guide. The CYE 18 capitation rates for the Acute Care Program are effective for the 12-month time period from October 1, 2017 through September 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 the Acute Care Contractors. I have relied upon AHCCCS and the Acute Care Contractors 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	October 1, 2017
Matthew C. Varitek	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

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Arizona Health Care Cost Containment System

Appendix 2a: Certified Prospective Capitation Rates without APSI

Contractor	GSA	TANF/ Kidscare <1	TANF/ Kidscare 1-13	TANF/ Kidscare 14-44 Female	TANF/ Kidscare 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$376.12	$121.42	$239.93	$143.81	$390.38	$169.18	$1,007.84	$5,655.07	$459.06	$311.83
University Family Care	02	$371.55	$109.30	$212.57	$120.69	$323.86	$144.72	$934.28	$5,607.72	$452.58	$317.46
United Health Care	04	$387.89	$97.51	$203.27	$134.88	$360.14	$124.03	$932.73	$5,825.80	$435.80	$339.41
Health Choice Arizona	04	$397.66	$98.29	$213.68	$143.88	$388.14	$128.55	$1,006.22	$5,778.88	$465.70	$340.45
United Health Care	06	$379.40	$115.26	$250.29	$200.79	$444.08	$166.07	$1,239.28	$5,966.15	$505.11	$405.86
University Family Care	06	$387.32	$111.33	$247.12	$200.85	$400.65	$152.33	$1,102.59	$5,912.46	$486.83	$396.65
University Family Care	08	$419.16	$100.33	$248.95	$151.69	$515.03	$139.15	$1,044.69	$5,523.43	$480.44	$348.92
Health Choice Arizona	08	$421.55	$101.44	$256.53	$152.48	$546.97	$147.84	$963.78	$5,522.25	$494.77	$369.22
University Family Care	10	$403.19	$106.40	$222.33	$146.42	$401.99	$121.51	$1,077.83	$5,530.67	$409.48	$322.44
United Health Care	10	$399.41	$111.30	$239.38	$150.44	$417.72	$125.45	$1,018.73	$5,583.87	$402.20	$308.81
Health Choice Arizona	10	$443.19	$105.56	$221.28	$144.25	$372.14	$117.27	$946.20	$5,536.46	$396.68	$293.28
Care 1st	10	$420.99	$100.10	$216.44	$130.80	$349.33	$102.30	$895.74	$5,582.00	$368.94	$295.19
Mercy Care Plan	10	$373.82	$107.97	$229.30	$137.11	$393.05	$124.94	$985.17	$5,563.79	$395.34	$307.45
United Health Care	12	$457.04	$115.29	$268.83	$174.93	$479.64	$159.49	$1,068.89	$6,300.59	$523.67	$348.80
Care 1st	12	$438.88	$106.89	$248.31	$154.77	$413.64	$134.76	$970.11	$6,323.05	$497.42	$353.95
Health Choice Arizona	12	$457.10	$108.59	$249.43	$162.78	$455.75	$147.88	$1,024.84	$6,283.92	$516.62	$351.29
Mercy Care Plan	12	$446.11	$113.30	$264.90	$172.67	$488.31	$165.54	$1,099.64	$6,279.40	$553.98	$365.43
Health Net	12	$433.85	$101.11	$232.63	$150.02	$361.10	$118.78	$943.92	$6,316.03	$458.55	$341.49
University Family Care	14	$496.47	$113.91	$253.41	$174.51	$480.04	$151.72	$1,066.03	$5,443.54	$459.90	$353.63
United Health Care	14	$467.69	$115.47	$243.45	$169.32	$462.61	$154.37	$1,038.85	$5,495.05	$456.84	$346.48

Appendix 2b: Certified Prospective Capitation Rates with APSI

Contractor	GSA	TANF/ Kidscare <1	TANF/ Kidscare 1-13	TANF/ Kidscare 14-44 Female	TANF/ Kidscare 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$383.22	$121.81	$240.33	$144.10	$390.79	$169.18	$1,009.51	$5,655.07	$459.79	$312.16
University Family Care	02	$378.64	$109.66	$212.93	$120.93	$324.21	$144.72	$935.84	$5,607.72	$453.31	$317.79
United Health Care	04	$392.47	$97.79	$203.57	$135.03	$360.39	$124.03	$933.68	$5,825.80	$436.23	$339.79
Health Choice Arizona	04	$402.41	$98.58	$213.99	$144.05	$388.42	$128.55	$1,007.26	$5,778.88	$466.17	$340.84
United Health Care	06	$384.00	$115.74	$250.64	$201.14	$444.39	$166.07	$1,240.63	$5,966.15	$505.64	$406.18
University Family Care	06	$392.07	$111.80	$247.48	$201.21	$400.93	$152.33	$1,103.80	$5,912.46	$487.35	$396.96
University Family Care	08	$424.01	$101.29	$249.67	$152.27	$515.75	$139.15	$1,046.82	$5,523.43	$481.64	$349.36
Health Choice Arizona	08	$426.46	$102.41	$257.28	$153.08	$547.74	$147.84	$965.75	$5,522.25	$496.01	$369.69
University Family Care	10	$421.11	$108.35	$228.68	$148.81	$406.64	$121.51	$1,092.48	$5,530.67	$415.67	$327.14
United Health Care	10	$416.95	$113.33	$246.19	$152.88	$422.52	$125.45	$1,032.58	$5,583.87	$408.23	$313.30
Health Choice Arizona	10	$462.98	$107.49	$227.62	$146.60	$376.44	$117.27	$959.24	$5,536.46	$402.66	$297.52
Care 1st	10	$439.52	$101.92	$222.56	$132.91	$353.30	$102.30	$908.08	$5,582.00	$374.44	$299.46
Mercy Care Plan	10	$390.24	$109.94	$235.84	$139.34	$397.57	$124.94	$998.64	$5,563.79	$401.27	$311.91
United Health Care	12	$464.64	$116.56	$270.74	$175.90	$481.38	$159.49	$1,074.01	$6,300.59	$525.89	$350.14
Care 1st	12	$446.14	$108.06	$250.06	$155.61	$415.12	$134.76	$974.76	$6,323.05	$499.51	$355.31
Health Choice Arizona	12	$464.74	$109.79	$251.21	$163.68	$457.40	$147.88	$1,029.77	$6,283.92	$518.81	$352.64
Mercy Care Plan	12	$453.54	$114.55	$266.79	$173.63	$490.09	$165.54	$1,104.91	$6,279.40	$556.33	$366.84
Health Net	12	$441.10	$102.22	$234.27	$150.85	$362.38	$118.78	$948.47	$6,316.03	$460.48	$342.81
University Family Care	14	$510.43	$114.57	$256.14	$176.41	$482.90	$151.72	$1,072.08	$5,443.54	$462.86	$356.19
United Health Care	14	$480.72	$116.13	$246.03	$171.15	$465.35	$154.37	$1,044.69	$5,495.05	$459.75	$348.98

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Appendix 2c: Certified PPC Capitation Rates without APSI

Contractor	GSA	TANF/ Kidscare <1	TANF/ Kidscare 1-13	TANF/ Kidscare 14-44 Female	TANF/ Kidscare 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$402.80	$30.67	$171.79	$197.41	$182.90	$167.28	$962.78	$693.41	$363.08
University Family Care	02	$402.80	$30.67	$171.79	$197.41	$182.90	$167.28	$962.78	$693.41	$363.08
United Health Care	04	$398.79	$59.11	$173.14	$130.12	$232.42	$59.92	$455.79	$626.51	$419.89
Health Choice Arizona	04	$398.79	$59.11	$173.14	$130.12	$232.42	$59.92	$455.79	$626.51	$419.89
United Health Care	06	$465.71	$47.16	$206.06	$182.57	$372.68	$81.81	$415.89	$711.34	$390.83
University Family Care	06	$465.71	$47.16	$206.06	$182.57	$372.68	$81.81	$415.89	$711.34	$390.83
University Family Care	08	$262.30	$50.67	$168.24	$141.89	$179.34	$93.86	$387.91	$635.20	$348.23
Health Choice Arizona	08	$262.30	$50.67	$168.24	$141.89	$179.34	$93.86	$387.91	$635.20	$348.23
University Family Care	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
United Health Care	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
Health Choice Arizona	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
Care 1st	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
Mercy Care Plan	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
United Health Care	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
Care 1st	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
Health Choice Arizona	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
Mercy Care Plan	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
Health Net	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
University Family Care	14	$668.66	$57.24	$125.00	$93.96	$117.53	$47.48	$399.71	$496.97	$349.80
United Health Care	14	$668.66	$57.24	$125.00	$93.96	$117.53	$47.48	$399.71	$496.97	$349.80

Appendix 2d: Certified PPC Capitation Rates with APSI

Contractor	GSA	TANF/ Kidscare <1	TANF/ Kidscare 1-13	TANF/ Kidscare 14-44 Female	TANF/ Kidscare 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$417.17	$30.99	$172.24	$199.37	$182.90	$167.28	$975.99	$694.81	$363.89
University Family Care	02	$417.17	$30.99	$172.24	$199.37	$182.90	$167.28	$975.99	$694.81	$363.89
United Health Care	04	$404.99	$59.46	$173.39	$130.48	$233.10	$59.92	$456.17	$628.10	$420.66
Health Choice Arizona	04	$404.99	$59.46	$173.39	$130.48	$233.10	$59.92	$456.17	$628.10	$420.66
United Health Care	06	$474.17	$47.74	$206.68	$182.57	$372.68	$81.81	$417.20	$712.82	$390.83
University Family Care	06	$474.17	$47.74	$206.68	$182.57	$372.68	$81.81	$417.20	$712.82	$390.83
University Family Care	08	$265.26	$51.57	$169.08	$143.44	$179.40	$93.86	$387.92	$642.13	$350.23
Health Choice Arizona	08	$265.26	$51.57	$169.08	$143.44	$179.40	$93.86	$387.92	$642.13	$350.23
University Family Care	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
United Health Care	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
Health Choice Arizona	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
Care 1st	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
Mercy Care Plan	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
United Health Care	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
Care 1st	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
Health Choice Arizona	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
Mercy Care Plan	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
Health Net	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
University Family Care	14	$726.86	$58.36	$127.34	$96.02	$118.29	$47.48	$401.91	$505.08	$356.09
United Health Care	14	$726.86	$58.36	$127.34	$96.02	$118.29	$47.48	$401.91	$505.08	$356.09

Appendix 3a: Fiscal Impact Summary without APSI

Contract Type	Rate Cell	Proj Member Months CYE 18	Weighted CYE 17 (1/1/17) Cap Rate	CYE 17 Proj Expenditures	Weighted CYE 18 (10/1/17) Cap Rate	CYE 18 Proj Expenditures	Difference Expenditures	% Increase CYE 18 over CYE 17
Title XIX Prospective	TANF <1	571,868	$470.17	$268,876,578	$433.84	$248,099,020	-$20,777,558	-7.7%
Title XIX Prospective	TANF 1-13	5,991,273	$112.02	$671,154,087	$110.13	$659,808,967	-$11,345,120	-1.7%
Title XIX Prospective	TANF 14-44 Female	3,159,742	$254.40	$803,841,664	$248.93	$786,539,243	-$17,302,421	-2.2%
Title XIX Prospective	TANF 14-44 Male	1,669,038	$153.00	$255,358,570	$160.77	$268,337,064	$12,978,494	5.1%
Title XIX Prospective	TANF 45+	648,478	$437.34	$283,603,279	$441.40	$286,238,250	$2,634,971	0.9%
Title XIX Prospective	SSI with Medicare	1,110,736	$158.89	$176,484,085	$146.11	$162,284,753	-$14,199,332	-8.0%
Title XIX Prospective	SSI w/o Medicare	594,666	$931.88	$554,160,359	$1,036.31	$616,256,515	$62,096,156	11.2%
Title XIX Prospective	Delivery Supplement	35,631	$6,188.15	$220,487,299	$6,042.82	$215,309,102	-$5,178,197	-2.3%
Title XIX Prospective	Adults <= 106% FPL	3,386,913	$467.77	$1,584,292,640	$485.46	$1,644,227,502	$59,934,862	3.8%
Title XIX Prospective	Adults > 106% FPL	954,301	$389.09	$371,310,439	$344.27	$328,532,867	-$42,777,572	-11.5%
Total Title XIX Prospective		18,122,646		$5,189,569,000		$5,215,633,284	$26,064,284	0.5%
Title XIX PPC	TANF <1	20,162	$1,008.65	$20,336,070	$396.39	$7,991,858	-$12,344,211	-60.7%
Title XIX PPC	TANF 1-13	126,169	$53.95	$6,806,870	$50.13	$6,324,779	-$482,091	-7.1%
Title XIX PPC	TANF 14-44 Female	77,536	$195.06	$15,124,140	$195.88	$15,188,039	$63,899	0.4%
Title XIX PPC	TANF 14-44 Male	41,063	$144.55	$5,935,588	$154.43	$6,341,391	$405,803	6.8%
Title XIX PPC	TANF 45+	13,409	$329.42	$4,417,148	$250.17	$3,354,550	-$1,062,598	-24.1%
Title XIX PPC	SSI with Medicare	16,244	$68.64	$1,115,042	$101.83	$1,654,059	$539,017	48.3%
Title XIX PPC	SSI w/o Medicare	13,754	$578.82	$7,960,967	$513.31	$7,059,950	-$901,018	-11.3%
Title XIX PPC	Adults <= 106% FPL	131,089	$667.45	$87,495,758	$685.52	$89,863,721	$2,367,963	2.7%
Title XIX PPC	Adults > 106% FPL	33,126	$330.21	$10,938,541	$363.78	$12,050,830	$1,112,290	10.2%
Total Title XIX PPC		472,552		$160,130,123		$149,829,177	-$10,300,946	-6.4%
Total Title XIX		**18,595,198**		**$5,349,699,124**		**$5,365,462,461**	**$15,763,338**	**0.3%**
Title XXI Prospective	Kidscare <1	4,197	$470.17	$1,973,498	$433.84	$1,820,995	-$152,503	-7.7%
Title XXI Prospective	Kidscare 1-13	258,122	$112.02	$28,915,356	$110.13	$28,426,574	-$488,782	-1.7%
Title XXI Prospective	Kidscare 14-44 Female	41,903	$254.40	$10,660,247	$248.93	$10,430,789	-$229,458	-2.2%
Title XXI Prospective	Kidscare 14-44 Male	42,535	$153.00	$6,507,765	$160.77	$6,838,519	$330,754	5.1%
Total Title XXI		**346,758**		**$48,056,866**		**$47,516,877**	**-$539,989**	**-1.1%**
State Only Transplants		57	$16.50	$941	$16.50	$941	$0	0.0%
Grand Total Capitation		**18,942,013**		**$5,397,756,930**		**$5,412,980,279**	**$15,223,349**	**0.3%**

Appendix 3b: Fiscal Impact Summary with APSI

Contract Type	Rate Cell	Proj Member Months CYE 18	Weighted CYE 17 (1/1/17) Cap Rate	CYE 17 Proj Expenditures	Weighted CYE 18 (10/1/17) Cap Rate	CYE 18 Proj Expenditures	Difference Expenditures	% Increase CYE 18 over CYE 17
Title XIX Prospective	TANF <1	571,868	$470.17	$268,876,578	$442.67	$253,150,951	-$15,725,627	-5.8%
Title XIX Prospective	TANF 1-13	5,991,273	$112.02	$671,154,087	$111.33	$667,007,077	-$4,147,010	-0.6%
Title XIX Prospective	TANF 14-44 Female	3,159,742	$254.40	$803,841,664	$251.32	$794,091,186	-$9,750,478	-1.2%
Title XIX Prospective	TANF 14-44 Male	1,669,038	$153.00	$255,358,570	$161.84	$270,124,444	$14,765,874	5.8%
Title XIX Prospective	TANF 45+	648,478	$437.34	$283,603,279	$443.36	$287,510,479	$3,907,200	1.4%
Title XIX Prospective	SSI with Medicare	1,110,736	$158.89	$176,484,085	$146.11	$162,284,753	-$14,199,332	-8.0%
Title XIX Prospective	SSI w/o Medicare	594,666	$931.88	$554,160,359	$1,042.12	$619,715,475	$65,555,116	11.8%
Title XIX Prospective	Delivery Supplement	35,631	$6,188.15	$220,487,299	$6,042.82	$215,309,102	-$5,178,197	-2.3%
Title XIX Prospective	Adults <= 106% FPL	3,386,913	$467.77	$1,584,292,640	$488.09	$1,653,112,639	$68,819,999	4.3%
Title XIX Prospective	Adults > 106% FPL	954,301	$389.09	$371,310,439	$346.04	$330,228,600	-$41,081,839	-11.1%
Total Title XIX Prospective		18,122,646		$5,189,569,000		$5,252,534,705	$62,965,705	1.2%
Title XIX PPC	TANF <1	20,162	$1,008.65	$20,336,070	$409.22	$8,250,584	-$12,085,485	-59.4%
Title XIX PPC	TANF 1-13	126,169	$53.95	$6,806,870	$51.37	$6,481,077	-$325,794	-4.8%
Title XIX PPC	TANF 14-44 Female	77,536	$195.06	$15,124,140	$198.32	$15,377,387	$253,247	1.7%
Title XIX PPC	TANF 14-44 Male	41,063	$144.55	$5,935,588	$156.51	$6,426,790	$491,202	8.3%
Title XIX PPC	TANF 45+	13,409	$329.42	$4,417,148	$252.10	$3,380,342	-$1,036,806	-23.5%
Title XIX PPC	SSI with Medicare	16,244	$68.64	$1,115,042	$101.83	$1,654,059	$539,017	48.3%
Title XIX PPC	SSI w/o Medicare	13,754	$578.82	$7,960,967	$521.41	$7,171,423	-$789,544	-9.9%
Title XIX PPC	Adults <= 106% FPL	131,089	$667.45	$87,495,758	$694.18	$91,000,086	$3,504,329	4.0%
Title XIX PPC	Adults > 106% FPL	33,126	$330.21	$10,938,541	$367.95	$12,188,950	$1,250,409	11.4%
Total Title XIX PPC		472,552		$160,130,123		$151,930,698	-$8,199,426	-5.1%
Total Title XIX		**18,595,198**		**$5,349,699,124**		**$5,404,465,403**	**$54,766,279**	**1.0%**
Title XXI Prospective	Kidscare <1	4,197	$470.17	$1,973,498	$442.67	$1,858,075	-$115,423	-5.8%
Title XXI Prospective	Kidscare 1-13	258,122	$112.02	$28,915,356	$111.33	$28,736,691	-$178,666	-0.6%
Title XXI Prospective	Kidscare 14-44 Female	41,903	$254.40	$10,660,247	$251.32	$10,530,940	-$129,307	-1.2%
Title XXI Prospective	Kidscare 14-44 Male	42,535	$153.00	$6,507,765	$161.84	$6,884,070	$376,306	5.8%
Total Title XXI		**346,758**		**$48,056,866**		**$48,009,776**	**-$47,090**	**-0.1%**
State Only Transplants		57	$16.50	$941	$16.50	$941	$0	0.0%
Grand Total Capitation		**18,942,013**		**$5,397,756,930**		**$5,452,476,119**	**$54,719,189**	**1.0%**

Appendix 4a: Unadjusted and Adjusted Base Data and Projected Benefit Costs, Prospective

Unadjusted Base Data PMPMs (CYE 16)							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	$345.07	$380.07	$350.26	$397.52	$370.49	$396.68	$409.21
TANF 1-13	$99.33	$85.37	$92.37	$90.21	$92.66	$96.18	$98.69
TANF 14-44 Female	$191.91	$188.64	$206.75	$221.89	$197.68	$215.68	$208.58
TANF 14-44 Male	$116.42	$124.42	$174.47	$131.95	$122.57	$138.54	$141.94
TANF 45+	$302.80	$319.35	$354.94	$456.01	$330.41	$378.61	$383.73
SSI with Medicare	$135.11	$105.55	$129.79	$112.00	$99.89	$120.20	$123.25
SSI w/o Medicare	$829.93	$842.34	$1,010.19	$843.16	$924.86	$887.14	$849.85
Delivery Supplement	$4,276.93	$4,473.21	$4,470.95	$4,355.55	$4,311.07	$4,661.85	$4,134.89
Adults <= 106% FPL	$356.53	$368.34	$407.33	$411.00	$328.00	$424.10	$365.25
Adults > 106% FPL	$256.64	$287.18	$315.59	$306.09	$259.34	$300.20	$298.94

Completion Factors, Aggregated							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	0.9288	0.9424	0.9254	0.9614	0.9291	0.9237	0.9241
TANF 1-13	0.9525	0.9628	0.9579	0.9703	0.9572	0.9541	0.9551
TANF 14-44 Female	0.9501	0.9593	0.9590	0.9694	0.9501	0.9509	0.9418
TANF 14-44 Male	0.9501	0.9600	0.9591	0.9696	0.9483	0.9492	0.9381
TANF 45+	0.9489	0.9574	0.9611	0.9707	0.9513	0.9528	0.9436
SSI with Medicare	0.9426	0.9575	0.9529	0.9664	0.9429	0.9394	0.9434
SSI w/o Medicare	0.9491	0.9574	0.9604	0.9692	0.9463	0.9471	0.9455
Delivery Supplement	0.9190	0.9384	0.9141	0.9573	0.9193	0.9131	0.9160
Adults <= 106% FPL	0.9481	0.9551	0.9545	0.9679	0.9470	0.9460	0.9395
Adults > 106% FPL	0.9507	0.9568	0.9546	0.9696	0.9494	0.9515	0.9375

Loading Factors to Bring to Current Program/Reimbursement Levels							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	1.0257	1.0312	1.0300	1.0302	1.0180	1.0241	1.0351
TANF 1-13	1.0137	1.0089	1.0130	1.0074	1.0073	1.0099	1.0085
TANF 14-44 Female	1.0094	1.0051	1.0035	1.0050	1.0042	1.0049	1.0042
TANF 14-44 Male	1.0074	1.0046	1.0041	1.0047	1.0039	1.0049	1.0054
TANF 45+	1.0315	1.0262	1.0217	1.0201	1.0247	1.0228	1.0227
SSI with Medicare	1.0188	1.0163	1.0127	1.0194	1.0130	1.0152	1.0182
SSI w/o Medicare	1.0300	1.0265	1.0212	1.0287	1.0246	1.0262	1.0259
Delivery Supplement	1.0123	1.0112	1.0109	1.0122	1.0101	1.0120	1.0120
Adults <= 106% FPL	1.0429	1.0406	1.0361	1.0386	1.0431	1.0380	1.0396
Adults > 106% FPL	1.0438	1.0378	1.0345	1.0367	1.0398	1.0361	1.0356

Utilization Trend, Aggregated across All COS							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	-4.6%	-4.7%	-1.5%	-4.9%	-4.6%	-4.1%	-4.0%
TANF 1-13	-2.9%	-4.4%	1.4%	-3.4%	-3.3%	-2.1%	-3.0%
TANF 14-44 Female	-2.8%	-4.6%	-3.5%	-4.2%	-3.3%	-2.4%	-2.5%
TANF 14-44 Male	-1.6%	-4.3%	-0.6%	-3.8%	-1.3%	-1.4%	-0.4%
TANF 45+	-3.0%	0.8%	-4.0%	-3.7%	-3.5%	-3.0%	-3.6%
SSI with Medicare	-2.8%	-2.4%	-1.0%	3.2%	-1.6%	-1.9%	-2.8%
SSI w/o Medicare	0.0%	-3.5%	0.4%	-0.4%	-0.7%	1.3%	0.5%
Delivery Supplement	1.3%	1.3%	1.9%	1.9%	0.5%	2.6%	1.4%
Adults <= 106% FPL	0.1%	-4.4%	-3.7%	-3.3%	-1.9%	-2.3%	-2.9%
Adults > 106% FPL	-4.7%	-3.5%	-3.6%	-4.8%	-3.9%	-3.7%	-3.7%

Unit Cost Trend, Aggregated across All COS							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	1.1%	1.5%	-2.3%	1.8%	0.9%	2.0%	4.1%
TANF 1-13	5.5%	4.3%	1.8%	3.0%	4.4%	2.2%	3.1%
TANF 14-44 Female	5.2%	1.7%	4.2%	4.4%	3.0%	4.0%	2.5%
TANF 14-44 Male	3.4%	3.0%	4.6%	4.0%	3.9%	4.6%	3.6%
TANF 45+	6.0%	-0.9%	5.2%	5.3%	4.8%	4.8%	7.3%
SSI with Medicare	2.6%	2.4%	4.1%	0.8%	1.9%	3.6%	3.5%
SSI w/o Medicare	4.0%	7.3%	3.8%	4.7%	4.6%	3.3%	3.5%
Delivery Supplement	3.1%	3.1%	2.6%	2.3%	2.5%	2.3%	2.8%
Adults <= 106% FPL	3.7%	6.8%	5.3%	5.4%	2.9%	5.0%	5.6%
Adults > 106% FPL	4.8%	2.4%	7.1%	4.3%	2.6%	2.7%	1.6%

Percentage Impact of Program and Reimbursement Changes Effective 10/1/17							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	0.9%	0.6%	0.6%	0.8%	0.8%	0.7%	0.8%
TANF 1-13	0.9%	0.8%	0.5%	0.7%	1.1%	0.6%	1.3%
TANF 14-44 Female	1.0%	2.2%	2.3%	2.0%	1.6%	1.5%	2.0%
TANF 14-44 Male	1.7%	2.4%	3.0%	2.4%	1.7%	1.7%	2.5%
TANF 45+	0.5%	1.2%	1.0%	1.2%	1.3%	0.9%	1.4%
SSI with Medicare	0.8%	2.0%	2.9%	2.7%	1.9%	2.0%	2.5%
SSI w/o Medicare	0.6%	0.8%	1.0%	0.8%	0.5%	0.7%	0.9%
Delivery Supplement	0.0%	0.3%	0.1%	0.2%	0.3%	0.3%	0.0%
Adults <= 106% FPL	0.9%	1.2%	1.7%	1.2%	1.2%	1.0%	1.4%
Adults > 106% FPL	0.8%	1.1%	1.8%	1.4%	1.1%	1.1%	1.4%

Adjusted Base Data PMPMs, Trended to CYE 18							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	$357.70	$391.49	$363.71	$402.15	$379.84	$423.54	$460.86
TANF 1-13	$111.90	$89.68	$104.59	$93.44	$100.54	$102.47	$105.42
TANF 14-44 Female	$215.11	$190.24	$223.72	$234.66	$210.74	$238.24	$226.75
TANF 14-44 Male	$129.81	$129.64	$203.28	$140.28	$138.92	$158.84	$165.99
TANF 45+	$349.55	$345.05	$388.44	$497.76	$368.22	$424.41	$450.66
SSI with Medicare	$146.55	$114.33	$150.70	$131.09	$109.96	$136.90	$138.15
SSI w/o Medicare	$978.70	$975.54	$1,179.37	$981.34	$1,086.13	$1,060.37	$1,005.55
Delivery Supplement	$5,146.00	$5,273.34	$5,402.10	$5,016.00	$5,034.72	$5,708.95	$4,960.68
Adults <= 106% FPL	$425.99	$423.02	$461.97	$463.91	$372.89	$493.83	$430.49
Adults > 106% FPL	$283.29	$307.64	$371.30	$326.62	$279.46	$322.82	$320.60

Appendix 4b: Unadjusted and Adjusted Base Data and Projected Benefit Costs, PPC

Unadjusted Base Data PMPMs (CYE 16)							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	$353.66	$359.57	$408.10	$243.61	$339.68	$349.88	$583.16
TANF 1-13	$24.76	$47.02	$37.73	$41.25	$39.67	$39.86	$44.45
TANF 14-44 Female	$130.87	$137.62	$155.85	$132.56	$144.12	$154.17	$95.88
TANF 14-44 Male	$147.12	$100.45	$137.21	$110.96	$126.17	$113.32	$69.75
TANF 45+	$136.61	$178.53	$277.71	$139.77	$122.47	$210.67	$86.99
SSI with Medicare	$134.14	$48.80	$65.76	$77.62	$72.02	$83.79	$37.90
SSI w/o Medicare	$709.84	$348.16	$305.49	$299.85	$339.45	$380.32	$293.96
Adults <= 106% FPL	$515.21	$473.97	$527.29	$491.29	$359.99	$562.71	$367.90
Adults > 106% FPL	$271.83	$318.76	$290.28	$268.78	$215.53	$282.18	$257.26

Completion Factors, Aggregated							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	0.9163	0.9326	0.9086	0.9575	0.9113	0.9053	0.9096
TANF 1-13	0.9410	0.9434	0.9415	0.9651	0.9299	0.9316	0.9176
TANF 14-44 Female	0.9303	0.9487	0.9307	0.9616	0.9254	0.9249	0.9210
TANF 14-44 Male	0.9260	0.9470	0.9319	0.9610	0.9146	0.9198	0.9150
TANF 45+	0.9262	0.9462	0.9239	0.9606	0.9259	0.9158	0.9088
SSI with Medicare	0.9449	0.9588	0.9478	0.9661	0.9426	0.9269	0.9435
SSI w/o Medicare	0.9184	0.9481	0.9143	0.9590	0.9227	0.9119	0.9157
Adults <= 106% FPL	0.9245	0.9419	0.9225	0.9602	0.9199	0.9153	0.9146
Adults > 106% FPL	0.9288	0.9418	0.9217	0.9577	0.9196	0.9180	0.9161

Loading Factors to Bring to Current Program/Reimbursement Levels							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	1.0188	1.0180	1.0179	1.0150	1.0161	1.0163	1.0178
TANF 1-13	1.0120	1.0136	1.0120	1.0072	1.0091	1.0073	1.0086
TANF 14-44 Female	1.0116	1.0110	1.0104	1.0110	1.0099	1.0098	1.0097
TANF 14-44 Male	1.0153	1.0145	1.0124	1.0123	1.0145	1.0122	1.0132
TANF 45+	1.0137	1.0105	1.0127	1.0115	1.0108	1.0136	1.0046
SSI with Medicare	1.0148	1.0159	1.0153	1.0199	1.0081	1.0131	1.0097
SSI w/o Medicare	1.0165	1.0174	1.0178	1.0142	1.0141	1.0159	1.0182
Adults <= 106% FPL	1.0164	1.0169	1.0158	1.0141	1.0142	1.0141	1.0076
Adults > 106% FPL	1.0135	1.0145	1.0136	1.0140	1.0121	1.0124	1.0183

Utilization Trend, Aggregated across All COS							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	-4.9%	-4.9%	-4.8%	-4.8%	-4.7%	-4.6%	-4.6%
TANF 1-13	3.5%	4.3%	4.3%	4.6%	1.1%	4.7%	4.4%
TANF 14-44 Female	3.5%	3.2%	3.5%	3.3%	2.5%	4.8%	2.6%
TANF 14-44 Male	5.0%	4.7%	5.0%	4.9%	4.9%	5.0%	4.7%
TANF 45+	4.8%	4.7%	4.8%	4.7%	4.9%	4.8%	4.9%
SSI with Medicare	4.9%	5.0%	5.0%	5.0%	5.0%	4.9%	5.0%
SSI w/o Medicare	4.7%	4.8%	4.7%	4.8%	4.8%	4.9%	4.8%
Adults <= 106% FPL	4.9%	4.3%	4.9%	5.0%	4.9%	5.0%	4.9%
Adults > 106% FPL	4.9%	4.9%	5.0%	5.0%	5.0%	5.0%	5.0%

Unit Cost Trend, Aggregated across All COS							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	0.9%	0.5%	0.5%	0.5%	0.3%	-0.1%	0.7%
TANF 1-13	-1.7%	-1.6%	-2.0%	-1.6%	2.6%	-2.5%	-1.5%
TANF 14-44 Female	0.6%	-0.1%	1.1%	0.9%	1.8%	0.1%	0.8%
TANF 14-44 Male	-0.1%	-0.4%	0.0%	-0.4%	-0.2%	0.0%	-0.1%
TANF 45+	0.1%	0.1%	0.2%	0.0%	-0.5%	0.1%	-0.1%
SSI with Medicare	-2.4%	-2.6%	-2.4%	-3.0%	-1.1%	-0.4%	-2.1%
SSI w/o Medicare	0.3%	0.0%	0.2%	0.1%	0.1%	0.1%	0.0%
Adults <= 106% FPL	0.0%	0.6%	0.1%	0.0%	0.0%	0.0%	0.1%
Adults > 106% FPL	0.0%	-0.1%	0.0%	-0.1%	-0.2%	0.0%	-0.1%

Adjusted Base Data PMPMs, Trended to CYE 18							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	$362.28	$358.72	$418.77	$236.20	$346.08	$356.97	$602.07
TANF 1-13	$27.60	$53.23	$42.42	$45.65	$46.32	$44.89	$51.65
TANF 14-44 Female	$154.51	$155.88	$185.26	$151.26	$171.33	$185.00	$112.51
TANF 14-44 Male	$177.51	$117.01	$164.17	$127.57	$153.51	$137.45	$84.52
TANF 45+	$164.51	$209.05	$335.24	$161.31	$145.66	$256.97	$105.75
SSI with Medicare	$150.95	$53.99	$73.97	$84.93	$83.07	$100.02	$42.82
SSI w/o Medicare	$865.84	$409.87	$374.32	$348.96	$410.28	$466.88	$359.62
Adults <= 106% FPL	$623.53	$563.28	$639.85	$571.41	$436.97	$687.17	$446.82
Adults > 106% FPL	$326.51	$377.53	$351.51	$313.17	$260.59	$342.93	$314.61

Appendix 5: Base Data Program and Reimbursement Changes

Effective Date	Programmatic Change	Estimated Annual Impact	Original Rate Certification Description
1/1/2016	High Acuity Pediatrics Adjustor	$5.9 million (nine-month impact)	The AHCCCS All Patient Refined Diagnosis Related Group (APR-DRG) payment system includes several policy adjustors. One such adjustor applies a factor of 1.25 to the reimbursement amount that would otherwise apply for "claims for members under age 19," so long as the claim is not subject to one of the other policy adjustors. Beginning January 1, 2016, AHCCCS addressed the costs associated with high-acuity pediatric cases by using an adjustment factor of 1.60 in place of the above pediatric policy adjustor in the following instances only: for inpatient stays, where an APR-DRG assignment of level 3 or 4 Severity of Illness is indicated.
10/1/2016	Long-Acting Reversible Contraception (LARC)	$1.7 million	Many repeat births could be prevented through postpartum use of LARC. Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices since many members do not attend their 6-week post-partum office visits. Currently no ICD-10 PCS code for the LARC device exists for inpatient hospital use thus, effective October 1, 2016, AHCCCS began paying hospitals for the device in addition to a DRG payment.
10/1/2016	Podiatry	$2.5 million	During the 2016 legislative session, services provided by a podiatrist were reinstated. Effective October 1, 2016 AHCCCS restored this covered service.
10/1/2016	Reinsurance (RI) for Cinryze	($3.6 million)	Effective October 1, 2016, Cinryze was added to the list of drugs eligible for catastrophic reinsurance.

Effective Date	Programmatic Change	Estimated Annual Impact	Original Rate Certification Description
10/1/2016	Value-Based Purchasing (VBP) Differential Payments	$6.5 million	AHCCCS proposed VBP Differential Adjusted Fee Schedule rates 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. The proposed VBP differential rates are applicable for dates of service from October 1, 2016 through September 30, 2017. FFS rates for select providers meeting specific criteria will be increased 1% for qualified AHCCCS-registered Arizona Nursing Facility providers and 0.5% for qualified AHCCCS-registered Arizona Hospital providers for inpatient and outpatient services. Contractors are required to adopt the VBP Differential payment adjustments for qualified providers meeting the specific criteria.
10/1/2016	IMD	$0.9 million	AHCCCS previously permitted funding for "in-lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. In accordance with 438.6(e) in the Medicaid Managed Care Regulations, IMD utilization data for adults aged 21-64 was repriced at the higher State Plan service rates.

Effective Date	Programmatic Change	Estimated Annual Impact	Original Rate Certification Description
10/1/2016	AzEIP	$0.3 million	The Arizona Early Intervention Program (AzEIP) is a program that provides services to enhance the capacity of families and caregivers to support infants and toddlers with developmental delays or disabilities in their development. AzEIP members may be AHCCCS enrolled, in which case AHCCCS pays for the services, or non-AHCCCS enrolled, in which case AzEIP pays directly. Effective October 1, 2016, AHCCCS modified the speech therapy rate structure for services provided to a member who is a child identified in the AHCCCS system as an AzEIP recipient in order to more closely align the rates with the AzEIP rate structure. This change is intended to assure continued access to care, particularly for rural AzEIP members, where providers often travel to provide services in the natural setting, and should limit the rate differential whether the provider is paid the AHCCCS rates or the AzEIP rates. This will ensure there is not different access to services for AzEIP children based on whether the payer is AHCCCS or AzEIP.
10/1/2016	Provider Fee Schedule Changes	$13.7 million	Effective October 1, 2016, AHCCCS changed Fee For Service (FFS) provider rates for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates.
1/1/2017	High Acuity Pediatrics Adjustor	$5.5 million (nine-month impact)	On January 1, 2016, AHCCCS addressed the costs associated with high-acuity pediatric cases by using an adjustment factor of 1.60 in place of the above pediatric policy adjustor in the following instances only: for inpatient stays, where an APR-DRG assignment of level 3 or 4 Severity of Illness is indicated. Effective January 1, 2017, AHCCCS will change the adjustment factor of 1.60 established January 1, 2016 to 1.945.

*Note: The PMPM impact varies by rate cell and GSA.

Appendix 6a: Base Data for Development of CYE 18 RI Offset by Rate Cell and GSA, Prospective

RI Payments PMPM for Regular Cases (CYE 16)							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	$24.35	$40.79	$25.27	$25.26	$16.57	$22.46	$20.48
TANF 1-13	$2.87	$0.83	$1.32	$1.08	$0.39	$0.76	$0.04
TANF 14-44 Female	$1.39	$1.39	$0.95	$1.41	$2.15	$2.31	$0.86
TANF 14-44 Male	$2.60	$0.93	$3.29	$2.18	$3.47	$4.18	$8.48
TANF 45+	$5.71	$4.33	$1.09	$7.25	$3.18	$5.89	$17.26
SSI with Medicare	$0.42	$0.29	$0.00	$1.18	$1.07	$1.14	$0.10
SSI w/o Medicare	$44.23	$44.02	$39.96	$47.14	$51.74	$67.81	$25.50
Adults <= 106% FPL	$4.69	$10.42	$7.29	$12.87	$6.82	$12.94	$7.51
Adults > 106% FPL	$4.15	$7.42	$8.01	$5.15	$5.66	$6.18	$7.45

RI Payments PMPM for Non-Regular Cases (CYE 16)							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01	$0.00
TANF 1-13	$0.02	$0.11	$0.00	$0.21	$1.06	$0.62	$0.06
TANF 14-44 Female	$0.22	$0.00	$0.00	$2.19	$0.01	$0.22	$0.00
TANF 14-44 Male	$0.00	$3.33	$15.45	$0.00	$2.97	$1.88	$0.00
TANF 45+	$0.00	$0.00	$0.00	$0.00	$2.26	$0.00	$0.00
SSI with Medicare	$0.03	$0.00	$1.33	$0.00	$0.07	$0.15	$0.00
SSI w/o Medicare	$25.72	$36.85	$43.70	$2.44	$92.02	$21.72	$12.26
Adults <= 106% FPL	$0.02	$0.00	$0.00	$0.18	$1.00	$2.73	$1.94
Adults > 106% FPL	$0.00	$0.02	$0.00	$0.00	$0.37	$2.65	$0.02

Appendix 6b: PMPM Cost Trends for Development of CYE 18 RI Offset by Rate Cell and GSA, Prospective

PMPM Cost Trend Assumed for Regular Cases (CYE 18)							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	-5.0%	-5.0%	-4.8%	-5.0%	-5.0%	-2.6%	1.2%
TANF 1-13	1.4%	-5.0%	1.4%	-0.9%	-5.0%	-5.0%	4.0%
TANF 14-44 Female	-2.5%	-5.0%	-5.0%	-5.0%	-4.1%	-0.2%	-5.0%
TANF 14-44 Male	5.0%	-5.0%	5.0%	-2.5%	5.0%	5.0%	5.0%
TANF 45+	5.0%	-5.0%	-3.6%	5.0%	-3.3%	0.7%	4.6%
SSI with Medicare	-5.0%	-5.0%	-5.0%	5.0%	-5.0%	3.7%	-5.0%
SSI w/o Medicare	5.0%	2.5%	4.7%	5.0%	5.0%	5.0%	5.0%
Adults <= 106% FPL	5.0%	5.0%	5.0%	4.9%	1.8%	5.0%	5.0%
Adults > 106% FPL	-4.8%	-5.0%	5.0%	-5.0%	-5.0%	-5.0%	2.4%

PMPM Cost Trend Assumed for Non-Regular Cases (CYE 18)							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%
TANF 1-13	5.0%	0.9%	5.0%	5.0%	3.5%	5.0%	5.0%
TANF 14-44 Female	5.0%	-1.5%	5.0%	5.0%	2.4%	5.0%	5.0%
TANF 14-44 Male	-2.8%	-5.0%	5.0%	5.0%	2.5%	5.0%	5.0%
TANF 45+	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
SSI with Medicare	-0.7%	-4.6%	5.0%	5.0%	-3.2%	-5.0%	-5.0%
SSI w/o Medicare	3.1%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Adults <= 106% FPL	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Adults > 106% FPL	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	-5.0%

Appendix 6c: PMPM Adjustments and CYE 18 RI Offset by Rate Cell and GSA, Prospective

PMPM Adjustments to Non-Regular RI for High-Cost Biologics Added Effective 10/1/16							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF 1-13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF 14-44 Female	$0.00	$0.00	$0.00	$0.00	$0.00	$0.46	$0.00
TANF 14-44 Male	$0.00	$0.00	$0.00	$0.00	$0.00	$0.28	$0.00
TANF 45+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.14	$0.00
SSI with Medicare	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
SSI w/o Medicare	$0.00	$0.00	$0.00	$0.00	$3.68	$4.68	$0.00
Adults <= 106% FPL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.11	$0.00
Adults > 106% FPL	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

PMPM Adjustments to Non-Regular RI for High-Cost Biologics Added Effective 10/1/17							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF 1-13	$0.00	$0.00	$0.00	$0.00	$0.13	$0.03	$0.00
TANF 14-44 Female	$0.00	$0.00	$0.00	$0.00	$0.00	$0.21	$0.00
TANF 14-44 Male	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF 45+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.73	$0.00
SSI with Medicare	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
SSI w/o Medicare	$1.96	$0.00	$0.00	$0.00	$4.01	$0.10	$0.00
Adults <= 106% FPL	$0.00	$0.00	$0.00	$0.00	$0.32	$0.25	$0.00
Adults > 106% FPL	$0.00	$0.00	$0.00	$0.00	$0.86	$0.38	$0.00

RI Offset PMPM Assumed in Rates (CYE 18)							
Rate Cell	GSA 02	GSA 04	GSA 06	GSA 08	GSA 10	GSA 12	GSA 14
TANF <1	-$21.98	-$36.81	-$22.91	-$22.79	-$14.96	-$21.33	-$21.00
TANF 1-13	-$2.96	-$0.86	-$1.36	-$1.29	-$1.63	-$1.40	-$0.11
TANF 14-44 Female	-$1.56	-$1.26	-$0.86	-$3.69	-$1.99	-$3.22	-$0.77
TANF 14-44 Male	-$2.87	-$3.85	-$20.66	-$2.07	-$6.95	-$6.96	-$9.35
TANF 45+	-$6.29	-$3.91	-$1.02	-$8.00	-$5.46	-$6.85	-$18.87
SSI with Medicare	-$0.40	-$0.26	-$1.47	-$1.30	-$1.03	-$1.37	-$0.09
SSI w/o Medicare	-$78.03	-$86.91	-$92.03	-$54.65	-$166.18	-$103.49	-$41.64
Adults <= 106% FPL	-$5.19	-$11.49	-$8.03	-$14.37	-$8.48	-$17.64	-$10.41
Adults > 106% FPL	-$3.76	-$6.72	-$8.84	-$4.65	-$6.38	-$8.88	-$7.82

Appendix 7a: CYE 18 Projected Gross Medical Expenses PMPM by MCO, Rate Cell and GSA, Prospective

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$357.70	$111.90	$215.11	$129.81	$349.55	$146.55	$978.70	$5,146.00	$425.99	$283.29
University Family Care	02	$357.70	$111.90	$215.11	$129.81	$349.55	$146.55	$978.70	$5,146.00	$425.99	$283.29
United Health Care	04	$391.49	$89.68	$190.24	$129.64	$345.05	$114.33	$975.54	$5,273.34	$423.02	$307.64
Health Choice Arizona	04	$391.49	$89.68	$190.24	$129.64	$345.05	$114.33	$975.54	$5,273.34	$423.02	$307.64
United Health Care	06	$363.71	$104.59	$223.72	$203.28	$388.44	$150.70	$1,179.37	$5,402.10	$461.97	$371.30
University Family Care	06	$363.71	$104.59	$223.72	$203.28	$388.44	$150.70	$1,179.37	$5,402.10	$461.97	$371.30
University Family Care	08	$402.15	$93.44	$234.66	$140.28	$497.76	$131.09	$981.34	$5,016.00	$463.91	$326.62
Health Choice Arizona	08	$402.15	$93.44	$234.66	$140.28	$497.76	$131.09	$981.34	$5,016.00	$463.91	$326.62
University Family Care	10	$379.84	$100.54	$210.74	$138.92	$368.22	$109.96	$1,086.13	$5,034.72	$372.89	$279.46
United Health Care	10	$379.84	$100.54	$210.74	$138.92	$368.22	$109.96	$1,086.13	$5,034.72	$372.89	$279.46
Health Choice Arizona	10	$379.84	$100.54	$210.74	$138.92	$368.22	$109.96	$1,086.13	$5,034.72	$372.89	$279.46
Care 1st	10	$379.84	$100.54	$210.74	$138.92	$368.22	$109.96	$1,086.13	$5,034.72	$372.89	$279.46
Mercy Care Plan	10	$379.84	$100.54	$210.74	$138.92	$368.22	$109.96	$1,086.13	$5,034.72	$372.89	$279.46
United Health Care	12	$423.54	$102.47	$238.24	$158.84	$424.41	$136.90	$1,060.37	$5,708.95	$493.83	$322.82
Care 1st	12	$423.54	$102.47	$238.24	$158.84	$424.41	$136.90	$1,060.37	$5,708.95	$493.83	$322.82
Health Choice Arizona	12	$423.54	$102.47	$238.24	$158.84	$424.41	$136.90	$1,060.37	$5,708.95	$493.83	$322.82
Mercy Care Plan	12	$423.54	$102.47	$238.24	$158.84	$424.41	$136.90	$1,060.37	$5,708.95	$493.83	$322.82
Health Net	12	$423.54	$102.47	$238.24	$158.84	$424.41	$136.90	$1,060.37	$5,708.95	$493.83	$322.82
University Family Care	14	$460.86	$105.42	$226.75	$165.99	$450.66	$138.15	$1,005.55	$4,960.68	$430.49	$320.60
United Health Care	14	$460.86	$105.42	$226.75	$165.99	$450.66	$138.15	$1,005.55	$4,960.68	$430.49	$320.60

Appendix 7b: CYE 18 Projected Risk Adjustment Factors by MCO, Rate Cell and GSA, Prospective

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	1.0004	1.0232	1.0272	1.0385	1.0398	1.0288	1.0180	1.0000	1.0022	0.9946
University Family Care	02	0.9989	0.9257	0.9122	0.8735	0.8633	0.8773	0.9531	1.0000	0.9949	1.0139
United Health Care	04	0.9767	0.9889	0.9567	0.9501	0.9429	0.9761	0.9515	1.0000	0.9589	0.9982
Health Choice Arizona	04	1.0133	1.0065	1.0236	1.0281	1.0345	1.0251	1.0323	1.0000	1.0357	1.0015
United Health Care	06	0.9873	1.0108	1.0007	0.9965	1.0361	1.0212	1.0427	1.0000	1.0102	1.0087
University Family Care	06	1.0202	0.9841	0.9989	1.0052	0.9376	0.9392	0.9375	1.0000	0.9809	0.9846
University Family Care	08	0.9939	0.9937	0.9807	0.9969	0.9648	0.9585	1.0431	1.0000	0.9818	0.9659
Health Choice Arizona	08	1.0046	1.0055	1.0152	1.0026	1.0297	1.0256	0.9633	1.0000	1.0130	1.0262
University Family Care	10	0.9967	0.9937	0.9754	1.0180	1.0175	1.0042	1.0722	1.0000	1.0365	1.0526
United Health Care	10	0.9758	1.0333	1.0449	1.0376	1.0503	1.0288	1.0129	1.0000	1.0096	1.0052
Health Choice Arizona	10	1.1004	0.9847	0.9718	1.0019	0.9400	0.9682	0.9539	1.0000	1.0024	0.9513
Care 1st	10	1.0307	0.9253	0.9396	0.9007	0.8703	0.8241	0.9027	1.0000	0.9210	0.9579
Mercy Care Plan	10	0.9133	1.0040	1.0019	0.9477	0.9885	1.0282	0.9854	1.0000	0.9939	1.0005
United Health Care	12	1.0157	1.0380	1.0425	1.0477	1.0458	1.0458	1.0225	1.0000	1.0060	0.9842
Care 1st	12	0.9697	0.9549	0.9555	0.9210	0.8914	0.8663	0.9293	1.0000	0.9513	0.9997
Health Choice Arizona	12	1.0212	0.9773	0.9679	0.9760	0.9955	0.9689	0.9842	1.0000	0.9945	0.9917
Mercy Care Plan	12	0.9935	1.0226	1.0299	1.0371	1.0690	1.0929	1.0533	1.0000	1.0676	1.0342
Health Net	12	0.9684	0.9032	0.8934	0.8961	0.7737	0.7548	0.9109	1.0000	0.8780	0.9622
University Family Care	14	1.0352	0.9969	1.0266	1.0193	1.0239	0.9939	1.0171	1.0000	1.0082	1.0118
United Health Care	14	0.9661	1.0031	0.9744	0.9801	0.9785	1.0032	0.9827	1.0000	0.9932	0.9901

Appendix 7c: CYE 18 Projected RI Offsets PMPM by MCO, Rate Cell and GSA, Prospective

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	-$21.98	-$2.96	-$1.56	-$2.87	-$6.29	-$0.40	-$78.03	$0.00	-$5.19	-$3.76
University Family Care	02	-$21.98	-$2.96	-$1.56	-$2.87	-$6.29	-$0.40	-$78.03	$0.00	-$5.19	-$3.76
United Health Care	04	-$36.81	-$0.86	-$1.26	-$3.85	-$3.91	-$0.26	-$86.91	$0.00	-$11.49	-$6.72
Health Choice Arizona	04	-$36.81	-$0.86	-$1.26	-$3.85	-$3.91	-$0.26	-$86.91	$0.00	-$11.49	-$6.72
United Health Care	06	-$22.91	-$1.36	-$0.86	-$20.66	-$1.02	-$1.47	-$92.03	$0.00	-$8.03	-$8.84
University Family Care	06	-$22.91	-$1.36	-$0.86	-$20.66	-$1.02	-$1.47	-$92.03	$0.00	-$8.03	-$8.84
University Family Care	08	-$22.79	-$1.29	-$3.69	-$2.07	-$8.00	-$1.30	-$54.65	$0.00	-$14.37	-$4.65
Health Choice Arizona	08	-$22.79	-$1.29	-$3.69	-$2.07	-$8.00	-$1.30	-$54.65	$0.00	-$14.37	-$4.65
University Family Care	10	-$14.96	-$1.63	-$1.99	-$6.95	-$5.46	-$1.03	-$166.18	$0.00	-$8.48	-$6.38
United Health Care	10	-$14.96	-$1.63	-$1.99	-$6.95	-$5.46	-$1.03	-$166.18	$0.00	-$8.48	-$6.38
Health Choice Arizona	10	-$14.96	-$1.63	-$1.99	-$6.95	-$5.46	-$1.03	-$166.18	$0.00	-$8.48	-$6.38
Care 1st	10	-$14.96	-$1.63	-$1.99	-$6.95	-$5.46	-$1.03	-$166.18	$0.00	-$8.48	-$6.38
Mercy Care Plan	10	-$14.96	-$1.63	-$1.99	-$6.95	-$5.46	-$1.03	-$166.18	$0.00	-$8.48	-$6.38
United Health Care	12	-$21.33	-$1.40	-$3.22	-$6.96	-$6.85	-$1.37	-$103.49	$0.00	-$17.64	-$8.88
Care 1st	12	-$21.33	-$1.40	-$3.22	-$6.96	-$6.85	-$1.37	-$103.49	$0.00	-$17.64	-$8.88
Health Choice Arizona	12	-$21.33	-$1.40	-$3.22	-$6.96	-$6.85	-$1.37	-$103.49	$0.00	-$17.64	-$8.88
Mercy Care Plan	12	-$21.33	-$1.40	-$3.22	-$6.96	-$6.85	-$1.37	-$103.49	$0.00	-$17.64	-$8.88
Health Net	12	-$21.33	-$1.40	-$3.22	-$6.96	-$6.85	-$1.37	-$103.49	$0.00	-$17.64	-$8.88
University Family Care	14	-$21.00	-$0.11	-$0.77	-$9.35	-$18.87	-$0.09	-$41.64	$0.00	-$10.41	-$7.82
United Health Care	14	-$21.00	-$0.11	-$0.77	-$9.35	-$18.87	-$0.09	-$41.64	$0.00	-$10.41	-$7.82

*Note: RI does not apply to PPC capitation rates.

Appendix 7d: CYE 18 Projected UW Gain PMPM by MCO, Rate Cell and GSA, Prospective

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$3.58	$1.14	$2.21	$1.35	$3.63	$1.51	$9.96	$51.46	$4.27	$2.82
University Family Care	02	$3.57	$1.04	$1.96	$1.13	$3.02	$1.29	$9.33	$51.46	$4.24	$2.87
United Health Care	04	$3.82	$0.89	$1.82	$1.23	$3.25	$1.12	$9.28	$52.73	$4.06	$3.07
Health Choice Arizona	04	$3.97	$0.90	$1.95	$1.33	$3.57	$1.17	$10.07	$52.73	$4.38	$3.08
United Health Care	06	$3.59	$1.06	$2.24	$2.03	$4.02	$1.54	$12.30	$54.02	$4.67	$3.75
University Family Care	06	$3.71	$1.03	$2.23	$2.04	$3.64	$1.42	$11.06	$54.02	$4.53	$3.66
University Family Care	08	$4.00	$0.93	$2.30	$1.40	$4.80	$1.26	$10.24	$50.16	$4.55	$3.15
Health Choice Arizona	08	$4.04	$0.94	$2.38	$1.41	$5.13	$1.34	$9.45	$50.16	$4.70	$3.35
University Family Care	10	$3.79	$1.00	$2.06	$1.41	$3.75	$1.10	$11.65	$50.35	$3.87	$2.94
United Health Care	10	$3.71	$1.04	$2.20	$1.44	$3.87	$1.13	$11.00	$50.35	$3.76	$2.81
Health Choice Arizona	10	$4.18	$0.99	$2.05	$1.39	$3.46	$1.06	$10.36	$50.35	$3.74	$2.66
Care 1st	10	$3.92	$0.93	$1.98	$1.25	$3.20	$0.91	$9.80	$50.35	$3.43	$2.68
Mercy Care Plan	10	$3.47	$1.01	$2.11	$1.32	$3.64	$1.13	$10.70	$50.35	$3.71	$2.80
United Health Care	12	$4.30	$1.06	$2.48	$1.66	$4.44	$1.43	$10.84	$57.09	$4.97	$3.18
Care 1st	12	$4.11	$0.98	$2.28	$1.46	$3.78	$1.19	$9.85	$57.09	$4.70	$3.23
Health Choice Arizona	12	$4.33	$1.00	$2.31	$1.55	$4.23	$1.33	$10.44	$57.09	$4.91	$3.20
Mercy Care Plan	12	$4.21	$1.05	$2.45	$1.65	$4.54	$1.50	$11.17	$57.09	$5.27	$3.34
Health Net	12	$4.10	$0.93	$2.13	$1.42	$3.28	$1.03	$9.66	$57.09	$4.34	$3.11
University Family Care	14	$4.77	$1.05	$2.33	$1.69	$4.61	$1.37	$10.23	$49.61	$4.34	$3.24
United Health Care	14	$4.45	$1.06	$2.21	$1.63	$4.41	$1.39	$9.88	$49.61	$4.28	$3.17

Appendix 7e: CYE 18 Projected Administrative Expenses PMPM by MCO, Rate Cell and GSA, Prospective

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$29.16	$6.31	$13.52	$7.65	$21.77	$13.91	$59.48	$344.50	$23.87	$24.79
University Family Care	02	$25.23	$5.46	$11.70	$6.62	$18.89	$12.37	$51.47	$298.10	$20.66	$24.79
United Health Care	04	$30.77	$6.85	$16.65	$11.62	$28.23	$9.10	$63.51	$383.21	$28.86	$29.19
Health Choice Arizona	04	$25.84	$6.03	$13.98	$10.23	$23.77	$7.87	$55.89	$337.23	$25.39	$29.19
United Health Care	06	$32.04	$7.53	$20.03	$12.84	$29.74	$8.78	$64.53	$390.71	$31.71	$28.32
University Family Care	06	$27.73	$6.51	$17.33	$11.11	$25.80	$7.80	$55.84	$338.09	$27.44	$28.32
University Family Care	08	$29.86	$5.83	$15.22	$9.49	$27.68	$10.76	$44.57	$346.81	$25.19	$27.96
Health Choice Arizona	08	$27.86	$5.81	$14.48	$9.46	$26.38	$10.39	$44.42	$345.65	$24.62	$27.96
University Family Care	10	$27.72	$4.99	$12.27	$7.61	$21.02	$8.58	$46.21	$334.99	$19.39	$25.29
United Health Care	10	$32.04	$5.77	$14.18	$8.80	$24.24	$9.71	$53.40	$387.13	$22.41	$25.29
Health Choice Arizona	10	$27.13	$5.08	$12.01	$7.74	$20.57	$8.43	$47.00	$340.67	$19.72	$25.29
Care 1st	10	$32.10	$5.77	$14.11	$8.76	$24.13	$9.76	$53.74	$385.29	$23.18	$25.29
Mercy Care Plan	10	$30.91	$5.48	$13.46	$8.35	$23.02	$9.28	$50.69	$367.45	$21.60	$25.29
United Health Care	12	$34.76	$6.96	$15.81	$10.32	$28.61	$13.06	$55.97	$408.54	$29.06	$29.81
Care 1st	12	$36.61	$7.33	$16.65	$10.88	$30.12	$13.65	$58.95	$430.55	$30.61	$29.81
Health Choice Arizona	12	$32.44	$6.68	$14.75	$9.91	$26.73	$12.32	$53.73	$392.20	$27.90	$29.81
Mercy Care Plan	12	$33.53	$6.60	$15.00	$9.80	$27.18	$12.49	$53.12	$387.77	$28.03	$29.81
Health Net	12	$32.27	$7.02	$16.22	$10.22	$29.07	$13.40	$52.97	$423.67	$29.09	$29.81
University Family Care	14	$25.67	$5.60	$14.02	$9.48	$23.28	$10.10	$53.33	$324.38	$22.76	$26.76
United Health Care	14	$29.66	$6.47	$16.20	$10.96	$26.86	$11.40	$61.64	$374.86	$26.30	$26.76

Appendix 7f: CYE 18 Premium Tax PMPM by MCO, Rate Cell and GSA, Prospective

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$7.52	$2.43	$4.80	$2.88	$7.81	$3.38	$20.16	$113.10	$9.18	$6.24
University Family Care	02	$7.43	$2.19	$4.25	$2.41	$6.48	$2.89	$18.69	$112.15	$9.05	$6.35
United Health Care	04	$7.76	$1.95	$4.07	$2.70	$7.20	$2.48	$18.65	$116.52	$8.72	$6.79
Health Choice Arizona	04	$7.95	$1.97	$4.27	$2.88	$7.76	$2.57	$20.12	$115.58	$9.31	$6.81
United Health Care	06	$7.59	$2.31	$5.01	$4.02	$8.88	$3.32	$24.79	$119.32	$10.10	$8.12
University Family Care	06	$7.75	$2.23	$4.94	$4.02	$8.01	$3.05	$22.05	$118.25	$9.74	$7.93
University Family Care	08	$8.38	$2.01	$4.98	$3.03	$10.30	$2.78	$20.89	$110.47	$9.61	$6.98
Health Choice Arizona	08	$8.43	$2.03	$5.13	$3.05	$10.94	$2.96	$19.28	$110.45	$9.90	$7.38
University Family Care	10	$8.06	$2.13	$4.45	$2.93	$8.04	$2.43	$21.56	$110.61	$8.19	$6.45
United Health Care	10	$7.99	$2.23	$4.79	$3.01	$8.35	$2.51	$20.37	$111.68	$8.04	$6.18
Health Choice Arizona	10	$8.86	$2.11	$4.43	$2.88	$7.44	$2.35	$18.92	$110.73	$7.93	$5.87
Care 1st	10	$8.42	$2.00	$4.33	$2.62	$6.99	$2.05	$17.91	$111.64	$7.38	$5.90
Mercy Care Plan	10	$7.48	$2.16	$4.59	$2.74	$7.86	$2.50	$19.70	$111.28	$7.91	$6.15
United Health Care	12	$9.14	$2.31	$5.38	$3.50	$9.59	$3.19	$21.38	$126.01	$10.47	$6.98
Care 1st	12	$8.78	$2.14	$4.97	$3.10	$8.27	$2.70	$19.40	$126.46	$9.95	$7.08
Health Choice Arizona	12	$9.14	$2.17	$4.99	$3.26	$9.11	$2.96	$20.50	$125.68	$10.33	$7.03
Mercy Care Plan	12	$8.92	$2.27	$5.30	$3.45	$9.77	$3.31	$21.99	$125.59	$11.08	$7.31
Health Net	12	$8.68	$2.02	$4.65	$3.00	$7.22	$2.38	$18.88	$126.32	$9.17	$6.83
University Family Care	14	$9.93	$2.28	$5.07	$3.49	$9.60	$3.03	$21.32	$108.87	$9.20	$7.07
United Health Care	14	$9.35	$2.31	$4.87	$3.39	$9.25	$3.09	$20.78	$109.90	$9.14	$6.93

Appendix 7g: CYE 18 Capitation Rates PMPM by MCO, Rate Cell and GSA, Prospective, without APSI

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$376.12	$121.42	$239.93	$143.81	$390.38	$169.18	$1,007.84	$5,655.07	$459.06	$311.83
University Family Care	02	$371.55	$109.30	$212.57	$120.69	$323.86	$144.72	$934.28	$5,607.72	$452.58	$317.46
United Health Care	04	$387.89	$97.51	$203.27	$134.88	$360.14	$124.03	$932.73	$5,825.80	$435.80	$339.41
Health Choice Arizona	04	$397.66	$98.29	$213.68	$143.88	$388.14	$128.55	$1,006.22	$5,778.88	$465.70	$340.45
United Health Care	06	$379.40	$115.26	$250.29	$200.79	$444.08	$166.07	$1,239.28	$5,966.15	$505.11	$405.86
University Family Care	06	$387.32	$111.33	$247.12	$200.85	$400.65	$152.33	$1,102.59	$5,912.46	$486.83	$396.65
University Family Care	08	$419.16	$100.33	$248.95	$151.69	$515.03	$139.15	$1,044.69	$5,523.43	$480.44	$348.92
Health Choice Arizona	08	$421.55	$101.44	$256.53	$152.48	$546.97	$147.84	$963.78	$5,522.25	$494.77	$369.22
University Family Care	10	$403.19	$106.40	$222.33	$146.42	$401.99	$121.51	$1,077.83	$5,530.67	$409.48	$322.44
United Health Care	10	$399.41	$111.30	$239.38	$150.44	$417.72	$125.45	$1,018.73	$5,583.87	$402.20	$308.81
Health Choice Arizona	10	$443.19	$105.56	$221.28	$144.25	$372.14	$117.27	$946.20	$5,536.46	$396.68	$293.28
Care 1st	10	$420.99	$100.10	$216.44	$130.80	$349.33	$102.30	$895.74	$5,582.00	$368.94	$295.19
Mercy Care Plan	10	$373.82	$107.97	$229.30	$137.11	$393.05	$124.94	$985.17	$5,563.79	$395.34	$307.45
United Health Care	12	$457.04	$115.29	$268.83	$174.93	$479.64	$159.49	$1,068.89	$6,300.59	$523.67	$348.80
Care 1st	12	$438.88	$106.89	$248.31	$154.77	$413.64	$134.76	$970.11	$6,323.05	$497.42	$353.95
Health Choice Arizona	12	$457.10	$108.59	$249.43	$162.78	$455.75	$147.88	$1,024.84	$6,283.92	$516.62	$351.29
Mercy Care Plan	12	$446.11	$113.30	$264.90	$172.67	$488.31	$165.54	$1,099.64	$6,279.40	$553.98	$365.43
Health Net	12	$433.85	$101.11	$232.63	$150.02	$361.10	$118.78	$943.92	$6,316.03	$458.55	$341.49
University Family Care	14	$496.47	$113.91	$253.41	$174.51	$480.04	$151.72	$1,066.03	$5,443.54	$459.90	$353.63
United Health Care	14	$467.69	$115.47	$243.45	$169.32	$462.61	$154.37	$1,038.85	$5,495.05	$456.84	$346.48

Appendix 7h: CYE 18 Projected APSI Payments PMPM by MCO, Rate Cell and GSA, Prospective

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$6.95	$0.39	$0.39	$0.28	$0.40	$0.00	$1.63	$0.00	$0.72	$0.31
University Family Care	02	$6.94	$0.35	$0.35	$0.24	$0.34	$0.00	$1.53	$0.00	$0.71	$0.32
United Health Care	04	$4.49	$0.28	$0.29	$0.15	$0.25	$0.00	$0.93	$0.00	$0.42	$0.38
Health Choice Arizona	04	$4.66	$0.28	$0.31	$0.16	$0.27	$0.00	$1.01	$0.00	$0.45	$0.38
United Health Care	06	$4.51	$0.47	$0.35	$0.35	$0.31	$0.00	$1.32	$0.00	$0.52	$0.32
University Family Care	06	$4.66	$0.46	$0.34	$0.35	$0.28	$0.00	$1.19	$0.00	$0.51	$0.31
University Family Care	08	$4.76	$0.94	$0.71	$0.58	$0.71	$0.00	$2.09	$0.00	$1.18	$0.44
Health Choice Arizona	08	$4.81	$0.95	$0.73	$0.58	$0.75	$0.00	$1.93	$0.00	$1.21	$0.46
University Family Care	10	$17.56	$1.91	$6.23	$2.34	$4.56	$0.00	$14.37	$0.00	$6.06	$4.60
United Health Care	10	$17.19	$1.99	$6.67	$2.39	$4.70	$0.00	$13.57	$0.00	$5.90	$4.39
Health Choice Arizona	10	$19.39	$1.89	$6.21	$2.30	$4.21	$0.00	$12.78	$0.00	$5.86	$4.16
Care 1st	10	$18.16	$1.78	$6.00	$2.07	$3.90	$0.00	$12.09	$0.00	$5.39	$4.19
Mercy Care Plan	10	$16.09	$1.93	$6.40	$2.18	$4.43	$0.00	$13.20	$0.00	$5.81	$4.37
United Health Care	12	$7.44	$1.25	$1.88	$0.94	$1.70	$0.00	$5.01	$0.00	$2.17	$1.31
Care 1st	12	$7.11	$1.15	$1.72	$0.83	$1.45	$0.00	$4.56	$0.00	$2.05	$1.33
Health Choice Arizona	12	$7.49	$1.18	$1.74	$0.88	$1.62	$0.00	$4.83	$0.00	$2.15	$1.32
Mercy Care Plan	12	$7.28	$1.23	$1.85	$0.93	$1.74	$0.00	$5.16	$0.00	$2.30	$1.38
Health Net	12	$7.10	$1.09	$1.61	$0.81	$1.26	$0.00	$4.47	$0.00	$1.89	$1.29
University Family Care	14	$13.67	$0.64	$2.67	$1.87	$2.80	$0.00	$5.93	$0.00	$2.89	$2.51
United Health Care	14	$12.76	$0.65	$2.53	$1.80	$2.68	$0.00	$5.72	$0.00	$2.85	$2.45

Appendix 7i: CYE 18 Capitation Rates PMPM by MCO, Rate Cell and GSA, Prospective, including APSI

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$383.22	$121.81	$240.33	$144.10	$390.79	$169.18	$1,009.51	$5,655.07	$459.79	$312.16
University Family Care	02	$378.64	$109.66	$212.93	$120.93	$324.21	$144.72	$935.84	$5,607.72	$453.31	$317.79
United Health Care	04	$392.47	$97.79	$203.57	$135.03	$360.39	$124.03	$933.68	$5,825.80	$436.23	$339.79
Health Choice Arizona	04	$402.41	$98.58	$213.99	$144.05	$388.42	$128.55	$1,007.26	$5,778.88	$466.17	$340.84
United Health Care	06	$384.00	$115.74	$250.64	$201.14	$444.39	$166.07	$1,240.63	$5,966.15	$505.64	$406.18
University Family Care	06	$392.07	$111.80	$247.48	$201.21	$400.93	$152.33	$1,103.80	$5,912.46	$487.35	$396.96
University Family Care	08	$424.01	$101.29	$249.67	$152.27	$515.75	$139.15	$1,046.82	$5,523.43	$481.64	$349.36
Health Choice Arizona	08	$426.46	$102.41	$257.28	$153.08	$547.74	$147.84	$965.75	$5,522.25	$496.01	$369.69
University Family Care	10	$421.11	$108.35	$228.68	$148.81	$406.64	$121.51	$1,092.48	$5,530.67	$415.67	$327.14
United Health Care	10	$416.95	$113.33	$246.19	$152.88	$422.52	$125.45	$1,032.58	$5,583.87	$408.23	$313.30
Health Choice Arizona	10	$462.98	$107.49	$227.62	$146.60	$376.44	$117.27	$959.24	$5,536.46	$402.66	$297.52
Care 1st	10	$439.52	$101.92	$222.56	$132.91	$353.30	$102.30	$908.08	$5,582.00	$374.44	$299.46
Mercy Care Plan	10	$390.24	$109.94	$235.84	$139.34	$397.57	$124.94	$998.64	$5,563.79	$401.27	$311.91
United Health Care	12	$464.64	$116.56	$270.74	$175.90	$481.38	$159.49	$1,074.01	$6,300.59	$525.89	$350.14
Care 1st	12	$446.14	$108.06	$250.06	$155.61	$415.12	$134.76	$974.76	$6,323.05	$499.51	$355.31
Health Choice Arizona	12	$464.74	$109.79	$251.21	$163.68	$457.40	$147.88	$1,029.77	$6,283.92	$518.81	$352.64
Mercy Care Plan	12	$453.54	$114.55	$266.79	$173.63	$490.09	$165.54	$1,104.91	$6,279.40	$556.33	$366.84
Health Net	12	$441.10	$102.22	$234.27	$150.85	$362.38	$118.78	$948.47	$6,316.03	$460.48	$342.81
University Family Care	14	$510.43	$114.57	$256.14	$176.41	$482.90	$151.72	$1,072.08	$5,443.54	$462.86	$356.19
United Health Care	14	$480.72	$116.13	$246.03	$171.15	$465.35	$154.37	$1,044.69	$5,495.05	$459.75	$348.98

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Arizona Health Care Cost Containment System

Appendix 7j: CYE 18 Projected Gross Medical Expenses PMPM by MCO, Rate Cell and GSA, PPC

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$362.28	$27.60	$154.51	$177.51	$164.51	$150.95	$865.84	$623.53	$326.51
University Family Care	02	$362.28	$27.60	$154.51	$177.51	$164.51	$150.95	$865.84	$623.53	$326.51
United Health Care	04	$358.72	$53.23	$155.88	$117.01	$209.05	$53.99	$409.87	$563.28	$377.53
Health Choice Arizona	04	$358.72	$53.23	$155.88	$117.01	$209.05	$53.99	$409.87	$563.28	$377.53
United Health Care	06	$418.77	$42.42	$185.26	$164.17	$335.24	$73.97	$374.32	$639.85	$351.51
University Family Care	06	$418.77	$42.42	$185.26	$164.17	$335.24	$73.97	$374.32	$639.85	$351.51
University Family Care	08	$236.20	$45.65	$151.26	$127.57	$161.31	$84.93	$348.96	$571.41	$313.17
Health Choice Arizona	08	$236.20	$45.65	$151.26	$127.57	$161.31	$84.93	$348.96	$571.41	$313.17
University Family Care	10	$346.08	$46.32	$171.33	$153.51	$145.66	$83.07	$410.28	$436.97	$260.59
United Health Care	10	$346.08	$46.32	$171.33	$153.51	$145.66	$83.07	$410.28	$436.97	$260.59
Health Choice Arizona	10	$346.08	$46.32	$171.33	$153.51	$145.66	$83.07	$410.28	$436.97	$260.59
Care 1st	10	$346.08	$46.32	$171.33	$153.51	$145.66	$83.07	$410.28	$436.97	$260.59
Mercy Care Plan	10	$346.08	$46.32	$171.33	$153.51	$145.66	$83.07	$410.28	$436.97	$260.59
United Health Care	12	$356.97	$44.89	$185.00	$137.45	$256.97	$100.02	$466.88	$687.17	$342.93
Care 1st	12	$356.97	$44.89	$185.00	$137.45	$256.97	$100.02	$466.88	$687.17	$342.93
Health Choice Arizona	12	$356.97	$44.89	$185.00	$137.45	$256.97	$100.02	$466.88	$687.17	$342.93
Mercy Care Plan	12	$356.97	$44.89	$185.00	$137.45	$256.97	$100.02	$466.88	$687.17	$342.93
Health Net	12	$356.97	$44.89	$185.00	$137.45	$256.97	$100.02	$466.88	$687.17	$342.93
University Family Care	14	$602.07	$51.65	$112.51	$84.52	$105.75	$42.82	$359.62	$446.82	$314.61
United Health Care	14	$602.07	$51.65	$112.51	$84.52	$105.75	$42.82	$359.62	$446.82	$314.61

Appendix 7k: CYE 18 Projected UW Gain PMPM by MCO, Rate Cell and GSA, PPC

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$3.62	$0.28	$1.55	$1.78	$1.65	$1.51	$8.66	$6.24	$3.27
University Family Care	02	$3.62	$0.28	$1.55	$1.78	$1.65	$1.51	$8.66	$6.24	$3.27
United Health Care	04	$3.59	$0.53	$1.56	$1.17	$2.09	$0.54	$4.10	$5.63	$3.78
Health Choice Arizona	04	$3.59	$0.53	$1.56	$1.17	$2.09	$0.54	$4.10	$5.63	$3.78
United Health Care	06	$4.19	$0.42	$1.85	$1.64	$3.35	$0.74	$3.74	$6.40	$3.52
University Family Care	06	$4.19	$0.42	$1.85	$1.64	$3.35	$0.74	$3.74	$6.40	$3.52
University Family Care	08	$2.36	$0.46	$1.51	$1.28	$1.61	$0.85	$3.49	$5.71	$3.13
Health Choice Arizona	08	$2.36	$0.46	$1.51	$1.28	$1.61	$0.85	$3.49	$5.71	$3.13
University Family Care	10	$3.46	$0.46	$1.71	$1.54	$1.46	$0.83	$4.10	$4.37	$2.61
United Health Care	10	$3.46	$0.46	$1.71	$1.54	$1.46	$0.83	$4.10	$4.37	$2.61
Health Choice Arizona	10	$3.46	$0.46	$1.71	$1.54	$1.46	$0.83	$4.10	$4.37	$2.61
Care 1st	10	$3.46	$0.46	$1.71	$1.54	$1.46	$0.83	$4.10	$4.37	$2.61
Mercy Care Plan	10	$3.46	$0.46	$1.71	$1.54	$1.46	$0.83	$4.10	$4.37	$2.61
United Health Care	12	$3.57	$0.45	$1.85	$1.37	$2.57	$1.00	$4.67	$6.87	$3.43
Care 1st	12	$3.57	$0.45	$1.85	$1.37	$2.57	$1.00	$4.67	$6.87	$3.43
Health Choice Arizona	12	$3.57	$0.45	$1.85	$1.37	$2.57	$1.00	$4.67	$6.87	$3.43
Mercy Care Plan	12	$3.57	$0.45	$1.85	$1.37	$2.57	$1.00	$4.67	$6.87	$3.43
Health Net	12	$3.57	$0.45	$1.85	$1.37	$2.57	$1.00	$4.67	$6.87	$3.43
University Family Care	14	$6.02	$0.52	$1.13	$0.85	$1.06	$0.43	$3.60	$4.47	$3.15
United Health Care	14	$6.02	$0.52	$1.13	$0.85	$1.06	$0.43	$3.60	$4.47	$3.15

Appendix 7I: CYE 18 Projected Administrative Expenses PMPM by MCO, Rate Cell and GSA, PPC

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$28.84	$2.18	$12.30	$14.17	$13.09	$11.47	$69.02	$49.78	$26.04
University Family Care	02	$28.84	$2.18	$12.30	$14.17	$13.09	$11.47	$69.02	$49.78	$26.04
United Health Care	04	$28.51	$4.17	$12.24	$9.34	$16.63	$4.19	$32.71	$45.06	$30.19
Health Choice Arizona	04	$28.51	$4.17	$12.24	$9.34	$16.63	$4.19	$32.71	$45.06	$30.19
United Health Care	06	$33.44	$3.37	$14.82	$13.10	$26.64	$5.46	$29.50	$50.87	$27.99
University Family Care	06	$33.44	$3.37	$14.82	$13.10	$26.64	$5.46	$29.50	$50.87	$27.99
University Family Care	08	$18.50	$3.55	$12.10	$10.21	$12.83	$6.20	$27.70	$45.37	$24.97
Health Choice Arizona	08	$18.50	$3.55	$12.10	$10.21	$12.83	$6.20	$27.70	$45.37	$24.97
University Family Care	10	$27.11	$3.38	$13.35	$12.16	$11.57	$6.65	$32.29	$34.96	$20.73
United Health Care	10	$27.11	$3.38	$13.35	$12.16	$11.57	$6.65	$32.29	$34.96	$20.73
Health Choice Arizona	10	$27.11	$3.38	$13.35	$12.16	$11.57	$6.65	$32.29	$34.96	$20.73
Care 1st	10	$27.11	$3.38	$13.35	$12.16	$11.57	$6.65	$32.29	$34.96	$20.73
Mercy Care Plan	10	$27.11	$3.38	$13.35	$12.16	$11.57	$6.65	$32.29	$34.96	$20.73
United Health Care	12	$28.47	$3.57	$14.78	$11.00	$20.53	$7.96	$37.35	$54.97	$27.43
Care 1st	12	$28.47	$3.57	$14.78	$11.00	$20.53	$7.96	$37.35	$54.97	$27.43
Health Choice Arizona	12	$28.47	$3.57	$14.78	$11.00	$20.53	$7.96	$37.35	$54.97	$27.43
Mercy Care Plan	12	$28.47	$3.57	$14.78	$11.00	$20.53	$7.96	$37.35	$54.97	$27.43
Health Net	12	$28.47	$3.57	$14.78	$11.00	$20.53	$7.96	$37.35	$54.97	$27.43
University Family Care	14	$47.19	$3.94	$8.87	$6.72	$8.38	$3.28	$28.50	$35.75	$25.05
United Health Care	14	$47.19	$3.94	$8.87	$6.72	$8.38	$3.28	$28.50	$35.75	$25.05

Appendix 7m: CYE 18 Premium Tax PMPM by MCO, Rate Cell and GSA, PPC

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$8.06	$0.61	$3.44	$3.95	$3.66	$3.35	$19.26	$13.87	$7.26
University Family Care	02	$8.06	$0.61	$3.44	$3.95	$3.66	$3.35	$19.26	$13.87	$7.26
United Health Care	04	$7.98	$1.18	$3.46	$2.60	$4.65	$1.20	$9.12	$12.53	$8.40
Health Choice Arizona	04	$7.98	$1.18	$3.46	$2.60	$4.65	$1.20	$9.12	$12.53	$8.40
United Health Care	06	$9.31	$0.94	$4.12	$3.65	$7.45	$1.64	$8.32	$14.23	$7.82
University Family Care	06	$9.31	$0.94	$4.12	$3.65	$7.45	$1.64	$8.32	$14.23	$7.82
University Family Care	08	$5.25	$1.01	$3.36	$2.84	$3.59	$1.88	$7.76	$12.70	$6.96
Health Choice Arizona	08	$5.25	$1.01	$3.36	$2.84	$3.59	$1.88	$7.76	$12.70	$6.96
University Family Care	10	$7.69	$1.02	$3.80	$3.41	$3.24	$1.85	$9.12	$9.72	$5.79
United Health Care	10	$7.69	$1.02	$3.80	$3.41	$3.24	$1.85	$9.12	$9.72	$5.79
Health Choice Arizona	10	$7.69	$1.02	$3.80	$3.41	$3.24	$1.85	$9.12	$9.72	$5.79
Care 1st	10	$7.69	$1.02	$3.80	$3.41	$3.24	$1.85	$9.12	$9.72	$5.79
Mercy Care Plan	10	$7.69	$1.02	$3.80	$3.41	$3.24	$1.85	$9.12	$9.72	$5.79
United Health Care	12	$7.94	$1.00	$4.11	$3.06	$5.72	$2.22	$10.39	$15.29	$7.63
Care 1st	12	$7.94	$1.00	$4.11	$3.06	$5.72	$2.22	$10.39	$15.29	$7.63
Health Choice Arizona	12	$7.94	$1.00	$4.11	$3.06	$5.72	$2.22	$10.39	$15.29	$7.63
Mercy Care Plan	12	$7.94	$1.00	$4.11	$3.06	$5.72	$2.22	$10.39	$15.29	$7.63
Health Net	12	$7.94	$1.00	$4.11	$3.06	$5.72	$2.22	$10.39	$15.29	$7.63
University Family Care	14	$13.37	$1.14	$2.50	$1.88	$2.35	$0.95	$7.99	$9.94	$7.00
United Health Care	14	$13.37	$1.14	$2.50	$1.88	$2.35	$0.95	$7.99	$9.94	$7.00

Appendix 7n: CYE 18 Capitation Rates PMPM by MCO, Rate Cell and GSA, PPC, without APSI

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$402.80	$30.67	$171.79	$197.41	$182.90	$167.28	$962.78	$693.41	$363.08
University Family Care	02	$402.80	$30.67	$171.79	$197.41	$182.90	$167.28	$962.78	$693.41	$363.08
United Health Care	04	$398.79	$59.11	$173.14	$130.12	$232.42	$59.92	$455.79	$626.51	$419.89
Health Choice Arizona	04	$398.79	$59.11	$173.14	$130.12	$232.42	$59.92	$455.79	$626.51	$419.89
United Health Care	06	$465.71	$47.16	$206.06	$182.57	$372.68	$81.81	$415.89	$711.34	$390.83
University Family Care	06	$465.71	$47.16	$206.06	$182.57	$372.68	$81.81	$415.89	$711.34	$390.83
University Family Care	08	$262.30	$50.67	$168.24	$141.89	$179.34	$93.86	$387.91	$635.20	$348.23
Health Choice Arizona	08	$262.30	$50.67	$168.24	$141.89	$179.34	$93.86	$387.91	$635.20	$348.23
University Family Care	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
United Health Care	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
Health Choice Arizona	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
Care 1st	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
Mercy Care Plan	10	$384.33	$51.18	$190.20	$170.61	$161.93	$92.39	$455.80	$486.02	$289.72
United Health Care	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
Care 1st	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
Health Choice Arizona	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
Mercy Care Plan	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
Health Net	12	$396.96	$49.91	$205.74	$152.88	$285.79	$111.20	$519.28	$764.30	$381.43
University Family Care	14	$668.66	$57.24	$125.00	$93.96	$117.53	$47.48	$399.71	$496.97	$349.80
United Health Care	14	$668.66	$57.24	$125.00	$93.96	$117.53	$47.48	$399.71	$496.97	$349.80

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Appendix 7o: CYE 18 Projected APSI Payments PMPM by MCO, Rate Cell and GSA, PPC

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$14.08	$0.31	$0.44	$1.92	$0.01	$0.00	$12.94	$1.37	$0.79
University Family Care	02	$14.08	$0.31	$0.44	$1.92	$0.01	$0.00	$12.94	$1.37	$0.79
United Health Care	04	$6.08	$0.34	$0.24	$0.35	$0.66	$0.00	$0.38	$1.56	$0.75
Health Choice Arizona	04	$6.08	$0.34	$0.24	$0.35	$0.66	$0.00	$0.38	$1.56	$0.75
United Health Care	06	$8.29	$0.57	$0.61	$0.00	$0.00	$0.00	$1.28	$1.45	$0.00
University Family Care	06	$8.29	$0.57	$0.61	$0.00	$0.00	$0.00	$1.28	$1.45	$0.00
University Family Care	08	$2.90	$0.88	$0.83	$1.52	$0.06	$0.00	$0.02	$6.80	$1.95
Health Choice Arizona	08	$2.90	$0.88	$0.83	$1.52	$0.06	$0.00	$0.02	$6.80	$1.95
University Family Care	10	$25.72	$2.09	$6.70	$5.08	$3.71	$0.00	$17.25	$16.84	$8.72
United Health Care	10	$25.72	$2.09	$6.70	$5.08	$3.71	$0.00	$17.25	$16.84	$8.72
Health Choice Arizona	10	$25.72	$2.09	$6.70	$5.08	$3.71	$0.00	$17.25	$16.84	$8.72
Care 1st	10	$25.72	$2.09	$6.70	$5.08	$3.71	$0.00	$17.25	$16.84	$8.72
Mercy Care Plan	10	$25.72	$2.09	$6.70	$5.08	$3.71	$0.00	$17.25	$16.84	$8.72
United Health Care	12	$9.31	$1.21	$1.93	$1.61	$2.03	$0.00	$6.99	$7.87	$3.57
Care 1st	12	$9.31	$1.21	$1.93	$1.61	$2.03	$0.00	$6.99	$7.87	$3.57
Health Choice Arizona	12	$9.31	$1.21	$1.93	$1.61	$2.03	$0.00	$6.99	$7.87	$3.57
Mercy Care Plan	12	$9.31	$1.21	$1.93	$1.61	$2.03	$0.00	$6.99	$7.87	$3.57
Health Net	12	$9.31	$1.21	$1.93	$1.61	$2.03	$0.00	$6.99	$7.87	$3.57
University Family Care	14	$57.03	$1.10	$2.30	$2.02	$0.74	$0.00	$2.15	$7.95	$6.17
United Health Care	14	$57.03	$1.10	$2.30	$2.02	$0.74	$0.00	$2.15	$7.95	$6.17

Appendix 7p: CYE 18 Capitation Rates PMPM by MCO, Rate Cell and GSA, PPC, including APSI

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	$417.17	$30.99	$172.24	$199.37	$182.90	$167.28	$975.99	$694.81	$363.89
University Family Care	02	$417.17	$30.99	$172.24	$199.37	$182.90	$167.28	$975.99	$694.81	$363.89
United Health Care	04	$404.99	$59.46	$173.39	$130.48	$233.10	$59.92	$456.17	$628.10	$420.66
Health Choice Arizona	04	$404.99	$59.46	$173.39	$130.48	$233.10	$59.92	$456.17	$628.10	$420.66
United Health Care	06	$474.17	$47.74	$206.68	$182.57	$372.68	$81.81	$417.20	$712.82	$390.83
University Family Care	06	$474.17	$47.74	$206.68	$182.57	$372.68	$81.81	$417.20	$712.82	$390.83
University Family Care	08	$265.26	$51.57	$169.08	$143.44	$179.40	$93.86	$387.92	$642.13	$350.23
Health Choice Arizona	08	$265.26	$51.57	$169.08	$143.44	$179.40	$93.86	$387.92	$642.13	$350.23
University Family Care	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
United Health Care	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
Health Choice Arizona	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
Care 1st	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
Mercy Care Plan	10	$410.58	$53.32	$197.03	$175.80	$165.72	$92.39	$473.40	$503.20	$298.62
United Health Care	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
Care 1st	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
Health Choice Arizona	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
Mercy Care Plan	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
Health Net	12	$406.46	$51.15	$207.71	$154.52	$287.86	$111.20	$526.41	$772.33	$385.07
University Family Care	14	$726.86	$58.36	$127.34	$96.02	$118.29	$47.48	$401.91	$505.08	$356.09
United Health Care	14	$726.86	$58.36	$127.34	$96.02	$118.29	$47.48	$401.91	$505.08	$356.09

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Appendix 7q: CYE 18 RI Offsets PMPM as a Percentage of Prospective Capitation Rates by MCO, Rate Cell and GSA, PPC, including APSI

MCO	GSA	TANF <1	TANF 1-13	TANF 14-44 Female	TANF 14-44 Male	TANF 45+	SSI with Medicare	SSI w/o Medicare	Delivery Supplement	Adults <= 106% FPL	Adults > 106% FPL
United Health Care	02	5.7%	2.4%	0.7%	2.0%	1.6%	0.2%	7.7%	0.0%	1.1%	1.2%
University Family Care	02	5.8%	2.7%	0.7%	2.4%	1.9%	0.3%	8.3%	0.0%	1.1%	1.2%
United Health Care	04	9.4%	0.9%	0.6%	2.9%	1.1%	0.2%	9.3%	0.0%	2.6%	2.0%
Health Choice Arizona	04	9.1%	0.9%	0.6%	2.7%	1.0%	0.2%	8.6%	0.0%	2.5%	2.0%
United Health Care	06	6.0%	1.2%	0.3%	10.3%	0.2%	0.9%	7.4%	0.0%	1.6%	2.2%
University Family Care	06	5.8%	1.2%	0.3%	10.3%	0.3%	1.0%	8.3%	0.0%	1.6%	2.2%
University Family Care	08	5.4%	1.3%	1.5%	1.4%	1.6%	0.9%	5.2%	0.0%	3.0%	1.3%
Health Choice Arizona	08	5.3%	1.3%	1.4%	1.4%	1.5%	0.9%	5.7%	0.0%	2.9%	1.3%
University Family Care	10	3.6%	1.5%	0.9%	4.7%	1.3%	0.8%	15.2%	0.0%	2.0%	1.9%
United Health Care	10	3.6%	1.4%	0.8%	4.5%	1.3%	0.8%	16.1%	0.0%	2.1%	2.0%
Health Choice Arizona	10	3.2%	1.5%	0.9%	4.7%	1.5%	0.9%	17.3%	0.0%	2.1%	2.1%
Care 1st	10	3.4%	1.6%	0.9%	5.2%	1.5%	1.0%	18.3%	0.0%	2.3%	2.1%
Mercy Care Plan	10	3.8%	1.5%	0.8%	5.0%	1.4%	0.8%	16.6%	0.0%	2.1%	2.0%
United Health Care	12	4.6%	1.2%	1.2%	4.0%	1.4%	0.9%	9.6%	0.0%	3.4%	2.5%
Care 1st	12	4.8%	1.3%	1.3%	4.5%	1.7%	1.0%	10.6%	0.0%	3.5%	2.5%
Health Choice Arizona	12	4.6%	1.3%	1.3%	4.3%	1.5%	0.9%	10.0%	0.0%	3.4%	2.5%
Mercy Care Plan	12	4.7%	1.2%	1.2%	4.0%	1.4%	0.8%	9.4%	0.0%	3.2%	2.4%
Health Net	12	4.8%	1.4%	1.4%	4.6%	1.9%	1.1%	10.9%	0.0%	3.8%	2.6%
University Family Care	14	4.1%	0.1%	0.3%	5.3%	3.9%	0.1%	3.9%	0.0%	2.2%	2.2%
United Health Care	14	4.4%	0.1%	0.3%	5.5%	4.1%	0.1%	4.0%	0.0%	2.3%	2.2%