AHCCCS
Arizona Health Care Cost Containment System

CONTRACT YEAR ENDING 2018 COMPREHENSIVE MEDICAL AND DENTAL PROGRAM CAPITATION RATE CERTIFICATION

JULY 1, 2017 THROUGH JUNE 30, 2018

March 31, 2017

AHCCCS
Arizona Health Care Cost Containment System

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Introduction

This rate certification provides documentation on the development of the July 1, 2017 through June 30, 2018 (Contract Year Ending 2018 or CYE 18) capitation rates for Arizona's Comprehensive Medical and Dental Program (CMDP) for compliance with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). The structure of the rate certification follows the outline of the 2017 Medicaid Managed Care Rate Development Guide (2017 Guide) for rating periods starting between January 1, 2017 and June 30, 2017, released by the Centers for Medicare & Medicaid Services (CMS). The Medicaid Managed Care Rate Development Guide for rating periods that begin on or after July 1, 2017 was not available at the time this rate certification was submitted to CMS. The structure of the rate certification follows the outline of the 2017 Guide in order to facilitate the CMS review of the rate development process.

Section I Medicaid Managed Care Rates

Section I of the 2017 Medicaid Managed Care Rate Development Guide is applicable to the CMDP because the CYE 18 capitation rates for the CMDP are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 of 81 FR 27497.

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

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(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 ASOP 49 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."

1. General Information

This section provides documentation for the General Information section of the 2017 Guide.

A. Rating Period

The CYE 18 capitation rates for the CMDP are effective for the twelve month time period from July 1, 2017 through June 30, 2018.

B. Rate Certification Documentation

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

C. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2017 Guide. Sections from the 2017 Guide that are not applicable to the CYE 18 capitation rates for the CMDP have still been included in this rate certification. This was done to demonstrate completeness with the 2017 Guide.

D. Rate Certification Items

i. Letter from Certifying Actuary

The actuarial certification letter for the CYE 18 capitation rates for the CMDP, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 of 81 FR 27497 and is provided below for reference.

> 42 CFR § 438.2 of 81 FR 27497: *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 CMDP contained in this rate certification are "actuarially sound" and meet the standards within the applicable provisions of 42 CFR § 438.4 of 81 FR 27497.

ii. Final and Certified Capitation Rates

The certified capitation rates by rate cell are located in Appendix 2.

iii. Final and Certified Capitation Rate Ranges

This is not applicable because rate ranges were not developed for the CYE 18 capitation rates for the CMDP.

iv. Program Information

(a) Summary of Program

CMDP is the health plan within the Arizona Department of Child Safety (DCS) that is responsible for managing the health care needs for children in foster care. CMDP was formed in July 1970 by state law

under Arizona Revised Statute (A.R.S.) § 8-512. Services covered by the CMDP include physical health services (excluding specialty care for children who have a CRS-qualifying condition as those services are provided by the Children's Rehabilitative Services (CRS) Contractor); and limited behavioral health services (i.e. treatment for ADHD, anxiety and depression when provided by the member's primary care physician).

CMDP operates on a statewide basis with two rate cells. The CMDP contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 and the 2017 Guide.

The first rate cell includes the costs of providing covered services during the Prospective time period. The Prospective time period is the period of time after the member's enrollment.

The second rate cell includes the costs of providing covered services during the Prior Period Coverage (PPC) time period. The PPC time period is the period of time prior to the member's enrollment, during which a member is eligible for covered services. Capitation rates for PPC are developed based on the expenses and member enrollment between the effective date of eligibility and the date a member is enrolled with CMDP. It is the responsibility of the CMDP to pay for all claims for covered services provided to members during this timeframe.

(b) Rating Period

The CYE 18 capitation rates for the CMDP are effective for the twelve month time period from July 1, 2017 through June 30, 2018.

(c) Covered Populations

The populations covered under the CMDP are children under the age of 18 years of age and who are:

- Placed in a foster home;
- In the custody of DES and placed with a relative, in a certified adoptive home prior to the final order of adoption, or in an independent living program as provided in A.R.S. § 8-512; or
- In the custody of the Arizona Department of Juvenile Corrections or the Administrative Office of the Courts/Juvenile Probation Office and placed in foster care.

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

(d) Eligibility and Enrollment Criteria

AHCCCS operates as a mandatory managed care program and choice of enrollment or auto-assignment is used pursuant to the terms of the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions. AHCCCS will enroll the child with the CMDP and notify the CMDP of the child's AHCCCS enrollment. The CMDP is responsible for timely notification to AHCCCS if a member no longer meets the criteria for the CMDP coverage as set for in A.R.S. § 8-512. Additional information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the CMDP contract.

There are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the populations to be covered under the CMDP during CYE 18.

(e) Covered Services

The following list is a general description of services covered under CMDP. Additional information regarding covered services can be found in the Scope of Services section of the CMDP contract.

- Hospital Inpatient
- Hospital Outpatient
- Physician
- Emergency Services
- Pharmacy
- Dental
- Durable Medical Equipment
- Transportation
- Laboratory and radiology

The CMDP members receive behavioral health services through a Regional Behavioral Health Authority (RBHA), or for American Indians, through a Tribal Regional Behavioral Health Authority (TRBHA) or an Indian Health Services (IHS) provider, or a 638 Tribal Facility. Expenses for behavioral health services are included in the capitation rates for the RBHA Program or CRS Program and paid fee-for-service for TRBHAs, IHS providers, and 638 Tribal Facilities. Additional information regarding behavioral health services, along with the coordination of behavioral health services for the CMDP enrolled members, can be found in the Behavioral Health Services section of the CMDP contract.

2. Data

This section provides documentation for the Data section of the 2017 Guide.

A. Data Used to Develop Capitation Rates

i. Description of the Data

(a) Types of Data

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

- Adjudicated and approved encounter data submitted by the CMDP;
- Enrollment data tied to capitation paid to the CMDP;
- Projected enrollment data;
- Quarterly and annual financial statements submitted by the CMDP;
- Data on reinsurance payments made from AHCCCS to the CMDP;
- Detailed administrative expense data and projections from the CMDP; and
- Supplemental encounter data files for physician and dental services provided by the CMDP that had not been submitted for processing by the AHCCCS data warehouse.

(b) Time Periods of Data

The encounter data serving as the base experience in the capitation rate development process was incurred during state fiscal years 2014 through 2016 (July 1, 2013 to June 30, 2016) (SFY 14, 15, and 16) and paid through January 2017.

The enrollment data tied to the capitation paid to the CMDP aligned with the encounter data time periods of SFY 14, SFY 15, and SFY 16. The projected enrollment data for CYE 18 was provided by the AHCCCS Division of Business and Finance (DBF).

The financial statement data reviewed as part of the rate development process included financial statements for the SFY 14, SFY 15, and SFY 16 time periods.

The reinsurance payment data from AHCCCS was for payments made on reinsurance eligible services incurred between October 1, 2013 and September 30, 2016. Each reinsurance case is administered over the course of a federal fiscal year.

The detailed administrative expense data received from the CMDP reflected calendar year 2016, and the detailed administrative expense projections were for CYE18.

The CMDP supplemental encounter data file for physician and dental services incurred during SFY 15 and SFY 16.

(c) Sources of Data

The enrollment and encounter data were provided from the AHCCCS PMMIS mainframe. The financial statement data were provided by the AHCCCS finance team. The CMDP supplemental encounter data

file for dental and physician services was provided by the CMDP encounter specialist. The reinsurance payments are tracked and provided by the DBF.

(d) Sub-capitated Data

The CMDP does not have sub-capitated contracts with providers. Therefore, the encounter data does not contain sub-capitated payment amounts.

ii. Quality and Availability of the Data

(a) Validation of Data

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 PMMIS mainframe and are subject to approximately 500 claims type edits resulting in the approval, denial or pend of each encounter.

(i) Completeness of Data

AHCCCS performs encounter data validation studies, as required to meet the Special Terms and Conditions of AHCCCS' 1115 Waiver from CMS, to evaluate the completeness, accuracy, and timeliness of the collected encounter data on at least an annual basis.

(ii) 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.

(iii) Consistency of Data

AHCCCS compared the encounter data for each SFY against the financial statement reports submitted by CMDP. AHCCCS did not adjust the encounter data based on the review of the encounter data against the financial statement reports. However, observations from this review led to discussions with the CMDP and the additional submission of physician and dental encounters from the CMDP.

(b) Actuary's Assessment of the Data

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon certain data and information provided by the CMDP. The values presented in this letter are dependent upon this reliance.

AHCCCS has determined that the three years of encounter data for SFY 14, SFY 15, and SFY 16, along with the CMDP supplemental encounter data file for physician and dental services, to be appropriate for the purposes of developing the CYE 18 capitation rates for the CMDP.

(c) Actuary's Concern with the Data

There were no concerns with the quality or accuracy of the data. Outside of the CMDP supplemental encounter data file for dental services, it was determined that there were no outstanding encounter submission and processing issues.

iii. Using Data Other Than Fee-for-Service or Encounters

Encounter data was used to develop the CYE 18 capitation rates for the CMDP.

iv. Explanation of Using Data Other Than Fee-for-Service or Encounters

This does not apply because encounter data was used to develop the CYE 18 capitation rates for the CMDP.

v. Reliance or Use of a Data Book

The capitation rate development process relied primarily on a data book created from the AHCCCS PMMIS mainframe. The data book contained summarized enrollment data by SFY and rate cell, and encounter data by SFY, rate cell, and category of service. Detailed enrollment and encounter data was accessible for further analysis.

B. Data Adjustments

Capitation rates were developed from SFY 14, SFY 15, and SFY 16 encounter data, paid through January 2017. The three years of data were blended to smooth out volatility. The blending percentages were based on a 1-2-3 weighting of the encounter data, except for the FQHC/RHC service category. The SFY 16 time period was given a 100% weight for FQHC/RHC service category. The annual SFY data, weights, and weighted base data are included in Appendix 6. Adjustments to base data include completion, trend, reimbursement and program changes, and the addition of the CMDP supplemental encounter data file for dental and physician services.

i. Credibility

The SFY 14, SFY 15, and SFY 16 encounter data were determined by AHCCCS to be fully credible. No credibility adjustment was applied.

ii. Completeness

An adjustment was made to the encounter data to reflect the level of completion. AHCCCS calculated completion factors using the development method with monthly encounter data from July 1, 2013 through June 30, 2016, paid through January 2017. The monthly completion factors were aggregated by SFY to determine annual completion factors and applied to the encounter data. The completion factors were developed by major category of service and are shown in Table 1 below.

Table 1: Annual Completion Factors by Major Category of Service and SFY

Major Category of Service	SFY 14	SFY 15	SFY 16
Professional and Other Services	1.0000	0.9991	0.9816
Prescription Drugs	1.0000	1.0000	0.9903
Dental Services	1.0000	0.9991	0.9934
Inpatient	1.0000	0.9998	0.9121
Nursing Facility	1.0000	1.0000	1.0000
Outpatient Hospital	1.0000	0.9999	0.9883

iii. Errors

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

iv. Program and Reimbursement Changes

The table in Appendix 5, Program and Reimbursement Changes, identifies the program and reimbursement changes that were implemented after the beginning of the base experience period (July 1, 2013). The dollar impacts of each change as identified in the table represent the projected impact of the change for the portion of the rating year in which the change took effect. For purposes of adjusting the encounter data, each change was expressed in terms of percentage impact to the PMPM projected for the relevant COS prior to the change, so that cumulative loading factors for each COS could be developed for each of the three base years.

v. Exclusions

No adjustments were made to the data for exclusions of certain payments or services.

3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2017 Guide.

A. Compliance with 42 CFR 438.4(b)(6)

The "actuarially sound" capitation rates comply with 42 CFR § 438.4(b)(6) of 81 FR 27497.

B. Rate Development Standards and Federal Medical Assistance Percentage

Variations in the assumptions used to develop the projected benefit costs for the covered populations were based on valid rate development standards and not based on the rate of Federal Medical Assistance Percentage (FMAP). The covered populations under the CMDP receive the regular FMAP. The enhanced FMAP amounts for the CHIP do not apply because the CHIP is not a covered population under the CMDP. AHCCCS administers the CHIP through the AHCCCS KidsCare Program.

C. Development of Projected Benefit Costs

i. Data, Assumptions, and Methodologies

The adjusted encounter data years described in Section 2(B) reflects assumed completion, benefits, program requirements, and provider reimbursement levels as of the date of the most recent change (January 1, 2017). The per-member-per-month (PMPM) expenditures for each category of service (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.

As noted in Section 2.A, data from SFY 14, SFY 15, and SFY 16 served as the base for projections to CYE 18, and was used in development of trends and completion factors. The historical encounter data was summarized by SFY, COS, and rate cell.

There were no prospective program or reimbursement changes included in the CYE 18 capitation rates for the CMDP.

ii. Material changes

No material changes have been made to the data, assumptions, and methodologies since the last rate certification. The development of the CYE 18 capitation rates for the CMDP followed similar processes used during the last rate development process.

D. Projected Benefit Cost Trends

i. Descriptions

(a) Data and Assumptions

The adjusted encounter data by SFY, COS and rate cell, and the enrollment data by SFY and rate cell, was used to develop the utilization and unit cost trends assumed in projecting PMPM expenditures by COS and rate cell for the rating period. No external sources were referenced.

(b) Methodologies

Annualized growth rates in utilization and unit costs by COS and rate cell, observed over the three-year base data period, were the basis for trend assumptions by COS and rate cell. Some COS observed negative trends in utilization and/or unit cost during that time frame. In some of those COS, the observed PMPM trend was also negative. AHCCCS judged that those negative trends were not likely to continue, and applied a 0% floor to the PMPM trend assumption for each COS. The assumed trends in part ii below reflect the application of that floor to the historical trends.

(c) Trend Comparisons

Historical trends should not be used in a formulaic manner to determine future trends; actuarial judgment with consideration of external forces, is also needed. Discussions with the CMDP highlighted the enhanced efforts already underway to reach out to the CMDP members' caregivers and help ensure more frequent utilization of wellness visits, immunizations, dental services, and other forms of care.

ii. Projected Benefit Cost Trends by Component

Table 2a and Table 2b contain the assumed trend rates by rate cell and COS. These trends include both utilization and unit cost components. For PPC, all COS other than Hospital Inpatient and Physician were combined to enhance credibility.

Table 2a: Prospective Projected Trends by Category of Service

Service Category	Prospective Trend		
	Utilization	Unit Cost	PMPM
Hospital Inpatient	0.00%	0.00%	0.00%
Physician	-1.85%	1.88%	0.00%
Emergency Services	-0.30%	0.30%	0.00%
Pharmacy	6.24%	-1.17%	5.00%
Lab, X-ray, & med image	-1.23%	2.54%	1.27%
Outpatient Facility	3.62%	-3.49%	0.00%
Durable Med Equip	-2.92%	5.06%	1.99%
Dental	0.00%	0.00%	0.00%
FQHC/RHC	4.77%	-1.00%	3.72%
Transportation	-1.63%	1.66%	0.00%
NF, Home HC	-2.85%	3.28%	0.34%
PT, Other Prof, Misc Med	9.54%	-8.71%	0.00%

Table 2b: PPC Projected Trends by Category of Service

Service Category	PPC Trend		
	Utilization	Unit Cost	PMPM
Hospital Inpatient	-4.05%	4.22%	0.00%
Physician	0.00%	0.00%	0.00%
PT, Other Prof, Misc Med	-1.22%	1.23%	0.00%

(a) Components of Trend

(i) Changes in Price

See Table 2a and Table 2b for the assumed annualized growth in unit costs.

(ii) Changes in Utilization

See Table 2a and Table 2b for the assumed annualized growth in utilization.

(b) Description and Justification of Other Methods

No other methods for developing trend assumptions were used or considered.

(c) Other Trend Components

No other components to the annualized trend assumptions provided in Table 2a and Table 2b are included in the capitation rates.

iii. Variations in Trend

(a) By Medicaid Population

Trend rates by COS were developed for all of the CMDP members in each rate cell. No further stratification of experience applied to trend development or projections for the rating period.

(b) By Rate Cell

AHCCCS uses a single statewide monthly capitation rate for the prospective rate cell and a single statewide rate for the PPC rate cell. No other rate cells are used. There is no correlation between the historical trends for each rate cell within any particular COS.

(c) By Category of Service

AHCCCS developed trends by rate cell and COS. Within each rate cell, variations among service categories reflect observed variation in the underlying historical experience and actuarial judgment as described in Section 3(D)(i)(b).

iv. Any Other Material Adjustments

No other material adjustments were made to the trend assumptions.

v. Any Other Adjustments

No other adjustments were made to the trend assumptions.

(a) Managed Care Impacts

The CMDP operates as managed care, thus no adjustment to the data was needed.

(b) Changes Outside of Utilization and Unit Cost

AHCCCS did not adjust the trend assumptions for changes other than utilization and unit cost.

E. Parity Standards of the Mental Health Parity and Addiction Equity Act

AHCCCS is currently reviewing health plan contracts across all programs to ensure compliance is met with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements that are effective October 1, 2017. These reviews are expected to be completed during the summer of 2017, at which

time AHCCCS will determine if additional services will be added to the health plan contracts to ensure compliance with the MHPAEA.

F. 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 the development of the CYE 18 capitation rates for the CMDP.

G. Institution for Mental Disease Payments

This is not applicable because institution for mental disease payments in accordance with 42 CFR § 438.6(e) of 81 FR 27497 are for enrollees aged 21 to 64. The CMDP enrollees are children up to age 18 years of age.

H. Retrospective Eligibility Periods

i. Managed Care Plan Responsibility

The CMDP receives a separate PPC capitation rate to cover services provided to members between their date of eligibility and their date of enrollment with the CMDP.

ii. Claims Data Included in Base Data

Encounters delivered during the PPC time period for each member are distinguished as PPC within the data book.

iii. Enrollment Data Included in Base Data

Member months are distinguished as PPC within the data book.

iv. Adjustments, Assumptions, and Methodology

The PPC capitation rates are developed separately from the Prospective capitation rates.

I. Final Projected Benefit Costs

Appendix 7 contains the SFY 18 projected benefit costs by rate cell.

J. Impact of Projected Costs

This section covers material changes to the covered benefits or services since the last rate certification. The last rate certification for the CMDP was an update to the July 1, 2016 through June 30, 2017 capitation rates to reflect program changes that were effective October 1, 2016 and were not known at the time the original rate certification was submitted to CMS.

i. Covered Benefit Changes

There were no material changes to covered benefits or services since the last rate certification related to changes in covered benefits.

ii. Provider Payments

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

iii. Applicable Waiver Changes

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

iv. Applicable Litigation Impacts

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

K. Documentation of Material and 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. Pass-Through and Supplemental Payments

This is not applicable because pass-through payments, as defined in 42 CFR § 438.6(a) of 81 FR 27497, were not developed for the CYE 18 capitation rates for the CMDP.

Supplemental payments are not applicable because fee-for-service data were not used in developing the CYE 18 capitation rates for the CMDP.

5. Projected Non-Benefit Costs

This section provides documentation for the Projected Non-Benefit Costs section of the 2017 Guide.

A. Rate Development Standards and Federal Medical Assistance Percentage

Variations in the assumptions used to develop the projected benefit costs for the covered populations were based on valid rate development standards and not based on the rate of Federal Medical Assistance Percentage (FMAP). The covered populations under the CMDP receive the regular FMAP. The enhanced FMAP amounts for the CHIP do not apply because the CHIP is not a covered population under the CMDP. AHCCCS administers the CHIP through the AHCCCS KidsCare Program.

B. Description of the Projected Non-Benefit Costs

i. Data, Assumptions, and Methodology

The administrative expenses are not developed using a ground up approach based upon fixed and variable cost allocations. Instead, the CMDP provides AHCCCS with an administrative expense request for funding that details employee compensation, data processing costs, management fees, interest charges, occupancy (rent/utilities), and other administrative expenses. The administrative expense request typically includes the most recent calendar year of administrative expense data and a projection of the administrative expenses for the upcoming contract year. These administrative expense requests are reviewed by AHCCCS for reasonableness by comparing against the financial statements submitted by the CMDP and against previous administrative expense requests. Once the reports are determined to be reasonable by AHCCCS, an administrative expense PMPM is calculated using the appropriate projected member months for the contract year. This is typically the methodology to develop the administrative expenses on a PMPM basis.

The administrative expense request used for the CYE 18 capitation rates for the CMDP included the actual administrative expenses for calendar year 2016 and a projection of administrative expenses for CYE 18.

ii. Material Changes

Given that the projected CYE 18 administrative expense request would result in an AHCCCS medical loss ratio (MLR) (refer to section 7.E of this rate certification for more information about the AHCCCS MLR) under 85% for CYE 18, AHCCCS changed the existing administrative expense methodology to account for this MLR impact. The administrative expense PMPM included in the CYE 18 capitation rates for the CMDP was set to achieve an AHCCCS MLR of 85%. The administrative expense PMPMs included in the CYE 18 capitation rates for the CMDP are included in the table below.

C. Projected Non-Benefit Costs Categories

i. Administrative Costs

The CMDP provides actual and projected administrative expenses in the categories described above in part B.i. of this section.

ii. Care Coordination and Care Management

The CMDP care coordination functions are performed by certain employees included within the compensation line on the CMDP administrative expense request.

iii. Provision for Margin

The CYE 18 capitation rates for the CMDP include a provision of 1.0% for risk contingency.

iv. Taxes, Fees, and Assessments

The CYE 18 capitation rates for the CMDP include a provision for premium tax of 2.0% of capitation. No other taxes, fees, or assessments are applicable.

v. Other Material Non-Benefit Costs

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

D. Non-Benefit Cost Development

As described in B.ii of this section, the administrative expenses were developed as a percentage related to the MLR for the CYE 18 capitation rates for the CMDP. Table 3 below shows the administrative expenses on a PMPM basis.

Table 3: CYE 18 Projected Admin PMPM

Rate Cell	Admin PMPM
Prospective	$33.87
Prior Period Coverage	$33.87

E. Health Insurance Providers Fee

This is not applicable because the CMDP is a governmental entity and thus is excluded from the Health Insurance Providers Fee (HIPF).

F. Moratorium on Health Insurance Providers Fee

This is not applicable because the CMDP is a governmental entity and thus is excluded from the HIPF.

6. Rate Range Development

This is not applicable because rate ranges were not developed for the CYE 18 capitation rates for the CMDP.

7. Risk Mitigation, Incentives and Related Contractual Provisions

This section provides documentation for the Risk Mitigation, Incentives, and Related Contractual Provisions section of the 2017 Guide.

A. Descriptions

The CYE 18 contract for the CMDP includes a risk corridor arrangement, two MLR arrangements, and a reinsurance requirement. These contractual provisions are described in the applicable sections of this rate certification.

B. Risk Adjustment Model and Methodology

This is not applicable because risk adjustment, as defined in 42 CFR § 438.5(a) of 81 FR 27497, was not used for developing the CYE 18 capitation rates for the CMDP.

C. Acuity Adjustment

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

D. Other Risk-Sharing Arrangements

The CMDP contract includes a risk corridor arrangement for PPC medical cost experience. The contract uses the term reconciliation instead of risk corridor to refer to this arrangement. This rate certification will use the term risk corridor to be consistent with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 and the 2017 Guide. Additional information regarding the risk corridor arrangement can be found in the Compensation section of the CMDP contract.

i. Rationale for Arrangement

It is the intent of AHCCCS to limit the financial risk to the CMDP for PPC medical cost experience due to the variability in actual utilization and medical cost experience of the PPC rate cell.

ii. Description of the Arrangement

The risk corridor arrangement limits the profit or losses of the CMDP to 2% of PPC net capitation. Any losses in excess of the 2% will be reimbursed to the CMDP by AHCCCS and any profits in excess of the 2% will be recouped by AHCCCS from CMDP. The PPC net capitation is equal to the PPC capitation less the sum of the administration component and the premium tax component of the PPC capitation. The calculation takes the difference between the PPC net capitation paid to the CMDP during the contract year and the adjudicated encounter PPC medical expenses.

The risk corridor calculation includes an initial and final calculation. The initial calculation is completed no less than six months after the close of the contract year. The final calculation is completed no less than twelve months after the close of the contract year.

iii. Effect on Capitation Rate Development

The results of the risk corridor did not affect the development of the CYE 18 capitation rates for the CMDP.

iv. Risk-Sharing Arrangement Attestation

The development of the risk corridor arrangement is consistent with general actuarial principles and practices.

E. Medical Loss Ratio Requirements

There are two MLR arrangements included with the CYE 18 CMDP contract. The first MLR is the AHCCCS MLR, which is called the medical expense ratio in the CMDP contract. The second MLR is the MLR that is required for rates effective on or after July 1, 2017 and described in 42 CFR § 438.8 of 81 FR 27497. Both of these are further described below.

The AHCCCS MLR is included in the CMDP contract and includes a MLR standard of at least 85%. The CMDP must comply with the MLR established by AHCCCS. The MLR is reviewed by AHCCCS on a quarterly basis to monitor the financial health of CMDP. The CMDP contract uses the term medical expense ratio instead of MLR. This rate certification will use the term MLR to be consistent with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 and the 2017 Guide. Additional information regarding the AHCCCS MLR can be found in in the Financial Viability Standards section of the CMDP contract.

Regarding the MLR requirement described in 42 CFR § 438.8 of 81 FR 27497 and the State oversight of the MLR requirement described in 42 CFR § 438.74 of 81 FR 27497, both of these requirements became effective for contracts effective on and after July 1, 2017. Thus, the CYE 18 capitation rates for the CMDP align with the first reporting year of the MLR. Therefore, regarding the requirements in 42 CFR § 438.74(a) of 81 FR 27497 that rate certifications include a summary description of MLR reports received, this rate certification will include an overview what AHCCCS will include in the CMDP contract given that no reporting has yet occurred.

AHCCCS will be implementing contract language into the CMDP contract for compliance with the reporting of the MLR described in 42 CFR § 438.8 of 81 FR 27497 that will:

- Require calculation and reporting of the MLR.
- Mandate a minimum MLR of 85%.
- Create a team to determine the activities that will be considered as health care quality improvement.
- Set the MLR calculation in aggregate, but this may change in future years.
- Not require a remittance if the MLR is under 85%.
- Set the reporting requirements at a minimum to those described in 42 CFR § 438.8(k) of 81 FR 27497 and will determine if additional information is required.
- Determine the time period of which the report will be due.
- Exclude a newly contracted health plan, which is current practice with the AHCCCS MLR.

i. Methodology to Calculate Medical Loss Ratio

The AHCCCS MLR is the ratio of the numerator (as defined in the CMDP contract) to the denominator (as defined in the CMDP contract). The numerator is equal to the total medical expenses less third-party

liability payments. The denominator is equal to the sum of the total PPC capitation, the total Prospective capitation, the PPC risk corridor settlement, and Reinsurance, less the premium tax.

ii. Medical Loss Ratio Consequences

Sanctions and/or additional monitoring may be imposed if the CMDP does not meet the AHCCCS MLR requirements in the CMDP contract.

F. Reinsurance Requirements

The CMDP participates in the AHCCCS reinsurance program which is a stop-loss program provided by AHCCCS to the CMDP for the partial reimbursement of covered medical services incurred for a member beyond an annual deductible level. 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 will reimburse the CMDP for covered services incurred above the deductible. The deductible is the responsibility of the CMDP. PPC expenses are not eligible for the reinsurance program unless they qualify under transplant reinsurance. Additional information regarding the AHCCCS reinsurance program can be found in in the Reinsurance section of the CMDP contract.

The capitation rates are adjusted by subtracting the reinsurance offset amounts from the gross medical expenses since the CMDP will receive payment from AHCCCS for reinsurance cases. The data used for the reinsurance offset amounts are actual reinsurance payments from the base data period, with adjustments for the impact of the move to DRG reimbursement effective October 1, 2014. The assumptions used in developing the reinsurance offset amounts are to use the Inpatient COS as the trend rate since reinsurance payments are primarily associated with inpatient admissions for the CMDP program per reinsurance policy. The methodology to develop the CYE 18 reinsurance offset amount is 1-2-3 weighting of the adjusted data, trended forward at the assumed trend for Inpatient services.

The development of the reinsurance requirement is consistent with general actuarial principles and practices. Table 4 below shows the reinsurance PMPMs.

Table 4: CYE 18 Projected Reinsurance PMPM

Rate Cell	Reinsurance PMPM
Prospective	-$7.01
Prior Period Coverage	$0.00

G. Incentive Arrangements

This is not applicable because incentive arrangements, as defined in 42 CFR § 438.6(a) of 81 FR 27497, were not developed for the CYE 18 capitation rates for the CMDP.

H. Withhold Arrangements

This is not applicable because withhold arrangements, as defined in 42 CFR § 438.6(a) of 81 FR 27497, were not developed for the CYE 18 capitation rates for the CMDP.

8. Other Rate Development Considerations

This section provides documentation for the Other Rate Development Considerations section of the 2017 Guide.

A. Differences in Federal Medical Assistance Percentage

The covered populations under the CMDP receive the regular FMAP. The enhanced FMAP amounts for the CHIP are not shown separately in this rate certification because the CHIP is not a covered population under CMDP. AHCCCS administers the CHIP through the AHCCCS KidsCare Program.

The enhanced FMAP for family planning services is currently 90%. Family planning services are a covered service listed in the CMDP contract. The enhanced FMAP for family planning services are not shown separately in this rate certification because of current encounter and financial report coding processes that includes family planning services in other categories of service. AHCCCS is currently reviewing current encounter and financial report coding processes in order to identify any family planning services being utilized by the CMDP members so that they can be identified separately for the purposes of capitation rate development and rate certification documentation.

B. Rate Development Standards and Federal Medical Assistance Percentage

Proposed differences among the CYE 18 capitation rates for the CMDP are based on valid rate development standards.

C. Effective Dates of Changes

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

D. Generally Accepted Actuarial Principles and Practices

i. Reasonable, Appropriate, and Attainable Costs

All adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs and are included in this rate certification.

ii. Rate Setting Process

Adjustments are not made to the rates outside of the rate setting process described in this rate certification.

iii. Contracted Rates

The final contracted capitation rates should match the capitation rates included in this rate certification.

9. Procedures for Rate Certifications for Rate and Contract Amendments

This section provides documentation for the Procedures for Rate Certifications for Rate and Contract Amendments section of the 2017 Guide.

A. CMS Rate Certification Requirement for Rate Change

This is a new rate certification that documents the CMDP capitation rates will be changing effective July 1, 2017.

B. CMS Rate Certification Requirement for No Rate Change

This section is not applicable because the CMDP capitation rates will be changing effective July 1, 2017.

C. CMS Rate Certification Circumstances

This section is not applicable because rate ranges and risk scores were not developed for the CYE 18 capitation rates for the CMDP.

D. CMS Contract Amendment Requirement

A contract amendment will be submitted to CMS to reflect the CMDP capitation rates changing effective July 1, 2017.

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

Section II of the 2017 Medicaid Managed Care Rate Development Guide is not applicable to the CMDP.

Section III New Adult Group Capitation Rates

Section III of the 2017 Medicaid Managed Care Rate Development Guide is not applicable to the CMDP.

Limitations

The purpose of this rate certification is to demonstrate 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 is intended to be sent to CMS for review and approval of the "actuarially sound" certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose.

This rate certification may also be made available publicly on the AHCCCS website or distributed to other parties. If this rate certification is made available publicly on the AHCCCS website or 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, and generally accepted actuarial principles and practices.

The "actuarially sound" capitation rates represent projections of future events. Actual results may vary from the projections.

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 of 81 FR 27497:

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

Additionally, the term "actuarially sound" is defined in Actuarial Standard of Practice (ASOP) 49 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 use to develop the CYE 18 capitation rates for the CMDP have been documented according to the guidelines established by CMS in the 2017 Guide. The CYE 18 capitation rates for the CMDP are effective for the twelve month time period from July 1, 2017 through June 30, 2018.

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

SIGNATURE ON FILE	March 31, 2017
Matthew C. Varitek	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Rate Cell	Projected CYE 18 Member Months	CYE 17 Capitation Rate[1]	CYE 18 Capitation Rate	Percentage Impact
Prospective	213,146	$232.03	$225.52	-2.8%
Prior Period Coverage	5,431	$305.93	$234.29	-23.4%

Notes:

1. The CYE 17 Capitation Rate represents the recently submitted CYE 17 capitation rate effective from January 1, 2017 through June 30, 2017.

Appendix 3: Fiscal Impact Summary

Rate Cell	Projected CYE 18 Member Months	CYE 17 Capitation Rate[1]	CYE 18 Capitation Rate	PMPM Change
Prospective	213,146	$232.03	$225.52	-$6.51
Prior Period Coverage	5,431	$305.93	$234.29	-$71.64
Total	**218,577**	**$233.87**	**$225.74**	**-$8.13**

Rate Cell	CYE 17 Projected Expenditures	CYE 18 Projected Expenditures	Dollar Impact	Percentage Impact
Prospective	$49,456,240	$48,068,660	-$1,387,580	-2.8%
Prior Period Coverage	$1,661,551	$1,272,463	-$389,087	-23.4%
Total	**$51,117,790**	**$49,341,123**	**-$1,776,667**	**-3.5%**

Notes:

1. The CYE 17 Capitation Rate represents the recently submitted CYE 17 capitation rate effective from January 1, 2017 through June 30, 2017.

Appendix 4: Unadjusted and Adjusted Base Data

Prospective SFY 14					
Service Category	**Unadjusted Base Data PMPMs**	**Completion Factors**	**Reimbursement Changes**	**Supplemental Encounter Files**	**Adjusted Base Data**
Hospital Inpatient	$22.36	1.0000	1.1893	1.0000	$26.59
Physician	$51.03	1.0000	0.8569	1.0001	$43.73
Emergency Services	$11.35	1.0000	1.0016	1.0000	$11.37
Pharmacy	$25.28	1.0000	1.0005	1.0000	$25.29
Lab, X-ray, & med image	$5.17	1.0000	0.9867	1.0000	$5.10
Outpatient Facility	$29.42	1.0000	1.0138	1.0000	$29.82
Durable Med Equip	$13.60	1.0000	0.9867	1.0000	$13.42
Dental	$29.30	1.0000	1.0177	1.0765	$32.10
FQHC/RHC	$0.00	1.0000	1.0000	1.0000	$0.00
Transportation	$3.37	1.0000	1.0299	1.0000	$3.47
NF, Home HC	$0.16	1.0000	1.0098	1.0000	$0.17
PT, Other Prof, Misc Med	$0.31	1.0000	1.6389	1.0000	$0.51
Total	**$191.36**	**1.0000**	**0.9892**	**1.0121**	**$191.58**

Prospective SFY 15					
Service Category	**Unadjusted Base Data PMPMs**	**Completion Factors**	**Reimbursement Changes**	**Supplemental Encounter Files**	**Adjusted Base Data**
Hospital Inpatient	$17.41	0.9998	1.2074	1.0000	$21.02
Physician	$43.31	0.9991	0.9703	1.0028	$42.18
Emergency Services	$12.86	0.9999	1.0000	1.0000	$12.86
Pharmacy	$24.11	1.0000	1.0001	1.0000	$24.11
Lab, X-ray, & med image	$5.05	0.9991	0.9991	1.0000	$5.05
Outpatient Facility	$30.08	0.9999	1.0061	1.0000	$30.26
Durable Med Equip	$12.45	0.9991	0.9841	1.0000	$12.27
Dental	$22.61	0.9991	1.0057	1.3241	$30.14
FQHC/RHC	$7.80	0.9991	1.0874	1.0000	$8.49
Transportation	$2.78	0.9991	0.9682	1.0000	$2.69
NF, Home HC	$0.22	1.0000	1.0025	1.0000	$0.23
PT, Other Prof, Misc Med	$0.59	0.9991	1.4091	1.0000	$0.83
Total	**$179.26**	**0.9995**	**1.0182**	**1.0410**	**$190.11**

Prospective SFY 16					
Service Category	**Unadjusted Base Data PMPMs**	**Completion Factors**	**Reimbursement Changes**	**Supplemental Encounter Files**	**Adjusted Base Data**
Hospital Inpatient	$14.73	0.9121	1.1629	1.0000	$18.78
Physician	$36.21	0.9816	1.0079	1.0554	$39.24
Emergency Services	$7.52	0.9883	1.0000	1.0000	$7.61
Pharmacy	$28.15	0.9903	1.0000	1.0000	$28.43
Lab, X-ray, & med image	$5.13	0.9816	1.0000	1.0000	$5.23
Outpatient Facility	$22.80	0.9883	1.0125	1.0000	$23.35
Durable Med Equip	$13.51	0.9816	0.9835	1.0000	$13.54
Dental	$20.41	0.9934	1.0014	1.4344	$29.52
FQHC/RHC	$8.66	0.9816	1.0707	1.0000	$9.45
Transportation	$2.60	0.9816	0.9871	1.0000	$2.62
NF, Home HC	$0.21	1.0000	1.0000	1.0000	$0.21
PT, Other Prof, Misc Med	$0.64	0.9816	1.3324	1.0000	$0.87
Total	**$160.59**	**0.9790**	**1.0233**	**1.0655**	**$178.84**

Prior Period Coverage SFY 14					
Service Category	**Unadjusted Base Data PMPMs**	**Completion Factors**	**Reimbursement Changes**	**Supplemental Encounter Files**	**Adjusted Base Data**
Hospital Inpatient	$200.79	1.0000	0.9704	1.0000	$194.84
Physician	$80.73	1.0000	0.8826	1.0000	$71.26
All Other Service Categories	$61.29	1.0000	1.0277	1.0000	$62.98
Total	**$342.81**	**1.0000**	**0.9600**	**1.0000**	**$329.08**

Prior Period Coverage SFY 15					
Service Category	**Unadjusted Base Data PMPMs**	**Completion Factors**	**Reimbursement Changes**	**Supplemental Encounter Files**	**Adjusted Base Data**
Hospital Inpatient	$107.96	0.9998	0.9929	1.0000	$107.21
Physician	$53.68	0.9991	0.9856	1.0000	$52.95
All Other Service Categories	$53.10	0.9995	1.1240	1.0000	$59.72
Total	**$214.74**	**0.9996**	**1.0235**	**1.0000**	**$219.88**

Prior Period Coverage SFY 16					
Service Category	**Unadjusted Base Data PMPMs**	**Completion Factors**	**Reimbursement Changes**	**Supplemental Encounter Files**	**Adjusted Base Data**
Hospital Inpatient	$50.60	0.9121	1.0005	1.0000	$55.51
Physician	$28.67	0.9816	1.0079	1.0000	$29.43
All Other Service Categories	$51.85	0.9861	0.8692	1.0000	$45.71
Total	**$131.12**	**0.9552**	**0.9518**	**1.0000**	**$130.64**

Appendix 5: Program and Reimbursement Changes

Program or Reimbursement Change	Impact	Description
DRG reimbursement	Increase of about $84,600 (9 months)	Acute hospital inpatient stays with dates of discharge on and after October 1, 2014 are paid using an All Patient Refined Diagnosis Related Group (APR-DRG) payment system (with certain exclusions).
Fee schedule changes	Increase of about $48,000 (9 months)	Effective October 1, 2014, AHCCCS changed FFS provider rates for certain providers based either on access to care needs, Medicare or Arizona Department of Health Services (ADHS) fee schedule rates, and/or legislative mandates.
Ambulance reimbursement change	Increase of about $56,500 (9 months)	In accordance with Arizona Revised Statutes (A.R.S.) §36-2239, AHCCCS is required to pay ambulance providers rates equal to a prescribed percentage of the amounts approved by ADHS. This was effective October 1, 2014.
Automated Visual Screenings	Increase of about $10,000 (9 months)	AHCCCS began providing coverage for automated visual screenings for children aged one to three years of age. This was effective October 1, 2014.
Dental Homes & Varnish	Combined increase of about $46,400 (9 months)	AHCCCS Contractors were required to develop a process to assign all children ages 0 to 21 years of age (Early and Periodic Screening, Diagnostic and Treatment (EPSDT) members) to a dental home by one year of age. AHCCCS began allowing primary care providers (physicians, physician's assistants or nurse practitioners) to apply fluoride varnish during EPSDT visits beginning at first tooth eruption up to age two. This was effective April 1, 2014.
Newborn Screenings	Increase of about $11,700 (9 months)	An increase in newborn screening fee supported more accurate testing with fewer false positives, more thorough follow-up on abnormal results, more extensive provider education to reduce time from specimen collection to submission and testing and more comprehensive quality assurance activities. This was effective April 1, 2014.
FQHC/RHC Reimbursement Change	Increase of about $434,000 (3 months)	AHCCCS shifted payment responsibility for FQHC/RHC PPS rates to the Contractors in order to properly account for FQHC/RHC expenditures for managed care enrollees. This was effective April 1, 2015.
Fee schedule changes	Decrease of about $4,000 (9 months)	Effective October 1, 2015, AHCCCS is changing 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.
Ambulance reimbursement change	Decrease of about $34,000 (9 months)	In accordance with Arizona Revised Statutes (A.R.S.) §36-2239, AHCCCS is required to pay ambulance providers rates equal to a prescribed percentage of the amounts approved by ADHS. This was effective October 1, 2015.

Program or Reimbursement Change	Impact	Description
Reversal of Primary Care Provider (PCP) Parity Payment Increase	Decrease of $1,696,000 across SFY 14 and SFY 15 SFY 14 accounts for $1,369,000 of the decrease SFY 15 accounts for $327,000 of the decrease	Effective January 1, 2013 through December 31, 2014, AHCCCS and its Contractors were required to implement provisions of the Affordable Care Act of 2010 (ACA) regarding Medicare rate parity. Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act, required minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. The AHCCCS managed care model, with strict requirements regarding actuarially-sound capitation rates, necessitated that Contractors be funded for expected cost increases due to primary care rate parity. AHCCCS proposed to provide Contractors the necessary funds to increase primary care payments by using Model 3: Non-risk Reconciled Payments for Enhanced Rates as referenced in the Medicaid Managed Care Payment for PCP Services in 2013 and 2014, Technical Guidance and Rate Setting Practices (Technical Guidance) document released by CMS. In summary, under Model 3, prospective capitation rates were not adjusted for the enhanced primary care payments. Rather, AHCCCS queried actual encounter data on a quarterly basis to calculate the total payments that eligible providers were paid for eligible services in order to reach the mandated enhanced payment rates. Once the data on this report was verified, AHCCCS paid the Contractors the calculated additional payment amounts. A more detailed explanation of the process and methodology can be found in the Actuarial Certification submitted to CMS for approval of AHCCCS methodology. The increased payments were included in the encounter cost amounts and needed to be removed from the encounter cost amounts in order to reflect current conditions in provider reimbursement.
High Acuity Pediatric Adjustor	Increase of about $230,000 (6 months)	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," as long as the claim is not subject to one of the other policy adjustors. Beginning January 1, 2016, AHCCCS will address 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.
Fee schedule changes	Increase of about $183,000 (9 months)	Effective October 1, 2016, AHCCCS is changing Fee For Service (FFS) provider rates for certain providers based either on access to care needs, Medicare/Arizona Department of Health Services (ADHS) fee schedule rate changes, and/or legislative mandates.

Program or Reimbursement Change	Impact	Description
High Acuity Pediatric Adjustor	Increase of about $236,000 (6 months)	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," as long as the claim is not subject to one of the other policy adjustors. 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.
VBP Differential	Increase of about $34,000 (9 months)	AHCCCS has proposed Value-Based Purchasing (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, 0.5% for qualified AHCCCS-registered Arizona Hospital providers for inpatient and outpatient services, and 10% for qualified AHCCCS-registered Integrated Clinics for selected physical health services. Contractors are required to adopt the VBP Differential payment adjustments for qualified providers meeting the specific criteria.
Provider Reimbursement for AzEIP Members	Increase of about $41,000 (9 months)	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 is modifying 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.

Appendix 6: Blended Base Data

Prospective							
Service Category	**Adjusted Base Data SFY 14**	**Adjusted Base Data SFY 15**	**Adjusted Base Data SFY 16**	**Blending Factor SFY 14**	**Blending Factor SFY 15**	**Blending Factor SFY 16**	**Blended Base Data**
Hospital Inpatient	$26.59	$21.02	$18.78	0.1667	0.3333	0.5000	$20.83
Physician	$43.73	$42.18	$39.24	0.1667	0.3333	0.5000	$40.97
Emergency Services	$11.37	$12.86	$7.61	0.1667	0.3333	0.5000	$9.99
Pharmacy	$25.29	$24.11	$28.43	0.1667	0.3333	0.5000	$26.47
Lab, X-ray, & med image	$5.10	$5.05	$5.23	0.1667	0.3333	0.5000	$5.15
Outpatient Facility	$29.82	$30.26	$23.35	0.1667	0.3333	0.5000	$26.73
Durable Med Equip	$13.42	$12.27	$13.54	0.1667	0.3333	0.5000	$13.09
Dental	$32.10	$30.14	$29.52	0.1667	0.3333	0.5000	$30.15
FQHC/RHC	$0.00	$8.49	$9.45	0.0000	0.0000	1.0000	$9.45
Transportation	$3.47	$2.69	$2.62	0.1667	0.3333	0.5000	$2.78
NF, Home HC	$0.17	$0.23	$0.21	0.1667	0.3333	0.5000	$0.21
PT, Other Prof, Misc Med	$0.51	$0.83	$0.87	0.1667	0.3333	0.5000	$0.80
Total	**$191.58**	**$190.11**	**$178.84**				**$186.62**

Prior Period Coverage							
Service Category	**Adjusted Base Data SFY 14**	**Adjusted Base Data SFY 15**	**Adjusted Base Data SFY 16**	**Blending Factor SFY 14**	**Blending Factor SFY 15**	**Blending Factor SFY 16**	**Blended Base Data**
Hospital Inpatient	$194.84	$107.21	$55.51	0.1667	0.3333	0.5000	$95.96
Physician	$71.26	$52.95	$29.43	0.1667	0.3333	0.5000	$44.24
All Other Service Categories	$62.98	$59.72	$45.71	0.1667	0.3333	0.5000	$53.26
Total	**$329.08**	**$219.88**	**$130.64**				**$193.46**

Appendix 7: CYE 18 Projected Capitation Rates

Prospective				
Service Category	**Blended Base Data**	**Trend**	**Program Changes**	**CYE 18 PMPM**
Hospital Inpatient	$20.83	0.0%	0.0%	$20.83
Physician	$40.97	0.0%	0.0%	$40.97
Emergency Services	$9.99	0.0%	0.0%	$9.99
Pharmacy	$26.47	5.0%	0.0%	$30.14
Lab, X-ray, & med image	$5.15	1.3%	0.0%	$5.32
Outpatient Facility	$26.73	0.0%	0.0%	$26.73
Durable Med Equip	$13.09	2.0%	0.0%	$13.80
Dental	$30.15	0.0%	0.0%	$30.15
FQHC/RHC	$9.45	3.7%	0.0%	$10.17
Transportation	$2.78	0.0%	0.0%	$2.78
NF, Home HC	$0.21	0.3%	0.0%	$0.21
PT, Other Prof, Misc Med	$0.80	0.0%	0.0%	$0.80
Total	**$186.62**			**$191.90**

Gross Medical Expense PMPM	$191.90
Less Reinsurance PMPM	($7.01)
Net Claim Cost PMPM	**$184.88**
Admin Expenses PMPM	$33.87
Risk Contingency PMPM	$2.26
Premium Tax Rate	2.0%
Effective Capitation PMPM	**$225.52**

Prior Period Coverage				
Service Category	**Blended Base Data**	**Trend**	**Program Changes**	**CYE 18 PMPM**
Hospital Inpatient	$95.96	0.0%	0.0%	$95.96
Physician	$44.24	0.0%	0.0%	$44.24
All Other Service Categories	$53.26	0.0%	0.0%	$53.26
Total	**$193.46**			**$193.46**

Gross Medical Expense PMPM	$193.46
Less Reinsurance PMPM	$0.00
Net Claim Cost PMPM	**$193.46**
Admin Expenses PMPM	$33.87
Risk Contingency PMPM	$2.27
Premium Tax Rate	2.0%
Effective Capitation PMPM	**$234.29**