315 CYE 15

Attachment C

Acute Care Program Payment Reform Initiative
Shared Savings Arrangement Certification

Contractor Name: _____

Contract Year: **10/1/2014 - 9/30/2015**

	(1)	(2)	(3) = (1) + (2)	(4)	(5) = (4) / (1)
Service Category	**Projected Contracted Health Care Cost PMPM [1]**	**Projected Non-Contracted Health Care Cost PMPM [2]**	**Projected Health Care Cost PMPM**	**Projected PMPM Under Shared Savings Arrangements**	**% Under Shared Savings Arrangements (3)**
Hospital Inpatient			-		0.0%
Outpatient facility			-		0.0%
Emergency--facility			-		0.0%
Physician			-		0.0%
Other Professional			-		0.0%
Pharmacy			-		0.0%
Lab & Radiology			-		0.0%
Physical Therapy			-		0.0%
DME			-		0.0%
Nursing Fac. & H. Health			-		0.0%
Transportation			-		0.0%
Dental			-		0.0%
Other			-		0.0%
Total	**$ -**		**$ -**	**$ -**	**0.0%**

[1] PMPM for payments under all contracts executed with health care providers.

[2] PMPM for payments that are not contracted.

[3] Total percentage must be greater than or equal to 10%. Total shared-savings may include PPC.

I certify that the information provided in the certification is accurate and complete.

_____
Signature Title

_____
Print Name

Must be signed by Chief Financial Officer of Contractor
Both executed copy and Excel template must be submitted to AHCCCS Division of Health Care Management - Finance Manager