

**Arizona Department of Health Services
Division of Behavioral Health Services
Updated Actuarial Memorandum**

I. Purpose

This memorandum presents a discussion of the revision to the already approved Contract Year Ending 2015 (CYE 15) rates for the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS). Please see Attachment A for the actuarial memorandum for the already-approved ADHS/BHS capitation rates which details the original rate build up.

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

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

II. Overview of Changes

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

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

III. Methodology for Calculating Capitation Adjustments

FQHC/RHC All-Inclusive PPS Rates

AHCCCS will shift payment responsibility for FQHC/RHC PPS rates to the Contractors in order to properly account for FQHC/RHC expenditures for managed care enrollees. To identify the amount of full-funding needed for Contractors to pay the PPS rates on a per visit

basis, it was necessary to identify the historical FQHC/RHC visits in order to distribute the quarterly supplemental and annual reconciliation payments made by the Administration.

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

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

Additional adjustments were made to the data due to:

- The introduction of three new FQHCs/RHCs - historical encounter data is available since these providers were in place during the data period, but they did not have historical supplemental or reconciliation payments since they were not designated as FQHCs/RHCs until after the data period
- The integration of services in the Children Rehabilitative Services (CRS) program
- The integration of services for members with Serious Mental Illness (SMI) in Maricopa County

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

- The adjustment for the new FQHCs/RHCs involved projecting the reconciliation and quarterly supplemental payments from historical visits multiplied by the PPS rates and subtracting historical encounter payments
- The two integration models necessitated a reassignment of historical encounter and member month data for members moved to the integrated programs

The estimated impact of shifting payment responsibility from the Administration to the Contractors across all AHCCCS lines of business combined is budget neutral, but the estimated six month impact to the ADHS/BHS program is an increase of approximately \$14.9 million.

Physical Health/Behavioral Health Payment Responsibility

AHCCCS policy dictates that the principal diagnosis on an inpatient hospital claim determines the appropriate party payer: a claim with a physical health principal diagnosis code is paid by the Acute Care Contractor, and a claim with a behavioral health principal diagnosis code is paid by the Behavioral Health Contractor (the Regional Behavioral Health

Authority – RBHA). Under certain circumstances however, when both physical and behavioral health services were provided during the same inpatient stay, Acute Care Contractors sometimes paid claims even when the principal diagnoses were behavioral health.

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

Additional adjustments were made to the data due to:

- The rates that RBHAs will pay versus the rates that Acute Care Contractors pay
- The integration of services in the CRS program
- The integration of services for members with SMI in Maricopa County

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

- For rate differences between RBHAs and Acute Care Contractors, historical visits were re-priced at the appropriate payment rates to determine the amount to add into the RBHA capitation rates
- The two integration models necessitated a reassignment of historical encounter and member month data for members moved to the integrated programs

The estimated six month impact to the ADHS/BHS program is an increase of approximately \$1.6 million.

IV. Proposed Revised Capitation Rates and Their Impacts

Table I below summarizes the changes from the current approved CYE 15 capitation rates and the estimated budget impact, effective for the period April 1, 2015 through September 30, 2015 on a statewide basis.

Table I: Proposed Capitation Rates and Budget Impact Using 4/1/15 - 9/30/15 Member Months

4/1/15 - 9/30/15 Capitation Rates								
Rate Category	Statewide Rates		4/1/15-9/30/15	Projected Expenditures			% Change	
	10/1/14 Rates	4/1/15 Rates	Projected MMs ¹	10/1/14 Rates	4/1/15 Rates			
Statewide Behavioral Health Capitation Rates								
TXIX and TXXI non-CMDP Children	\$ 37.14	\$ 37.55	3,765,611	\$ 139,854,778	\$ 141,385,687			1.1%
CMDP Children	\$ 924.13	\$ 928.82	94,322	\$ 87,165,867	\$ 87,608,127			0.5%
No Integration								
TXIX GMH/SA and TXXI Adult	\$ 44.13	\$ 45.83	4,649,326	\$ 205,174,772	\$ 213,088,861			3.9%
Non-integrated SMI	\$ 33.92	\$ 34.07	4,534,760	\$ 153,819,064	\$ 154,489,825			0.4%
Maricopa Integrated								
Integrated SMI ²	\$ 2,398.27	\$ 2,426.39	113,555	\$ 272,336,000	\$ 275,529,386			1.2%
Total			13,157,574	\$ 858,350,482	\$ 872,101,886			1.6%

1) 4/1/15-9/30/15 Projected Member Months apply to both 10/1/14 and 4/1/15 Rates

2) Physical health costs as well as behavioral health costs are included in the Integrated SMI capitation rate

Actuarial Certification of the Capitation Rates

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

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

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

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

RBHAs are advised that the use of these rates may not be appropriate for their particular circumstance. RBHAs should analyze their own projected medical expense, administrative expense and other premium needs.

This certification letter assumes the reader is familiar with the BHS program, Medicaid eligibility rules and actuarial rating techniques. It is intended for BHS and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

SIGNATURE ON FILE

Anthony Wittmann

02/12/15

Date

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

ATTACHMENT A

**Arizona Department of Health Services
Division of Behavioral Health Services
Actuarial Memorandum**

I. Purpose

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

Arizona Health Cost Containment System (AHCCCS) has implemented, on April 1, 2014, a program in Maricopa County to integrate physical health and behavioral health service delivery for members with serious mental illness (SMI). This memorandum includes a description of the development of capitation rates for the physical health component of this program and a description of the development of behavioral health capitation rates for the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS) for Contract Year Ending 2015 (CYE 15). These capitation rates are for Maricopa County (GSA 6) and the Greater Arizona Regional Behavioral Health Authorities (RBHA) in Arizona.

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

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

II. Overview of SMI Physical Health Rate Setting Methodology

These rates cover the twelve month period of October 1, 2014 through September 30, 2015.

Historical Medicaid managed care encounter data was used as the primary data source in developing base period experience. This encounter data was made available to AHCCCS' actuaries via an extract that provides utilization data, cost data and member month information, referred to as the "databook". The databook included both encounter and member month data only for those members who would have met the criteria used for enrollment in the SMI integrated population effective April 1, 2014. The contract between AHCCCS and ADHS/BHS specifies that the ADHS/BHS may cover additional

services not covered by Medicaid. Non-covered services were removed from the databook for all time periods and excluded from the rate development.

Actuarially sound capitation rates were developed utilizing the steps outlined as follows:

1. Develop base period data
 - a. AHCCCS historical Medicaid managed care encounter data for the population covered by these rates was used as the primary basis for developing capitation rates.
 - b. Apply completion factors and adjust base period data for programmatic and AHCCCS provider fee schedule changes.
2. Develop actuarially sound rates
 - a. Apply a trend factor to bring base period claim costs forward to the midpoint of the rating period.
 - b. Adjust claims costs for prospective programmatic and provider fee schedule changes.
 - c. Add provision for administration and risk contingency.

III. SMI Physical Health Base Period Experience

AHCCCS used historical encounter data for the time period from October 1, 2010 through September 30, 2013. The base period data was adjusted by application of completion factors and historical programmatic and provider rate change factors. Weights were then applied to the adjusted base period data for the three periods of CYE 11 (October 1, 2010 through September 30, 2011), CYE 12 (October 1, 2011 through September 30, 2012) and CYE 13 (October 1, 2012 through September 30, 2013), with higher weights applied to more recent periods.

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

IV. SMI Physical Health Projected Trend Adjustments

Historical trend rates by major category of service were developed from the adjusted base period data. Due to the small population size, the historical trend rates for the SMI

integrated population were not reliable for projecting future experience. Thus, the trend rates used in the Acute capitation rate development for CYE 15 for similar populations were reviewed and deemed to be reasonable for use in this rate development and thus were utilized. Composite prospective PMPM trends are shown below in Table I.

Category of Service	PMPM Trend
Hospital Inpatient	0.0%
Outpatient facility	9.5%
Emergency--facility	7.4%
Physician	3.3%
Other Professional	4.0%
Pharmacy	4.1%
Other	-1.4%
Total	2.9%

V. SMI Physical Health Programmatic and Fee Schedule Changes – Prospective Adjustments

The changes in this section describe changes not reflected in the adjusted base period claims costs that will occur in the CYE 15 rating period. Estimated impacts are for the CYE 15 rating period.

ADHS Ambulance Rates

In accordance with A.R.S. § 36-2239, AHCCCS is required to pay ambulance providers rates equal to a percentage of the amounts prescribed by ADHS. Currently AHCCCS' rates are equal to 68.59% of the ADHS rates per Laws 2013, First Special Session, Chapter 10. However, AHCCCS is required by this same section of law to increase this percentage to 74.74% of the ADHS rates for rates effective October 1, 2014. This mandated adjustment results in a 9% increase in payments, assuming all utilization stays the same. The legislation also updates the base ADHS rates that are used to calculate the payments, which will result in further increases greater than 9%. The estimated impact to the program is an increase of approximately \$600,000.

Diagnosis Related Group (DRG) Impacts

Acute hospital inpatient stays with dates of discharge on and after October 1, 2014 will be paid using an All Patient Refined Diagnosis Related Group (APR-DRG) payment system (with certain exclusions). This payment system replaces the 20+ year tiered per diem inpatient reimbursement system in accordance with Arizona Revised Statutes (A.R.S.) § 36-2903.01 and Arizona Administrative Code (A.A.C.) R9-22-712.60 through 712.81. The impact of this move to APR-DRG is budget neutral to the state, but does

vary by Program. The estimated impact to this program is an increase of approximately \$36,000.

Insulin Pumps

Effective October 1, 2014, the State of Arizona's 2014 Health and Welfare Budget Reconciliation Bill (BRB) reinstated insulin pumps, which were previously eliminated October 1, 2010, as a covered service for enrolled adults. The estimated impact to the program is an increase of approximately \$32,000.

Hepatitis C – Sovaldi and New Hepatitis C Drugs

The FDA approved Sovaldi, a treatment option for hepatitis C, in December 2013. Sovaldi has the potential to positively impact the care and outcomes for certain hepatitis C-positive individuals, but it also has significant financial implications. New Hepatitis C drugs are anticipated to be released in the fall of 2014. The estimated impact is an increase of approximately \$4 million.

AHCCCS Fee Schedule Changes

Effective October 1, 2014, AHCCCS is changing FFS provider rates for certain providers based either on access to care needs, Medicare or ADHS fee schedule rates, and/or legislative mandates. The unit cost (inflation) trends were adjusted appropriately for these changes. The estimated impact is an increase of approximately \$140,000.

Medically Preferred Treatment Options

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

Primary Care Provider (PCP) Payment Increase

Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act, requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. The AHCCCS managed care model, with strict requirements regarding actuarially-sound capitation rates, necessitates that Contractors be funded for expected cost increases due to primary care rate parity. AHCCCS 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 would not be adjusted for the enhanced primary care payments. Rather, AHCCCS would query 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 is verified, AHCCCS would pay the Contractors the calculated additional payment amounts. A more detail explanation of the process and methodology can be

found in the Actuarial Certification submitted March 2013 to CMS for approval of AHCCCS methodology. There is no impact to the CYE 15 capitation rates.

VI. SMI Physical Health Administration and Risk Contingency

The capitation rates include a provision for administration and risk contingency of 9% which is calculated as a percentage of the final capitation rate.

VII. Risk Corridors

A risk corridor arrangement is utilized between ADHS/BHS and the RBHAs that provides motivation for the RBHAs to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for the RBHAs to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

VIII. Overview of Behavioral Health Rate Setting Methodology

The contract year ending 2015 (CYE 15) rates cover the twelve month contract period of October 1, 2014 through September 30, 2015.

Actuarially sound capitation rates were developed utilizing the steps outlined as follows:

1. Develop base period data
 - a) Regional Behavioral Health Authority (RBHA) financial statement data covering the period of 10/1/12 through 9/30/13 and member month data provided by ADHS/BHS were used as the primary basis for developing capitation rates for each rate category.
 - b) Adjust base period data for programmatic and ADHS/BHS provider fee schedule changes.
2. Develop CYE 15 actuarially sound rates
 - a) Apply a trend factor to bring base period claim costs forward to the CYE 15 rating period.
 - b) Adjust CYE 15 claims costs for programmatic and ADHS provider fee schedule changes.
 - c) Make an adjustment for the change in expected claims costs due to the shift of costs associated with Children's Rehabilitative Services (CRS) recipients to the integrated CRS program in CYE 15.
 - d) Add provision for administration and risk contingency.

IX. Base Period Experience

The base period data consisted of financial statement and member month data for all RBHAs for the October 1, 2012 through October 31, 2013 time period.

Adjustments were made to the base period data for fee schedule and programmatic changes.

A reallocation of base period claims costs among rate cells was made based on financial experience subsequent to the base period. This reallocation was made to realign the relationship among rate cells based on emerging current year financial experience, which was deemed by ADHS to more appropriately represent expectations of future results. This reallocation resulted in no change in aggregate base period claims costs for any of the RBHAs.

Included in the base period data is funding for "in lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. State-approved fee-for-service (FFS) rates at inpatient non-specialty hospitals are approximately 93.5% more expensive than those provided in alternative inpatient settings. The proposed capitation rates allow for the provision of services in alternative inpatient settings that are licensed by Arizona Department of Health Services/Division of Licensing Services/Office of Behavioral Health Licensing, in lieu of services in an inpatient non-specialty hospital, with unit cost savings of approximately 48.3% and total yearly cost savings of approximately \$1.8 million. These savings are already reflected in the base data.

BHS has periodically performed reviews of the RBHA-submitted data and has determined that the data does not include any non-covered services.

Inherent in the base period data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 to SFY 2014, encounter-reported COB cost avoidance grew by greater than 211%, from \$7.7 million to \$24.0 million. Additionally, in CYE 14 RBHAs cost-avoided \$7.3 million in additional claims in the nine months ending March 31, 2014 for which the RBHAs had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and therefore those services are excluded completely from capitation expenditure projections. AHCCCS continues to emphasize the importance of COB activities with BHS.

X. Projected Trend Rates

A trend analysis was performed using services expenses from RBHA audited financial statements for July, 2010 through October, 2013. In addition, standard sources of health care cost trends were examined, including the 2013 Actuarial Report on the Financial Outlook for Medicaid and the National Health Expenditure (NHE) Report published by CMS.

The RBHA service expense trend analysis was adjusted for fee schedule and programmatic changes made during the respective periods. Service expenses for the behavioral health category for members with Serious Mental Illness (SMI) were also adjusted for the effect of population changes during the period of the study. The resulting overall average "residual" trend rate of 2.2% for the observation period for all RBHAs and behavioral health categories was deemed to be a reasonable estimate of future trend since it was specific to the behavioral health population base and represented a large enough volume of experience to provide a reliable statistic.

Claim costs PMPM were trended from the midpoint of the base period to the midpoint of the rating period.

XI. Programmatic and Fee Schedule Changes – Prospective Adjustments

The changes in this section describe changes not reflected in the adjusted base claims costs that will occur in the CYE 15 rating period. Estimated impacts are for the CYE 15 rating period.

ADHS Ambulance Rates

The statewide impact on behavioral health capitation rates due to the change in ADHS ambulance rates described above is approximately \$690,000.

Behavioral Health Provider Fee Schedule Changes

BHS implemented a 2% provider rate increase effective October 1, 2014 for multiple community-based, inpatient and residential services, but excluding transportation, laboratory and radiology, pharmacy, and electro-convulsive therapy services. The statewide impact of this change is approximately \$17.8 million.

Capitation Payment Method Change

Prior to April 1, 2014, behavioral health capitation rates for SMI recipients and GMH/SA recipients were calculated and paid over the entire eligible adult population. Beginning on April 1, 2014 with the implementation of the integrated RBHA contract, capitation rates for the SMI population in Maricopa County are calculated and paid specifically on

the SMI population. This also impacts how the GMH/SA and SMI non-integrated population are paid since they are now paid over the entire eligible adult population less the SMI population in Maricopa County. This method change is expected to be budget neutral.

CRS Integration

In order to facilitate efficient coordination of care and improve member outcomes, AHCCCS has integrated the services for children with special health care needs effective October 1, 2013. Members with diagnoses who qualify for Children's Rehabilitative Services now receive care related to their CRS services, unrelated physical health services, and behavioral health care through a single CRS Contractor. All behavioral health costs for these members have been removed as well as the associated member months. This results in a shift of approximately \$5.2 million to the CRS Contractor for CYE 15.

XII. Administration and Risk Contingency

The CYE 15 capitation rates include a provision for RBHA administration, RBHA interpretive services administration, and RBHA risk contingency. The component for administration and risk contingency is calculated as a percentage of the final capitation rate. A 9% load was added across all populations, which is the same as was applied to current capitation rates. The component for interpretive services administration was determined by ADHS/BHS. Another adjustment to administration was made to account for the shift of certain administrative responsibilities from the RBHA to ADHS. This results in an impact of approximately \$1.6 million for CYE 15.

XIII. Risk Corridors

A risk corridor arrangement is utilized between ADHS/BHS and the RBHAs that provides motivation for the RBHAs to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for the RBHAs to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

XIV. Tribal FFS Claims Estimate

Tribal claims data was reviewed and an amount of \$75.8 million was projected for CYE 15.

XV. BHS Administration and Premium Tax

AHCCCS has placed BHS Administration at financial risk for the provision of behavioral health covered services and limited physical health covered services for CYE 15. Accordingly, the capitation rates were developed to include compensation to BHS for the

cost of ensuring the delivery of all covered services. The capitation rates paid to BHS include an administrative load, which was negotiated between AHCCCS and BHS administration. The load represents a 2% premium tax and a 1.173% administrative load for the twelve month period of October 1, 2014 through September 30, 2015. The BHS administrative costs ensure the efficient delivery of services in a managed care environment.

XVI. Title XXI Capitation Rates

For CYE 15, the Title XXI population includes those children whose household has income levels between 133-200% of the FPL. This program is frozen to new enrollment. However if a child loses Medicaid as a result of modified adjusted gross income (MAGI) determination they can enroll in KidsCare.

Due to the small amount of experience data for the Title XXI population, the RBHAs will be paid one blended capitation rate that includes experience from both the traditional Medicaid population and the Title XXI KidsCare population.

The service expense and member month data for the Title XXI members that are under the age of 18 are included in the non-CMDP Child capitation rate development and the service expense and member month data for the Title XXI members that are age 18 and older are included in the GMH/SA capitation rate development. As a result, the CYE 15 capitation rates for these populations are the same as for the Title XIX members.

XVII. Proposed Revised Capitation Rates and Projection of Expenditure

Tables II and III below summarize the changes from the currently approved capitation rates and the expenditure projection, effective for the contract period on a statewide basis.

Table II shows the total projected expenditures based on projected October 1, 2014 through September 30, 2015 member months for both the April 1, 2014 and October 1, 2014 rates.

Table II: Proposed Capitation Rates and Budget Impact Using 10/1/14 - 9/30/15 Member Months

10/1/14 - 9/30/15 Capitation Rates							
Rate Category	Statewide Rates		10/1/14-9/30/15	Projected Expenditures			% Change
	4/1/14 Rates	10/1/14 Rates	Projected MMs ¹	4/1/14 Rates	10/1/14 Rates		
Statewide Behavioral Health Capitation Rates No Integration	TXIX and TXXI non-CMDP Children	\$ 37.20	\$ 37.14	8,005,442	\$ 297,802,452	\$ 297,294,801	-0.2%
	CMDP Children	\$ 1,128.01	\$ 924.13	186,508	\$ 210,382,470	\$ 172,356,558	-18.1%
	TXIX GMH/SA and TXXI Adult	\$ 46.61	\$ 44.13	8,140,942	\$ 379,449,286	\$ 359,241,110	-5.3%
	non-integrated SMI	\$ 31.89	\$ 33.92	8,139,514	\$ 259,569,087	\$ 276,121,365	6.4%
Maricopa Integrated	Integrated SMI ²	\$ 2,425.06	\$ 2,398.27	216,233	\$ 524,378,670	\$ 518,584,180	-1.1%
Total					\$ 1,671,581,966	\$ 1,623,598,014	-2.9%

1) 10/1/14-9/30/15 Projected Member Months apply to both 4/1/14 and 10/1/14 Rates
 2) Physical health costs as well as behavioral health costs are included in the integrated SMI capitation rate

Table III shows the projected expenditure for the April 1, 2014 rates based on October 1, 2013 through September 30, 2014 member months and the projected expenditure for the October 1, 2014 rates based on October 1, 2014 through September 30, 2015 member months.

Table III: Proposed Capitation Rates and Budget Impact Using 10/1/13 - 9/30/14 Actual/Projected Member Months Applied to the 4/1/14 Rates and 10/1/15 - 9/30/15 Projected Member Months Applied to the 10/1/14 Rates

10/1/14 - 9/30/15 Capitation Rates									
Rate Category		Stawide Rates		Actual/Projected MMs ^{1,3}		Projected Expenditures			% Change
		4/1/14 Rates	10/1/14 Rates	10/1/13 - 9/30/14	10/1/14 - 9/30/15	4/1/14 Rates	10/1/14 Rates		
Statewide Behavioral Health Capitation Rates	TXIX and TXXI non-CMDP Children	\$ 37.20	\$ 37.14	7,263,974	8,005,442	\$ 270,219,833	\$ 297,294,801		10.0%
	CMDP Children	\$ 1,128.01	\$ 924.13	168,274	186,508	\$ 189,814,755	\$ 172,356,558		-9.2%
	TXIX GMH/SA and TXXI Adult	\$ 46.61	\$ 44.13	6,804,589	8,140,942	\$ 317,161,909	\$ 359,241,110		13.3%
	non-integrated SMI	\$ 31.89	\$ 33.92	6,796,918	8,139,514	\$ 216,753,726	\$ 276,121,365		27.4%
Maricopa Integrated	Integrated SMI ^{2,3}	\$ 2,425.06	\$ 2,398.27	201,872	216,233	\$ 489,552,339	\$ 518,584,180		5.9%
Total						\$ 1,483,502,562	\$ 1,623,598,014		9.4%

1) 10/1/14-9/30/15 Projected Member Months apply to the 10/1/14 Rates and 10/1/13-9/30/14 Member Months apply to the 4/1/14 Rates

2) Physical health costs as well as behavioral health costs are included in the Integrated SMI capitation rate

3) The integrated RBHA became effective 4/1/14 (i.e. 6 months into the Contract Year). For display purposes only this table assumes the integrated RBHA was in place for the entire year

XVIII. Actuarial Certification of the Capitation Rates

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

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

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

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

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

RBHAs are advised that the use of these rates may not be appropriate for their particular circumstance. RBHAs should analyze their own projected medical expense, administrative expense and other premium needs.

This certification letter assumes the reader is familiar with the BHS program, Medicaid eligibility rules and actuarial rating techniques. It is intended for BHS and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

SIGNATURE ON FILE

Anthony Wittmann

08/28/14

Date

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

XIX. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.0: Overview of rate setting methodology

AHCCCS is performing a rebase from the previously approved contract year ending 2014 (CYE 14) rates under 42 CFR 438.6(c). Please refer to Sections I-II and VIII.

AA.1.1: Actuarial certification

Please refer to Section XVIII.

AA.1.2: Projection of expenditure

Please refer to Section XVII.

AA.1.3: Procurement, prior approval and rate setting

This is a sole source contracting method, between AHCCCS and ADHS.

AA.1.5: Risk contract

The contract is an at risk contract, however there is a provision for a risk corridor reconciliation. Please refer to Sections VII and XIII.

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Critical Access Hospitals (CAH). GME is paid in accordance with state plan. DSH and CAH payments are paid in accordance with the Waiver Special Terms and Conditions. None of the additional payments to providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Sections III-V and Sections IX-XI.

2. Base Year Utilization and Cost Data

AA.2.0: Base year utilization and cost data

Please refer to Sections III and IX.

AA.2.1: Medicaid eligibles under the contract

The data includes only those members eligible for managed care.

AA.2.2: Dual Eligibles (DE)

There are dual eligibles.

AA.2.3: Spenddown

Not applicable, not covered under this contract.

AA.2.4: State plan services only

Please refer to Sections II and IX.

AA.2.5: Services that can be covered by a capitated entity out of contract savings.

Same as AA.2.4.

3. Adjustments to the Base Year Data

AA.3.0 Adjustments to base year data

Please refer to Sections III-IV and IX-X.

AA.3.1 Benefit differences

Not applicable.

AA.3.2 Administrative cost allowance calculation

Please refer to Sections VI, XII and XV.

AA.3.3 Special populations' adjustment

Please refer to Sections VIII, XI, and XIV.

AA.3.4 Eligibility Adjustments

No adjustment was made.

AA.3.5 DSH Payments

No DSH payment was included in the capitation development.

AA.3.6 Third party Liability (TPL)

Please refer to Section IX.

AA.3.7 Copayments, coinsurance and deductible in the capitated rates

In general, members utilizing behavioral health services do not pay any copays, coinsurance or deductibles, but there are a few that pay copays. The data is net of copays. Further adjustments might be necessary due to Health Care Reform and if so the capitation rates will appropriately be adjusted at that time with an amendment.

AA.3.8 Graduate Medical Education

The experience excludes any payment for GME.

AA.3.9 FQHC and RHC reimbursement

The experience excludes any additional payments that FQHCs may receive from the state.

AA.3.10 Medical cost/trend inflation

Please refer to Section IV and X.

AA.3.11 Utilization adjustment

Please refer to Section IV and X.

AA.3.12 Utilization and cost assumptions

Not applicable since actual experience was used.

AA.3.13 Post-eligibility treatment of income (PETI)

Not applicable, not required to consider PETI.

AA.3.14 Incomplete data adjustment

Please refer to Section III.

4. Establish Rate Category Groupings

AA.4.0: Establish rate category groupings

Please refer to Section XVII.

AA.4.1: Age

Please refer to Section XVII.

AA.4.2: Gender

Not applicable.

AA.4.3: Locality/region

Not applicable.

AA.4.4: Eligibility category

Please refer to Section XVII.

5. Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0: Data smoothing

Please refer to Section III.

AA.5.1: Special populations and assessment of the data for distortions

Data was not adjusted for special populations.

AA.5.2: Cost-neutral data smoothing adjustments

Please refer to Section IX.

AA.5.3: Risk-adjustment

Not applicable.

6. Stop Loss, Reinsurance, or Risk-Sharing arrangements

AA.6.1: Commercial reinsurance

There is no commercial reinsurance.

AA.6.2: Simple stop loss program

Not applicable.

AA.6.3: Risk corridor program

Please refer to Sections VII and XIII.

7. Incentive Arrangements

Not Applicable

