

Attachment C

Payment Reform Initiative (PRI) Shared Savings Arrangement Certification

Contractor Name: _____

Contract Year: 10/1/2013 - 9/30/2014

	(1)	(2)	(3)	(4) = (2) + (3)	(5) = (3) / (1)	(6) = (4) / (1)
Service Category	Projected Health Care Cost PMPM ⁽¹⁾	Projected PMPM Under Shared Savings Arrangements ⁽²⁾	Projected PMPM Under Sub-capitated Arrangements with no SS ⁽³⁾	Projected PMPM Under Shared Savings or Sub-capitated Arrangements	% Under Sub-capitated Arrangements with no SS ⁽⁴⁾	% Under Shared Savings or Sub-capitated Arrangements ⁽⁵⁾
Hospital Inpatient				-	0.0%	0.0%
Outpatient facility				-	0.0%	0.0%
Emergency--facility				-	0.0%	0.0%
Physician				-	0.0%	0.0%
Other Professional				-	0.0%	0.0%
Pharmacy				-	0.0%	0.0%
Lab & Radiology				-	0.0%	0.0%
Physical Therapy				-	0.0%	0.0%
DME				-	0.0%	0.0%
Nursing Fac. & H. Health				-	0.0%	0.0%
Transportation				-	0.0%	0.0%
Dental				-	0.0%	0.0%
Total **	\$ -	\$ -	\$ -	\$ -	0.0%	0.0%

- ⁽¹⁾ PMPM for payments under all contracts executed with health care providers
- ⁽²⁾ Includes sub-capitated arrangements that have a shared savings component
- ⁽³⁾ Applies to sub-capitated arrangements that do not also have a shared savings (SS) component
- ⁽⁴⁾ Total percentage must not be greater than 2.5%
- ⁽⁵⁾ Total percentage must be greater than or equal to 5%

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

Signature Title Date

Print Name

Must be signed by Chief Financial Officer of Contractor
Submit form to AHCCCS Division of Health Care Management - Finance Manager