Contract Year Ending 2018 Arizona Long Term Care System Department of Economic Security/Division of Developmental Disabilities Capitation Rate Certification

July 1, 2017 through June 30, 2018

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

September 9, 2017

AHCCCS
Arizona Health Care Cost Containment System

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Introduction and Limitations

The purpose of this rate certification is to provide documentation, including the data, assumptions, and methodologies, used in the development of the retroactive adjustment to the July 1, 2017 through June 30, 2018 (Contract Year Ending 2018 or CYE 18) actuarially sound capitation rates for the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Program for compliance with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). The CYE 18 actuarial memorandum for capitation rates as signed by Matthew C. Varitek dated April 5, 2017 will detail the original capitation rate build up. In addition to the retroactive change to July 1, 2017, this rate certification will also provide documentation of the data, assumptions, and methodologies used to update the acute component of the capitation rate effective October 1, 2017 through June 30, 2018 for compliance with the above mentioned regulation. This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 of 81 FR 27497 applicable to this rate certification, the 2018 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2018 Medicaid Managed Care Rate Development Guide (2018 Guide) describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2018 Guide to help facilitate the review of this rate certification by CMS. Sections of the 2018 Guide that do not apply will be marked as “Not Applicable” and will be included in this rate certification as requested by CMS.

Section I Medicaid Managed Care Rates

The capitation rates included with this rate certification are considered actuarially sound according to the following criteria from 42 CFR § 438.4 at 81 FR 27858:

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

Additionally, the term actuarially sound is defined in Actuarial Standard of Practice (ASOP) 49, “Medicaid Managed Care Capitation Rate Development and Certification,” as:

> “Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.”

As stated on page 2 of the 2018 Guide, CMS will also use these three principles in applying the regulation standards:

- the capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
- the rate development process complies with all applicable laws (statutes and regulations)for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- the documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR Part 438 and generally accepted actuarial principles and practices.

1. General Information

This section provides documentation for the General Information section of the 2018 Guide.

A. Rate Development Standards

i. Rating Period

The CYE 18 capitation rates for the ALTCS DES/DDD Program are effective for the twelve month time period from July 1, 2017 through June 30, 2018. This certification is updating the previous ALTCS DES/DDD rates that were effective from July 1, 2017 through June 30, 2018. A retroactive (to July 1, 2017) capitation rate adjustment is being made to address the increased labor costs resulting from the Arizona minimum wage increase and employee benefit provisions mandated by Proposition 206, and the Flagstaff minimum wage increase mandated by Proposition 414 effective July 1, 2017 and a prospective change (effective October 1, 2017) is being made due to the acute component of the rate being subcontracted on an October 1st to September 30th basis, as well as the need for additional funding in the LTC component of the rate for a differential adjusted payment (DAP) to certain nursing facilities.

ii. Rate Certification Documentation

This rate certification includes the following items and information:

(a) Letter from Certifying Actuary

The actuarial certification letter for the CYE 18 capitation rates for the ALTCS DES/DDD Program, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854 and is provided below for reference.

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Mr. Varitek certifies that the CYE 18 capitation rates for the ALTCS DES/DDD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 of 81 FR 27497.

(b) Final and Certified Capitation Rates

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ALTCS DES/DDD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856. The ALTCS DES/DDD contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 and the 2018 Guide.

(c) Final and Certified Capitation Rate Ranges

Not Applicable. Rate ranges were not developed for the CYE 18 capitation rates for the ALTCS DES/DDD Program.

(d) Program Information

(i) Summary of Program

(A) Type and Number of Managed Care Plans

ALTCS DES/DDD is the only managed care plan for this program. They subcontract a portion of their responsibilities (acute care services) to other managed care organizations (MCOs), and thus, the acute component of the capitation rate is set on a different time basis since ALTCS DES/DDD runs on a state fiscal year basis, but their acute subcontractors run on a federal fiscal year (FFY) basis.

(B) Covered Services

The following is a general description of services covered under the ALTCS DES/DDD Program. Additional information regarding covered services can be found in the Scope of Services section of the ALTCS DES/DDD contract.

Services covered by ALTCS DES/DDD include long-term care services, physical health services (excluding specialty care for children who have a Children's Rehabilitative Services (CRS) qualifying condition as those services are provided by the CRS Contractor); limited behavioral health services (i.e. treatment for ADHD, anxiety and depression when provided by the member's primary care physician); and Targeted Case Management (TCM) for those members who do not meet the functional requirements for ALTCS services.

ALTCS DES/DDD 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. Therefore, most behavioral health services are excluded from ALTCS DES/DDD. Additional information regarding the excluded behavioral health services, along with the coordination of behavioral health services for ALTCS DES/DDD enrolled members, can be found in the Behavioral Health Services section of the ALTCS DES/DDD contract.

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

The ALTCS DES/DDD Program has operated on a statewide basis in the State of Arizona since the late 1980s.

(ii) Rating Period Covered

The updated CYE 18 capitation rates for ALTCS DES/DDD are effective for the twelve month time period from July 1, 2017 through June 30, 2018. There are different capitation rates in effect for the three month time period between July 1, 2017 and September 30, 2017, and the nine month period beginning October 1, 2017 through June 30, 2018 due to the prospective change in the acute component occurring at October 1, 2017 as well as the DAP for certain nursing facilities effective October 1, 2017.

(iii) Covered Populations

The populations covered under ALTCS DES/DDD are individuals with a qualifying developmental disability.

Additional information regarding covered populations can be found in the Enrollment and Disenrollment section of the ALTCS DES/DDD contract.

The ALTCS DES/DDD Program has two rate cells.

The first rate cell (regular DDD capitation rate) includes the costs of providing long-term care and physical health (i.e. Acute) covered services for DD members. This rate cell is being retroactively adjusted for the impact of minimum wage and employee benefit changes effective July 1, 2017. There is also a prospective adjustment for the long-term care component effective October 1, 2017 for the DAP to certain nursing facilities. Additionally, the acute rate component (including the acute reinsurance offset and administrative expenses for the acute sub-contractors) of the regular DDD capitation rate is being rebased for this certification.

The second rate cell (Targeted Case Management (TCM)) includes the costs of providing case management services for members who have a DD diagnosis and meet the financial eligibility of Title XIX or Title XXI programs, but do not meet the functional requirements of Arizona Long Term Care Services. This rate cell is not being updated at this time, as the rate is still actuarially sound, and there have been no updates which would affect this rate cell since the last capitation rate submission.

(iv) Eligibility or Enrollment Criteria Impacts

ALTCS DES/DDD determines eligibility for ALTCS/DD services through four diagnoses: cerebral palsy, epilepsy, autism, or a cognitive disability.

There are 3 types of DDD eligibility.

Members who are DDD State Only receive Support Coordination and direct services based on assessed need and availability of state funds. Members in this category have the right to choose the type of contact, as applicable. These members are not eligible for Targeted Case Management or ALTCS, and are not considered in this rate certification.

Members who are Targeted Case Management are eligible for Title XIX or Title XXI acute care services including Early Periodic Screening Diagnosis and Treatment (EPSDT), but do not meet the functional requirements of ALTCS. Members in this category receive Support Coordination.

Members who are ALTCS eligible receive Support Coordination and direct services based on assessed need including medical necessity and cost effectiveness, and acute services including EPSDT. Members eligible for ALTCS have choice with regards to which ALTCS DES/DDD sub-contracted acute health plan they wish to enroll in.

There are no expected changes to the eligibility and enrollment criteria during CYE 18 that could have an impact on the populations to be covered under the ALTCS DES/DDD Program.

(v) Summary of Special Contract Provisions Related to Payment

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE 18 capitation rates are:

- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- AHCCCS Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Alternative Payment Model (APM) Initiative – Performance Based Payments (42 CFR § 438.6(b)(2) at 81 FR 27859)

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

(vi) Retroactive Capitation Rate Adjustments

This rate cert includes a retroactive capitation rate adjustment to the rates submitted April 5, 2017 for July 1, 2017 to June 30, 2018. This capitation rate adjustment is necessary to address increased labor costs resulting from the Arizona minimum wage increase and employee benefit provisions mandated by Proposition 206, and the Flagstaff minimum wage increase mandated by Proposition 414 effective July 1, 2017, which increased the fee schedule rates for select Nursing Facility (NF) and Home and Community Based Service (HCBS)

providers, and has an impact of $13.4 million for the twelve month period beginning July 1, 2017.

(A) Rationale for Adjustment

Increased labor costs related to minimum wage and employee benefit provisions with effective dates of July 1, 2017 were implemented by legislative action after the previous submission of actuarially sound capitation rates for July 1, 2017 to June 1, 2018.

(B) Data, Assumptions, Methodologies Used to Develop Magnitude of Adjustment

Effective July 1, 2017, AHCCCS increased fee schedule rates for select HCBS codes, all NF codes and all alternative living facility services codes to address the increased labor costs resulting from the Arizona minimum wage increase and employee benefit provisions as approved by voters as Proposition 206 on November 8, 2016, and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. Effective July 1, 2017, Flagstaff minimum wage increase is larger than the statewide increase as mandated by Proposition 414 and later amended through action of the Flagstaff City Council. Through continued discussion with the Contractors, AHCCCS knows the increased rates are similarly adopted by the Contractors, and thus a retroactive capitation rate adjustment is appropriate to account for the increased cost of providing these services.

AHCCCS will be retroactively adjusting CYE 18 capitation rates back to July 1, 2017 for the increased labor costs due to the state minimum wage and employee benefit provisions of Propositions 206 and 414. AHCCCS received projected spend by service code for January 1, 2017 through June 30, 2017 from ALTCS DES/DDD. The actuary pulled NF and HCBS encounter data (October 1, 2015 through September 30, 2016) by zip code to get weights to apply to the ALTCS DES/DDD projected data since the minimum wage increases vary by area.

From the zip code data, the actuary calculated the percentage of encounters that were in Flagstaff and then applied the Proposition 206 and Proposition 414 rate increases by way of those percentages to develop a statewide minimum wage rate increase as shown in the table below.

COS	Percentage of Encounter Costs Serviced in Flagstaff	Proposition 206 and Proposition 414 Fee Schedule Increases: Flagstaff	Proposition 206 Fee Schedule Increases: Non-Flagstaff	Statewide
NF	0.01%	1.00%	0.30%	0.30%
HCBS	1.86%	3.30%	1.70%	1.73%

These statewide minimum wage and employee benefit cost increases were applied to the ALTCS DES/DDD projected service costs by service code to develop the projected services costs for the July 1, 2017 effective date. These costs were then divided by the member months for the same time frame (January 1, 2017 through June 30, 2017) to develop the PMPM increases that were then added to the most recently submitted capitation rates.

iii. Rate Development Standards and Federal Financial Participation

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

iv. Rate Cell Cross-subsidization

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

v. Effective Dates of Changes

The effective dates of changes to the ALTCS DES/DDD Program are consistent with the assumptions used to develop the CYE 18 capitation rates for the DES/DDD Program.

vi. Generally Accepted Actuarial Principles and Practices

(a) Reasonable, Appropriate, and Attainable Costs

In the actuary's judgement, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To the actuary's knowledge, there are no reasonable, appropriate, and attainable costs which have not been included in the rate certification.

(b) Rate Setting Process

Adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the rate certification are not considered actuarially

sound under 42 CFR §438.4. There are no adjustments to the rates performed outside the rate setting process.

(c) Contracted Rates

Consistent with 42 CFR §438.7(c), the final contracted rates in each cell must either match the capitation rates or be within the rate ranges in the rate certification. This is required in total and for each and every rate cell. The CYE 18 capitation rates certified in this report represent the contracted rates by rate cell.

vii. Rates from Previous Rating Periods

Not Applicable. Capitation rates from previous rating periods are not used in the development of the CYE 18 capitation rates for the ALTCS DES/DDD Program.

viii. Rate Certification Procedures

(a) CMS Rate Certification Requirement for Rate Change

This is an updated rate certification that documents the ALTCS DES/DDD Program capitation rates will be changing retroactively effective July 1, 2017, as well as prospectively effective October 1, 2017.

(b) CMS Rate Certification Requirement for No Rate Change

Not Applicable. This rate certification will retroactively change the previously submitted ALTCS DES/DDD Program capitation rates effective July 1, 2017 through June 30, 2018. This rate certification will also prospectively change the ALTCS DES/DDD Program capitation rates effective October 1, 2017 due to a rebase of the acute component of the capitation rate, which is adjusted on a federal fiscal year basis due to contracts between the ALTCS DES/DDD Program and its acute subcontractors. There is also an update to the LTC component of the ALTCS DES/DDD capitation rate due to the DAP effective October 1, 2017 for certain nursing facilities.

(c) CMS Rate Certification Circumstances

This section of the 2018 Guide provides information on when CMS would not require a new rate certification, and is not applicable to this certification.

(d) CMS Contract Amendment Requirement

A contract amendment will be submitted to CMS to reflect the ALTCS DES/DDD Program capitation rates changing effective July 1, 2017 and October 1, 2017.

B. Appropriate Documentation

i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 18 capitation rates for the ALTCS DES/DDD Program.

ii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2018 Guide. Sections of the 2018 Guide that do not apply will be marked as "Not Applicable" and will be included in this rate certification as requested by CMS.

iii. Differences in Federal Medical Assistance Percentage

The covered populations under the ALTCS DES/DDD Program receive the regular FMAP. ALTCS DES/DDD Program receives some Children's Health Insurance Program (CHIP) funding for TCM for those acute enrolled members who are TXXI.

iv. Rate Ranges

Not Applicable. Rate ranges were not developed for the CYE 18 capitation rates for the ALTCS DES/DDD Program.

v. Rate Range Development

Not Applicable. Rate ranges were not developed for the CYE 18 capitation rates for the ALTCS DES/DDD Program.

2. Data

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

A. Rate Development Standards

i. Compliance with 42 CFR § 438.5(c)

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

B. Appropriate Documentation

i. Data Request

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

ii. Data Used for Rate Development

(a) Description of Data

(i) Types of Data Used

The types of data that AHCCCS relied upon for developing the CYE 18 capitation rates for the ALTCS DES/DDD Program were:

For the retroactive update effective July 1, 2017, the types of data AHCCCS relied on were:

- Projected spend by service code for January 1, 2017 through June 30, 2017 from ALTCS DES/DDD;
- Adjudicated and approved NF and HCBS encounter data (October 1, 2015 through September 30, 2016) by zip code;
- Member month data for ALTCS DES/DDD members for January 1, 2017 through June 30, 2017; and
- Updated AHCCCS FFS schedules for NF and HCBS services.

For the prospective acute component being updated effective October 1, 2017, the types of data AHCCCS relied on were:

- Adjudicated and approved encounter data (October 1, 2013 through September 30, 2016 (FFY 14, FFY 15, and FFY16)) submitted by the acute subcontractors (FFY 15 used as base for acute component development);
- Reinsurance payments for FFY 14, FFY 15, and FFY 16 (FFY 15 used as base for reinsurance offset);
- Historical member month data for the acute subcontractors for FFY 14, FFY 15, and FFY 16 from ALTCS DES/DDD;

- Historical member month data for ALTCS DES/DDD for FFY 14, FFY 15, and FFY 16 from the AHCCCS PMMIS mainframe;
- Projected member month data provided by AHCCCS Division of Business and Finance (DBF) Budget Team for CYE 18;
- Financial statements (with sub-capitated expenses reported by category of service (COS)) submitted by the acute subcontractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team for FFY 14, FFY 15, and FFY 16;
- Historical and Future Fee For Service (FFS) schedules developed by DHCM Rates & Reimbursement Team; and
- Data from DHCM Rates & Reimbursement Team related to DAP, see section I.4.D.

For the prospective update to the LTC component for the DAP to certain nursing facilities effective October 1, 2017, AHCCCS relied on data from DHCM Rates & Reimbursement Team related to DAP, see Section I.4.D.

For all other components of the rate not specifically updated by this certification, please see the prior certification signed April 5, 2017.

(ii) Age of Data

For the retroactive update effective July 1, 2017:

The projected NF and HCBS expense data provided were for the time frame from January 1, 2017 through June 30, 2017.

For the prospective acute component update effective October 1, 2017:

The encounter data serving as the base experience in the acute component rate development process was incurred during FFY 2015 (October 1, 2014 to September 30, 2015) and paid through April 2017. For the purposes of trend development and analyzing historical experience, AHCCCS also reviewed encounter data from FFY 14 (October 1, 2013 through September 30, 2014, paid through April 2017) and FFY 16 (October 1, 2015 through September 30, 2016, paid through April 2017).

The historical enrollment data for ALTCS DES/DDD aligned with the encounter data time periods of FFY 14, FFY 15, and FFY 16.

The financial statement data reviewed as part of the rate development process included financial statements for the FFY 14, FFY 15, and FFY 16 time periods. The historical acute subcontractor administration and sub-capitated expense data came from these same financial statements.

For the prospective LTC component update effective October 1, 2017:

The utilization data specific to the qualifying nursing facilities was incurred during FFY 16 (October 1, 2015 to September 30, 2016).

(iii) Sources of Data

For the retrospective update effective July 1, 2017:

The projected NF and HCBS expense data was provided by ALTCS DES/DDD.

For the prospective acute component update effective October 1, 2017:

The enrollment data for ALTCS DES/DDD (which includes all American Indian Health Plan (AIHP) members who are eligible for services through ALTCS DES/DDD) and the encounter data for ALTCS DES/DDD (and their acute subcontractors) were provided from the AHCCCS PMMIS mainframe. Additionally, enrollment data for the acute subcontractors was provided by ALTCS DES/DDD. This acute subcontractor enrollment data only includes those AIHP members who chose one of the acute subcontractors for their services (this enrollment fluctuates through the year as AIHP members can change where and what delivery system they receive their acute services through at any time). The difference between the two enrollment figures is defined as the enrollment of AIHP members solely in ALTCS DES/DDD, not in ALTCS DES/DDD and their acute subcontractors. This data is needed since ALTCS DES/DDD is responsible for all services and is paid on all members enrolled in ALTCS DES/DDD, but when AIHP members choose to not be enrolled in one of the acute subcontractors, ALTCS DES/DDD is responsible for those services and not the acute subcontractors. The projected enrollment data for CYE 18 was provided by the AHCCCS DBF Budget Team. The acute subcontractors' financial statement data were reported to and reviewed the AHCCCS Finance & Reinsurance Team.

For the prospective LTC component update effective October 1, 2017:

All data provided was from the AHCCCS Rates & Reimbursement Team.

(iv) Sub-capitated Arrangements

ALTCS DES/DDD acute sub-contractors have sub-capitated/block purchasing arrangements. Over the three federal fiscal years used for base data, the acute subcontractors paid an average of 22.53% of total medical expenditures through sub-capitated arrangements. The sub-capitated arrangements between the ALTCS DES/DDD acute subcontractors and their providers still require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated encounters, and health plan paid amount equaling zero. After the

encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05, and health plan paid of zero (i.e. sub-capitated)) encounters to estimate a health plan valued amount for these encounters. For the ALTCS DES/DDD acute subcontractors only, the formula by which this is calculated does not provide a reasonable value for the sub-capitated encounters. As a result, AHCCCS relied on the ALTCS DES/DDD subcontractors' financial data for the total dollar amounts for sub-capitated expenses, and adjusted encounter data to reflect those dollar amounts reported by the subcontractors in categories of service Professional and Dental (the only categories of service with reported sub-capitated arrangements). The units of service data from the encounters was still used for the basis of calculating utilization and unit cost.

(b) Availability and Quality of the Data

(i) Data Validation Steps

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

(A) Completeness of the Data

The AHCCCS DHCM Data & Research Team 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.

(B) Accuracy of the Data

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

Through the DHCM Actuarial Team review of the encounter data provided from the AHCCCS PMMIS mainframe, we ensured that encounter data only with valid AHCCCS member IDs was used in developing the CYE 18 capitation rates for the ALTCS DES/DDD Program. Additionally, the actuary

ensured that only services covered under the state plan were included in the capitation rate development process.

(C) Consistency of the Data

AHCCCS compared the encounter data for each FFY against the financial statement reports, modified for prior period adjustments, submitted by ALTCS DES/DDD subcontractors as shown in the table below. AHCCCS adjusted encounter data to reflect the dollar amounts reported by the subcontractors for sub-capitated encounters in categories of service Professional and Dental, as described above in Section I.2.B.ii.(a).(iv). The units reported in the sub-capitated encounters were still utilized in the rate development process, only the dollar amounts were adjusted to reflect financials.

Comparison of Encounters + Subcap from Financials to Total Financials

	FFY14	FFY15	FFY16
Encounters + Subcap	107,970,854	113,286,131	125,240,261
Total Financials	109,210,621	113,660,501	125,939,796
(Encounters + Subcap)/Total Financials	98.86%	99.67%	99.44%

(ii) Actuary's Assessment of the Data

As required by ASOP No. 23, the actuary discloses that the rate development process has relied upon encounter data submitted by ALTCS DES/DDD and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by ALTCS DES/DDD and its subcontractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP and fee schedule impacts, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment, and the costs associated with APM in conjunction with ALTCS DES/DDD.

AHCCCS has determined the FFY 15 encounter data, along with the amounts listed in the subcontractor financials for sub-capitated arrangements, to be appropriate for the purposes of developing the acute component of the CYE 18 capitation rates for the ALTCS DES/DDD Program. Additionally, the FFY 14 and FFY 16 encounter data and subcontractor financials for sub-capitated arrangements were deemed appropriate for use in trends once manual smoothing had been applied to account for issues with encounter submissions in FFY 16.

(iii) Data Concerns

There were encounter issues for the ALTCS DES/DDD acute subcontractors in FFY 16 which are still being corrected, which is why the actuary chose to use FFY 15 as the base year, even though more recent data was available. FFY 16 encounter data and sub-capitated financial data were still used in the rate development process to inform the trend, but with smoothing adjustments applied due to uneven encounter submissions.

(c) Appropriate Data for Rate Development

Encounter data was used to develop the acute component of the CYE 18 capitation rates for the ALTCS DES/DDD Program, with the dollar adjustment for sub-capitated encounters described in Section I.2.B.ii.(a).(iv).

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

As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 18 capitation rates for the ALTCS DES/DDD Program. The financial data used to make the adjustment to the encounters was appropriate for use in developing the acute component of the capitation rate since it was a direct reflection of what the ALTCS DES/DDD subcontractors paid for their subcapitation contracts.

(ii) Not using Managed Care Encounter Data

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

(d) Use of a Data Book

The rate development process of the capitation rate for both the retroactive adjustment to the LTC component as well as the prospective change to the acute care component relied primarily on data extracted from the AHCCCS PMMIS mainframe or supplemental data from ALTCS DES/DDD. The extracted data contained summarized enrollment data by month, and encounter data by month and COS.

iii. Adjustments to the Data

The encounter data was adjusted as described in Section I.2.B.ii.(a).(iv) to reflect dollar amounts associated with the ALTCS DES/DDD acute subcontractors' sub-capitated arrangements for categories of service, Professional and Dental. Additionally, projected annualized expenses of $195,600 related to a member with hepatitis C (experience not reflected in the base period) were added to the projected FFY 18 acute component.

(a) Credibility of the Data

No credibility adjustment was necessary.

(b) Completion Factors

Adjustments to the encounter data were made to reflect the level of completion. AHCCCS calculated completion factors using the development method with monthly encounter data from October 1, 2013 through September 30, 2016, paid through April 2017. The monthly completion factors were applied to the encounter data on a monthly basis. The aggregated completion factors applied to each category of service are shown below.

Completion Factors

COS	FFY14	FFY15	FFY16
Professional	100.00%	99.92%	97.61%
Pharmacy	100.00%	100.00%	97.39%
Dental	100.00%	99.92%	97.61%
Inpatient	100.00%	99.81%	81.59%
LTC	100.00%	99.81%	81.59%
Outpatient	100.00%	99.88%	92.70%
Total	100.00%	99.85%	93.45%

(c) Errors Found in the Data

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

(d) Changes in the Program

Enteral services were removed from the data due to a shift in responsibility from ALTCS DES/DDD subcontractors to another AHCCCS program's (Child Rehabilitative Services) contractors for those services.

All programmatic and reimbursement changes since the base data time period (October 1, 2014 to September 30, 2015) used to bring the base data to current are provided below. The actuary reviewed and/or revised each program change adjustment prior to January 1, 2016 for actual results and used the actual experience to normalize earlier time periods. Changes on or after January 1, 2016 use the original projections for this rate certification.

Historical Program Changes

Effective Date	Program Change	PMPM impact	Original Rate Certification Description
1/1/2014	Physical Therapy Habilitation	$ 0.01	Effective January 1, 2014, AHCCCS Contractors must provide physical therapy benefits to get and keep a level of function for members 21 years of age and older, limited to 15 visits per year.
4/1/2014	Dental Home	$ 0.09	Effective April 1, 2014, AHCCCS Contractors must 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 or upon assignment to the Contractor, and to communicate the assignment to the member. The Contractor must regularly notify the oral health professional which members have been assigned to the provider's dental home for routine preventative care. This provides a "panel" of patients for outreach purposes so that the oral health professional can deliver services, send reminder notifications, etc. The goal of this program is to increase utilization of EPSDT oral health services to a level/rate mandated by CMS.
10/1/2014	Insulin Pumps	$ 0.02	Effective 10/1/14, reinstatement of insulin pumps, which were eliminated 10/1/10 as a covered service for enrolled adults.
10/1/2014	DRG	$ 4.99	Acute hospital stays with dates of discharge on and after 10/1/14 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 ARS 36-2903.01(G)(12). The impact of this move to APR-DRG is budget neutral to the state, but does vary by Program.
3/1/2015	Incontinence briefs	$ 2.38	AHCCCS is adjusting capitation rates effective April 1, 2015, while including an assumption for new utilization going back to December 15, 2014 in its adjustment. The utilization assumption is based on the distribution of ALTCS DES/DDD members by gender and age group, and an assumed prevalence rate of incontinence among members of each gender and age group. The prevalence rate assumptions begins with CYE 13 membership and encounter data for members age 18-20 who were already receiving a similar benefit and adjusts for older age groups as illustrated by the Urological Diseases in America (UDA) Project. The total rate impact assumes that the full benefit will be used by each member who is projected to utilize. The utilization assumption includes an adjustment for membership growth during CYE 14 and CYE 15. The unit cost assumption considers CYE 13 encounter data for members age 18 to 20 as described.

Effective Date	Program Change	PMPM impact	Original Rate Certification Description
4/1/2015	FQHC	$ 4.95	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 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.
1/1/2016	High Acuity Peds (1)	$ 8.12	The AHCCCS All Patient Refined Diagnosis Related Group (APR-DRG) payment system includes several policy adjustors. One such adjustor applies a factor of 1.25 to the reimbursement amount that would otherwise apply for "claims for members under age 19," so long as the claim is not subject to one of the other policy adjustors. Beginning January 1, 2016, AHCCCS 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.
10/1/2016	Non-emergency dental	$ 3.39	During the 2016 legislative session, non-emergency (basic and preventive) dental services were reinstated for DDD adults up to a limit of $1,000 annually per member. Effective October 1, 2016 AHCCCS will restore this covered service.
1/1/2017	High Acuity Peds (2)	$ 7.42	The AHCCCS All Patient Refined Diagnosis Related Group (APR-DRG) payment system includes several policy adjustors. One such adjustor applies a factor of 1.25 to the reimbursement amount that would otherwise apply for "claims for members under age 19," so long as the claim is not subject to one of the other policy adjustors. 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.

Historical Reimbursement Changes to bring unit cost current

	FFY14	FFY15	FFY16
Professional	2.57%	0.65%	0.73%
Pharmacy	0.00%	0.00%	0.00%
Dental	-0.24%	-0.24%	0.11%
Inpatient	1.85%	1.85%	1.85%
LTC	2.75%	2.75%	2.75%
Outpatient	0.04%	-1.02%	-0.40%

(e) Exclusions of Payments or Services

Payments for enteral services were excluded from the data, as the responsibility for covering those services has transitioned to another AHCCCS program. This amounted to approximately $2.56 million removed from the encounters for FFY 14, FFY 15, and FFY 16.

	FFY14	FFY15	FFY16
Enteral Amounts Excluded	$804,009	$823,640	$932,417

Additional amounts related to PCP Parity (which ended December 31, 2014) paid by acute subcontractors were removed from FFY 14 and FFY 15 encounter data for amounts paid in calendar years 2013 and 2014 in the amount of $2.14 million.

Additionally, $14k was removed from the encounters for non-covered services across the three federal fiscal years utilized for capitation rate development.

3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2018 Guide.

A. Rate Development Standards

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

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

ii. Variations in Assumptions

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

iii. Projected Benefit Cost Trend Assumptions

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

iv. In-Lieu-Of Services

This is not applicable because in-lieu-of services, as defined in 42 CFR § 438.3(e)(2) at 81 FR 27856, were not used in developing the CYE 18 capitation rates for ALTCS DES/DDD Program. The ALTCS DES/DDD Program does not have in-lieu-of services. All services provided are covered under the 1115 Waiver, and thus are considered State Plan Services.

v. Institution for Mental Disease

Institution for mental disease (IMD) payments in accordance with 42 CFR § 438.6(e) at 81 FR 27861 are for enrollees aged 21 to 64. This is not applicable to the ALTCS DES/DDD Program, since there was no utilization of IMDs for enrollees aged 21 to 64 in the encounter data used for the development of the capitation rate.

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

This is not applicable to the ALTCS DES/DDD Program, since there was no utilization of IMDs for enrollees aged 21 to 64 in the encounter data used for the development of the capitation rate.

B. Appropriate Documentation

i. Projected Benefit Costs

See Appendix 4 for final projected benefit costs.

ii. Projected Benefit Cost Development

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

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

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

Prospective Program Changes

There is a state plan benefit reinstated effective October 1, 2017 that was included in the projected benefit costs (emergency adult dental services) which is described below in I.3.B.vii.(a).

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DHCM Finance Team regarding their fee schedules.

Effective October 1, 2017, AHCCCS will be updating provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 18 capitation rates have been adjusted to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to the CYE 18 capitation rates was the CYE 16 encounter data across all programs. The AHCCCS DHCM Rates & Reimbursement Team applied the AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 18 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. The annualized impact to the ALTCS DES/DDD Program before administrative load, premium tax and underwriting gain is $453,400.

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

The methodology for developing the acute component of the capitation rate has changed since the CYE 17 capitation rate development process. The acute component of the capitation rates was previously developed at the GSA and MCO specific level and then weighted by member months to calculate the statewide average that goes into the full capitation rate for the ALTCS DES/DDD Program. The acute component is now set at the statewide level using combined data from all acute subcontractors. This change brings it into alignment with how the rest of the components of the ALTCS DES/DDD capitation rate are developed.

There were no other material changes to the data, assumptions, or methodologies since the last rate certification.

iii. Projected Benefit Cost Trends

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

(a) Requirements

(i) Projected Benefit Cost Trends Data

Please see Section I.2.B.ii.(a) for the types of data that AHCCCS relied upon for developing the projected benefit cost trends for the acute component of the capitation rates for the ALTCS DES/DDD Program.

All data used was specific to the ALTCS DES/DDD population, but comparisons were made to other AHCCCS populations for reasonability of observed trends.

(ii) Projected Benefit Cost Trends Methodologies

Historical utilization, unit cost and PMPM data was organized by month, and category of service for the acute component of the rate. The three federal fiscal years of data were adjusted for completion by month and normalized for historical program and fee schedule changes. Additionally, the dollar amounts of the sub-capitated services from the acute subcontractor financials were added to the encounter data as a replacement for the formulaic dollar amounts calculated by the mainframe for those encounters, as described above in Section I.2.B.ii.(a).(iv). Trend rates were developed to adjust the base data (midpoint of April 1, 2015) forward 36 months to the midpoint of the contract period for the acute subcontractors (April 1, 2018). Moving averages over 3-month, 6-month, and 12-month periods were calculated to identify changes in the underlying patterns overtime, for each of the three types of trend (utilization, unit cost, and PMPM). 24-month trends were utilized to smooth out fluctuations from year to year. No simple formulaic solution exists to determine future trend, actuarial judgement is required. Each category of service was analyzed in the same manner, but different trend decisions were made for each based off additional knowledge of the actuary with regards to the ALTCS DES/DDD acute care component, as well as in conjunction with knowledge of other AHCCCS programs.

(iii) Projected Benefit Cost Trends Comparisons

Trends were compared to the trends being observed by category of service in other AHCCCS programs.

(b) Projected Benefit Cost Trends by Component

(i) Changes in Price and Utilization

The acute component trend was developed by unit cost and utilization. The table below shows the components of the projected benefit cost trend by category of service for the acute component of the capitation rates.

Projected Benefit Cost Trends by COS

COS	Utilization/1000	Unit Cost	PMPM
Professional	4.2%	-4.5%	-0.5%
Pharmacy	3.8%	9.2%	13.3%
Dental	3.0%	6.2%	9.4%
Inpatient	0.0%	12.0%	12.0%
LTC	0.0%	0.0%	0.0%
Outpatient	4.2%	4.0%	8.4%

(ii) Alternative Methods

Not applicable.

(iii) Other Components

No other components were used in the development of the annualized trend assumptions provided in the table in I.3.B.iii.(b).(i).

(c) Variation in Trend

Projected benefit cost trends do not vary except by category of service.

(d) Any Other Material Adjustments

No other material adjustments were made to the trend assumptions.

(e) Any Other Adjustments

No other adjustments were made to the trend assumptions.

iv. Mental Health Parity and Addiction Equity Act Compliance

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

v. In-Lieu-Of Services

This is not applicable because in-lieu-of services, as defined in 42 CFR § 438.3(e)(2) at 81 FR 27856, were not used in developing the CYE 18 capitation rates for ALTCS DES/DDD Program. The ALTCS DES/DDD Program does not have in-lieu-of services. All services provided are covered under the 1115 Waiver, and thus are considered State Plan Services.

vi. Retrospective Eligibility Periods

(a) Managed Care Plan Responsibility

It is the responsibility of ALTCS DES/DDD to pay all claims for covered services incurred by members in the timeframe between the effective date of eligibility and the date a member is enrolled with ALTCS DES/DDD.

(b) Claims Data Included in Base Data

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

(c) Enrollment Data Included in Base Data

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

(d) Adjustments, Assumptions, and Methodology

Due to limited number of members in the PPC time frame, a separate PPC capitation rate was not developed and all covered expenses and member months are included in the regular DDD capitation rate cell.

vii. Impact of All Material Changes

This section of the 2018 Guide provides information on what must be documented for all material changes to covered benefits or services since the last rate certification.

(a) Covered Benefits

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

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

The AHCCCS DHCM Actuarial Team developed dental PMPMs by rate cell and GSA for both the FFY10 and FFY11 time frames. The difference between FFY 10 PMPMs and

FFY 11 PMPMs was assumed to be the impact of removing the emergency adult dental services. This difference between the FFY 10 PMPMs and FFY 11 PMPMs was trended forwarded to FFY 18 using an annualized trend of 2.0%. The 2.0% trend was derived using actuarial judgement with consideration of the following information:

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

The FFY 18 emergency adult dental services PMPMs were then added to the capitation rates. The estimated impact is an increase of approximately $452,500.

(b) Recoveries of Overpayments

No adjustments were made to reflect recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d) at 81 FR 27892. The AHCCCS DHCM Actuarial Team will be working with the AHCCCS Office of Inspector General (OIG) Team to collect historical and current recoveries of overpayments to determine if adjustments will need to be included in future rate development processes.

(c) Provider Payment Requirements

Adjustments related to provider reimbursement changes are discussed in Section I.3.B.ii.(a). Adjustments related to provider payment requirements are discussed in Section I.4.D of this rate certification.

(d) Applicable Waivers

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

(e) Applicable Litigation

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

viii. Impact of All Material and Non-Material Changes

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

(a) Non-Material Changes

Per 42 CFR § 438.7(b)(4) at 81 FR 27861, all material and non-material adjustments related to the projected benefit costs and trends have been described.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Any Incentive Arrangements

The APM Initiative - Performance Based Payments incentive arrangement is a special provision for payment where the Contractor may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractor that are aimed at improving access to care. This incentive arrangement does not exceed 105% of the capitation payments.

(i) Time Period

The time period of the incentive arrangement coincides with the rating period.

(ii) Enrollees, Services, and Providers Covered

All enrollees, children and adults, may be covered by this incentive arrangement. Network providers offering direct care services have the opportunity to participate in the APM arrangements.

(iii) Purpose

The purpose of the APM Initiative - Performance Based Payments incentive arrangement is to align incentives between the Contractor and providers to ensure members continued access to care.

(iv) Effect on Capitation Rate Development

Incentive payments for the APM Initiative - Performance Based Payments are not included in the certified capitation rates nor had any effect on the development of the capitation rates. Anticipated incentive payments are approximately $33 million. Incentive payments for the APM Initiative – Performance Based Payments will be paid by AHCCCS to ALTCS DES/DDD through four lump sum payments to ALTCS DES/DDD during the contract year.

B. Withhold Arrangements

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Any Withhold Arrangements

This is not applicable because withhold arrangements, as defined in 42 CFR § 438.6(a) at 81 FR 27859, were not developed for the CYE 18 capitation rates for ALTCS DES/DDD.

C. Risk-Sharing Mechanisms

i. Rate Development Standards

This section of the 2018 Guide provides information on the requirements for risk-sharing mechanisms.

ii. Appropriate Documentation

(a) Description of Risk-Sharing Mechanisms

See section on reinsurance I.4.C.ii.(c) below.

(b) Description of Medical Loss Ratio

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

(c) Description of Reinsurance Requirements

(i) Reinsurance Requirements

AHCCCS provides a reinsurance program to ALTCS DES/DDD for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than ALTCS DES/DDD paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical. One could view the reinsurance offset as a premium. Historical reinsurance experience is the basis of the reinsurance offset.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with General Fund for State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses ALTCS DES/DDD for covered services incurred above the deductible.

The deductible is the responsibility of ALTCS DES/DDD. There has been no change to the deductible or coinsurance factors since the last rate setting period.

The actual reinsurance case amounts are paid to ALTCS DES/DDD whether the actual amount is above or below the reinsurance offset in the capitation rates. This can result in a loss or gain by ALTCS DES/DDD based on actual reinsurance payments versus expected reinsurance payments.

The reinsurance offset represents $9.6 million for CYE 18, and thus 0.69% of the total capitation rates.

For additional information, including all deductibles and coinsurance amounts, on the reinsurance program refer to the Reinsurance section of the ALTCS DES/DDD Program contract.

(ii) Effect on Development of Capitation Rates

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical PMPM calculated for the rate setting period. It is a separate calculation, and does not affect the methodologies for development of the gross medical capitation PMPM rate.

(iii) Development in Accordance with Generally Accepted Actuarial Principles and Practices

Projected reinsurance offsets are developed in accordance with generally accepted actuarial principles and practices.

(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset

The data used to develop the reinsurance offset are historical reinsurance payments to ALTCS DES/DDD for FFY 15. The historical payments were turned into PMPMs using FFY 15 member months, and then adjusted for completion (FFY 15 factors provided in Section I.2.B.iii.(b)), historical programmatic and reimbursement changes, and trended to midpoint of the rating period using the same trend factors applied to the gross medical capitation rates by category of service (provided in Section I.3.B.iii.(b).(i)).

The actuary recognized the large increase of the CYE 18 offset over CYE 17 offset, and confirmed that it was due to increased reinsurance payments in the ALTCS DES/DDD Program in conjunction with the projected Inpatient unit cost trend of 12%. The Inpatient category COS is the bulk of the reinsurance payments for ALTCS DES/DDD.

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Delivery System and Provider Payment Initiatives

(i) Description

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

(ii) Amount

The total amount of payments before premium tax, admin or underwriting gain included as an adjustment to the capitation rates is approximately $287,800 or $0.77 PMPM.

(iii) Providers Receiving Payment

The qualifying providers receiving the payments include Hospitals Subject to APR-DRG Reimbursement (eligible for a 0.5% increase), Other Hospitals and Inpatient Facilities (eligible for a 0.5% increase), Nursing Facilities (eligible for up to 2% increase), Integrated Clinics (eligible for a 10% increase on a limited set of codes), Physicians, Physician Assistants, and Registered Nurse Practitioners (all eligible for a 1% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

(iv) Effect on Capitation Rate Development

Funding for DAP is included in the certified capitation rates. The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP was the CYE 16 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 18 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program.

E. Pass-Through Payments

Not applicable. There are no pass-through payments in the CYE 18 capitation rates for the ALTCS DES/DDD Program.

5. Projected Non-Benefit Costs

A. Rate Development Standards

This section of the 2018 Guide provides information on the non-benefit component of the capitation rates.

B. Appropriate Documentation

i. Description of the Development of Projected Non-Benefit Costs

(a) Data, Assumptions, Methodology

Please see the prior certification for the administrative build-up for all components of the ALTCS DES/DDD capitation rate exclusive of the acute component of the capitation rate.

The administrative rate for the acute component was developed using financial reporting from the acute subcontractors. The historical reported administrative costs were compared to the historical amounts built into the capitation rates for the acute subcontractors. Two of the subcontractors were consistent between financials and assumptions, the third, a small membership subcontractor had higher reported admin as a percent of capitation than was assumed, and the actuary increased the administrative assumption for that contractor, due to fixed costs being allocated over a lower number of members. The increase to the administrative assumption for the small membership subcontractor has an annualized impact on the ALTCS DES/DDD capitation rate of $81,000.

(b) Material Changes

The increase described above was not material, and there were no other material changes to data, assumption or methodologies for projected non-benefit costs since the last rate certification.

(c) Description of Other Material Adjustments

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

ii. Projected Non-Benefit Costs by Category

The actuary estimated the projected non-benefit costs for each of the listed categories of costs in the guide. Please see the table below.

Non-Benefit Costs	CYE 18 Capitation Rate (original submitted April 2017)	Retroactive CYE 18 Capitation Rate (effective 7/1/17 to 9/30/17)	Percentage Impact from original submission	Prospective CYE 18 Capitation Rate (effective 10/1/17 to 6/30/18)	Percentage Impact from retroactive rate
Case Management	$ 170.74	$ 170.74	0.00%	$ 170.74	0.00%
Administration	$ 201.45	$ 201.45	0.00%	$ 203.80	1.17%
Underwriting Gain	$ 33.56	$ 33.92	1.07%	$ 34.10	0.52%
Premium Tax	$ 72.76	$ 73.50	1.02%	$ 73.83	0.45%
Total Non-Benefit Costs	**$ 478.51**	**$ 479.61**	**0.23%**	**$ 482.47**	**0.60%**

Other than HIPF (addressed below in I.5.B.iii), there are no other taxes, fees or assessments applicable for this filing.

(a) Administrative Costs

The annualized administrative costs for the ALTCS DES/DDD program are estimated to be $76.5 million.

(b) Taxes and Other Fees

The CYE 18 capitation rates for the ALTCS DES/DDD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 18 capitation rate for the ALTCS DES/DDD Program includes a provision of 1% for risk margin (i.e. underwriting gain).

(d) Other Material Non-Benefit Costs

No other material or non-material non-benefit costs are reflected in the CYE 18 capitation rates for the ALTCS DES/DDD Program.

iii. Health Insurance Provider's Fee

(a) Address if in Rates

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

(b) Data Year or Fee Year

Not applicable. The HIPF is not incorporated into the CYE 18 capitation rates for the ALTCS DES/DDD Program.

(c) Description of how Fee was Determined

Not applicable. The HIPF is not incorporated into the CYE 18 capitation rates for the ALTCS DES/DDD Program.

(d) Address if not in Rates

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

The PMPM capitation adjustments will be developed based on the fee liability reported to AHCCCS. ALTCS DES/DDD subcontractors are notified of the fee liability for the entire entity by the Treasury Department. Contractors (in this case, subcontractors) who receive multiple streams of revenue applicable to the HIPF calculation will be responsible for allocating an appropriate portion of their fee liability to AHCCCS programs, which will be verified by AHCCCS for reasonableness and appropriateness. To determine if the reported revenue and the HIPF liability allocations to AHCCCS from the Contractors is reasonable and appropriate, AHCCCS will review for each Contractor the HIPF liability allocated to AHCCCS as a percentage of the total HIPF liability from the IRS, and the revenue allocated to AHCCCS as a percentage of the total revenue reported to the IRS. Additionally, AHCCCS will compare the revenue allocated to each AHCCCS program from each Contractor against paid capitation data and determine if the revenue allocated by Contractor to each AHCCCS program is reasonable and appropriate.

As in previous years, the PMPM adjustments will be developed based on each entity's actual member months within each applicable rate cell. This adjustment is expected to be calculated in late 2018. The estimated impact to the ALTCS DES/DDD Program of this adjustment is a statewide increase of approximately $3.6 million.

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

The portion of the CYE 18 capitation rates for the ALTCS DES/DDD Program attributable to nursing facility services, and related home and community based services, are as follows:

PMPMs for Nursing Facilities and Home and Community Based Services	CYE 18 Capitation Rate (original submitted April 2017)	Retroactive CYE 18 Capitation Rate (effective 7/1/17 to 9/30/17)	Prospective CYE 18 Capitation Rate (effective 10/1/17 to 6/30/18)
Nursing facility services and HCBS provided by ALTCS DDD/DES	$ 2,759.37	$ 2,795.18	$ 2,795.36
Nursing facility services and HCBS provided by acute subcontractors	$ 2.65	$ 2.65	$ 2.23
Nursing facility services and HCBS Total	$ 2,762.02	$ 2,797.82	$ 2,797.59

6. Risk Adjustment and Acuity Adjustments

This section of the 2018 Guide is not applicable to the ALTCS DES/DDD Program. The ALTCS DES/DDD Program does not have risk adjustments or acuity adjustments. This is not anticipated to change.

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

Section II of the 2018 Medicaid Managed Care Rate Development Guide is applicable to the ALTCS DES/DDD Program because the CYE 18 capitation rates for ALTCS DES/DDD are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 at 81 FR 27858 and the ALTCS DES/DDD Program includes managed long-term services and supports (MLTSS).

Please refer to the prior certification signed April 5, 2017. This certification has only updated sections relevant to the retroactive change due to minimum wage and employee benefits provision and prospective change related to the DAP referenced above in Sections I.1.A.ii.(d).(vi) and I.4.D., respectively.

1. Managed Long-Term Services and Supports

A. CMS Expectations

The rate development standards and appropriate documentation described in Section I of the 2018 Guide are applicable to the MLTSS rate development process.

B. Rate Development Standards

i. Rate Cell Structure

This section of the 2018 Guide provides the two most common approaches to structuring the rate cells.

C. Appropriate Documentation

i. Considerations

(a) Rate Cell Structure

The monthly capitation rate for each rate cell is developed as a blended rate payable for each enrolled member.

(b) Data, Assumptions, Methodologies

Please refer to the prior certification signed April 5, 2017.

Additional data, assumptions and methodologies used for the retroactive adjustment to the capitation rates is described above in Section I.1.A.ii.(d).(vi).

The data, assumptions and methodologies for the prospective change to the capitation rates relative to MLTSS are also described above in Section I.4.D.

(c) Other Payment Structures, Incentives, or Disincentives

There are no other payment structures, incentives or disincentives to pay ALTCS DES/DDD other than what has already been described.

(d) Effect of MLTSS on Utilization and Unit Cost

The ALTCS DES/DDD Program operates as managed care. No data is available that would quantify the impacts of care management on utilization or unit costs.

(e) Effect of MLTSS on Setting of Care

The ALTCS DES/DDD Program operates as managed care. No data is available that quantifies the effect that the management of this care is expected to have on the level of care within each care setting.

ii. Projected Non-benefit Costs

Please refer to the previous certification, dated April 5, 2017.

iii. Additional Information

No additional information beyond the data sources described in Section I.1.A.ii.(d).(vi).(B) of this certification was considered for the retroactive change to the LTSS rate component. The data sources and analysis related to the prospective change to the LTSS rate component for DAP is documented above in Section I.4.D.

Section III New Adult Group Capitation Rates

Section III of the 2018 Medicaid Managed Care Rate Development Guide is not applicable to the ALTCS DES/DDD Program.

Appendix 1: Actuarial Certification

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

The capitation rates included with this rate certification are considered actuarially sound according to the following criteria from 42 CFR § 438.4 at 81 FR 27858:

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

Additionally, the term actuarially sound is Actuarial Standard of Practice (ASOP) 49, “Medicaid Managed Care Capitation Rate Development and Certification,” as:

> “Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows,

and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

The data, assumptions, and methodologies used to develop the CYE 18 capitation rates for the ALTCS DES/DDD Program have been documented according to the guidelines established by CMS in the 2018 Guide. The CYE 18 capitation rates for the ALTCS DES/DDD Program 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 ALTCS DES/DDD. I have relied upon AHCCCS and the ALTCS DES/DDD Program 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	September 9, 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 18 Capitation Rate (original submitted April 2017)	Retroactive CYE 18 Capitation Rate (effective 7/1/17 to 9/30/17)	Percentage Impact from original submission	Prospective CYE 18 Capitation Rate (effective 10/1/17 to 6/30/18)	Percentage Impact from retroactive rate
Regular DDD	375,609	$ 3,638.21	$ 3,675.11	1.01%	$ 3,691.33	0.44%
Targeted Case Management	58,603	$ 160.11	$ 160.11	0.00%	$ 160.11	0.00%

Projected member months have been updated since the prior certification submitted April 5, 2017.

Appendix 3: Fiscal Impact Summary

Rate Cell	Projected CYE 18 Member Months	CYE 18 Capitation Rate Original (submitted April 2017)	Retroactive CYE 18 Capitation Rate (effective 7/1/17 to 9/30/17)	PMPM change from original submission	Prospective CYE 18 Capitation Rate (effective 10/1/17 to 6/30/18)	PMPM change from retroactive rate
Regular DDD	375,609	$ 3,638.21	$ 3,675.11	$ 36.90	$ 3,691.33	$ 16.21
Targeted Case Management	58,603	$ 160.11	$ 160.11	$ -	$ 160.11	$ -

Projected member months have been updated since the prior certification submitted April 5, 2017.

Rate Cell	CYE 18 Original Projected Annualized Expenditures	CYE 18 Retroactive Projected Annualized Expenditures	Dollar Impact	Percentage Impact
Regular DDD	$1,366,546,604	$1,380,406,824	$13,860,220	1.01%
Targeted Case Management	$9,383,164	$9,383,164	$0	0.00%
Total	**$1,375,929,768**	**$1,389,789,988**	**$13,860,220**	**1.01%**

Rate Cell	CYE 18 Retroactive Projected Annualized Expenditures	CYE 18 Prospective Projected Annualized Expenditures	Dollar Impact	Percentage Impact
Regular DDD	$1,380,406,824	$1,386,496,720	$6,089,896	0.44%
Targeted Case Management	$9,383,164	$9,383,164	$0	0.00%
Total	**$1,389,789,988**	**$1,395,879,884**	**$6,089,896**	**0.44%**

Appendix 4: Projected Benefit and Non-Benefit Costs

Regular DDD Capitation Rate	CYE 18 Capitation Rate (original submitted April 2017)	Retroactive CYE 18 Capitation Rate (effective 7/1/17 to 9/30/17)	Percentage Impact from original submission	Prospective CYE 18 Capitation Rate (effective 10/1/17 to 6/30/18)	Percentage Impact from retroactive rate
Claim Costs					
Institutional Services	$ 113.10	$ 113.23	0.11%	$ 113.42	0.17%
Home and Community Based Services	$ 2,646.27	$ 2,681.95	1.35%	$ 2,681.95	0.00%
Acute Services	$ 426.21	$ 426.21	0.00%	$ 443.67	4.10%
Total Claim Costs	**$ 3,185.59**	**$ 3,221.39**	**1.12%**	**$ 3,239.04**	**0.55%**
Share of Cost	$ (4.70)	$ (4.70)	0.00%	$ (4.70)	0.00%
Acute Services Reinsurance	$ (21.19)	$ (21.19)	0.00%	$ (25.48)	20.25%
Total Net Claim Costs	**$ 3,159.70**	**$ 3,195.50**	**1.13%**	**$ 3,208.86**	**0.42%**
Non-Benefit Costs					
Case Management	$ 170.74	$ 170.74	0.00%	$ 170.74	0.00%
Administration	$ 201.45	$ 201.45	0.00%	$ 203.80	1.17%
Underwriting Gain	$ 33.56	$ 33.92	1.07%	$ 34.10	0.52%
Premium Tax	$ 72.76	$ 73.50	1.02%	$ 73.83	0.45%
Total Non-Benefit Costs	**$ 478.51**	**$ 479.61**	**0.23%**	**$ 482.47**	**0.60%**
Regular DDD Capitation Rate	**$ 3,638.21**	**$ 3,675.11**	**1.01%**	**$ 3,691.33**	**0.44%**

Targeted Case Management (TCM)	CYE 18 Capitation Rate (original submitted April 2017)	Retroactive CYE 18 Capitation Rate (effective 7/1/17 to 9/30/17)	Percentage Impact from original submission	Prospective CYE 18 Capitation Rate (effective 10/1/17 to 6/30/18)	Percentage Impact from retroactive rate
Non-Benefit Costs					
Case Management	$ 156.91	$ 156.91	0.00%	$ 156.91	0.00%
Premium Tax	$ 3.20	$ 3.20	0.00%	$ 3.20	0.00%
Targeted Case Management Rate	**$ 160.11**	**$ 160.11**	**0.00%**	**$ 160.11**	**0.00%**