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 for the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS) for the period of October 1, 2013 through September 30, 2014 were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

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 a revision once the impacts are known.

II. Overview of Rate Setting Methodology

The contract year ending 2014 (CYE 14) rates cover the twelve month contract period of October 1, 2013 through September 30, 2014.

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

1. Develop base period data

    a) State fiscal year 2012 (SFY 12) Regional Behavioral Health Authority (RBHA) audited financial statements 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 data for programmatic, ADHS/BHS provider fee schedule changes, encounter data completeness, and revenue neutral service expense reallocation.

2. Develop CYE 14 actuarially sound rates

    a) Apply a trend factor to bring SFY 12 claim costs forward to CYE 14.

    b) Adjust base CYE 14 claims costs for programmatic and ADHS provider fee schedule changes occurring between the base period and CYE 14.

    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 14.

d) Add provision for administration and risk contingency.

III. Base Period Experience

The base data consisted of audited financial statements and member month data for all RBHAs for the July 1, 2011 through June 30, 2012 (SFY 12) time period. BHS has periodically performed reviews of the RBHA financial statements and has determined that the data does not include any non-covered services.

Adjustments were made to the base data for fee schedule and programmatic changes and encounter data completeness, described as follows:

a) 10/1/2011 Provider Fee Schedule (Rate) Reduction – BHS implemented a 5% provider rate decrease effective October 1, 2011 for all provider types, excluding pharmacy.

   The estimated statewide impact due to this adjustment is a decrease of approximately $10.6 million to the base period costs.

b) Respite Hour Reduction – effective October 1, 2011, the number of respite hours for adults and children receiving BHS services was reduced from 720 to 600 hours per twelve month period, October 1 through September 30 each year.

   The estimated statewide impact due to this adjustment is a decrease of approximately $66,000 to the base period costs.

c) Best for Babies Initiative – This change was introduced in Maricopa County on July 1, 2011. However, the program did not fully affect claims costs in SFY 12, so an adjustment was made to reflect an expected full year's cost. The Best for Babies/Court Team Project is a national initiative sponsored by Zero to Three, targeting children from birth to three years of age involved with dependency court. This project is based on best practices in infant mental health to improve outcomes for young dependent children exposed to trauma and separation through greater judicial oversight of their services and time to permanency. Timely assessment and services for both children and parents, emotional care of infants in foster care, addressing health issues and developmental delays, frequent visitation which supports security and skill building for parents and improving child-centered court procedures are all emphasized in the national initiative. This initiative only affects CMDP capitation rates for GSA 6.

   The estimated statewide impact due to this adjustment is an increase of approximately $900,000 to the base period costs.

d) 340B Pricing – Effective April 2012, the RBHAs began reimbursing claims for 340B drugs consistent with the requirements of AHCCCS Rule A.A.C. R9-22-

710 C. In general, this provision requires that claims for drugs identified on the 340B pricing file dispensed by federally qualified health centers (FQHCs) and FQHC Look Alike pharmacies be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price, plus a dispensing fee listed in the AHCCCS capped FFS schedule.

The estimated statewide impact due to this adjustment is a decrease of approximately $233,000 to the base period costs.

e) Encounter Data Adjustment – ADHS/BHS has for several years stressed the importance of timely and accurate encounter data submission by the RBHAs for capitation rate setting (among other valuable uses). An adjustment factor was applied to the base data which incorporated the relative level of completeness of the encounter data submitted by the RBHAs.

The total statewide dollar impact of the adjustment was a decrease of $6.4 million to the base period costs.

f) Revenue Neutral Service Expense Reallocation – In GSA 6, a CYE 14 revenue neutral adjustment was made to the base period service costs to reallocate expense between the TXIX/TXXI non-CMDP and CMDP rate categories. ADHS reviewed the service expense reporting relationship between these two rate categories for SFY 12 and SFY 13. The adjustment was made to realign the service expense allocation based on the SFY 13 relationship, which was deemed to be appropriate by ADHS.

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 proposes 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 to CMS for approval of AHCCCS methodology. There is no impact to the CYE 14 capitation rates.

"In Lieu of" Services

Included in the base rates 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.

Coordination of Benefits (COB)

Inherent in the encounter and financial 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 SFY 2008 to SFY 2013, encounter-reported COB cost avoidance grew by greater than 171%, from $7.7 million to $20.9 million. Additionally, in CYE 13, BHS subcontractors cost-avoided $9.0 million in the nine months ending March 31, 2013, in additional claims for which the Contractor 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 Contractors.

IV. Projected Trend Rates

A trend analysis was performed using services expenses from RBHA audited financial statements for July, 2009 through June, 2012 (SFY 10-SFY 12). In addition, standard sources of health care cost trends were examined, including the 2012 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 3.6% for the SFY 10-SFY 12 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.

For all RBHAs excluding GSA 6, claims PMPMs were trended 27 months from the midpoint of the base claims period to the midpoint of the projected claims period. The midpoint of the projected claims period is April 1, 2014. The midpoint of the base claims period is January 1, 2012.

For the GSA 6 RBHA, a subcontractor change is expected to transpire on or around January 1, 2014. Simultaneously the AHCCCS membership is expected to materially increase due to the restoration of a previously frozen eligibility group and Medicaid expansion. Consequently, it was desired to split the CYE 14 rates into two periods – October 1, 2013 to December 31, 2013 (Period 1) and January 1, 2014 to September 30, 2014 (Period 2). Accordingly, the claims PMPMs were trended 22.50 months from the midpoint of the base claims period to the midpoint of Period 1 and 28.50 months to the midpoint of Period 2. This action helps ensure that rates which are developed to be actuarially sound over the course of a potentially volatile 12 month period are also actuarially sound over the two periods of membership change that might cross over two subcontractors.

V. Programmatic and Fee Schedule Changes – Prospective Adjustments

The following adjustments have taken place after the SFY12 base period.

a) 4/1/2013 Provider Fee Schedule (Rate) Increase – BHS implemented a provider rate increase effective April 1, 2013 for multiple community-based services, but excluding inpatient, residential, subacute facility, transportation, laboratory and radiology, pharmacy, and electro-convulsive therapy services.

   The estimated statewide impact due to this adjustment is an increase of approximately $18.1 million to CYE 14 costs.

b) 10/1/2013 Provider Fee Schedule (Rate) Increase – BHS implemented a provider rate increase effective October 1, 2013 for multiple community-based and residential services, but excluding inpatient, subacute facility, transportation, laboratory and radiology, pharmacy, and electro-convulsive therapy services.

   The estimated statewide impact due to this adjustment is an increase of approximately $25.2 million to CYE 14 costs.

c) Psych Consults – Effective since the start of the 2013 contract period, the RBHAs are responsible for payment of medically necessary psychiatric consultations and evaluations provided to acute care members in inpatient facilities in medical/surgical beds, regardless of the bed or floor where the member is placed, including emergency departments, even if the member is being treated for other co-morbid physical conditions. Historically, the AHCCCS Acute Care

Contractors were financially responsible for these psychiatric consultations/evaluations. This adjustment represents a shift of dollars from the AHCCCS Acute Care Contractors to the RBHAs.

The estimated statewide impact due to this adjustment is an increase of approximately $363,000 to CYE 14 costs.

d) ER Transportation – Effective July 1, 2012, the AHCCCS Acute Care Contractors pay for all emergency transportation for a behavioral health member, unless the emergency transport is to a behavioral health facility. Historically, the RBHAs were financially responsible for emergency transportation for a behavioral health member. This adjustment represents a shift of dollars out of the RBHAs and into the AHCCCS Acute Care Contractors.

The estimated statewide impact due to this adjustment is a decrease of approximately $520,000 to CYE 14 costs.

e) Benzodiazepines and Barbiturates – Effective January 1, 2013, for dual eligible members, Medicare pays for benzodiazepines for any condition and barbiturates used for the treatment of epilepsy, cancer or chronic mental health conditions. Therefore, the RBHAs will no longer be required to reimburse prescription claims for these services as they relate to mental health conditions.

The estimated statewide impact due to this adjustment is a decrease of approximately $852,000 to CYE 14 costs.

f) 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 will 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 and shifted to the CRS Contractor. After the CRS members were removed an acuity difference was observed in the non-CMDP children category only. The resulting PMPM rate for the non-CMDP children category is reduced by 2%.

g) Behavioral Health Penetration Adjustment – Previous capitation developments included an adjustment for projected increases or decreases in the rate of members utilizing BHS services compared to the entire AHCCCS population. This "penetration rate" incorporated two effects: Effect 1, a change due to the premise that the rate of change in BHS-utilizing members is different than the rate of change in the eligible population, and Effect 2, the general trend in the rate of BHS-utilizing members compared to the eligible population. It was surmised that Effect 1 would be realized in the SMI population due to a significant rise and then decline in the eligible population of the AHCCCS Medical Expense Deduction (MED) and Childless Adult populations due to an elimination and enrollment

freeze, respectively, associated with these programs, coupled with a corresponding effort to maintain enrollment for SMI members via another risk group.

A statistical analysis was done to test Effect 1 which suggested that the penetration rate for SMI members was affected by changes in the eligible population. An adjustment was made in the historical SMI PMPMs of the trend analysis to reflect this effect. This analysis was also performed on the other behavioral health categories, but Effect 1 was not conclusively observed in those populations.

For the RBHAs excluding GSA 6, no adjustment for Effect 1 was made in CYE 14 capitation rates due to the high degree of the uncertainty inherent in the amount and timing of the 2014 Medicaid enrollment expansion which was not conducive to the development of a reliable rating factor.

For the GSA 6 RBHA, the SMI enrollment for Period 1 is expected to be considerably lower than the enrollment for Period 2 and the effect was significant enough to warrant the use of a penetration adjustment for Effect 1 which was subsequently applied to the rates for GSA 6 in the respective periods.

No adjustment was included in this rate development for Effect 2 since the historical aggregate penetration rate increase is included in the residual trend rate noted above. The penetration rate data was not considered to be of sufficient quality to warrant any further use in the rate development.

VI. Administration and Risk Contingency

The CYE 14 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 the CYE 13 capitation rates. The component for interpretive services administration was determined by ADHS/BHS. For GSA 6 capitation rates effective January 1, 2014, an adjustment to administration was made to account for the shift of certain administrative responsibilities from the RBHA to ADHS. This resulted in shift of approximately $1.1 million for the nine month period through September 30, 2014.

VII. Risk Corridors and Performance Incentive

BHS has in place a risk corridor arrangement with 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.

The proposed CYE 14 BHS risk corridor approach provides for gain/loss risk sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. Also, as in prior years, the RBHAs' contracts provide for a potential 1% performance incentive.

VIII. Tribal FFS Claims Estimate

Tribal claims data was reviewed and an amount of $73.1 million was projected for CYE 14.

IX. BHS Administration and Premium Tax

AHCCCS has placed BHS Administration at financial risk for the provision of BHS covered services for CYE 14. Accordingly, the capitation rates were developed to include compensation to BHS for the cost of ensuring the delivery of all BHS 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, a 1.356% administrative load for the twelve month period of October 1, 2013 through September 30, 2014, and a 0.239% administrative load for the nine month period of January 1, 2014 through September 30, 2014. The BHS administrative costs ensure the efficient delivery of services in a managed care environment.

X. Title XXI Capitation Rates

For CYE 14, the Title XXI population includes those children enrolled in KidsCare II as well as those members in the traditional KidsCare program. On April 6, 2012, CMS approved a new 2012 Waiver Amendment, which included funding for KidsCare II. KidsCare II provides coverage to children who have income levels up to 175% of the federal poverty level (FPL) and meet other eligibility requirements.

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 SCHIP 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 14 capitation rates for these populations are the same as for the Title XIX members.

XI. Development of Statewide Capitation Rates and Their Budget Impact

Statewide capitation rates were developed by blending the CYE 14 capitation rates for each RBHA and rate category using projected CYE 14 member months, the estimated

dollar amount of CYE 14 tribal claims and the administrative percentage add-on component for BHS.

Table I shows the current and proposed capitation rates on a statewide basis for all BHS risk groups as well as their estimated budget impact off of CYE 14 projected member months for the October 1, 2013 through December 31, 2013 and January 1, 2014 through September 30, 2014 rating periods.

Table I: Proposed Capitation Rates and Budget Impact

Note: This section uses CYE 14 Projected Member Months applied to both CYE 13 and CYE 14 Rates

10/1/13 - 12/31/13 Statewide Capitation Rates

	Statewide Rates		10/1/13-12/31/13	Projected Expenditures		
Rate Category	4/1/13 Rates	10/1/13-12/31/13	Projected MMs	4/1/2013	10/1/13-12/31/13	Change
Children	60.55	60.89	1,917,190	116,083,034	116,737,356	0.6%
SMI	77.62	81.99	1,565,654	121,526,049	128,365,409	5.6%
GMH/SA and TXXI Adult	44.03	44.48	1,570,860	69,157,528	69,878,107	1.0%
Total	60.70	62.33	5,053,704	306,766,610	314,980,872	2.7%

	Statewide Rates		10/1/13-12/31/13	Projected Expenditures		
Rate Category	4/1/13 Rates	10/1/13-12/31/13	Projected MMs	4/1/2013	10/1/13-12/31/13	Change
TXIX and TXXI non-CMDP Children	38.88	36.60	1,873,799	72,848,575	68,573,197	-5.9%
CMDP Children	996.38	1,109.99	43,392	43,234,459	48,164,159	11.4%
Total Children	60.55	60.89	1,917,190	116,083,034	116,737,356	0.6%

1/1/14 - 9/30/14 Statewide Capitation Rates

	Statewide Rates		1/1/14-9/30/14	Projected Expenditures		
Rate Category	4/1/13 Rates	1/1/14-9/30/14	Projected MMs	4/1/2013	1/1/14-9/30/14	Change
Children	57.04	57.65	6,451,821	368,015,031	371,918,851	1.1%
SMI	77.62	79.73	5,594,545	434,248,622	446,073,507	2.7%
GMH/SA and TXXI Adult	44.03	44.99	5,595,307	246,334,908	251,714,362	2.2%
Total	59.44	60.64	17,641,674	1,048,598,561	1,069,706,720	2.0%

	Statewide Rates		1/1/14-9/30/14	Projected Expenditures		
Rate Category	4/1/13 Rates	1/1/14-9/30/14	Projected MMs	4/1/2013	1/1/14-9/30/14	Change
TXIX and TXXI non-CMDP Children	38.88	36.98	6,329,435	246,072,479	234,056,469	-4.9%
CMDP Children	996.38	1,126.46	122,386	121,942,552	137,862,382	13.1%
Total Children	57.04	57.65	6,451,821	368,015,031	371,918,851	1.1%

XII. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.1.0: Overview of rate setting methodology

AHCCCS is performing a rebase from the previously approved contract year ending 2013 (CYE 13) rates under 42 CFR 438.6(c). Please refer to Sections I-II.

AA.1.1: Actuarial certification

Please refer to Section XIII.

AA.1.2: Projection of expenditure

Please refer to Section XI.

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 Section VII.

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. GME is paid in accordance with state plan. DSH and Critical Access Hospital 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 through V.

2. Base Year Utilization and Cost Data

AA.2.0: Base year utilization and cost data

Please refer to Section III.

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 Section III.

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 through IX.

AA.3.1 Benefit differences

Not applicable.

AA.3.2 Administrative cost allowance calculation

Please refer to Sections VI and IX.

AA.3.3 Special populations' adjustment

Please refer to Sections II, V and VIII.

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)

This is a contractual arrangement between AHCCCS and its Contractors.

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.

AA.3.11 Utilization adjustment

Please refer to Section V.

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 XI.

AA.4.1: Age

Please refer to XI.

AA.4.2: Gender

Not applicable.

AA.4.3: Locality/region

Not applicable.

AA.4.4: Eligibility category

Please refer to XI.

5. Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0: Data smoothing

Please refer to Sections II, III and X.

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 III.

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 Section VII.

7. Incentive Arrangements

Please refer to Section VII.

XIII. 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 attached capitation 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, 2013.

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 BHS and the AHCCCS internal database. I have accepted the data without audit and have relied upon the ADHS 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 considering contracting with BHS should analyze their own projected medical expense, administrative expense and other premium needs for comparison to these rates before deciding whether to contract with BHS.

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.

Anthony Wittmann — 9/27/13

Anthony Wittmann — Date

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