



**Contract Year Ending 2019
Comprehensive Medical and Dental
Program Capitation Rate Certification**

October 1, 2018 through June 30, 2019

**Prepared for:
The Centers for Medicare & Medicaid
Services**

**Prepared by:
AHCCCS Division of Health Care
Management**

August 15, 2018



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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies, used to develop the amendment for the July 1, 2018 through June 30, 2019 (Contract Year Ending 2019 or CYE 19) actuarially sound capitation rate for the period October 1, 2018 through June 30, 2019 for Arizona's Comprehensive Medical and Dental Program (CMDP).. 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 2019 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2019 Medicaid Managed Care Rate Development Guide (2019 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 2019 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

The capitation rate included with this rate certification is 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)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
 - § 438.4(b)(4) Be specific to payments for each rate cell 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 2019 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.

I.1. General Information

This section provides documentation for the General Information section of the 2019 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The amended CYE 19 capitation rate for the CMDP is effective for the nine month time period from October 1, 2018 through June 30, 2019.

I.1.A.ii. Required Elements

I.1.A.ii.(a) Letter from Certifying Actuary

The actuarial certification letter for the amended CYE 19 capitation rate for the CMDP, 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 amended CYE 19 capitation rate for the CMDP contained in this rate certification is actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 of 81 FR 27497.

I.1.A.ii.(b) Final and Certified Capitation Rates

The final and certified capitation rate is located in Appendix 2. Additionally, the CMDP contract includes the final and certified capitation rate in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856.

I.1.A.ii.(c) Program Information

I.1.A.ii.(c)(i) Summary of Program

I.1.A.ii.(c)(i)(A) Type and Number of Managed Care Plans

The CMDP is the health plan within the Arizona Department of Child Safety (DCS) that is responsible for managing the health care needs for children in foster care. The CMDP does not contract with any external managed care plans to deliver covered services.

I.1.A.ii.(c)(i)(B) Covered Services

Services covered by the CMDP include physical health services, limited behavioral health services (i.e. treatment for ADHD, anxiety and depression when provided by the member's primary care physician) and specialty care. Prior to October 1, 2018, specialty care was provided through the Children's Rehabilitative Services (CRS) program to CMDP members who were diagnosed with a CRS-qualifying health condition. Effective October 1, 2018, those specialty services are provided through the CMDP. Capitation rates have been amended to reflect this program change.

Additional information regarding covered services can be found in the CMDP contract.

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I.1.A.ii.(c)(i)(C) Areas of State Covered and Length of Time of Operation

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.1.A.ii.(c)(ii) Rating Period Covered

The rate certification for the amended CYE 19 capitation rate for the CMDP is effective for the nine month time period from October 1, 2018 through June 30, 2019.

I.1.A.ii.(c)(iii) Covered Populations

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.1.A.ii.(c)(iv) Eligibility or Enrollment Criteria Impacts

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.1.A.ii.(c)(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 amended CYE 19 capitation rate are:

- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

I.1.A.ii.(c)(vi) Retroactive Capitation Rate Adjustments

Not Applicable. This rate certification does not cover retroactive adjustments for previous capitation rates.

I.1.A.iii. Rate Development Standards and Federal Financial Participation

The amended CYE 19 capitation rate for the CMDP is based on valid rate development standards and is not based on the rate of Federal Financial Participation for the populations covered under the CMDP.

I.1.A.iv. Rate Cell Cross-subsidization

The amended capitation rates were developed as one statewide rate cell.

I.1.A.v. Effective Dates of Changes

The effective dates of changes to the CMDP are consistent with the assumptions used to develop the amended CYE 19 capitation rates for the CMDP.

I.1.A.vi. Generally Accepted Actuarial Principles and Practices

I.1.A.vi.(a) Reasonable, Appropriate, and Attainable Costs

In the actuary's judgment, all adjustments to the capitation rate, or to any portion of the capitation rate, 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.

I.1.A.vi.(b) Rate Setting Process

Adjustments to the rate 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 rate performed outside the rate setting process.

I.1.A.vi.(c) Contracted Rates

Consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The amended CYE 19 capitation rate certified in this report represents the final contracted rate.

I.1.A.vii. Rates from Previous Rating Periods

Not Applicable. Capitation rates from previous rating periods are not used in the development of the amended CYE 19 capitation rate for the CMDP.

I.1.A.viii. Rate Certification Procedures

I.1.A.viii.(a) CMS Rate Certification Requirement for Rate Change

This is a new rate certification that documents the CMDP capitation rates are changing effective October 1, 2018.

I.1.A.viii.(b) CMS Rate Certification Requirement for No Rate Change

Not Applicable. This rate certification will change the CMDP capitation rates effective October 1, 2018.

I.1.A.viii.(c) CMS Rate Certification Circumstances

This section of the 2019 Guide provides information on when CMS would not require a new rate certification, and is not applicable to this certification. which includes increasing or decreasing capitation rates up to 1.5% per rate cell in accordance with 42 CFR §438.7(c)(3) and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract in accordance with 42 CFR §438.7(b)(5)(iii).

I.1.A.viii.(d) CMS Contract Amendment Requirement

CMS requires a contract amendment be submitted whenever capitation rates change for any reason other than application of an approved payment term (e.g. risk adjustment methodology) which was included in the initial managed care contract. The capitation rates are changing due to prospective program and reimbursement changes effective October 1, 2018, and thus a contract amendment is required to be submitted.

I.1.B. Appropriate Documentation

I.1.B.i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the amended CYE 19 capitation rate for the CMDP.

I.1.B.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 relevant section numbers from the 2019 Guide. Sections that do not apply will be marked as “Not Applicable”; any section wherein all subsections are not applicable will be collapsed to the section heading.

I.1.B.iii. Differences in Federal Medical Assistance Percentage

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.1.B.iv. Comparison of Rates

I.1.B.iv.(a) Comparison to Previous Rate Certification

The most recently submitted CMDP capitation rate effective July 1, 2018, and the proposed capitation rate effective October 1, 2018, are available in Appendix 2 for comparative purposes.

I.1.B.iv.(b) Material Changes to Capitation Rate Development

Previously certified CMDP capitation rates funded costs of providing physical health and a limited number of behavioral health services to members. For the new rating period, rates additionally fund specialty services provided to CMDP members with CRS-qualifying health conditions.

I.2. Data

This section provides documentation for the Data section of the 2019 Guide.

I.2.A. Rate Development Standards

I.2.A.i. Compliance with 42 CFR § 438.5(c)

This section of the 2019 Guide provides information related to base data. AHCCCS has provided validated encounter data and audited annual and unaudited quarterly financial statement data submitted by the Children’s Rehabilitative Services (CRS) Contractor, demonstrating experience for the populations with CRS conditions to be served by the CMDP to the actuary developing the capitation rates, for at least the three most recent and complete years prior to the rating period. The actuary is using the most appropriate base data, which is derived from the Medicaid population and this specific program to develop the amended capitation rate. No exception request is required as the data being used to develop rates is no older than the three most recent and complete years prior to the rating period.

I.2.B. Appropriate Documentation

I.2.B.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 to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) at 81 FR 27858.

I.2.B.ii. Data Used for Rate Development

I.2.B.ii.(a) Description of Data

I.2.B.ii.(a)(i) Types of Data Used

The types of data that AHCCCS relied upon for developing the amendment to the CYE 19 capitation rate for the CMDP were:

- Adjudicated and approved encounter data submitted by the CMDP and the CRS Contractor;
- Enrollment data tied to capitation paid to the CMDP and the CRS Contractor;
- Projected enrollment data; and
- Quarterly and annual financial statements submitted by the CRS Contractor.

I.2.B.ii.(a)(ii) Age of Data

All data used during the rate development process was for the calendar years 2015, 2016, and 2017 (January 1, 2015 through December 31, 2017).

I.2.B.ii.(a)(iii) Sources of Data

The enrollment, encounter, and reinsurance payment data were provided from the AHCCCS PMMIS mainframe. The financial statement data were provided by the AHCCCS DHCM Finance & Reimbursement Team. The projected enrollment data for CYE 19 was provided by the AHCCCS Division of Business and Finance (DBF) Budget Team.

I.2.B.ii.(a)(iv) Sub-capitated Arrangements

While the CMDP does not have sub-capitated contracts with providers, the encounter data for specialty services provided to children with CRS-eligible health conditions does contain sub-capitated payment amounts. The CRS Contractor uses a sub-capitated/block purchasing arrangement for some professional services. The sub-capitated arrangements between the CRS Contractor and its 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 subcapitated 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. subcapitated)) encounters to estimate a health plan valued amount for these encounters. The units of service data from the encounters and the estimated health plan valued amounts were used for the basis of calculating utilization and unit cost. An estimated \$0.61 PMPM is incorporated into the calendar year 2017 encounter PMPM for subcapitated specialty care services provided to CMDP members.

I.2.B.ii.(b) Availability and Quality of the Data

I.2.B.ii.(b)(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.

The AHCCCS Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a PMPM basis looking for anomalous patterns in encounter, unit, or cost totals, such as incurred months where totals are unusually low or high. If any anomalies are found, the AHCCCS Actuarial Team reports the findings to the AHCCCS Data Analysis & Research (DAR) Team, which then works with the CMDP to determine causal factors. In addition, the AHCCCS DAR Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

The CRS Contractor knows encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides the CRS Contractor with the “Encounter Monthly Data File” (aka the “magic” file) which contains the previous 36 months of encounter data. Data fields contained in this file include, but are not limited to, adjudication status, AHCCCS ID, Claim Reference Number (CRN), Provider ID and various cost amounts. The adjudication status has five types: adjudicated/approved, adjudicated/plan denied, adjudicated/AHCCCS denied, pending and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters, but providing this file to the CRS Contractor allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions.

All of these processes create confidence in the quality of the encounter data.

I.2.B.ii.(b)(i)(A) Completeness of the Data

The AHCCCS DHCM DAR Team performs encounter data validation studies to evaluate the completeness, accuracy, and timeliness of the collected encounter data.

I.2.B.ii.(b)(i)(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 only encounter data with valid AHCCCS member IDs was used in developing

the amended CYE 19 capitation rate for the CMDP. Additionally, we ensured that only services covered under the state plan were included.

I.2.B.ii.(b)(i)(C) Consistency of the Data

The AHCCCS DHCM Actuarial Team reviewed the encounter data for consistency by viewing month over month, year over year as well as encounter data versus financial statements. The encounter data was deemed to be consistent for capitation rate setting.

The monthly encounter cycle of the AHCCCS data warehouse ensures that no duplicated encounters exist among the adjudicated and approved encounters.

I.2.B.ii.(b)(ii) Actuary's Assessment of the Data

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon encounter data submitted by the CRS Contractor 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 the CRS Contractor and reviewed by the AHCCCS Rates & Reimbursement Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements 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.

AHCCCS has determined the calendar year 2017 encounter data to be appropriate for the purposes of developing the amended CYE 19 capitation rate for the CMDP. Additionally, the calendar year 2015 and 2016 encounter data was deemed appropriate for use in trends.

I.2.B.ii.(b)(iii) Data Concerns

There are no concerns with the data used.

I.2.B.ii.(c) Appropriate Data for Rate Development

The calendar year 2017 encounter data was appropriate to use as the base data for developing the amended CYE 19 capitation rate for the CMDP.

I.2.B.ii.(c)(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 amended CYE 19 capitation rate for the CMDP.

I.2.B.ii.(c)(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 amended CYE 19 capitation rate for the CMDP.

I.2.B.ii.(d) Use of a Data Book

Not Applicable. The rate development process of the capitation rate relied primarily on data extracted from the AHCCCS PMMIS mainframe by the AHCCCS DHCM Actuarial Team.

I.2.B.iii Adjustments to the Data

The encounter data was adjusted for completion. Historical program and fee schedule changes were applied to bring the historical data to current program and reimbursement levels.

I.2.B.iii.(a) Credibility of the Data

No credibility adjustment was necessary.

I.2.B.iii.(b) Completion Factors

Completion factors were applied to the encounter data for CRS specialty services. The aggregated calendar year 2015, 2016, and 2017 encounter adjustments applied to each category of service are shown in Appendix 4.

I.2.B.iii.(c) Errors Found in the Data

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

I.2.B.iii.(d) Changes in the Program

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2016 through September 30, 2017) are described below. All program and fee schedule changes which occurred or are effective on or after October 1, 2017 are described in Section I.3.B.ii.(a).

Removal of DAP from Base Period

CYE 17 and CYE 18 capitation rates funded Differential Adjusted Payments (DAP) made to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health and reduce cost of care growth. AHCCCS removed the impact of ~~CYE 17~~ DAP payments from the base period. The change reduces statewide costs for the CRS specialty services that will now be delivered through the CMDP Program by approximately \$10,000 or \$0.05 PMPM. See section I.4.D.ii below for information on adjustments included in CYE 19 rates for DAP that are effective from October 1, 2018 through September 30, 2019.

Other adjustment factors to reflect historical changes applied to the base data period are provided in Appendix 4.

I.2.B.iii.(e) Exclusions of Payments or Services

The AHCCCS DHCM Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the amended CYE 19 capitation rate.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2019 Guide.

I.3.A Rate Development Standards

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.3.B. Appropriate Documentation

I.3.B.i Projected Benefit Costs

Appendix 7 contains the projected October 1, 2018 gross medical expenses PMPM on a statewide basis for CRS and Non-CRS components of the rate.

I.3.B.ii. Projected Benefit Cost Development

I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies

The data described in Section I.2.B.ii.(a) was adjusted to reflect historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The per-member-per-month (PMPM) expenditures for each COS in the base year are trended forward to the midpoint of the effective period of the capitation rate 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 Section I.2.B.ii.(a).(ii), data from calendar year 2017 served as the base for projections to CYE 19 for the capitation rate, while data from calendar years 2015 and 2016 was used in development of trends. The historical encounter data was summarized by calendar year and COS.

DRG Reimbursement Rate Changes

AHCCCS transitioned from version 31 to version 34 of the All Patient Refined Diagnostic Related Groups (APR-DRG) payment classification system on January 1, 2018. To make the APR-DRG grouper fully ICD-10 code compliant, AHCCCS rebased the inpatient system by updating the DRG grouper version, relative weights and DRG base rates via payment simulation modeling using more recent data.

The AHCCCS DHCM Actuarial Team estimated and incorporated the impact of the DRG rebase in CYE 18 capitation rates. The method used to develop the CYE 18 capitation rates was deemed appropriate for continued use in developing CYE 19 capitation rates. The only adjustment from the method used to develop the CYE 18 capitation rates was to regroup into the new rate cells and program. This adjustment was possible because the CYE 18 method included AHCCCS rate code detail so there was a map from the old programs' rate cells to the new ACC program rate cells. This method was described in the CYE 18 certification and the language has been copied here for convenience of review.

“Navigant Consulting did the rebase of the AHCCCS DRG system. Their modeling approach: “Rebasing calculations included updated base rates (both standardized amounts and wage indices), relative weights, and addition and change of policy adjusters. Outlier identification and payment methodology has not changed nor has any other underlying claim pricing calculation (notwithstanding the above noted changes to factors, indices, and statewide standardized base rate).

To affect a budget neutral payment system change, Navigant first repriced the FFY 2016 claims under current APR-DRG v31 FFS rates, including changes to the payment system which have occurred since the FFY 2016 claims period (such as the removal of the transition factor, coding improvement factor, and the increase of the high acuity pediatric adjuster to 1.945). Navigant then repriced the same claims set using the APR-DRG v34 grouper and weights and calculated a

statewide standardized amount (adjusted to each facility’s labor cost using CMS’s published FFY 2017 Final Rule Wage Indices). The statewide standardized amount was calculated to result in total simulated rebased payments equal to current system payments.

The next modeling step was to increase select policy adjusters to meet program funding goals, as determined by AHCCCS. These adjustments included an increase of the high acuity pediatric policy adjuster to 2.30, the addition of a service policy adjuster for burn cases (as identified by APR-DRG groups 841-844) of 2.70, the increase of the policy adjuster for other adult services to 1.025, and the increase of the existing High Volume Hold Harmless adjuster to 1.11.”

The PMPM adjustments to apply to each rate cell were then developed as the total simulated APR-DRG rebased payments with the new policy adjuster factors applied to each inpatient hospital admission during FFY 16 by members in each rate cell, minus the total actual payments associated with those admissions, divided by the FFY 16 member months for each rate cell.

The AHCCCS Division of Health Care Management (DHCM) Actuarial Team relied upon Navigant and AHCCCS DHCM Rates & Reimbursement Team for the reasonableness of these assumptions.”

The overall impact of the DRG reimbursement program change by GSA is an increase of approximately \$1.55 PMPM.

CRS Specialty Services

Effective October 1, 2018, specialty care services provided to CMDP members are shifted from the CRS Program to the CMDP. The estimated nine month impact to CMDP adjusted base medical expenditures of this shift is an increase of approximately \$2.4 million, partially offset by an increase to adjusted base reinsurance payments of approximately \$290,000, for a combined increase of \$2.1 million to medical expenditures net of reinsurance. Table 1 below provides the PMPM impact to the statewide rate.

Table 1: PMPM Impacts (10/1/18 – 6/30/19) to Medical Expenditures and Reinsurance (RI) Offsets

<u>Rate Cell</u>	<u>Projected SFY 19 (Oct-Jun) Member Months</u>	<u>Increase to Medical Expense PMPM (10/1/18)</u>	<u>Increase to RI Offset PMPM (10/1/18)</u>	<u>Net Impact to Medical Expense PMPM (10/1/18)</u>
Statewide	129,912	\$18.36	-\$2.23	\$16.13

Amounts in Table 1 reflect adjusted base costs of specialty care services and exclude trend, program, reimbursement, and other adjustments made to specialty care data that are discussed elsewhere in the certification. Please see Appendix 7 for additional adjustments made to the amended CYE 19 CMDP rate for CRS specialty care services.

Genetic Testing

Effective January 1, 2018, AHCCCS policy guidance clarifies that covered genetic testing services include specific chromosomal tests for diagnosing developmental delays in infants and children. The policy clarification is expected to increase use of these currently covered services. Upon analyzing prior year Contract Year Ending 2019

encounters and projecting the increase in use of genetic testing services, the change was estimated to increase costs under the CMDP by approximately \$153,000 over nine months, or \$1.18 PMPM. The impact was incorporated into PMPM adjustments for rate development.

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 & Reinsurance Team regarding their fee schedules.

Effective October 1, 2018, 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 19 capitation rate has been adjusted effective October 1, 2018 to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to CYE 19 capitation rates was the CYE 17 encounter data across all programs. The AHCCCS DHCSM 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 19 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. The overall impact to the CMDP is approximately \$57,000 for the nine months from October 1, 2018 through June 30, 2019.

I.3.B.ii.(b) Material Changes to the Data, Assumptions, and Methodologies

There were no other material changes to the components of the capitation rates or the process of their development.

I.3.B.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.

I.3.B.iii.(a) Requirements

I.3.B.iii.(a)(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 CRS specialty services added to the CMDP.

All data used was specific to the CRS specialty services provided to CMDP members with a CRS qualifying condition.

I.3.B.iii.(a)(ii) Projected Benefit Cost Trends Methodologies

Historical utilization, unit cost and PMPM data for CRS specialty services provided to CMDP members from calendar years 2015, 2016, and 2017 were organized by incurred year and month and category of

service (COS). The three years of data were normalized for historical program and fee schedule changes. Trend rates were developed to adjust the base data (midpoint of July 1, 2017) forward 19.5 months to the midpoint of the amended contract period (February 15, 2019). Projected benefit cost trends were based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. No simple formulaic solution exists to determine future trend; actuarial judgment is required. Each category of service was analyzed in the same manner.

The amended CYE 19 CMDP capitation rate does not include a modification from the amounts specified in the original submitted CYE 19 CMDP capitation rate to projected benefit cost trends for non-specialty care services. For more information about methodologies used in projecting benefit cost trends for services other than specialty care, please see the CYE 19 CMDP Capitation Rate Certification dated May 15, 2018.

I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons

The projected benefit cost PMPM trends for specialty care services were compared in aggregate to NHE projection of growth in Medicaid spending per capita. Due to the high acuity of the small number of CMDP members with a CRS health condition, however, comparisons to national data may have limited usefulness. The PMPM trends by COS were also compared to the CYE 18 rate development PMPM trends for CMDP members receiving specialty care services through the CRS Program (aggregated to the CYE 19 categories of service). The actuary judged the overall increase in PMPM trends for all categories of service to be reasonable in consideration of current program conditions.

I.3.B.iii.(b) Projected Benefit Cost Trends by Component

I.3.B.iii.(b)(i) Changes in Price and Utilization

The trend assumptions for CRS specialty care services were developed by unit cost and utilization. Appendix 5 contains the components of the projected benefit cost trend by COS for the capitation rate. For information on unit cost and utilization trends developed for other non-specialty care services to CMDP members, please see the CYE 19 CMDP Capitation Rate Certification dated May 15, 2018.

I.3.B.iii.(b)(ii) Alternative Methods

Not applicable.

I.3.B.iii.(b)(iii) Other Components

No other components were used in the development of the annualized trend assumptions summarized in Appendix 5.

I.3.B.iii.(c) Variation in Trend

Projected benefit cost trends vary by category of service.

I.3.B.iii.(d) Any Other Material Adjustments

No other material adjustments were made to the trend assumptions.

I.3.B.iii.(e) Any Other Adjustments

No other adjustments were made to the trend assumptions.

Contract Year Ending 2019

Comprehensive Medical and Dental Program

Capitation Rate Certification

I.3.B.iv. Mental Health Parity and Addiction Equity Act Compliance

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.3.B.v. In-Lieu-Of Services

The following types of services can be provided as in-lieu-of-services: home and community based services (HCBS) covered in lieu of a nursing facility and services in alternative inpatient settings licensed by ADHS/DLS in lieu of services in an inpatient hospital. These services are then included in CMDP's capitation rate development categories of service. Encounters which are in-lieu-of-services are not identified separately in the data. Thus, the actuaries cannot define the percentage of cost that in-lieu-of services represented in the capitation rate development categories of service. However, the in-lieu-of services are treated exactly the same as all other State Plan approved services in capitation rate development.

I.3.B.vi. Retrospective Eligibility Periods

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.3.B.vii. Impact of All Material Changes to Covered Benefits or Services

This section of the 2019 Guide provides information on what must be documented for all material changes to covered benefits or services since the last rate certification.

I.3.B.vii.(a) Covered Benefits

Documentation of impacts for all material changes to covered benefits or services since the last rate certification has been provided above in Section I.3.B.ii.

I.3.B.vii.(b) Recoveries of Overpayments

Base period data was not adjusted to reflect recoveries of overpayments made to providers because Contractors are required to adjust encounters for recovery of overpayments, per the following contract requirement:

“The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted.”

I.3.B.vii.(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.

I.3.B.vii.(d) Applicable Waivers

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

I.3.B.vii.(e) Applicable Litigation

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

I.3.B.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.

I.3.B.viii.(a) Non-Material Changes

Per 42 CFR § 438.7(b)(4) of 81 FR 27497, all material and non-material adjustments related to the projected benefit costs and trends have been described.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.4.B. Withhold Arrangements

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2019 Guide provides information on the requirements for risk-sharing mechanisms.

I.4.C.ii. Appropriate Documentation

I.4.C.ii.(a) Description of Risk-Sharing Mechanisms

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.4.C.ii.(b) Description of Medical Loss Ratio

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.4.C.ii.(c) Description of Reinsurance Requirements

I.4.C.ii.(c)(i) Reinsurance Requirements

AHCCCS provides a reinsurance program to the CMDP for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what one would see in 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 the CMDP paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical expense. One could view the reinsurance offset as a premium.

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 the CMDP for covered services incurred above the deductible. The deductible is the responsibility of the CMDP. 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 the CMDP whether the actual amount is above or below the reinsurance offset in the capitation rates. This can result in a loss or gain by the CMDP based on actual reinsurance payments versus expected reinsurance payments.

This component of the rate cell has been updated with an effective date of October 1, 2018 to incorporate costs for specialty services provided to CMDP members with CRS-qualifying health conditions and other programmatic and reimbursement changes described in section I.3.B. The table in Appendix 7 includes the projected reinsurance payments assumed in the amended CYE 19 capitation rate.

For additional information, including all deductibles and coinsurance amounts, on the reinsurance program refer to the Reinsurance section of the CMDP contract.

I.4.C.ii.(c)(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 expense 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.

I.4.C.ii.(c)(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.

I.4.C.ii.(c)(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset

The data used to develop the reinsurance offset are calculated reinsurance payments to the CMDP for services and to the CRS Contractor for specialty services for CMDP members incurred during calendar year 2017. Prior years' capitation rates included a reinsurance offset developed using historical reinsurance payment data. Calculated reinsurance payments were used to develop the CYE 19 reinsurance offset in order to align expected payments with the timing of incurred services. The calculated payments were expressed as PMPMs using calendar year 2017 member months, and then adjusted for historical programmatic and reimbursement changes, and trended to midpoint of the rating period using the same trend factors applied to the gross medical capitation rate by category of service (provided in Section I.3.B.iii.(b).(i)).

I.4.D. Delivery System and Provider Payment Initiatives

I.4.D.i. Rate Development Standards

This section of the 2019 Guide provides information on delivery system and provider payment initiatives.

I.4.D.ii. Appropriate Documentation

I.4.D.ii.(a) Description of Delivery System and Provider Payment Initiatives

I.4.D.ii.(a)(i) Description

The Differential Adjusted Payment (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.

I.4.D.ii.(a)(ii) Amount

The total amount of DAP payments before reinsurance, premium tax, admin or underwriting gain included as an adjustment to the capitation rate is approximately \$101,000 per calendar quarter (\$404,000 annualized) or \$2.50 PMPM. The PMPM amounts are displayed by provider type in Appendix 8.

I.4.D.ii.(a)(iii) Providers Receiving Payment

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to a 3.0% increase), other hospitals and inpatient facilities (eligible for up to a 3.0% increase), nursing facilities (eligible for a 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), and federally qualified health centers (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

I.4.D.ii.(a)(iv) Effect on Capitation Rate Development

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 FFY 17 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 FFY 19 time period, part of which falls within CYE 19 for CMDP rating purposes. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. AHCCCS describes the methodology, data and assumptions related to the DAP within the 438.6(c) pre-prints, which have been submitted but not yet approved.

I.4.D.ii.(a)(v) Inclusion of Payments in the Capitation Rates

Differential Adjusted Payment

Funding for DAP is included in the certified capitation rates.

I.4.E. Pass-Through Payments

Not applicable. Pass-through payments, as defined in 42 CFR § 438.6(a) of 81 FR 27497, were not developed for the amended CYE 19 capitation rates for the CMDP.

I.5 Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2019 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

I.5.B.i. Description of the Development of Projected Non-Benefit Costs

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.5.B.ii. Projected Non-Benefit Costs by Category

I.5.B.ii.(a) Administrative Costs

For more information, please refer to the Contract Year Ending 2019 CMDP Rate Certification dated May 15, 2018.

I.5.B.ii.(b) Taxes and Other Fees

The amended CYE 19 capitation rate for the CMDP includes 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.

I.5.B.ii.(c) Contribution to Reserves, Risk Margin, and Cost of Capital

The amended CYE 19 capitation rate for the CMDP includes a provision of 1% for margin (i.e. underwriting gain).

I.5.B.ii.(d) Other Material Non-Benefit Costs

No other material or non-material non-benefit costs are reflected in the amended CYE 19 capitation rate for the CMDP.

I.5.B.iii. Health Insurance Provider's Fee

I.5.B.iii.(a) Address if in Rates

Not applicable. The CMDP is a governmental entity and thus is excluded from the Health Insurance Providers Fee (HIPF).

I.6. Risk Adjustment and Acuity Adjustments

This section of the 2019 Guide is not applicable to the CMDP. The CMDP does not utilize 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 2019 Guide is not applicable to the CMDP. Managed long-term services and supports, as defined at 42 CFR § 438.2 at 81 FR 27855, are not covered services under the CMDP. The CMDP does cover nursing facility services, and related home and community based services, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates

Section III of the 2019 Guide is not applicable to the CMDP.

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 rate included with this rate certification is 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)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
 - § 438.4(b)(4) Be specific to payments for each rate cell 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 amended CYE 19 capitation rate for the CMDP have been documented according to the guidelines established by CMS in the 2019 Guide. The amended CYE 19 capitation rate for the CMDP is effective for the nine-month time period from October 1, 2018 through June 30, 2019.

The actuarially sound capitation rate is based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rate, I have relied upon data and information provided by AHCCCS and the CMDP. I have relied upon AHCCCS and the CMDP 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

August 21, 2018

Matthew C. Varitek

Date

Fellow, Society of Actuaries

Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rate

Rate Cell	Projected SFY 19 (Oct – June) Member Months	Submitted CYE 19 Capitation Rate (7/1/18)	CYE 19 Capitation Rate (10/1/18)	Percentage Impact
Statewide	129,912	\$279.18	\$298.38	6.88%

The submitted SFY 19 Capitation Rate represents the most recently submitted rates effective from July 1, 2018.

Appendix 3: Fiscal Impact Summary

Rate Cell	Statewide
Projected SFY 19 (Oct – June) Member Months	129,912
Submitted CYE 19 Capitation Rate (7/1/18)	\$279.18
Projected Expenditures (7/1/18 Rate)	\$36,268,803
CYE 19 Capitation Rate (10/1/18)	\$298.38
Projected Expenditures (10/1/18 Rate)	\$38,763,111
Dollar Impact	\$2,494,308
Percentage Impact	6.88%

Appendix 4: Base Data and Base Data Adjustments (CRS Expense Only)

Calendar Year 2015					
Service Category	Unadjusted Base Data PMPMs	Completion Factors	Reimb Changes	DAP PMPM Removed	Adjusted Base Data
Professional	\$7.66	1.0000	1.0057	\$0.00	\$7.70
Pharmacy	\$3.75	1.0000	1.0000	\$0.00	\$3.75
Dental	\$0.08	1.0000	1.0035	\$0.00	\$0.08
Inpatient & NF	\$3.74	1.0000	1.2799	\$0.00	\$4.79
Outpatient	\$2.53	1.0000	1.0007	\$0.00	\$2.53
Total	\$17.76			\$0.00	\$18.85

Calendar Year 2016					
Service Category	Unadjusted Base Data PMPMs	Completion Factors	Reimb Changes	DAP PMPM Removed	Adjusted Base Data
Professional	\$5.29	1.0000	1.0054	\$0.00	\$5.32
Pharmacy	\$4.06	1.0000	1.0000	\$0.00	\$4.06
Dental	\$0.11	1.0000	1.0007	\$0.00	\$0.11
Inpatient & NF	\$3.64	1.0000	1.1641	\$0.00	\$4.23
Outpatient	\$1.49	1.0000	1.0047	\$0.00	\$1.49
Total	\$14.59			-\$0.01	\$15.21

Calendar Year 2017					
Service Category	Unadjusted Base Data PMPMs	Completion Factors	Reimb Changes	DAP PMPM Removed	Adjusted Base Data
Professional	\$4.82	0.9700	1.0000	\$0.00	\$4.97
Pharmacy	\$4.29	0.9700	1.0000	\$0.00	\$4.43
Dental	\$0.10	0.9700	1.0000	\$0.00	\$0.10
Inpatient & NF	\$7.09	0.9700	1.0547	-\$0.04	\$7.67
Outpatient	\$1.17	0.9700	1.0000	-\$0.01	\$1.20
Total	\$17.47			-\$0.05	\$18.36

For information about base data and base data adjustments for non-CRS services, please see the CYE 19 CMDP Capitation Rate Certification dated May 15, 2018.

Appendix 5: Projected Benefit Cost Trends (CRS Expense Only)

Service Category	Annualized Trend Rates		
	Utilization	Unit Cost	PMPM
Professional	0.2%	1.6%	1.8%
Pharmacy	0.1%	5.7%	5.8%
Dental	3.0%	1.0%	4.0%
Inpatient & NF	-1.1%	8.4%	7.2%
Outpatient	0.2%	2.5%	2.7%

For information about trend assumptions used in projecting benefit costs for non-CRS expenses, please see the CYE 2019 CMDP Capitation Rate Certification dated May 15, 2018.

Appendix 6: Projected CYE 19 Gross Medical Expense (GME) by Category of Service

Gross Medical Expense (Excluding CRS)							
Service Category	7/1/2018 Rate	Trend ¹	Prgm Chg 10/1/2018	Reimb Chg 10/1/2018	Remove 7/1/2018 DAP	10/1/2018 DAP	CYE 19 Proj GME PMPM
Professional	\$101.80	\$0.00	\$1.11	\$0.35	(\$0.29)	\$0.09	\$103.06
Pharmacy	\$20.52	\$0.00	\$0.00	\$0.00	\$0.00	\$0.26	\$20.78
Dental	\$35.56	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$35.56
Inpatient & NF	\$32.21	\$0.00	\$0.00	\$0.00	(\$0.09)	\$1.85	\$33.97
Outpatient	\$34.59	\$0.00	\$0.00	\$0.00	(\$0.06)	\$0.03	\$34.56

Gross Medical Expense (CRS Expense)							
Service Category	Adj Base Data PMPM	Trend	Prgm Chg 10/1/2018	Reimb Chg 10/1/2018	Remove 7/1/2018 DAP	10/1/2018 DAP	CYE 19 Proj GME PMPM
Professional	\$4.97	\$0.15	\$0.07	\$0.03	\$0.00	\$0.00	\$5.21
Pharmacy	\$4.43	\$0.43	\$0.00	\$0.00	\$0.00	\$0.00	\$4.86
Dental	\$0.10	\$0.01	\$0.00	\$0.00	\$0.00	\$0.00	\$0.11
Inpatient & NF	\$7.67	\$0.92	\$0.00	\$0.00	\$0.00	\$0.23	\$8.82
Outpatient	\$1.20	\$0.05	\$0.00	\$0.06	\$0.00	\$0.02	\$1.33

- No trend applies to the non-CRS gross medical expense projection effective 7/1/2018, because the projection was developed to be sound for the SFY 19 contract period.

Appendix 7: Projected CYE 19 Capitation Rate Development

Service Category	Submitted SFY 19 Proj PMPM (7/1/18)	Rebase	Trend	Pgm Chg Eff 10/1/18	Reimb Chg Eff 10/1/18	Remove 7/1/18 DAP	10/1/18 DAP	Revised SFY 19 Proj PMPM (10/1/18)
<u>PMPM Excluding CRS Portion</u>								
Total Gross Medical Expense PMPM	\$224.67	\$0.00	\$0.00	\$1.11	\$0.35	(\$0.45)	\$2.24	\$227.93
Less Reinsurance PMPM	(\$9.33)	\$0.00	\$0.00	(\$0.11)	(\$0.04)	\$0.05	(\$0.23)	(\$9.66)
Less TPL PMPM	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Net Claim Cost PMPM	\$215.34	\$0.00	\$0.00	\$1.00	\$0.32	(\$0.40)	\$2.01	\$218.27
Care Management PMPM	\$15.17	(\$0.49)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$14.68
Administrative Expenses PMPM	\$37.41	(\$1.21)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$36.20
Underwriting Gain PMPM	\$2.77	(\$0.02)	\$0.00	\$0.01	\$0.00	(\$0.00)	\$0.02	\$2.79
Premium Tax Rate	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Capitation PMPM (Non-CRS)	\$276.22	(\$1.76)	\$0.00	\$1.03	\$0.33	(\$0.42)	\$2.08	\$277.48
<u>PMPM of CRS Costs</u>								
Total Gross Medical Expense PMPM		\$18.36	\$1.55	\$0.07	\$0.08	\$0.00	\$0.26	\$20.32
Less Reinsurance PMPM		(\$2.23)	(\$0.52)	(\$0.02)	(\$0.02)	\$0.00	(\$0.06)	(\$2.85)
Less TPL PMPM		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Net Claim Cost PMPM		\$16.13	\$1.03	\$0.05	\$0.06	\$0.00	\$0.20	\$17.48
Care Management PMPM	\$2.54	(\$0.08)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2.45
Administrative Expenses PMPM	\$0.33	(\$0.01)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.32
Underwriting Gain PMPM	\$0.03	\$0.18	\$0.02	\$0.00	\$0.00	\$0.00	\$0.00	\$0.23
Premium Tax Rate	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Capitation PMPM (CRS)	\$2.96	\$16.56	\$1.07	\$0.05	\$0.07	\$0.00	\$0.20	\$20.90
Combined CMDP PMPM	\$279.18	\$14.80	\$1.07	\$1.08	\$0.39	(\$0.42)	\$2.28	\$298.38

Appendix 8: Projected CYE 19 Differential Adjusted Payment PMPM by Provider Type

Differential Adjustment Payments (DAP)	Acute Non- CRS	Acute CRS	Statewide PMPM
E-Prescribing	\$ 0.26	\$ 0.00	\$ 0.27
Integrated Clinic	\$ 0.00	\$ 0.00	\$ 0.00
Inpatient Hospital	\$ 1.85	\$ 0.23	\$ 2.09
Nursing Facility	\$ 0.00	\$ 0.00	\$ 0.00
Other Hospital	\$ 0.03	\$ 0.02	\$ 0.05
FQHC/RHC	\$ 0.09	\$ 0.00	\$ 0.09
Total CMDP DAP	\$ 2.24	\$ 0.26	\$ 2.50

1. Amounts reflect gross medical expense and are prior to adjustments for reinsurance, premium tax and underwriting gain.