Comprehensive Medical and Dental Program (CMDP)
Updated Actuarial Memorandum

I. Purpose

This memorandum presents a discussion of the revision to the already approved State Fiscal Year Ending 2015 (SFY 15) CMDP capitation rates. Please see Attachment A for the actuarial memorandum of the already-approved CMDP capitation rates which detail the original rate build up.

This update to the capitation rates is required as a result of a new contract mandate requiring Contractors to pay the all-inclusive per visit Prospective Payment System (PPS) rates for Federally Qualified Health Centers/Rural Health Clinics (FQHCs/RHCs).

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

II. Overview of Changes

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

III. Methodology for Calculating Capitation Adjustments

FQHC/RHC All-Inclusive PPS Rates

AHCCCS will shift payment responsibility for FQHC/RHC PPS rates to the Contractors in order to properly account for FQHC/RHC expenditures for managed care enrollees. To identify the amount of full-funding needed for Contractors to pay the PPS rates on a per visit basis, it was necessary to identify the historical FQHC/RHC visits in order to distribute the quarterly supplemental and annual reconciliation payments made by the Administration.

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

another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

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

Additional adjustments were made to the data due to the introduction of three new FQHCs/RHCs. Historical encounter data is available since these providers were in place during the data period, but they did not have historical supplemental or reconciliation payments since they were not designated as FQHCs/RHCs until after the data period. The adjustment for the new FQHCs/RHCs involved projecting the reconciliation and quarterly supplemental payments from historical visits multiplied by the PPS rates and subtracting historical encounter payments

The estimated three month impact to the CMDP program is a statewide increase of approximately $434,000.

IV. Proposed Revised Capitation Rates and Their Impacts

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

Table I: Proposed Capitation Rates and Budget Impact

Rate Cell	Projected SFY 15 Member Months (4/1/15 - 6/30/15)	Approved SFY 15 Rate (10/1/14)	Proposed SFY 15 Rate (4/1/15)	Estimated SFY 15 Capitation (Approved)	Estimated SFY 15 Capitation (Proposed)	Dollar Impact	Percentage Impact
Prospective	49,070	$239.41	$248.27	$11,747,909	$12,182,671	$434,762	3.7%
PPC	1,313	$464.56	$471.05	$609,947	$618,468	$8,521	1.4%
Total				$12,357,856	$12,801,139	$443,283	3.6%

V. Actuarial Certification of the Capitation Rates

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 from time-to-time by the Actuarial Standards Board.

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

In developing the actuarially sound capitation rates, I have relied upon data and information provided by CMDP and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the CMDP 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.

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

SIGNATURE ON FILE *02/15/2015*

Matthew C. Varitek Date

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

ATTACHMENT A

Comprehensive Medical and Dental Program (CMDP)
Actuarial Memorandum

I. Purpose:

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

This memorandum presents a discussion of the adjustment to the capitation rates effective from October 1, 2014 through June 30, 2015 (CYE 15). CMDP is moving its contract year to a state fiscal year basis effective July 1, 2015.

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

II. Overview of Rate Setting Methodology:

The CYE 15 rates were developed as a rate update from the CYE 14 rates as approved by Center for Medicare and Medicaid Services (CMS). These rates represent the nine-month contract period October 1, 2014 through June 30, 2015.

Trend rates were calculated from encounter data and other sources on a unit cost and/or utilization basis by category of service (COS) and a cap was applied to limit the negative and positive trends to a reasonable level. Other data sources include Contractor financial statements, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates, AHCCCS fee for service (FFS) provider rate changes and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information. No adjustment was made other than those described.

Ideally, the experience should be analyzed by different rate cells, which are comprised of members with similar risk characteristics; however, segregating the CMDP population into different rate cells would lead to a statistical credibility problem due to CMDP's relatively small membership base. Therefore, AHCCCS believes that having only two rate cells, prospective and Prior Period Coverage (PPC), is more actuarially sound than creating more rate cells.

The experience only includes CMDP Medicaid eligible expenses for CMDP Medicaid eligible individuals. In addition, the experience includes reinsurance

amounts. PPC rates are reconciled to a maximum of 2% profit or loss. There are no other incentives or risk sharing arrangements.

In general, the claim PMPMs by category of service from the CYE 14 rates are trended from the midpoint of the CYE 14 rating period, or July 1, 2014, to the midpoint of the effective period or February 15, 2015. The next step involves adjusting for program changes and reinsurance offset. In the final step, the projected administrative expenses and premium tax are then added to the projected claim PMPMs to obtain the capitation rates. Each step is described in the sections below.

III. Projected Trend Rates

The trend analysis includes encounter experience from October 2009 through September 2012. In addition to using encounter data, AHCCCS used information from CMS NHE Report estimates, GI information, and the trend analysis considered changes in AHCCCS' Professional and Outpatient Fee Schedules, Dental Fee Schedule, Transportation Schedule and other sources. AHCCCS developed utilization and unit cost trend estimates using the encounter data. These trends were developed by major category of service (COS), with a cap on the percentage increase and decrease to smooth out unreasonable trends. Once these trends were developed, they were analyzed by comparing the results to the assumptions made for other AHCCCS programs.

The trend rates used in projecting the claim costs are as follows.

Table I: Prospective and PPC Average Annual Trend Rate

Service Category	Average Annual Trend	
	Prospective	PPC
Hospital Inpatient	3.0%	7.2%
Physician	0.4%	7.0%
Emergency Services	8.6%	n/a
Pharmacy	0.0%	n/a
Lab, X-ray, & med image	-1.0%	n/a
Outpatient Facility	7.8%	n/a
Durable Med Equip	10.0%	n/a
Dental	3.0%	n/a
Transportation	6.0%	n/a
NF, Home HC	9.5%	n/a
PT, Other Prof, Misc Med	5.0%	3.7%

IV. Projected Gross Claim PMPM

The claims PMPMs were trended from the midpoint of the previous rating period to the midpoint of the projected claims period. The midpoint of the projected claims period is February 15, 2015. The midpoint of the previous rating period is July 1, 2014.

V. State Mandates, Court Ordered Programs and Program Changes

AHCCCS Fee Schedule Changes
Effective October 1, 2014, AHCCCS is changing FFS provider rates for certain providers based either on access to care needs, Medicare or Arizona Department of Health Services (ADHS) fee schedule rates, and/or legislative mandates. The unit cost (inflation) trends were adjusted appropriately for these changes. The estimated nine month statewide impact is an increase of approximately $48,000.

ADHS Ambulance Rates
In accordance with Arizona Revised Statutes (A.R.S.) §36-2239, AHCCCS is required to pay ambulance providers rates equal to a prescribed percentage of the amounts approved by ADHS. Currently AHCCCS' rates are equal to 68.59% of the ADHS rates per Laws 2013, First Special Session, Chapter 10. However, AHCCCS is required by this same section of law to increase this percentage to 74.74% of the ADHS rates for rates effective October 1, 2014. This mandated adjustment results in a 9% increase in payments, assuming all utilization stays the same. The legislation also updates the base ADHS rates that are used to calculate the payments, which will result in further increases greater than 9%. The estimated nine month impact is an increase of approximately $56,500.

Automated Visual Screenings
Effective October 1, 2014, AHCCCS is providing coverage for automated visual screenings for children aged one to three years of age. Children ages four to five years of age may have a second screening if shown to be developmentally disabled or otherwise incapable of cooperating with traditional visual screening techniques. The estimated nine month impact is an increase of approximately $10,000.

Dental Homes
Effective April 1, 2014, AHCCCS Contractors must develop a process to assign all children ages 0 to 21 years of age (Early and Periodic Screening, Diagnostic and Treatment (EPSDT) members) to a dental home by one year of age or upon assignment to the Contractor, and to communicate the assignment to the member. The Contractor must regularly notify the oral health professional which members have been assigned to the provider's dental home for routine preventative care. This provides a "panel" of patients for outreach purposes so that the oral health professional can deliver services, send reminder notifications, etc. The goal of this program is to increase utilization of EPSDT oral health services to a level/rate

mandated by CMS. The estimated nine month impact is an increase of approximately $36,400.

Dental Varnish
Effective April 1, 2014, AHCCCS is allowing primary care providers (physicians, physician's assistants or nurse practitioners) to apply fluoride varnish during EPSDT visits beginning at first tooth eruption up to age two. The frequency is limited to no more than one every six months. There is an additional payment outside the EPSDT visit fee for this application. This increase includes the PCP education and discussion with the parents of the need of oral health care referral to a dental home. The estimated nine month impact is an increase of approximately $10,000.

Diagnosis Related Group (DRG) Impacts
Acute hospital inpatient stays with dates of discharge on and after October 1, 2014 will be paid using an All Patient Refined Diagnosis Related Group (APR-DRG) payment system (with certain exclusions). This payment system replaces the 20+ year tiered per diem inpatient reimbursement system in accordance with A.R.S. § 36-2903.01 and Arizona Administrative Code (A.A.C.) R9-22-712.60 through 712.81. The impact of this move to APR-DRG is budget neutral to the state, but does vary by Program. In addition to the methodological change there are impacts to what qualifies for reinsurance since the DRG method of payment will no longer allow Contractors to split inpatient encounters in most cases. The estimated, combined nine month impact of both the methodological and reinsurance change is an increase of approximately $84,600.

Newborn Screening
Effective April 1, 2014, per A.R.S. §41-1032, the newborn screening fee increased from $40.00 to $65.00. This increase in fee will allow for more accurate testing with fewer false positives, more thorough follow-up on abnormal results, more extensive provider education to reduce time from specimen collection to submission and testing and more comprehensive quality assurance activities. The estimated nine month impact is an increase of approximately $11,700.

Primary Care Provider (PCP) Payment Increase
Section 1902(a)(13)(C) of the Social Security Act, as amended by the ACA, 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 reimburses Contractors with 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 are not adjusted for the enhanced primary care payments. Rather, AHCCCS queries actual encounter data 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 these reports are verified, AHCCCS pays the Contractors the calculated additional payment amounts. A more detail explanation of the process and methodology can be found in the Actuarial Certification submitted March 2013 to CMS for approval of AHCCCS methodology. There is no impact to the CYE 15 capitation rates.

VI. Coordination of Benefits

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 state fiscal year (SFY) 2008 through SFY 2014, encounter-reported COB cost avoidance grew from $7,500 to $179,000 AHCCCS continues to emphasize the importance of COB activities.

VII. Projected Net Claim PMPM

The projected gross claim PMPMs were adjusted for the program changes and reinsurance offset to obtain the net claim PMPM. There is no reinsurance offset for PPC. For Prospective, the estimated reinsurance offset is $8.31 PMPM. The projected net claim PMPMs are as follows:

Table II: Projected Net Claim PMPM

Service Category	Projected CYE 15 Claim Cost PMPM	
	Prospective	PPC
Hospital Inpatient	$29.13	$224.13
Physician	$42.99	$94.59
Emergency Services	$14.65	$0.00
Pharmacy	$22.59	$0.00
Lab, X-ray, & med image	$5.38	$0.00
Outpatient Facility	$39.38	$0.00
Durable Med Equip	$15.90	$0.00
Dental	$34.36	$0.00
Transportation	$5.34	$0.00
NF, Home HC	$0.35	$0.00
PT, Other Prof, Misc Med	$0.32	$104.00
Total	$210.39	$422.72
Less Reinsurance	($8.31)	$0.00
Net Claim Cost	$202.08	$422.72

VIII. Administrative Expenses

The PMPM administrative expense increased from $28.53 to $32.55 due to the creation of a new state agency – Department of Child Safety (DCS) – and CMDP's move from the Department of Economic Security (DES) to DCS. As such, certain administrative functions that had previously been provided to CMDP through DES are no longer available and must be established by CMDP. Additionally, CMDP will add new positions to focus on care coordination between CMDP and other AHCCCS Contractors responsible for behavioral health service provision for CMDP kids. The proposed administrative expense is based on actual and projected administrative data provided by CMDP as well as financial statement data and expected future administrative expenses.

IX. Proposed Capitation Rates and Their Impacts

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VII) and the projected administrative expenses PMPM (in section VIII), divided by one minus the two percent premium tax. Table III below shows the current and proposed capitation rates and the budget impact from CYE 14 to CYE 15 using the same membership base.

Table III: Proposed Capitation Rates and Budget Impact

Rate Cell	Projected CYE 15 Member Months	CYE 14 Rate (1/1/14 - 9/30/14)	CYE 15 Rate	Estimated CYE 14 Capitation	Estimated CYE 15 Capitation	Dollar Impact	Percentage Impact
Prospective	144,423	$228.55	$239.41	$33,007,940	$34,576,377	$1,568,437	4.8%
PPC	3,864	$449.94	$464.56	$1,738,696	$1,795,192	$56,496	3.2%
Total				$34,746,636	$36,371,569	$1,624,933	4.7%

X. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.1: Actuarial certification

Please refer to Section XI.

AA.1.2: Projection of expenditure

Please refer to Section IX.

AA.1.3: Procurement, prior approval and rate setting

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

AA.1.5: Risk contract

The contract is an at risk contract, however there are some provisions for reconciliation and reinsurance.

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payments to providers, except supplemental payments to hospitals including Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments and Critical Access Hospital payments (CAH). GME is paid in accordance with state plan. DSH and CAH 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 Section III, V, VII and VIII.

XI. Actuarial Certification of the Capitation Rates:

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 from time-to-time by the Actuarial Standards Board.

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

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

In developing the actuarially sound capitation rates, I have relied upon data and information provided by CMDP and AHCCCS internal database. I have accepted the data without audit and have relied upon the CMDP 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.

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

SIGNATURE ON FILE *08/26/2014*

Matthew C. Varitek Date

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Member, American Academy of Actuaries