MERCY CARE

AHCCCS Complete Care Request For Proposal YH19-0001

Cost Proposal Narrative for Central, North and South Geographic Service Areas

October 1, 2018 through September 30, 2019

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INTRODUCTION AND EXECUTIVE SUMMARY

BACKGROUND (AHCCCS COMPLETE CARE)

This letter provides documentation of the assumptions and loads used in the development of the Central, North and South Geographic Service Area (GSA) Cost Proposal submissions for Mercy Care as required in Section H.19 of the AHCCCS Complete Care (ACC) Request for Proposal YH19-0001.

The purpose of this rate narrative is to provide documentation, including the assumptions and methodologies, used in the development of the October 1, 2018 through September 30, 2019 (CYE19) Non-Benefit Cost Proposal that the Arizona Health Care Cost Containment System (AHCCCS) will use in evaluating Mercy Care's Cost Proposal submission and incorporate into the capitation rates paid to Mercy Care for CYE19.

This rate narrative was prepared for AHCCCS and the Division of Health Care Management (DHCM) Actuarial Team, the state's actuarial department. This rate narrative may not be appropriate for any other purpose. If this rate narrative is made available to third parties, then this rate narrative should be provided in its entirety. Any third party reviewing this rate narrative should be familiar with the AHCCCS Complete Care program, the provisions of 42 CFR § 438 applicable to this rate narrative, the 2018 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

To facilitate review, this document has been organized in the same manner as the 2017-2018 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in April 2017.

APPENDICES

Appendix 1 shows the projection of the administrative expenses for Mercy Care for contract year ending 2019 using the historical expense level methodology.

Appendix 2 shows the projection of the administrative expenses for Mercy Care for contract year ending 2019 using the staffing model methodology.

NON-BENEFIT COST PROPOSAL

	GSA		
	Central	South	North
Member Months to Use for Bidding	3,170,000	1,630,000	990,000
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 25.83	$ 23.74	$ 24.63
% of Admin PMPM that is Fixed	13.55%	23.17%	24.36%
% of Admin PMPM that is Variable	86.45%	76.83%	75.64%
Detail Admin Break Out			
Compensation	$ 13.74	$ 12.63	$ 13.10
Occupancy	0.29	0.27	0.28
Depreciation	0.00	0.00	0.00
Care Management/Care Coordination	-	-	-
Professional and Outside Services	9.58	8.80	9.13
Office Supplies and Equipment	0.80	0.74	0.76
Travel	0.06	0.06	0.06
Repair and Maintenance	0.00	0.00	0.00
Bank Service Charge	0.18	0.17	0.17
Insurance	0.15	0.14	0.14
Marketing	0.26	0.24	0.25
Interest	-	-	-
Other Administrative	0.76	0.70	0.72
Total Admin PMPM	**$ 25.83**	**$ 23.74**	**$ 24.63**
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	1.00%	1.00%	1.00%

Notes:

1. The per member per month values are not rounded to the nearest $0.01, therefore, the total may not equal the sum of the subcomponents.

SECTION I. NON-BENEFIT COST PROPOSAL

1. GENERAL INFORMATION

The assumptions and loads included with this rate narrative are considered "actuarially sound" for purposes of 42 CFR § 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan 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 under 42 CFR § 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial Standards of Practice (ASOP) applicable to Medicaid managed care rate setting: ASOP 5 (Incurred Health and Disability Claims), ASOP 23 (Data Quality), ASOP 25 (Credibility Procedures), ASOP 41 (Actuarial Communications), ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies) and ASOP 49 (Medicaid Managed Care Rate Development and Certification).
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.
- Throughout this document, the term actuarially sound is defined in Actuarial Standard of Practice (ASOP) 49, 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."

A. RATE DEVELOPMENT STANDARDS

i. Rating Period

The CYE19 capitation rates for the ACC program are effective for the twelve (12) month time period from October 1, 2018 through September 30, 2019.

ii. Required Elements

(a) Actuarial certification

This narrative does not include an actuarial certification for the final capitation rates, as the state's Actuary will be creating the rates that will be certified to CMS. This narrative does include an actuarial certification that the non-benefit cost proposal bid for Mercy Care is actuarially sound and was developing using generally accepted actuarial practices.

(b) Certified capitation rates

The cost proposal does not include certified capitation rates; the AHCCCS Actuary will create the final capitation rates. This cost proposal includes the bid administrative expense and underwriting profit loads for Mercy Care. The member months represent the required values, provided by AHCCCS, to be used for the non-benefit cost proposal submission for CYE19.

(c) Certified rate range

Not applicable, a rate range was not developed.

(d) Program information

(i) Summary of program

This narrative was developed for the ACC program, the Medicaid managed care program operated by the State of Arizona.

AHCCCS is Arizona's Title XIX Medicaid program operating under a Section 1115 Waiver and Title XXI program operating under Title XXI State Plan authority. In 1982, Arizona introduced its innovative Medicaid program by establishing the Arizona Health Care Cost Containment System (AHCCCS), a demonstration program based on principles of managed care. The ACC program is proposing to fully integrate the physical and behavioral health services for the individuals eligible for the ACC program. The physical and behavioral health services for the eligible individuals were previously segmented between the Acute program contractors, Regional Behavioral Health Authority (RBHA) contractors and Child Rehabilitative Services (CRS) contractors.

AHCCCS continues its work to reduce fragmentation of service delivery and to create a more effective health care system. AHCCCS' efforts to further integrate care delivery systems and properly align incentives are designed to transition the structure of the Medicaid program to improve health outcomes and manage limited resources.

(A) Type and number of managed care plans

The ACC program currently expects to contract with two (2) contractors in the North Geographic Service Area (GSA), at least four (4) contractors in the Central GSA, two (2) contractors in the South GSA and one (1) additional contractor for Pima County only.

(B) Covered services

The ACC program's benefits are comprehensive in nature including all physical and behavioral health expenses, retail pharmacy, dental, and vision.

(C) Areas of state covered and length of time of operation

The ACC program has operated on a statewide basis, in all 15 counties, since 1982. The AHCCCS Care <106% FPL program has been in effect since 2001. The AHCCCS Care >106% FPL program started in January 2014 after passage of the Patient Protection and Affordable Care Act allowed for the expansion of Medicaid coverage to those individuals that have income less than 138% of the federal poverty level (FPL). All other programs have been covered since the inception of the Medicaid program, in 1982.

(ii) Rating period

The CYE19 capitation rates for ACC are effective for the twelve (12) month time period from October 1, 2018 through September 30, 2019.

(iii) Covered populations

The following populations are **included** in the ACC program:

TITLE XIX

- ***Parents/Caretaker Relatives***: Eligible individuals under the 1931 provision of the Social Security Act, with income at or below 106% of the FPL.
- ***SSI Cash****:* Eligible individuals receiving Supplemental Security Income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or who have a disability and have income at or below 100% of the Federal Benefit Rate (FBR).
- ***SSI Medical Assistance Only (SSI MAO) and Related Groups***: Eligible individuals who are aged, blind or who have a disability and have household income levels at or below 100% of the FPL.
- ***Freedom to Work (Ticket to Work)***: Eligible individuals under the Title XIX program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after allowable deductions is at or below 250% of the FPL, and who are not eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.
- **Pregnant Women:** Eligible pregnant women, with income at or below 156% of the FPL,
- **Children:** Eligible children with incomes ranging from below 133% to 147% of the FPL, depending on the age of the child.
- **Breast and Cervical Cancer Treatment Program (BCCTP):** Eligible individuals under the Title XIX expansion program for women with incomes at or below 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs. Eligible members cannot have other creditable health insurance coverage, including Medicare.
- **Title IV-E Foster Care and Adoption Subsidy:** Children who are in State foster care or are receiving federally funded adoption subsidy payments.
- **Young Adult Transitional Insurance (YATI):** Transitional medical care for individuals age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the Department of Child Safety in Arizona on their 18th birthday.

- **Adult Group at or below 106% FPL:** Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (Adults <= 106%).
- **Adult Group above 106% FPL:** Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (Adults > 106%).

TITLE XXI

- **KidsCare:** Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL).

STATE-ONLY

- **State-Only Transplants:** Title XIX individuals, for whom medical necessity for a transplant has been established and who subsequently lose Title XIX eligibility under a category other than Adult Group may become eligible for and select one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11. The extended eligibility is authorized only for those individuals who have met all of the following conditions:
  1. The individual has been determined ineligible for Title XIX due to excess income,
  2. The individual had been placed on a donor waiting list before eligibility expired, and
  3. The individual has entered into a contractual arrangement with the transplant facility to pay the amount of income which is in excess of the eligibility income standards (referred to as transplant share of cost).

(iv) Eligibility criteria

The populations covered under ACC are required to choose or be enrolled with one (1) of the contractors.

(v) Special contract provisions

This cost proposal narrative does not include any special contract provisions.

(vi) Retroactive adjustment to capitation rates

This cost proposal does not include or incorporate a retroactive adjustment to the current contract year rates.

iii. Differences Among Capitation Rates

Any differences between the proposed non-benefit costs, according to each GSA, are based on valid resource requirement differences based on the membership volume, concentration/dispersion of the eligible individuals and acuity by category of aid. The proposed non-benefit costs do not vary based on the rate of federal financial participation associated with the covered population.

iv. Cross-Subsidization of Rate Cell Payment

The non-benefit cost proposal rates were developed at the GSA level as required for the RFP submission and are intended to be self-sufficient for each GSA.

To avoid cross-subsidization by rate cell within each GSA, we recommend applying the fixed per member per month to all rate cells, except the maternity kick capitation rate. The variable non-benefit cost should be converted to a percent of revenue and applied as a uniform percentage load to each capitation rate, including the maternity kick capitation rate.

We expect the capitation rate, prior to the application of the premium tax, to be calculated as follows:

$$\frac{\text{(CYE19 Projected Medical Expense – Reinsurance Offset + Fixed Non-Benefit Cost)}}{\text{(1 – Variable Non-Benefit Cost Percent – Underwriting Margin Load Percent)}}$$

v. Effective Dates

The CYE19 capitation rates for the ACC program are effective for the twelve (12) month time period from October 1, 2018 through September 30, 2019.

vi. Generally Accepted Actuarial Practices and Principles

(a) Reasonable, appropriate and attainable

In our judgement, the fixed general administrative expense, variable general administrative expense and underwriting margin bids reflect reasonable, appropriate and attainable costs. To our knowledge, all reasonable, appropriate and attainable costs have been included in the cost proposal.

(b) Outside the rate setting process

To our knowledge, the only adjustment to the rates outside the rate setting process will be adjusting the capitation revenue paid to each contractor to account for the acuity of the individuals that have enrolled with each contractor.

(c) Final contracted rates

This cost proposal reflects Mercy Care's best estimate of the reasonable, appropriate and attainable costs of the non-benefit costs to manage the ACC program assuming the membership levels provided by AHCCCS for the non-benefit cost proposal. The final contracted rates will be developed by the AHCCCS Actuary.

vii. Rate certification for effective time periods

This cost proposal is intended to be effective for the 2019 contract year, from October 1, 2018 through September 30, 2019.

viii. Procedures for rate certification and amendment

This section is not applicable since the AHCCCS Actuary will be certifying the final rates and any amendments that may occur.

B. APPROPRIATE DOCUMENTATION

i. Documentation of Required Elements

This narrative contains appropriate documentation of all the elements described in the non-benefit cost proposal, including inflation assumptions, membership volume adjustments to the general administrative expense projections, addition of the necessary resources to manage the behavioral health and child rehabilitative services and development of the underwriting margin load. The methods for developing and analyzing the reasonableness and source of those assumptions are also included.

ii. Index

The index to this cost proposal narrative is the table of contents, found immediately following the title page. Sections not relevant to this narrative continue to be provided, with an exception noted if they are not applicable.

iii. Differences in FMAP

Not applicable since this cost proposal narrative is not dependent on the FMAP from CMS nor will it be provided to CMS.

iv. Assumptions and Methodology for Development and Certification of Rate Ranges

Not applicable, a rate range has not been developed for this cost proposal.

v. Documentation of Development and Certification of Rate Ranges

Not applicable, a rate range has not been developed for this cost proposal.

2. DATA

Section 2 is not applicable to this non-benefit cost proposal narrative. We have relied upon the state and its Actuary to have audited the base data and reviewed it for reasonableness and appropriateness.

We did not perform an independent audit of the data, comparison to the supplemental financial reports from the current contractors, nor did we independently value each of the programmatic and fee schedule changes.

We did perform a reasonableness check against Mercy Care's own experience and found the base data provided by AHCCCS to be reasonable. We also performed our own projection of the medical expenses to CYE19 to develop our own expectations of the final capitation rates that will be used solely to review the reasonableness of the final CYE19 rates once the AHCCCS Actuary performs their calculation.

Since we are not submitting a full capitation rate cost proposal, we are not including our internal calculations within this rate narrative.

3. PROJECTED BENEFIT COST AND TRENDS

Section 3 is not applicable to this cost proposal narrative; Mercy Care is not submitting a full capitation rate cost proposal.

We performed our own projection of the medical expenses to CYE19 to develop our own expectations of the CYE19 medical expenses. The sole use of that projection is to review the reasonableness of the final CYE19 rates once the AHCCCS Actuary performs their calculation.

Since we are not submitting a full capitation rate cost proposal, we are not including our internal calculations within this rate narrative.

4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the incentive programs in the ACC program RFP.

ii. Appropriate Documentation

(a) Description of the incentive program

(i) Time period and purpose

The incentive arrangement is measured on a contract year basis. The proposed measures are primarily focused on improving quality, health outcomes and access to care while also reducing costs.

(ii) Description of the total incentive

The ACC program provides for two (2) incentive programs: a Quality Measure Performance program and Performance Based Payments program. Any one (1) Contractor cannot receive greater than 5.0% of its annual capitation revenue as incentive payments.

Quality Measure Performance (QMP)

The program incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for performance on select quality measures identified in ACOM Policy 306. Payment is contingent on the Contractor meeting the minimum requirements of the percentage of payments that must be governed by Alternative Payment Model (APM) strategies defined in ACOM Policy 307. AHCCCS will make a lump-sum payment to the Contractor after the completion of the contract year and the computation of the quality measures.

Performance Based Payments (PBP)

The program incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractor that are aimed at quality improvement, such as reducing costs, improving health outcomes, or improving access to care.

(iii) Estimate of percent to be earned

Since the cost proposal is only for the non-benefit expense portion of the final capitation rates, there is no assumption of the estimated amount to be earned. However, the ability of a Contractor to achieve the incentive measures will be dependent on the reasonableness of the expected improvement in the measures and communication of the targets prior to the start of the measurement year.

(iv) Reasonableness of incentive arrangement

The incentive program arrangement is reasonable for measures that can be impacted and for levels of improvement that can be attained within a twelve (12) month period.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the ACC program.

ii. Appropriate Documentation

(a) Description of the incentive arrangement

(i) Time period and purpose

The withhold arrangement is measured on a contract year basis. The proposed measures are primarily focused on targeting an improvement in quality of life, access to care and quality of care.

(ii) Description of total withhold

The Alternative Payment Model (APM) Initiative – Quality Measure Performance (QMP) incorporates a withhold arrangement of 1.0% of the Contractor's capitation and a portion of, or all of, the withheld amount will be paid to the Contractor for performance on select quality measures identified in ACOM Policy 306. Payment is contingent on the Contractor meeting the minimum requirements of the percentage of payments that must be governed by APM strategies defined in ACOM Policy 307. AHCCCS will apply the withhold after the completion of the contract year by recouping the full amount of the annual withhold. Also after the completion of the contract year and the computation of the quality measures, AHCCCS will reconcile the Contractor's earned portion of the withhold against the withheld funds and will make a lump sum payment to the Contractor. The Contractor will not be paid greater than 100% of the withhold.

(iii) Estimate of percent to be returned

Since the cost proposal is only for the non-benefit expense portion of the final capitation rates, there is no assumption of the estimated percent to be returned. However, the ability of a Contractor to achieve a high rate of return of the quality withhold will be dependent on the reasonableness of the expected improvement in the measures and communication of the targets prior to the start of the measurement year.

(iv) Reasonableness of withhold arrangement

The withhold arrangement is reasonable for measures that can be impacted and for levels of improvement that can be attained within a twelve (12) month period.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

This section provides documentation of the risk sharing mechanisms in the ACC program.

ii. Appropriate Documentation

(a) Description of risk-sharing mechanism

AHCCCS will reconcile the Contractor's total medical cost expenses (prospective and PPC) to total net capitation paid (prospective and PPC) to the Contractor. For CYE19, this reconciliation will limit the Contractor's profits and losses as follows:

MCO Profit/(Loss) prior to Reconciliation	MCO Share	AHCCCS Share	Max MCO Profit/(Loss) in Corridor	Cumulative MCO Profit/(Loss)
> (2.0%)	0%	100%	0%	(2%)
<= (2.0%)	100%	0%	(2%)	(2%)
<= 2.0%	100%	0%	2%	2%
> 2.0% and <= 6.0%	50%	50%	2%	4%
> 6.0%	0%	100%	0%	4%

(b) Medical loss ratio

There is no minimum medical loss ratio mechanism in the ACC program.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate Development Standards

This section provides documentation of the delivery system and provider payment initiatives in the ACC program. Since the cost proposal is only for the non-benefit expense portion of the final capitation rates, there is no provision for these delivery system and provider payment initiatives included in this proposal.

ii. Appropriate Documentation

(a) Description of delivery system and provider payment initiatives

Access to Professional Services Initiative (APSI)

AHCCCS seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the Contractor's rates for professional services provided by qualified physicians and non-physician professionals affiliated with designated hospitals who meet the definition outlined in ACOM Policy 325.

The APSI, which began on October 1, 2017, allows the Contractor to provide a 40% increase to the otherwise contracted rates to Qualified Practitioners as defined in ACOM Policy 325 for all claims for which AHCCCS is the primary payer. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Because APSI is a new initiative and utilization of Qualified Practitioners will vary across Contractors, AHCCCS will mitigate the Contractor's risk associated with overpayment or underpayment through a risk corridor which will include a -/+ 0% risk band, further described in ACOM Policy 325.

AHCCCS may amend the APSI components effective October 1, 2018.

Targeted Investments (TI)

The Targeted Investments (TI) program is authorized under AHCCCS' Section 1115 Waiver for five years beginning in CYE 17. The TI program is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care.

In order to ensure the stability of AHCCCS' delivery system efforts, the Contractor is strongly encouraged to contract with eligible PCPs, behavioral health providers, integrated clinics and hospitals participating in TI beginning October 1, 2018. The Contractor will provide financial incentives (referenced below) under the TI initiative to the participating providers who demonstrate performance improvement by meeting certain benchmarks for integrating and coordinating physical and behavioral health care. Contractors are encouraged to:

1. Maintain membership numbers for those members assigned to contracted/TI eligible participating providers, as appropriate, and
2. Increase member assignment to high performing contracted/TI eligible participating providers, as appropriate.

The Contractor is required to contract with eligible TI providers serving adults transitioning from the criminal justice system participating in the TI program. In the event the Contractor and the provider fail to negotiate a contract, the Contractor shall permit members to continue receiving services from these providers and shall reimburse the provider at 100% of the AHCCCS FFS rates.

AHCCCS will collect information via the Provider Affiliation Transmission (PAT) file and evaluate the Contractor's network. If AHCCCS determines a material impact to TI participating provider(s), AHCCCS may require the Contractor to take steps to rectify the material impact.

AHCCCS will compute the participating provider financial incentives after completion of the contract year and will make available to the Contractor a list of TI providers and associated amounts of financial incentive payments owed for the contract year. Also after completion of the contract year, AHCCCS will adjust capitation rates in the form of a lump sum payment to the Contractor in an amount equal to the financial incentive payments due to TI providers plus an administrative payment for the Contractor. Requirements are further delineated in ACOM Policy 324.

This delivery system reform initiative:

1. Makes participation in the delivery system reform initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the reform initiative,
2. Uses a common set of performance measures across all payers and providers,
3. Does not set the amount or frequency of the expenditures, and
4. Does not allow AHCCCS to recoup any unspent funds allocated for these arrangements from the Contractor.

Differential Adjusted Payments (DAP)

AHCCCS has introduced multiple Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. AHCCCS may amend the DAP components effective October 1, 2018, including but not limited to, the qualifications, rate adjustments, and/or providers eligible for the increases. The Contractor will support the Rate Differential in accordance with 42 CFR 438.6(c)(1)(iii)(B). The DAP effective October 1, 2017 require that the Contractor shall adjust payments for specific providers and provider types as described below:

1. Nursing Facility

For CYE18, for qualified AHCCCS-registered Arizona Nursing Facility providers meeting criteria as set forth below, the Contractor is required to increase the rates that the Contractor would otherwise pay by 1.0% or 2.0%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria: Nursing Facilities that meet or exceed the Medicare Nursing Home Compare Arizona Average for the pneumococcal vaccine measure qualify for a 1.0% Differential Adjusted Payment increase.

1. The pneumococcal vaccine measure is the percent of long-stay residents assessed and appropriately given the vaccine
2. The facility's results on Medicare Nursing Home Compare for this quality measure will be compared to the accompanying Arizona Average results for the measure, for the most recently published rate as of April 30, 2017

AND/OR

Criteria: Nursing Facilities that meet or exceed the Medicare Nursing Home Compare Arizona Average for the influenza vaccine measure qualify for a 1.0% Differential Adjusted Payment increase.

1. The influenza vaccine measure is the percent of long-stay residents assessed and appropriately given the vaccine
2. The facility's results on Medicare Nursing Home Compare for this quality measure will be compared to the accompanying Arizona Average results for the measure, for the most recently published rate as of April 30, 2017

Nursing Facilities will be eligible for a 1.0% increase for meeting each variable, thus having the potential to earn up to a 2.0% Differential Adjusted Payment increase if both criteria are met.

2. Hospital subject to APR-DRG Reimbursement

For CYE18, for both inpatient and outpatient services for qualified AHCCCS-registered Arizona Hospital providers (provider type 02) meeting criteria as set forth below, the Contractor is required to increase the rates that the Contractor would otherwise pay by 0.5%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria: The hospital must participate in the Network, the state's health information exchange, by May 15, 2017 as evidenced by an executed agreement with a qualifying Health Information Exchange organization, and electronically submit laboratory, radiology, transcription, and medication information, plus admission, discharge, and transfer information (including data from the hospital emergency department) to a qualifying health information exchange organization.

3. Other Hospitals and Inpatient Facilities

Effective for dates of admission from January 1, 2018 through September 30, 2018, for both inpatient and outpatient services for qualified AHCCCS-registered Arizona Psychiatric Hospitals (Provider Type 71), Subacute Facilities (1- 16 Beds) (Provider Type B5), Rehabilitation Hospitals (Provider Type C4), and Long Term Acute Care Hospitals (Provider Type C4) meeting criteria as set forth below, the Contractor is required to increase the rates that the Contractor would otherwise pay by 0.5%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria:

1. The hospital must participate in the Network, the state's health information exchange, by October 1, 2017 as evidenced by an executed agreement with a qualifying health information exchange organization, and electronically submit admission, discharge, and transfer information (including data from the hospital emergency department) to a qualifying health information exchange organization.
2. Facilities must have an executed agreement and initiate activity with the state's HIE by May 15, 2017 to meet this October 1, 2017 deadline. Additionally, the Network will conduct a readiness assessment of all interested facilities and will determine, based on the results of the assessment, whether or not the facility is approved to proceed with connectivity and meeting the program deadlines

4. Integrated Clinic

For those dates of service in CYE18 that coincide with the provider's registration as a qualified AHCCCS-registered Integrated Clinics (IC) with claims for behavioral health services accounting for at least 40% of total claims, meeting criteria as set forth below, the Contractor is required to increase the rates that the Contractor would otherwise pay for select physical health services by 10.0%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria:

1. Providers registered with AHCCCS as Integrated Clinics and licensed by the Arizona Department of Health Services as Outpatient Treatment Center which provide both behavioral health services and physical health services and whose claims for behavioral health services account for at least 40% of total claims
2. AHCCCS will compute claims for behavioral health services as a percentage of total claims as of May 15, 2017 to determine which providers meet the 40% minimum threshold by utilizing

claims and encounter data for dates of service from October 1, 2015 through September 30, 2016

3. Select physical health services which qualify for the increase include Evaluation and Management (E&M) codes, vaccine administration codes, and a global obstetric code

5. Physicians, Physician Assistants, and Registered Nurse Practitioners

For CYE18, for all services billed on the CMS Form 1500 by qualified AHCCCS-registered physicians, physician assistants, and registered nurse practitioners (Provider Types 08, 31, 18, 19) meeting criteria as set forth below, the Contractor is required increase the rates that the Contractor would otherwise pay by 1.0%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider. Due to the operational issues related to contracting arrangements with entities rather than individual practitioner, the Contractor is permitted pay the increase in a manner other than on an individual claim basis, The Contractor would need to pay the increase on at least a quarterly basis. The Contractor shall ensure that the qualifying practitioner is paid the same amount that would have been paid on a claims basis, regardless of the payment methodology.

Criteria:

1. The provider must have written at least 100 prescriptions for AHCCCS members, and must have written at least 50% of their total AHCCCS prescriptions as Electronic Prescriptions (E-Prescriptions)
2. E-Prescription statistics will be identified by the AHCCCS provider ID for the prescribing provider, and computed by AHCCCS
3. The Differential Adjusted Payment will apply to claims for covered AHCCCS services where the rendering provider ID on the claim is the same as the prescribing provider ID that was identified and found to meet the criteria described above.

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

This section provides documentation of the pass-through payments in the ACC program. Since the cost proposal is only for the non-benefit expense portion of the final capitation rates, there is no provision for these pass-through payments included in this proposal.

ii. Appropriate Documentation

(a) Description of pass-through payments

In accordance with A.R.S. §36-2905.02, small rural hospitals shall receive additional payments from AHCCCS in order to increase inpatient reimbursement. The Contractor shall be required to pass-through payments to qualifying network providers. AHCCCS will compute the participating provider payments during the contract year and will make available to the Contractor a list of small rural hospitals and associated pass-through payment amounts for the contract year. At the same time, AHCCCS will adjust capitation rates either as a per member per month adjustment or in the form of a lump sum payment to the Contractor in an amount equal to the pass-through payments due small rural hospital providers. The pass-through payments shall not supplant any payments to eligible providers.

5. PROJECTED NON-BENEFIT COSTS

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR § 438.5(e), the development of the non-benefit components of the cost proposal includes reasonable, appropriate, and attainable expenses related to a bidder's administration on the ACC program.

The remainder of this section provides documentation of the data, assumptions and methodology that we utilized to develop the non-benefit cost component of the cost proposal.

ii. PMPM versus Percentage

The non-benefit costs were developed as per member per month costs, and then segmented into the fixed and variable portions according to the non-benefit cost bid template provided by AHCCCS.

iii. Basis for Variation in Assumptions

Any differences between the proposed non-benefit costs, according to each GSA, are based on valid resource requirement differences based on the membership volume, concentration/dispersion of the eligible individuals and acuity by category of aid. The proposed non-benefit costs do not vary based on the rate of federal financial participation associated with the covered population

iv. Health Insurance Providers Fee

As an not-for-profit organization Mercy Care will receive more than 80% of its revenue from governmental programs; therefore, it is not subject to the health insurance providers fee.

B. APPROPRIATE DOCUMENTATION

i. Development of Non-Benefit Costs

(a) Description of the data, assumptions and methodologies

Data

The primary sources used in the development of the CYE19 non-benefit costs are listed below:

- Mercy Care's historical administrative expenses
- Aetna Medicaid's standard staffing model
- The ACC RFP contract staffing requirements
- The ACC RFP contract capitalization requirements

Assumptions and Methodology

The administrative expense per member per month costs were developed by accounting for the resource requirements as described in the ACC RFP Contract as well as incorporating Aetna Medicaid Administrator's standard administrative management expense levels. Since Mercy Care Plan is currently a contractor in the Acute Care Program, we developed projections using two (2) different methods:

1. We used the historical expense levels of Mercy Care for calendar year 2017 (CY17), adjusted to account for the actual volume vs. the required assumed volume in the bid template, trended forward to account for inflation, added on the additional resources necessary to support the behavioral health and child rehabilitative services expenses to be integrated into the ACC program from the separate programs beginning October 1, 2018. This method is the primary methodology used to create the non-benefit cost proposal.
2. Aetna Medicaid Administrators is the sole administrator for Mercy Care. Aetna Medicaid Administrators utilizes a proprietary staffing model to evaluate the administrative expenses based on resource requirements but can also be used to evaluate the appropriateness of current market expenses. This method is the secondary methodology used to evaluate and validate the reasonableness of the primary methodology, described in #1 above.

Historical Expense Level Methodology

The base data year used was from January 1, 2017 through December 31, 2017. In consultation with Mercy Care's Finance Team, we split the expenses into Fixed vs. Variable expenses within the base data year. To adjust the expenses from the base period to contract year ending 2019, we included a 1.0% annual inflation adjustment to the fixed expenses and a 2.0% annual inflation adjustment to the variable expenses.

We also included the benefit expenses we project not to be accepted by AHCCCS. Mercy Care has a long history of submitting encounter data to AHCCCS, yet is still not able to achieve greater than a 99.0% acceptance rate. The roughly 1.0% of encounters not accepted are primarily due to eligibility changes that occur after claims are processed and paid that cannot be recovered from the provider. Aetna Medicaid Administrators is in the process of updating the encounter data submission software package in their claims processing system such that they expect the encounter acceptance rate to increase but still expect some level of encounters to remain unaccepted. Since AHCCCS bases the benefit portion of the capitation rate solely on the accepted encounter records, we have incorporated the expected unaccepted encounter expenses within the historical non-benefit expenses since those expenses are borne by Mercy Care, but are not accounted for in the benefit expenses. The historical unaccepted encounter data is 1.0% of the CY17 benefit expenses for Mercy Care. We have included a (8.0%) annual adjustment factor to account for the expected improvements in the encounter data accepted during the rating period.

Mercy Care Plan is currently a Contractor in the Maricopa and Pima Only GSAs. They have nearly a million member months more than the 3,170,000 required by AHCCCS for the non-benefit cost proposal in the Central GSA and over a million member months less than the 1,630,000 required in the South GSA. Therefore, a membership volume adjustment must be incorporated to adjust the fixed administrative expense per member per month value.

Along with Mercy Care's Finance Team, we consulted the Medical management and other subject matter experts to determine the necessary additional resources to support the behavioral health and child rehabilitative services benefits in the ACC RFP.

Mercy Care is currently not a Contractor in the North GSA. Therefore, we have developed the North GSA non-benefit cost proposal using the South GSA non-benefit cost proposal as the starting point. It was determined that the South GSA is a better starting point than the Central GSA due to the similarities in member month volume, geographic concentration and dispersion and the limitation of any Contractor being awarded the entire state and likelihood Mercy Care would be awarded only one (1) of those two as an incremental addition to the Central GSA. To adjust the South GSA to the North GSA, the fixed expense was adjusted for the member month volume difference and the variable expense was adjusted by 2.27% to account for the additional geographic dispersion in the North GSA.

Staffing Model Methodology

General administrative costs were built from the ground up based on the standard Aetna Medicaid Administrators staffing model, assuming the member month levels as required by AHCCCS for each GSA and assuming that Mercy Care would, at a minimum, be awarded the Central GSA. The North and South GSAs were then modeled as additional incremental additions to the Central GSA. The GSA combinations were performed such that the fixed administrative expenses would be distributed over more member months and more regions. It is highly unlikely any Contractor would be willing to accept being a Contractor for the North or South GSA only. A single GSA Contractor can only be viable and have a competitive administrative expense bid in the Central GSA.

Medical management and other subject matter experts were consulted to provide, confirm, and review staffing standards to support the resource requirements set forth in the ACC RFP.

(b) Material changes

Since the prior RFP, the administrative expense load in the capitation rates has been based on the Contractor's per member per month administrative expense RFP bid. No adjustments for inflation, volume or resource requirements were incorporated into the per member per month rate during each year's capitation rate update. The administrative expense load within this non-benefit cost proposal accounts for all those adjustments plus the additional resources necessary to manage the behavioral health and child rehabilitative services benefits.

(c) Other material changes

The prior RFP and prior per member per month rates did not include a separation of fixed versus variable expenses.

ii. Non-Benefit Costs by Category

(a) General administration

Historical Expense Level Projection

The administrative expenses were projected using actual expenses from January 1, 2017 through December 31, 2017. The detailed calculation for each GSA is included in Appendix 1.

Staffing Model Projection

The results from the staffing model for each GSA are included in Appendix 2. The staffing model does not account for the unaccepted encounter expenses so those were included based on the historical expense level projection.

Administrative Expense Bid

The results of the staffing model projection are greater than the historical expense projection, for each GSA. During consultation with the Mercy Care executive management team, we have concluded that Mercy Care has been able to perform more efficiently than the staffing model due to their size and long standing history of managing the various Medicaid programs in Arizona. They have been able to achieve a level of efficiency that the staffing model does not contemplate.

Therefore, Mercy Care has decided to use the historical expense level projection for the administrative expense bid.

(b) Underwriting gain load

The underwriting gain load is intended to include items such as cost of capital, risk mitigation, contingency, and profit.

Cost of Capital

Cost of Capital = Required Capital as a % of Revenue * Required Return on Capital / (1 – Tax Rate)

The ACC RFP Contract requires Contractors to maintain capital at $150 per member in CYE19, $200 per member in CYE20 and $250 per member in CYE21 or $12M in the Central GSA, $10M in the South GSA, or $7.5M in the North GSA, whichever is greater. Due to Mercy Care's size, we fully expect the per member capitalization requirement to prevail as the greater amount, each contract year. In our estimation, the capital requirements would equate to roughly 3.9%, 5.2% and 6.5% for CYE19, CYE20 and CYE21, respectively, of the annual revenue that must be set aside. It would also be financially prudent to hold more than the minimum required to allow for cash flow fluctuations, catastrophic losses and/or expenses that exceed revenues such that the minimum capital requirement will not be breached on a regular basis. It would be reasonable to increase the minimum capital by 15% to create a buffer against the aforementioned potential issues; that would set the capitalization assumption at 4.5%, 6.0% and 7.5%, respectively, of the annual revenue.

A reasonable return on capital is 7.00%, based on expected required returns on retained earnings versus expected returns from an investment portfolio invested moderately in corporate bonds, corporate equities and other investments.

Mercy Care is a 501.(c).(3) organization. As such, the company is not subject to federal, state or local taxes. Therefore, the corporate tax rate is 0.0%.

CYE19 Cost of Capital = 4.5% Required Capital * 7.0% Return on Capital / (1 – 0.0% Tax Rate) = 0.31%

Risk Mitigation and Contingency

We have studied the volatility that is typical and standard within Medicaid programs. The results vary by Medicaid program because of the inpatient facility fee schedule style (per diem, percent of billed charges, as well as interaction of the DRG schedule version and outlier provisions), acuity of individuals in the program and membership/revenue volume of the program and number of contractors. Prior to adjusting for other risk mitigation provisions within a program, it would be reasonable to set the risk mitigation and contingency load between 1.0% and 2.0%.

For the ACC program, prior to accounting for the AHCCCS provided reinsurance, we think it would be reasonable to include 1.0%. The inpatient facility reimbursement is DRG based which helps reduce the volatility caused by long and catastrophic inpatient stays, the membership/revenue volume is quite substantial due to the limited number of contractors and any changes to the covered populations, features and acuity of the ACC program is moderate and/or stable.

AHCCCS also provides reinsurance coverage for: 1) inpatient hospital expenses above a $50k threshold, 2) select, high cost, pharmaceuticals, and 3) transplants. As a result, it would be reasonable to reduce the 1.0% load to 0.5% since the contractor will not be subject to the expenses, which drive a large share of any monthly and/or annual expense volatility.

Profit

The cost of capital and the risk mitigation and contingency loads are calculated as the amounts to make the contractor whole based on best estimates of the minimum capital requirements and volatility risks. However, the contractor should also expect to generate a profit for taking on the risk of managing the program such that the business decision would be to invest the capital into the management of the program rather than investing that capital in a different investment opportunity. It would be reasonable to include 0.25% to 1.00% to cause the business to choose investing the capital into this opportunity rather than another investment opportunity.

Underwriting Gain Load

All combined, cost of capital + risk mitigation and contingency + profit, it would be reasonable for Mercy Care to expect an underwriting gain load between 1.06% and 2.02% to compensate and account for the risks they are taking in the ACC program. Within the ACC RFP, the bidding contractors are limited to bid the underwriting gain load between 0.0% and 1.0%. Therefore, 1.00% is included for years 1, 2 and 3 within the cost proposal.

	CYE19	CYE20	CYE21
Cost of Capital	0.31%	0.42%	0.52%
Risk Mitigation and Contigency	0.50%	0.50%	0.50%
Profit			
Low	0.25%	0.25%	0.25%
High	1.00%	1.00%	1.00%
Underwriting Gain Load			
Low	1.06%	1.17%	1.27%
High	1.81%	1.92%	2.02%
Proposed UW Gain Load	**1.00%**	**1.00%**	**1.00%**

(c) Premium tax

The premium tax is 2.00%. The final CYE19 capitation rates will incorporate a separate load for the premium tax during the final capitation rate development process. Therefore, the premium tax is not included within the non-benefit cost proposal.

iii. Health Insurance Providers Fee

As a not-for-profit organization Mercy Care will receive more than 80% of its revenue from governmental programs; therefore, it is not subject to the health insurance providers fee.

6. RISK AJDUSTMENT AND ACUITY ADJUSTMENTS

This section provides information on the risk adjustment included in the ACC program.

A. RATE DEVELOPMENT STANDARDS

i. Overview

The ACC program capitation rates will be developed as full risk rates. The Contractors assume risk for the cost of services covered under the contract and incur losses, limited to (2.0%), if the cost of furnishing the services exceeds the payments under the contract. The capitation rates for each of the TANF <1, TANF 1-20, TANF 21+, SSI with Medicare, SSI without Medicare, AHCCCS Care <106% FPL, AHCCCS Care >106% FPL rate cells will be prospectively risk adjusted by Contractor to reflect the estimated cost differences in the underlying population enrolling in each Contractor.

ii. Risk Adjustment Model

Due to the integration of the behavioral health and child rehabilitative services into the ACC program beginning October 1, 2018, AHCCCS intends to perform non-diagnostic based population risk adjustments for the first few years of the contract under the ACC program and then move to diagnostic based population risk adjustment. This will include non-diagnostic based population risk adjustment necessary for the movement (member choice) of behavioral health utilizers. AHCCCS intends to review member placement quarterly during the first year to see if the non-diagnostic based population risk adjustment factors should be adjusted.

The non-diagnostic based population risk adjustment factors will be developed using historical encounter and member month data and member placement files. The historical data and the member placement files will be compared to determine where each historical member is enrolled. The non-diagnostic based population risk adjustment factors will be developed by rate cell, by Contractor, and will be budget neutral. Development of the non-diagnostic based population risk adjustment factors involves taking the relationship of historical encounter PMPM data by rate cell by Contractor to the total historical encounter PMPM by rate cell. The capitation rates will be developed by rate cell by GSA and thus will represent the average of all Contractors in that GSA and rate cell. The non-diagnostic based population risk adjustment factors will then be applied to the average capitation rates to get each Contractor's specific capitation rates. Since this will be budget neutral, some Contractors will have non-diagnostic based population risk adjustment factors above 1.00 and some below 1.00.

B. APPROPRIATE DOCUMENTATION

i. Prospective Risk Adjustment

Section I.6.B.i is not applicable to this non-benefit cost proposal narrative.

ii. Retrospective Risk Adjustment

Not applicable; the population acuity adjustments will be a prospective methodology.

iii. Changes to the Risk Adjustment Model

The current Acute Care program capitation rates are prospectively risk adjusted using the Episode Risk Group (ERG) model v9.1, calibrated and calculated by Wakely Consulting Group.

Due to the integration of the behavioral health and child rehabilitative services into the ACC program beginning October 1, 2018, AHCCCS intends to perform non-diagnostic based population risk adjustments for the first few years of the contract under the ACC program and then move to a diagnostic based population risk adjustment model.

iv. Acuity Adjustments

Not applicable; the non-benefit cost proposal was developed assuming a 1.0 risk adjustment factor. No adjustment or load for acuity was included.

We recommend including an adjustment to the variable administrative expense load in the final capitation rates to account for the resources impacted by the acuity of the Contractor's enrolled individuals.

SECTON II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

Section II of the CMS Medicaid Managed Care Rate Development Guide is not applicable to the ACC program.

SECTON III. NEW ADULT GROUP CAPITATION RATES

AHCCCS expanded coverage for childless adults up to 100% of the federal poverty level (FPL) in 2000 under Proposition 204. In January 2011, this population was subject to an enrollment freeze. Effective January 2014, AHCCCS opted to expand Medicaid eligibility for all adults up to 133% FPL (Adult Expansion) and restored coverage for the childless adults up to 100% FPL program (Childless Adult Restoration). Collectively these two populations are considered new adult groups under Section III of the CMS Medicaid Managed Care Rate Development Guide.

The ACC program capitation rates include separate rate cells for the Adult Expansion and Childless Adult Restoration populations, which are also referred to as "Adults >106% FPL" and "Adults <=106% FPL", respectively.

Essentially, the new adult group will be treated as any other ACC program rate cell.

1. BASE DATA

Similar to Section I.2, this section is not applicable to this non-benefit cost proposal narrative. We have relied upon the state and its Actuary to have audited the base data and reviewed it for reasonableness and appropriateness.

We did not perform an independent audit of the data, comparison to the supplemental financial reports from the current contractors, nor did we independently value each of the programmatic and fee schedule changes.

We did perform a reasonableness check against Mercy Care's own experience and found the base data provided by AHCCCS to be reasonable. We also performed our own projection of the medical expenses to CYE19 to develop our own expectations of the final capitation rates that will be used solely to review the reasonableness of the final CYE19 rates once the AHCCCS Actuary performs their calculation.

Since we are not submitting a full capitation rate cost proposal, we are not including our internal calculations within this rate narrative.

2. PROJECTED BENEFIT COSTS

Similar to Section I.3, this section is not applicable to this cost proposal narrative; Mercy Care is not submitting a full capitation rate cost proposal.

We performed our own projection of the medical expenses to CYE19 to develop our own expectations of the CYE19 medical expenses. The sole use of that projection is to review the reasonableness of the final CYE19 rates once the AHCCCS Actuary performs their calculation.

Since we are not submitting a full capitation rate cost proposal, we are not including our internal calculations within this rate narrative.

3. PROJECTED NON-BENEFIT COSTS

A. CHANGES IN DATA SOURCES, ASSUMPTIONS OR METHODOLOGIES SINCE LAST CERTIFICATION

i. Changes in Data Sources, Assumptions and Methodologies

Non-benefit cost development for the Adult Expansion and Childless Adult Restoration populations are consistent with the development documentation included in Section I.5 of this narrative.

ii. Assumption Changes Since Previous Certification

Since this is an RFP cost proposal, this section is not applicable to this narrative.

B. KEY ASSUMPTIONS

There are no key assumptions specific to the New Adult Group populations, separate from the other populations in the ACC program.

4. FINAL CERTIFIED RATE OR RATE RANGES

This section is not applicable to this rate narrative since AHCCCS will be developing the full capitation rates.

5. RISK MITIGATION STRATEGIES

A. DESCRIPTION OF RISK MITIGATION STRATEGY

The ACC program does not include any risk mitigation strategy or methodology specific to the New Adult Group populations. The New Adult Group populations are subject to the same risk corridor methodology as described in Section I.4.C.ii.(a).

B. DOCUMENTATION

i. Changes in Risk Mitigation Strategies

Beginning with the introduction of coverage for the Adult Expansion population in January 2014, the Acute Care program applied a distinct risk corridor specific to that population, by contract year, until CYE18. The risk corridor limited the Contractors to expenses ± 1.0% of the projected expenses.

As noted in Section III.5.A above, the New Adult Group populations are subject to the same risk corridor as the other rate cells, in the ACC program.

SECTON IV. CAPITALIZATION TO MEET MINIMUM EQUITY REQUIREMENTS

This section, not included in the Medicaid Managed Care Rate Development Guide, is provided to meet the requirement of *Section F – Non-Benefit Cost Bid Requirements* that the Actuarial Certification include a statement and description of why the bidding Contractor has no concern meeting the capitalization requirements in the ACC program.

Mercy Care, formerly Mercy Care Plan, has been a Contractor within the Acute Care, ALTCS and DDD Programs for many years. They are currently well capitalized, holding $77.7M in net equity for their Acute Care contract versus a minimum requirement of $42.3M, as of December 2017.

The ACC RFP Contract requires Contractors to maintain capital at $150 per member in CYE19, $200 per member in CYE20 and $250 per member in CYE21 or $12M in the Central GSA, $10M in the South GSA, or $7.5M in the North GSA, whichever is greater. Due to Mercy Care's size, we fully expect the per member capitalization requirement to prevail as the greater amount, each contract year.

We are estimating that Mercy Care will need to maintain net equity levels of approximately $70M in CYE19, $95M in CYE20 and $120M in CYE21, taking into account the increased per member capitalization requirements and expected membership volume growth from a decrease in the number of Contractors as well as consolidation of the GSAs from 7 to 3.

There are three (3) different resources by which Mercy Care intends to capitalize the ACC program to meet the minimum equity requirements:

1. Retained Earnings from Current Operations

Mercy Care, formerly Mercy Care Plan, is currently an Acute Care program Contractor. Mercy Care expects to be able to increase the retained earnings of their Acute Care contract through current operating earnings. The owners of Mercy Care understand they will not be able to receive any distributions from the retained earnings in order to ensure the Acute Care / ACC program meets the minimum equity requirements.

2. Transfer of Retained Earnings from other AHCCCS Contract Accounts

Mercy Care, formerly Mercy Care Plan,s currently a Contractor for the ALTCS and DDD programs. Each of those contracts is capitalized well in excess of their minimum requirements. The ALTCS contract is $48.6M and the DDD contract is $16.3M in excess of their respective minimum equity requirements, as of December 2017. Mercy Care could request to have a portion of those excess funds transferred to the Acute Care / ACC program contract, if the retained earnings from the ongoing operations in #1 above are inadequate to meet the minimum equity requirements.

3. Capital Infusion from the Parent Organizations

Mercy Care is a joint venture between Dignity Health and Ascension Health. Both parent organizations are currently well capitalized, have the means and are prepared to infuse additional capital into Mercy Care, if the funding from #1 and #2 above are exhausted and inadequate to meet the minimum equity requirements.

LIMITATIONS

The information contained in this report has been prepared for the Arizona Health Care Cost Containment System (AHCCCS) and Department of Health Care Management (DHCM) Actuarial Team to provide documentation of the development of the contract year 2019 non-benefit cost proposal for Mercy Care. The data and information presented may not be appropriate for any other purpose.

The information contained in this narrative, including the attachments, has been prepared for AHCCCS, the DHCM Actuarial Team and their consultants. Any distribution of this narrative should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modelling so as not to misinterpret the information presented herein.

We have relied upon certain data and information provided by AHCCCS and the DHCM Actuarial Team in the development of this non-benefit cost proposal. We have relied upon AHCCCS and the DHCM Actuarial Team for the reasonableness and accuracy of the data, the programmatic change impacts and the fee schedule impact changes without audit. To the extent the data provided is not accurate, the non-benefit cost proposal may need to be modified to reflect the revised information.

Guidelines issues by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this narrative are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis contained within this narrative.

ATTESTATION

I, Jason Strandquist, am an employee of Aetna Life Insurance Company, the contracted administrator for Mercy Care, formerly Mercy Care Plan. I am also a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I have reviewed the assumptions and methods used to develop the non-benefit cost proposal submitted for the AHCCCS Complete Care RFP. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

In developing the assessment, I relied upon relied upon certain data and information provided by AHCCCS. I have accepted the data without audit and have relied upon AHCCCS for the accuracy of the data.

In my opinion, the assumptions used in developing the non-benefit cost proposal for RFP YH19-0001 are actuarially sound for the purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan 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 under 42 CFR § 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial Standards of Practice (ASOP) applicable to Medicaid managed care rate setting: ASOP 5 (Incurred Health and Disability Claims), ASOP 23 (Data Quality), ASOP 25 (Credibility Procedures), ASOP 41 (Actuarial Communications), ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies) and ASOP 49 (Medicaid Managed Care Rate Development and Certification).
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.

For the purposes of this attestation, and consistent with the requirements under 42 CFR § 438.4(a), "actuarial soundness" is defined as in ASOP 49:

> *"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."*

_____ January 24, 2018

Jason Strandquist, FSA Date

Member, American Academy of Actuaries

APPENDIX 1: Administrative Expense Projection -
Mercy Care Historical Data Methodology

State of Arizona
Arizona Health Care Cost Containment System
AHCCCS Complate Care RFP
CYE 2019 Administrative Expense Development
Historical Expense Methodology

	Calendar Year 2017		Annual	Inflation	Inflation	Bid MM	ACC Program Changes		Contract Year Ending 2019	
	MMs	PMPM	Inflation	Factor	Adjst'd PMPM	Volume Adj	Add BH	Add CRS	Bid MMs	PMPM
Mercy Care										
Fixed Expenses		$ 3.81	1.0%	1.0175	$ 3.87					
Variable Expenses		18.49	2.0%	1.0352	19.14					
Unaccepted Encounters		2.82	(8.0%)	0.8644	2.44					
Total	**4,549,599**	**$ 25.11**			**$ 25.45**					
Maricopa/Central GSA										
Fixed Expenses		$ 2.67	1.0%	1.0175	$ 2.72	1.2873	1.0000	1.0000		$ 3.50
Variable Expenses		18.75	2.0%	1.0352	19.42	1.0000	1.0163	1.0080		19.89
Unaccepted Encounters		2.82	(8.0%)	0.8644	2.44	1.0000	1.0000	1.0000		2.44
Total	**4,080,653**	**$ 24.25**			**$ 24.57**				**3,170,000**	**$ 25.83**
Pima/South GSA										
Fixed Expenses		$ 13.66	1.0%	1.0175	$ 13.90	0.2877	1.0000	1.0000		$ 4.00
Variable Expenses		16.14	2.0%	1.0352	16.71	1.0000	1.0261	1.0089		17.30
Unaccepted Encounters		2.82	(8.0%)	0.8644	2.44	1.0000	1.0000	1.0000		2.44
Total	**468,946**	**$ 32.62**			**$ 33.05**				**1,630,000**	**$ 23.74**
					South GSA PMPM	**Conversion to North GSA**				
North GSA										
Fixed Expenses	Not applicable since Mercy Care is not currently operating in the North GSA.				$ 4.00	1.1250				$ 4.50
Variable Expenses					17.30	1.0227				17.69
Unaccepted Encounters					2.44	1.0000				2.44
Total					**$ 23.74**				**990,000**	**$ 24.63**

APPENDIX 2: Administrative Expense Projection -

Staffing Model Projections

State of Arizona
Arizona Health Care Cost Containment System
AHCCCS Complate Care RFP
CYE 2019 Administrative Expense Development
Staffing Model Methdology

	GSA		
	Central	**South**	**North**
Member Months to Use for Bidding	3,170,000	1,630,000	990,000

Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 25.39	$ 27.39	$ 30.20
Unaccepted Ecnounters	2.44	2.44	2.44
Total Non-Benefit Costs (excluding UW Gain)	**$ 27.83**	**$ 29.83**	**$ 32.64**