Arizona Long Term Care System (ALTCS), Elderly and Physically Disabled (EPD) Updated Actuarial Memorandum

I. Purpose

This memorandum presents a discussion of the revision to the already approved Contract Year Ending 2015 (CYE 15) EPD capitation rates. Please see Attachment A for the actuarial memorandums of the already-approved EPD 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) and a requirement to cover incontinence briefs in order to prevent skin breakdown for adults in the ALTCS program.

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.

On December 15, 2014, the United States Supreme Court refused to hear AHCCCS' appeal of the Court of Appeals decision in *Alvarez v. Betlach* which upheld coverage of incontinence briefs for preventive purposes in the lawsuit brought by several adult ALTCS members. As a result of the Supreme Court action, incontinence briefs for ALTCS members age 21 years and older are covered when medically necessary for preventive purposes.

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. 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.

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 integration of services in the Children Rehabilitative Services (CRS) program

The adjustments made to account for each of these unique situations are described below:

- 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 integration model necessitated a reassignment of historical encounter and member month data for members moved to the integrated program

The estimated six month impact to the EPD program is an increase of approximately $821,000.

Incontinence Briefs

AHCCCS is adjusting capitation rates effective April 1, 2015, while including an assumption for new utilization going back to December 15, 2014 in its adjustment. The utilization assumption is based on the distribution of EPD members by gender and age group, and an assumed prevalence rate of incontinence among members of each gender and age group. The prevalence rate assumptions begins with CYE 13 membership and encounter data for members age 18-20 who were already receiving a similar benefit and adjusts for older age groups as illustrated by the Urological Diseases in America (UDA) Project. The total rate impact assumes that the full benefit will be used by each member who is projected to utilize. The utilization assumption includes an adjustment for membership growth during CYE 14 and CYE 15. The unit cost assumption considers CYE 13 encounter data for members age 18 to 20 as described. The estimated six month impact to the EPD program is an increase of approximately $5.23 million.

IV. Proposed Revised Capitation Rates and Their Impacts

Table I below summarizes the changes from the current approved CYE 15 capitation rates and the estimated budget impact, effective for the period April 1, 2015 through September 30, 2015 on a statewide basis. The adjustments impact Contractors ranging from 1.1% to 1.3%. Individual Contractor capitation rates will be impacted as shown in Section B of the Contracts.

Table I: Proposed Capitation Rates and Budget Impact

Rate Cell	EPD Prospective - Dual	EPD Prospective - Non-Dual	PPC	Acute Only	Total
CYE 15 Projected MMs (4/1/15 - 9/30/15)	133,052	25,046	5,714	2,450	
CYE 15 Rate (10/1/14)	$2,922.95	$4,666.42	$956.48	$503.79	
CYE 15 Rate (4/1/15)	$2,961.83	$4,697.93	$989.48	$542.68	
Estimated CYE 15 Capitation (10/1/14 Rates)	$388,904,085	$116,873,865	$5,465,264	$1,234,262	$512,477,476
Estimated CYE 15 Capitation (4/1/15 Rates)	$394,077,079	$117,662,940	$5,653,814	$1,329,541	$518,723,374
Dollar Impact on CYE15 estimated current capitation	$5,172,994	$789,076	$188,550	$95,279	$6,245,898
Percentage Impact on CYE 15 estimated capitation	1.3%	0.7%	3.4%	7.7%	1.2%

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 six-month period beginning April 1, 2015.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the Program Contractors and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the Program Contractors' 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 EPD program, Medicare and Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS 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 *02/12/2015*

Matthew C. Varitek Date

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

ATTACHMENT A

Arizona Long Term Care System (ALTCS), Elderly and Physically Disabled (EPD) Actuarial Memorandum

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD) capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

Arizona Health Care Cost Containment System (AHCCCS) intends to update these capitation rates quarterly on a retroactive basis to reflect enhanced payments to nursing facilities.

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.

The Affordable Care Act (ACA) places an annual fee on the health insurance industry nationwide including most Medicaid health plans effective January 1, 2014. The fee will be allocated to health insurers based on their respective market share of premium revenue in the previous year. Due to the uncertainty of the actual fees and other unknowns, AHCCCS will not be adjusting the capitation rates for this fee at this time, but intends to make retroactive capitation rate revision once the impacts are known.

II. Overview of Rate Setting Methodology

The contract year ending 2015 (CYE 15) rates were developed as a rate update from the CYE 14 rates approved by CMS. These rates represent the twelve month contract period October 1, 2014, through September 30, 2015.

The assumed trend rates were developed from EPD encounter data for CYE 11, CYE 12 and CYE 13. This encounter data was made available to AHCCCS' actuaries via an extract that provides utilization and cost data, referred to as the "databook". Claims' costs for all categories of service were then adjusted to reflect program changes and reimbursement reductions that were effective subsequent to the experience periods used, and the May 2012 termination of the EPD contract with the Senior Care Action Network (SCAN) health plan in Maricopa County. Prospective capitation rates for CYE 15 are built up separately for members who are dually eligible for Medicare and Medicaid ("duals") and members who are not eligible for Medicare ("non-duals"). The databook contained the information necessary to distinguish duals from non-duals. The dual and non-dual prospective capitation rates are actuarially sound, as are the rates for the Prior Period Coverage (PPC) and Acute Care Only rate cohorts. Those cohorts are not split out into dual and non-dual rates.

Other data sources used in setting the actuarially sound rates and ranges include health plan financial statements, projected changes in the home and community based services (HCBS) placement, and cost of living adjustment (COLA) figures from the Social Security Administration for use in updating the share of cost (SOC) projection for members placed in nursing facilities.

Trend rates were calculated from the databook and other sources on a unit cost and/or utilization basis by category of service (COS). For more information on trends see Section IV Projected Trend Rates.

Ideally, the experience data should be analyzed by different rate cells which are comprised of members with similar risk characteristics. However, segregating the ALTCS population into different rate cells would lead to a statistical credibility problem due to the statewide dispersion of the relatively small membership base. The ALTCS program has four rate cells: a prospective dual rate, a prospective non-dual rate, a prior period coverage (PPC) rate and an Acute Care Only rate. Capitation rates for the ALTCS population do not differ by gender and/or age, but do differ by Geographical Service Area (GSA).

The experience data includes only ALTCS Medicaid eligible expenses for ALTCS Medicaid eligible individuals, as well as reinsurance amounts. The Prior Period Coverage (PPC) rates are reconciled to a maximum 5% profit or loss.

The general process in developing the prospective rates involves:

- trending the CYE 14 projected capitation gross costs PMPM for nursing facility (NF) and HCBS components to the midpoint of the effective period, which is April 1, 2015, and applying the projected mix percentage;
- projecting the CYE 15 gross costs PMPM for acute care;
- making adjustments for share of cost offsets, provider reimbursement changes and program changes;
- applying a deduction of the reinsurance offsets;
- adding the projected case management, administrative expenses, risk/contingency and premium tax to the projected claim PMPMs to obtain the capitation rates.

Each step is described in the sections below. There are also separate sections describing the PPC population and the Acute Care Only population.

III. Gross Costs PMPM by Category of Service

For NF and HCBS components AHCCCS used the gross costs PMPM from the CYE 14 capitation rates and trended those components forward one year to develop the CYE 15 projected gross costs. For the acute component AHCCCS used actual CYE 13 encounter data, with completion factors, and trended that component forward two years to develop the CYE 15 projected acute component gross cost. The encounter data was reviewed and audited for accuracy, timeliness and completeness through encounter validation studies as well as studies comparing the encounter data to the Contractors' financial statements.

IV. Projected Trend Rates

The trend calculation is based on the time period from October 1, 2010 through September 30, 2013. The claim PMPMs were computed on a yearly basis and a trend factor was calculated. Trend factors are built up separately for dual, non-dual, and PPC. Trend factors also vary by COS. The trend rates developed were used to bring the base encounter data and gross cost projections from previous periods to the effective midpoint of the contract year.

The trend rates used in projecting the claim costs by rate cell and category of service are identified in Table I. The trend rates shown below in Table I do not include AHCCCS FFS provider rate changes.

Table I: Average Annual Trend Rate before Mix and SOC

	NF	HCBS	Acute
Prospective Dual	2.1%	-3.3%	3.1%
Prospective Non-Dual	2.2%	0.6%	2.2%
PPC	9.5%	-5.0%	31.2%

V. Projected Gross Claim PMPM

The contract period for CYE 15 rates is October 1, 2014, through September 30, 2015, so the midpoint is April 1, 2015. The claims' PMPMs from the base data were trended to the midpoint of the CYE 15 rate period.

VI. Mix Percentage

The CYE 15 dual and non-dual mix percentages are set using a combination of current placement percentages, program growth/saturation and the number of ALTCS members. These sources were reviewed by Contractor and by county. The HCBS mix percentages can be found in Table II.

Table II: HCBS Mix Percentages (Dual and Non-Dual)

			CYE14 HCBS Mix		CYE15 HCBS Mix	
GSA	County	Plan	Dual	Non-Dual	Dual	Non-Dual
40	Pinal/Gila	Bridgeway	74.23%	82.30%	75.71%	81.56%
42	LaPaz/Yuma	UHC LTC	61.79%	74.95%	65.24%	75.36%
44	Apache/Coconino/Mohave/Navajo	UHC LTC	67.77%	76.62%	68.07%	77.27%
46	Cochise/Graham/Greenlee	Bridgeway	59.28%	73.50%	58.83%	74.99%
48	Yavapai	UHC LTC	62.12%	79.11%	64.50%	79.37%
50	Pima/Santa Cruz	UHC LTC	74.72%	83.53%	75.19%	83.36%
50	Pima	Mercy Care	66.00%	71.16%	65.63%	69.65%
52	Maricopa	Bridgeway	77.49%	75.65%	78.52%	77.72%
52	Maricopa	UHC LTC	69.98%	78.48%	72.17%	79.37%
52	Maricopa	Mercy Care	74.12%	81.41%	73.67%	79.92%
Statewide Total			71.94%	79.11%	72.41%	78.71%

VII. State Mandates, Court Ordered Programs, Program Changes and Other Changes

NF and HCBS Provider Rate Changes
A 2% rate increase for NF service providers was included in the federal fiscal year 15 appropriation with an effective date of October 1, 2014.

A 2% rate increase with an effective date of October 1, 2014 for HCBS service providers was included due to a variety of factors impacting HCBS providers. As the economy continues to improve, HCBS providers will have increased challenges attracting individuals to work in direct care, which is more demanding both from a training and day-to-day work basis than jobs that pay comparable salaries. New federal mandates are also adding financial pressure for providers. The U.S. Department of Labor has passed new requirements related to payment for home care workers when traveling between patients, as well as overtime protections and compensation. In addition, the ACA employer mandate, which increases costs for the smaller HCBS providers, becomes effective January 1, 2015. These rates will help to continue the availability of HCBS services for AHCCCS members by supporting the HCBS provider network; these services are less expensive than the institutional services that would otherwise be required.

The unit cost (inflation) trends were adjusted appropriately for these changes. The estimated statewide impact is an increase of approximately $17.8 million.

Other Provider Rate Changes
Effective October 1, 2014, AHCCCS is changing FFS provider rates for certain providers based either on access to care needs, Medicare fee schedule rates, and/or legislative mandates. Arizona Department of Health Services (ADHS) implemented a 2% provider rate increase effective October 1, 2014 for multiple community-based, inpatient and residential services, but excluding transportation, laboratory and radiology, pharmacy, and electro-convulsive therapy services. The unit cost (inflation) trends were adjusted appropriately for these changes. The estimated statewide impact is an increase of approximately $0.1 million.

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 percentage of the amounts prescribed 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 impact to the EPD program is an increase of approximately $0.7 million.

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 (see section VIII for additional information on those changes). The estimated, combined impact of both the methodological and reinsurance change to the EPD program is a decrease of approximately $0.4 million.

Hepatitis C – Sovaldi and New Hepatitis C Drugs
The Food and Drug Administration (FDA) approved Sovaldi, a treatment option for hepatitis C, in December 2013. Sovaldi has the potential to positively impact the care and outcomes for certain Hepatitis C-positive individuals, but it also has significant financial implications. New Hepatitis C drugs are anticipated to be released in the fall of 2014. The estimated impact to the EPD program is an increase of approximately $1.2 million.

Medically Preferred Treatment Options
Effective October 1, 2014, AHCCCS will provide medically necessary orthotics services that are recognized as a preferred treatment option and are less expensive than other treatment or surgical options. More specifically, AHCCCS will reinstate orthotics instead of imminent surgery, or as necessary as a result of surgery, with prescribed criteria. There is no impact to rates as these orthotics are offered in place of more costly interventions.

In-Lieu of Services
Included in the base rates is funding for "in lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. State approved FFS rates at inpatient non-specialty hospitals are approximately 93.5% more expensive than those provided in alternative inpatient settings. The proposed capitation rates allow for the provision of services in alternative inpatient settings that are licensed by Arizona Department of Health Services/Arizona Licensing Services/Office of Behavioral Health License, in lieu of services in an inpatient non-specialty hospital, thus no increase to cap rates is included.

Primary Care Provider (PCP) Payment Increase
Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act, requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. The AHCCCS managed care model, with strict requirements regarding actuarially-sound capitation rates, necessitates that Contractors be funded for expected cost increases due to primary care rate parity. AHCCCS proposes to provide Contractors the necessary funds to increase primary care payments by using Model 3: Non-risk Reconciled Payments for Enhanced Rates

as referenced in the *Medicaid Managed Care Payment for PCP Services in 2013 and 2014, Technical Guidance and Rate Setting Practices* (Technical Guidance) document released by CMS.

In summary, under Model 3, prospective capitation rates would not be adjusted for the enhanced primary care payments. Rather, AHCCCS would query actual encounter data on a quarterly basis to calculate the total payments that eligible providers were paid for eligible services in order to reach the mandated enhanced payment rates. Once the data on this report is verified, AHCCCS would pay the Contractors the calculated additional payment amounts. A more detail explanation of the process and methodology can be found in the Actuarial Certification submitted March 2013 to CMS for approval of AHCCCS methodology. There is no impact to the CYE 15 capitation rates.

VIII. Projected Net Claim PMPM

The NF and HCBS projected gross claim PMPMs were adjusted for the mix percentages. The projected gross claims PMPMs were then discounted for the recipients' Share of Cost (SOC). The SOC component is fully reconciled with each Contractor. To develop the reinsurance offset PMPM AHCCCS used actual CYE 13 reinsurance payment data and trended forward two years using the trend assumption from the acute component of the capitation rates. Additional changes to the reinsurance offset were necessary due to the change in the DRG method of payment which will no longer allow Contractors to split inpatient encounters in most cases. Appropriate adjustments to the reinsurance offsets were made to accommodate this as well as the impact of the move to the DRG method. The calculation of the reinsurance offset PMPM was performed separately for dual and non-dual members.

IX. 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 to SFY 2014, encounter-reported COB cost avoidance grew by greater than 258%, from $130 million to $466 million. Additionally, ALTCS EPD Contractors cost-avoided $56 million in the nine months ending March 31, 2014, in additional claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

X. Case Management, Administrative Expenses and Risk Contingency

The Case Management rates represent the amounts built into the CYE 14 rates, adjusted for changes in the expected HCBS mix, and further adjusted to reflect hiring of additional case managers to reduce caseloads. This caseload adjustment reflects a more appropriate staffing assignment for the needs of the existing membership than the current requirements which were established over 20 years ago. The administrative expenses represent rates awarded as part of the RFP process. The risk contingency percentage remains the same as CYE 14 at 1%.

XI. Proposed Capitation Rates and Their Impacts

The proposed capitation rates for the EPD population equal the sum of the projected net claim PMPM (in Section VIII) and the projected case management, administrative expenses and risk contingency PMPM (in section X) divided by one minus the two percent premium tax. Tables IIIa and IIIb show the proposed dual and non-dual capitation rates for the EPD population statewide.

Table IIIa: Statewide Projected Net Capitation PMPM EPD - Dual

Service Category	Gross CYE14 Rate	Mix	Net CYE14 Rate	Pct Gross Change	Pct Net Change	Gross CYE15 Rate	Mix	Net CYE15 Rate
Nursing Facility (NF)	$5,718.75	28.10%	$1,607.03	4.2%	2.3%	$5,957.98	27.59%	$1,643.79
Share of Cost			($251.51)		1.2%			($254.53)
Net Nursing Facility			$1,355.52		2.5%			$1,389.26
Home/Community (HCBS)	$1,429.31	71.90%	$1,027.66	-1.4%	-0.7%	$1,409.23	72.41%	$1,020.43
Case Management			$113.73		6.2%			$120.78
Acute Care net of Reinsurance			$130.73		6.4%			$139.07
Administration			$165.88		0.0%			$165.88
Risk Contingency			$28.66		1.4%			$29.06
Premium Tax			$57.60		1.5%			$58.46
Net Capitation PMPM			$2,879.76		1.5%			$2,922.95

Table IIIb: Statewide Projected Net Capitation PMPM EPD - Non-Dual

Service Category	Gross CYE14 Rate	Mix	Net CYE14 Rate	Pct Gross Change	Pct Net Change	Gross CYE15 Rate	Mix	Net CYE15 Rate
Nursing Facility (NF)	$7,063.07	20.88%	$1,474.63	4.5%	6.5%	$7,378.48	21.29%	$1,570.76
Share of Cost			($32.36)		1.2%			($32.75)
Net Nursing Facility			$1,442.27		6.6%			$1,538.02
Home/Community (HCBS)	$1,784.08	79.12%	$1,411.60	2.5%	2.0%	$1,829.48	78.71%	$1,440.01
Case Management			$114.33		6.1%			$121.30
Acute Care net of Reinsurance			$1,397.89		-10.0%			$1,258.80
Administration			$163.08		0.0%			$163.08
Risk Contingency			$50.01		3.7%			$51.88
Premium Tax			$93.45		-0.1%			$93.33
Net Capitation PMPM			$4,672.63		-0.1%			$4,666.42

Note: The product of the gross NF or HCBS rate and mix percentages as shown may not equal the net rate due to rounding.

XII. Acute Care Only Members

As in prior years, for members who are only eligible for acute care services in the ALTCS program, Contractors will be paid the combined acute care component plus the case management and administrative components. Since the reinsurance policy is the same for these members as for the other ALTCS members, the same reinsurance offset is appropriate.

XIII. Prior Period Coverage (PPC) Rates

PPC rates cover the period of time from the effective date of eligibility to the day a member is enrolled with the Contractor. There is no PPC capitation for members enrolled with the Contractor who are initially found eligible for AHCCCS through hospital presumptive eligibility. These members will receive coverage of services during the PPC period through AHCCCS fee for service. AHCCCS developed the CYE 15 PPC rates by applying a trend factor to the CYE 14 rates. The trend calculation is based on the time period from October 1, 2010 through September 30, 2013. Due to the relatively short PPC enrollment period and low member month counts, AHCCCS' actuaries combined geographic regions in order to enhance statistical credibility when needed. Since PPC costs are highly volatile and unable to be managed by the Contractors, AHCCCS limits the magnitude of the rate change for each geographic area. PPC rates are reconciled to a five percent profit/loss corridor.

XIV. Proposed Capitation Rates and Budget Impact

Table IV includes the net capitation rates on a statewide basis for all rate cells as well as the estimated budget impact based off of CYE 15 projected member months. The adjustments impact Contractors ranging from -0.7% to +2.8%. Appendix I shows EPD rates by geographical service area and Contractor.

Table IV: Proposed Capitation Rates and Budget Impact

Rate Cell	EPD Prospective - Dual	EPD Prospective - Non-Dual	PPC	Acute Only	Total
CYE 15 Projected MMs	264,966	49,877	11,380	4,879	
CYE 14 Rate (10/1/13)	$2,879.76	$4,672.63	$898.10	$514.45	
CYE 15 Rate	$2,922.95	$4,666.42	$956.48	$503.79	
Estimated CYE 14 Capitation	$763,038,885	$233,057,548	$10,220,062	$2,509,996	$1,008,826,491
Estimated CYE 15 Capitation	$774,481,550	$232,748,010	$10,884,368	$2,457,967	$1,020,571,894
Dollar Impact on CYE14 estimated current capitation	$11,442,664	($309,538)	$664,306	($52,029)	$11,745,403
Percentage Impact on CYE 14 estimated capitation	1.5%	-0.1%	6.5%	-2.1%	1.2%

XV. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.1.0: Overview of rate setting methodology

AHCCCS is performing a rate update from the previously approved contract year ending 2014 (CYE 14) rates under 42 CFR 438.6(c). Please refer to Section II.

AA.1.1: Actuarial certification

Please refer to Section XVI.

AA.1.2: Projection of expenditure

Please refer to Section XIV.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

AA.1.5: Risk contract

The contract is an at risk contract.

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to the providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Critical Access Hospitals (CAH). GME is paid in accordance with state plan. DSH and CAH payments are paid in accordance with Waiver Special Terms and Conditions. None of the additional payments to the providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Sections III, IV, VI, VII, VIII, XII, and XIII.

XVI. 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 twelve-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 the Program Contractors and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the Program Contractors 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 EPD program, Medicare and Medicaid eligibility rules and actuarial rating techniques. It is intended for AHCCCS 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 *08/27/2014*

Matthew C. Varitek Date

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

Appendix I

GSA	County	Contractor	EPD Dual	EPD Non-Dual	Acute Only	PPC
40	Pinal/Gila	Bridgeway	$3,020.46	$4,209.26	$451.39	$1,049.28
42	LaPaz/Yuma	UHC LTC	$2,875.00	$4,243.04	$468.40	$1,049.28
44	Apache/Coconino/Mohave/Navajo	UHC LTC	$2,537.80	$4,692.61	$466.02	$1,049.28
46	Cochise/Graham/Greenlee	Bridgeway	$3,060.60	$3,833.36	$409.20	$1,049.28
48	Yavapai	UHC LTC	$3,096.34	$4,436.63	$374.05	$1,049.28
50	Pima/Santa Cruz	UHC LTC	$2,819.64	$3,843.92	$280.67	$781.05
50	Pima	Mercy Care	$3,181.00	$4,948.69	$462.35	$781.05
52	Maricopa	Bridgeway	$2,621.35	$5,096.72	$511.31	$958.39
52	Maricopa	UHC LTC	$2,846.92	$4,743.48	$351.71	$958.39
52	Maricopa	Mercy Care	$3,058.00	$4,785.91	$575.84	$958.39