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

July 1, 2018 through June 30, 2019

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

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AHCCCS
Arizona Health Care Cost Containment System

Table of Contents

Introduction and Limitations 1

Section I Medicaid Managed Care Rates 2

1. General Information 4

A. Rate Development Standards 4

i. Rating Period 4

ii. Required Elements 4

(a) Letter from Certifying Actuary 4

(b) Final and Certified Capitation Rates 4

(c) Program Information 4

(i) Summary of Program 4

(A) Type and Number of Managed Care Plans 4

(B) Covered Services 4

(C) Areas of State Covered and Length of Time of Operation 5

(ii) Rating Period Covered 5

(iii) Covered Populations 5

(iv) Eligibility or Enrollment Criteria Impacts 5

(v) Summary of Special Contract Provisions Related to Payment 6

(vi) Retroactive Capitation Rate Adjustments 6

iii. Rate Development Standards and Federal Financial Participation 6

iv. Rate Cell Cross-subsidization 6

v. Effective Dates of Changes 6

vi. Generally Accepted Actuarial Principles and Practices 6

(a) Reasonable, Appropriate, and Attainable Costs 6

(b) Rate Setting Process 6

(c) Contracted Rates 7

vii. Rates from Previous Rating Periods 7

viii. Rate Certification Procedures 7

(a) CMS Rate Certification Requirement for Rate Change 7

(b) CMS Rate Certification Requirement for No Rate Change 7

(c) CMS Rate Certification Circumstances 7

(d) CMS Contract Amendment Requirement 7

B. Appropriate Documentation 7
i. Elements 7
ii. Rate Certification Index 7
iii. Differences in Federal Medical Assistance Percentage 8
iv. Comparison of Rates 8
(a) Comparison to Previous Rate Certification 8
(b) Material Changes to Capitation Rate Development 8
2. Data 9
A. Rate Development Standards 9
i. Compliance with 42 CFR § 438.5(c) 9
B. Appropriate Documentation 9
i. Data Request 9
ii. Data Used for Rate Development 9
(a) Description of Data 9
(i) Types of Data Used 9
(ii) Age of Data 10
(iii) Sources of Data 10
(iv) Sub-capitated Arrangements 10
(b) Availability and Quality of the Data 10
(i) Data Validation Steps 10
(A) Completeness of the Data 12
(B) Accuracy of the Data 12
(C) Consistency of the Data 12
(ii) Actuary's Assessment of the Data 12
(iii) Data Concerns 13
(c) Appropriate Data for Rate Development 13
(i) Not using Encounter or Fee-for-Service Data 13
(ii) Not using Managed Care Encounter Data 13
(d) Use of a Data Book 13
iii. Adjustments to the Data 13
(a) Credibility of the Data 13
(b) Completion Factors 13

(c) Errors Found in the Data 14
(d) Changes in the Program 14
(e) Exclusions of Payments or Services 14
3. Projected Benefit Costs and Trends 14
A. Rate Development Standards 14
i. Compliance with 42 CFR § 438.3(c)(1)(ii) and § 438.3(e) 14
ii. Variations in Assumptions 14
iii. Projected Benefit Cost Trend Assumptions 14
iv. In-Lieu-Of Services 14
v. Institution for Mental Disease 15
vi. Section 12002 of the 21st Century Cures Act (P.L. 114-255) 15
B. Appropriate Documentation 15
i. Projected Benefit Costs 15
ii. Projected Benefit Cost Development 15
(a) Description of the Data, Assumptions, and Methodologies 15
(b) Material Changes to the Data, Assumptions, and Methodologies 16
iii. Projected Benefit Cost Trends 16
(a) Requirements 16
(i) Projected Benefit Cost Trends Data 16
(ii) Projected Benefit Cost Trends Methodologies 16
(iii) Projected Benefit Cost Trends Comparisons 16
(b) Projected Benefit Cost Trends by Component 17
(i) Changes in Price and Utilization 17
(ii) Alternative Methods 17
(iii) Other Components 17
(c) Variation in Trend 17
(d) Any Other Material Adjustments 17
(e) Any Other Adjustments 17
iv. Mental Health Parity and Addiction Equity Act Compliance 17
v. In-Lieu-Of Services 17
vi. Retrospective Eligibility Periods 18
(a) Managed Care Plan Responsibility 18

(b) Claims Data Included in Base Data 18
(c) Enrollment Data Included in Base Data 18
(d) Adjustments, Assumptions, and Methodology 18
vii. Impact of All Material Changes 18
(a) Covered Benefits 18
(b) Recoveries of Overpayments 18
(c) Provider Payment Requirements 19
(d) Applicable Waivers 19
(e) Applicable Litigation 19
viii. Impact of All Material and Non-Material Changes 19
(a) Non-Material Changes 19
4. Special Contract Provisions Related to Payment 19
A. Incentive Arrangements 19
B. Withhold Arrangements 19
C. Risk-Sharing Mechanisms 19
i. Rate Development Standards 19
ii. Appropriate Documentation 19
(a) Description of Risk-Sharing Mechanisms 19
(b) Description of Medical Loss Ratio 20
(c) Description of Reinsurance Requirements 20
(i) Reinsurance Requirements 20
(ii) Effect on Development of Capitation Rates 20
(iii) Development in Accordance with Generally Accepted Actuarial Principles and Practices 21
(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset 21
D. Delivery System and Provider Payment Initiatives 21
i. Rate Development Standards 21
ii. Appropriate Documentation 21
(a) Description of Delivery System and Provider Payment Initiatives 21
(i) Description 21
(ii) Amount 22
(iii) Providers Receiving Payment 22
(iv) Effect on Capitation Rate Development 22

(v) Inclusion of Payments in the Capitation Rates 22
E. Pass-Through Payments 22
5. Projected Non-Benefit Costs 23
A. Rate Development Standards 23
B. Appropriate Documentation 23
i. Description of the Development of Projected Non-Benefit Costs 23
(a) Data, Assumptions, Methodology 23
(b) Changes from the Previous Rate Certification 23
(c) Any Other Material Changes 24
ii. Projected Non-Benefit Costs by Category 24
(a) Administrative Costs 24
(b) Taxes and Other Fees 24
(c) Contribution to Reserves, Risk Margin, and Cost of Capital 24
(d) Other Material Non-Benefit Costs 24
iii. Health Insurance Provider's Fee 24
(a) Address if in Rates 24
6. Risk Adjustment and Acuity Adjustments 24
Section II Medicaid Managed Care Rates with Long-Term Services and Supports 25
Section III New Adult Group Capitation Rates 25
Appendix 1: Actuarial Certification 26
Appendix 2: Certified Capitation Rate 28
Appendix 3: Fiscal Impact Summary 29
Appendix 4: Base Data and Base Data Adjustments 30
Appendix 5: Projected Benefit Cost Trends 31
Appendix 6: Projected CYE 19 Gross Medical Expense (GME) by Category of Service 32
Appendix 7: Projected CYE 19 Capitation Rate Development 33

Introduction and Limitations

The purpose of this rate certification is to provide documentation, including the data, assumptions, and methodologies, used in the development of the July 1, 2018 through June 30, 2019 (Contract Year Ending 2019 or CYE 19) actuarially sound capitation rate for Arizona's Comprehensive Medical and Dental Program (CMDP) for compliance with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections. It is noted here for informational purposes that changes to the services covered by the CMDP will take effect on October 1, 2018. Rate development for those and other program and reimbursement changes will be completed and a new actuarial certification submitted for the time frame of October 1, 2018 to June 30, 2019.

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 of 81 FR 27497 applicable to this rate certification, the 2019 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2019 Medicaid Managed Care Rate Development Guide (2019 Guide) describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2019 Guide to help facilitate the review of this rate certification by CMS. Sections of the 2019 Guide that do not apply will be marked as "Not Applicable" and will be included in this rate certification as requested by CMS.

Section I Medicaid Managed Care Rates

The capitation rate included with this rate certification is considered actuarially sound according to the following criteria from 42 CFR § 438.4 at 81 FR 27858:

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
- § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
- § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.

Additionally, the term actuarially sound is defined in Actuarial Standard of Practice (ASOP) 49, "Medicaid Managed Care Capitation Rate Development and Certification," as:

> "Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

As stated on page 2 of the 2019 Guide, CMS will also use these three principles in applying the regulation standards:

- the capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
- the rate development process complies with all applicable laws (statutes and regulations)for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- the documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR Part 438 and generally accepted actuarial principles and practices.

1. General Information

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

A. Rate Development Standards

i. Rating Period

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

ii. Required Elements

(a) Letter from Certifying Actuary

The actuarial certification letter for the CYE 19 capitation rate for the CMDP, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854 and is provided below for reference.

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Mr. Varitek certifies that the CYE 19 capitation rate for the CMDP contained in this rate certification is actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 of 81 FR 27497.

(b) Final and Certified Capitation Rates

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

(c) Program Information

(i) Summary of Program

(A) Type and Number of Managed Care Plans

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

(B) Covered Services

Services covered by the CMDP include physical health services and limited behavioral health services (i.e. treatment for ADHD, anxiety and depression when provided by the member's primary care

physician). Specialty care is currently provided through the Children's Rehabilitative Services (CRS) program to CMDP members who have been diagnosed with a CRS-qualifying health condition. Effective October 1, 2018, those specialty services will be provided through the CMDP. Capitation rates will be amended at that point to reflect this program change.

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

(C) Areas of State Covered and Length of Time of Operation

CMDP was formed in July 1970 by state law under Arizona Revised Statute (A.R.S.) § 8-512. CMDP operates on a statewide basis.

(ii) Rating Period Covered

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

(iii) Covered Populations

The populations covered under the CMDP are children under the age of 18 years of age and who are:

- Placed in a foster home;
- In the custody of DES and placed with a relative, in a certified adoptive home prior to the final order of adoption, or in an independent living program as provided in A.R.S. § 8-512; or
- In the custody of the Arizona Department of Juvenile Corrections or the Administrative Office of the Courts/Juvenile Probation Office and placed in foster care.

Additional information regarding covered populations can be found in the Enrollment and Disenrollment section of the CMDP contract.

(iv) Eligibility or Enrollment Criteria Impacts

AHCCCS operates as a mandatory managed care program and choice of enrollment or auto-assignment is used pursuant to the terms of the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions. AHCCCS will enroll the child with the CMDP and notify the CMDP of the child's AHCCCS enrollment. The CMDP is responsible for timely notification to AHCCCS if a member no longer meets the criteria for the CMDP coverage as set for in A.R.S. § 8-512. Additional information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the CMDP contract.

There are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the populations to be covered under the CMDP during CYE 19.

(v) Summary of Special Contract Provisions Related to Payment

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE 19 capitation rate are:

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

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

(vi) Retroactive Capitation Rate Adjustments

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

iii. Rate Development Standards and Federal Financial Participation

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

iv. Rate Cell Cross-subsidization

The capitation rates were developed as one statewide rate cell.

v. Effective Dates of Changes

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

vi. Generally Accepted Actuarial Principles and Practices

(a) Reasonable, Appropriate, and Attainable Costs

In the actuary's judgment, all adjustments to the capitation rate, or to any portion of the capitation rate, reflect reasonable, appropriate, and attainable costs. To the actuary's knowledge, there are no reasonable, appropriate and attainable costs which have not been included in the rate certification.

(b) Rate Setting Process

Adjustments to the rate or rate range that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4. There are no adjustments to the rate performed outside the rate setting process.

(c) Contracted Rates

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

vii. Rates from Previous Rating Periods

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

viii. Rate Certification Procedures

(a) CMS Rate Certification Requirement for Rate Change

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

(b) CMS Rate Certification Requirement for No Rate Change

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

(c) CMS Rate Certification Circumstances

This section of the 2019 Guide provides information on when CMS would not require a new rate certification, and is not applicable to this certification.

(d) CMS Contract Amendment Requirement

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

B. Appropriate Documentation

i. Elements

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

ii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the section numbers from the 2019 Guide relevant to the CMDP.

iii. Differences in Federal Medical Assistance Percentage

Variations in the assumptions used to develop the projected benefit costs for the covered populations were based on valid rate development standards and not based on the rate of Federal Medical Assistance Percentage (FMAP). The covered populations under the CMDP receive the regular FMAP. The enhanced FMAP amounts for the CHIP do not apply because the CHIP is not a covered population under the CMDP. AHCCCS administers the CHIP through the AHCCCS KidsCare program.

iv. Comparison of Rates

(a) Comparison to Previous Rate Certification

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

(b) Material Changes to Capitation Rate Development

Previous certifications of CMDP capitation rates contained two statewide rate cells. One capitation rate was paid for Prospective member months, and a different capitation rate was paid for Prior Period Coverage (PPC) member months. For the new rating period, only one statewide capitation rate has been developed using all medical expenses, whether incurred during members' PPC or Prospective enrollment status. Accordingly, this capitation rate will be paid monthly for all members regardless of their enrollment status.

2. Data

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

A. Rate Development Standards

i. Compliance with 42 CFR § 438.5(c)

This section of the 2019 Guide provides information related to base data.

AHCCCS has provided validated encounter data and audited annual and unaudited quarterly financial statement data submitted by the CMDP, demonstrating experience for the populations to be served by the CMDP to the actuary developing the capitation rates, for at least the three most recent and complete years prior to the rating period. The actuary is using the most appropriate base data, which is derived from the Medicaid population and this specific program to develop the capitation rate. No exception request is required as the data being used to develop rates is no older than the three most recent and complete years prior to the rating period.

B. Appropriate Documentation

i. Data Request

Since AHCCCS employs their own actuaries, a formal data request was not needed between the AHCCCS Division of Health Care Management (DHCM) Actuarial Team and the State. The AHCCCS DHCM Actuarial Team worked with the appropriate teams at AHCCCS to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) at 81 FR 27858.

ii. Data Used for Rate Development

(a) Description of Data

(i) Types of Data Used

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

- Adjudicated and approved encounter data submitted by the CMDP;
- Additional encounter data submitted by the CMDP and pending adjudication and approval at the time of pulling data from the AHCCCS PMMIS warehouse;
- Enrollment data tied to capitation paid to the CMDP;
- Projected enrollment data;
- Quarterly and annual financial statements submitted by the CMDP;

- Detailed administrative expense data and projections from the CMDP; and
- Supplemental encounter data files for services provided by the CMDP that had not been submitted for processing by the AHCCCS data warehouse.

(ii) Age of Data

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

(iii) Sources of Data

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

(iv) Sub-capitated Arrangements

The CMDP does not have sub-capitated contracts with providers. Therefore, the encounter data does not contain sub-capitated payment amounts.

(b) Availability and Quality of the Data

(i) Data Validation Steps

Guidelines and formats for submitting individual encounters generally follow health insurance industry standards used by commercial insurance companies and Medicare; however some requirements are specific to the AHCCCS program. All encounter submissions are subject to translation and validation using standards and custom business rules (guidelines). Once translation has occurred and the encounters pass validation, they are passed to the AHCCCS PMMIS mainframe and are subject to approximately 500 claims type edits resulting in the approval, denial or pend of each encounter.

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

their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

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

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

As noted in Section I.2.B.ii.(a).(i), AHCCCS adjusted the adjudicated/approved base data to include encounters that were either pending adjudication/approval, or not yet submitted by the CMDP for processing. The adjustments were judged appropriate for multiple reasons:

- The encounter data used in the adjustment contained AHCCCS member IDs, service dates, servicing provider IDs, procedure codes, and paid amounts, so that duplicated amounts could be excluded from the adjustments;
- Because those informational fields were available, AHCCCS was comfortable making adjustments supported by medical expense data rather than an under-reporting factor calculated from high-level financial statements;
- The adjustment was applied to the encounter counts and health plan valued amounts for each incurred month in the base period as determined by the service dates on the encounters. This method of adjustment was more accurate for rate and trend development than estimating future runout by calculating completion factors.

(A) Completeness of the Data

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

(B) Accuracy of the Data

AHCCCS has an additional encounter process which ensures that each adjudicated and approved encounter contains a valid AHCCCS member ID for an individual who was enrolled on the date that the service was provided. The process also checks to ensure that each adjudicated and approved encounter is for a covered service under the state plan and contains the codes necessary to map it into one of the categories of service used in the rate development process.

Through the DHCM Actuarial team review of the encounter data provided from the AHCCCS PMMIS mainframe, we ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 19 capitation rate for the CMDP. Additionally, we ensured that only services covered under the state plan were included.

(C) Consistency of the Data

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

The monthly encounter cycle of the AHCCCS data warehouse ensures that no duplicated encounters exist among the adjudicated and approved encounters. AHCCCS further compared the pended and non-submitted encounters using the member ID, date of service, servicing provider ID, and paid amount to remove duplicated encounters from those sources so that the adjustment to base data, as quantified in the Supplemental Encounter Files column in Appendix 4, would be accurate.

(ii) Actuary's Assessment of the Data

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon encounter data submitted by the CMDP and provided from the AHCCCS PMMIS mainframe as well as the supplemental encounter files provided by the CMDP. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the CMDP and reviewed by the AHCCCS Rates & Reimbursement Team. The AHCCCS DHCM Actuarial Team

did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP and fee schedule impacts, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

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

(iii) Data Concerns

There are no concerns with the data used.

(c) Appropriate Data for Rate Development

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

(i) Not using Encounter or Fee-for-Service Data

As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 19 capitation rate for the CMDP.

(ii) Not using Managed Care Encounter Data

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 19 capitation rate for the CMDP.

(d) Use of a Data Book

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

iii. Adjustments to the Data

The encounter data was adjusted as described in Section I.2.B.ii.(a).(i) for pended and non-submitted encounters. Historical program and fee schedule changes were applied to bring the historical data to current program and reimbursement levels.

(a) Credibility of the Data

No credibility adjustment was necessary.

(b) Completion Factors

Completion factors were not applied due to the inclusion of pended and non-submitted encounters, for which the service unit counts and Health Plan Valued

amounts would have ordinarily been estimated by completion factors calculated using historical runout patterns. The aggregated calendar year 2015, 2016, and 2017 encounter adjustments applied to each category of service are shown in Appendix 4.

(c) Errors Found in the Data

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

(d) Changes in the Program

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

(e) Exclusions of Payments or Services

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

3. Projected Benefit Costs and Trends

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

A. Rate Development Standards

i. Compliance with 42 CFR § 438.3(c)(1)(ii) and § 438.3(e)

The final capitation rate is based only upon services allowed under 42 CFR § 438.3(c)(1)(ii) at 81 FR 27856 and 42 CFR § 438.3(e) at 81 FR 27861.

ii. Variations in Assumptions

Any variation in assumptions for covered populations is based upon valid rate development standards and is not based upon the rate of federal financial participation associated with the covered populations.

iii. Projected Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The actual experience of the covered populations was the primary data source used to develop the projected benefit cost trend assumptions.

iv. In-Lieu-Of Services

Not applicable. In-lieu-of services, as defined in 42 CFR § 438.3(e)(2) of 81 FR 27497, were not used in developing the CYE 19 capitation rate for the CMDP. The CMDP does not have in-lieu-of services. All services provided are covered under the 1115 Waiver, and thus are considered State Plan Services.

v. Institution for Mental Disease

Not applicable. Institution for mental disease (IMD) payments in accordance with 42 CFR § 438.6(e) of 81 FR 27497 are for enrollees aged 21 to 64. The CMDP covers members until age 18. Therefore, no adjustment was made to encounter data or to the capitation rate.

vi. Section 12002 of the 21st Century Cures Act (P.L. 114-255)

Not applicable. This section refers to Medicaid members between the ages of 21 and 64 who received treatment in an IMD. The CMDP has no enrolled members within that age range.

B. Appropriate Documentation

i. Projected Benefit Costs

Appendix 7 contains the projected gross medical expenses PMPM on a statewide basis.

ii. Projected Benefit Cost Development

(a) Description of the Data, Assumptions, and Methodologies

The data described in Section I.2.B.ii.(a) was adjusted to reflect historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The per-member-per-month (PMPM) expenditures for each COS in the base year are trended forward to the midpoint of the effective period of the capitation rate by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a).

As noted in Section I.2.B.ii.(a).(ii), data from calendar year 2017 served as the base for projections to CYE 19 for the capitation rate, while data from calendar years 2015 and 2016 was used in development of trends. The historical encounter data was summarized by calendar year and COS.

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known though health plan

surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding their fee schedules.

Effective October 1, 2018, AHCCCS will be updating provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 19 capitation rate will be adjusted effective as of that date to reflect these fee schedule changes when they are known.

(b) Material Changes to the Data, Assumptions, and Methodologies

The CYE 19 capitation rate is developed as one rate cell based on combined Prospective and PPC encounter data, where the CYE 18 capitation rates were developed as separate Prospective and PPC capitation rates using distinct encounter data. There were no other material changes to the components of the capitation rates or the process of their development.

iii. Projected Benefit Cost Trends

In accordance with 42 CFR § 438.7(b)(2) at 81 FR 27861, this section provides documentation on the projected benefit cost trends.

(a) Requirements

(i) Projected Benefit Cost Trends Data

Please see Section I.2.B.ii.(a) for the types of data that AHCCCS relied upon for developing the projected benefit cost trends for the CMDP.

All data used was specific to the CMDP population.

(ii) Projected Benefit Cost Trends Methodologies

Historical utilization, unit cost and PMPM data, including additions for pended and non-submitted encounters, from calendar years 2015, 2016, and 2017 were organized by incurred year and month and category of service (COS). The three years of data were normalized for historical program and fee schedule changes. Trend rates were developed to adjust the base data (midpoint of July 1, 2017) forward 18 months to the midpoint of the contract period (April 1, 2019). Projected benefit cost trends were based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. No simple formulaic solution exists to determine future trend; actuarial judgment is required. Each category of service was analyzed in the same manner.

(iii) Projected Benefit Cost Trends Comparisons

The projected benefit cost PMPM trends were compared in aggregate to NHE projection of growth in Medicaid spending per capita. The PMPM

trends by COS were also compared to the CYE 18 rate development PMPM trends for the CMDP (aggregated to the CYE 19 categories of service). The actuary judged the overall increase in PMPM trends for all categories of service excluding pharmacy to be reasonable in consideration of current program conditions. The decrease in the pharmacy trend has been analyzed and deemed reasonable due to an observed increase in the percentage of generic drugs among total pharmacy utilization, and ongoing efforts to achieve lower costs for pharmacy services. The utilization and unit cost trends were not compared to prior years due to different methodologies in place for rate development.

(b) Projected Benefit Cost Trends by Component

(i) Changes in Price and Utilization

The trend assumptions were developed by unit cost and utilization. Appendix 5 contains the components of the projected benefit cost trend by COS for the capitation rate.

(ii) Alternative Methods

Not applicable.

(iii) Other Components

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

(c) Variation in Trend

Projected benefit cost trends vary by category of service.

(d) Any Other Material Adjustments

No other material adjustments were made to the trend assumptions.

(e) Any Other Adjustments

No other adjustments were made to the trend assumptions.

iv. Mental Health Parity and Addiction Equity Act Compliance

The AHCCCS DHCM Medical Management Team, the AHCCCS Office of Administrative Legal Services (OALS) Legal Counsel Team, and the AHCCCS Office of the Director, have completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA.

v. In-Lieu-Of Services

Not applicable. In-lieu-of services, as defined in 42 CFR § 438.3(e)(2) of 81 FR 27497, were not used in developing the CYE 19 capitation rates for the CMDP. The CMDP

does not have in-lieu-of services. All services provided are covered under the 1115 Waiver, and thus are considered State Plan Services.

vi. Retrospective Eligibility Periods

(a) Managed Care Plan Responsibility

AHCCCS provides prior period coverage for the period of time prior to the member's enrollment during which the member is eligible for covered services. Prior period coverage refers to the time frame from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the CMDP. The CMDP receives notification from AHCCCS of the member's enrollment. The CMDP is responsible for payment of all claims for medically necessary services covered by the CMDP and provided to members during prior period coverage.

(b) Claims Data Included in Base Data

Encounters delivered during the prior period coverage (PPC) timeframe for each member are included in the base encounter data used for setting the capitation rate.

(c) Enrollment Data Included in Base Data

Member months during the PPC timeframe are included in the base enrollment data used for setting the capitation rate.

(d) Adjustments, Assumptions, and Methodology

Due to the limited number of members in the PPC time frame, a separate PPC capitation rate was not developed and all covered expenses and member months are included in the CMDP capitation rate cell.

vii. Impact of All Material Changes

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

(a) Covered Benefits

There were no material changes to covered benefits or services since the last rate certification related to changes in covered benefits.

(b) Recoveries of Overpayments

There were no adjustments were made to reflect recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d). The AHCCCS DHCM Actuarial Team will be working with the AHCCCS Office of Inspector General (OIG) Team to collect historical and current recoveries of overpayments to determine if adjustments will need to be included in future rate development processes.

(c) Provider Payment Requirements

Adjustments related to provider reimbursement changes are discussed in Section I.3.B.ii.(a). Adjustments related to provider payment requirements are discussed in Section I.4.D of this rate certification.

(d) Applicable Waivers

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

(e) Applicable Litigation

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

viii. Impact of All Material and Non-Material Changes

Documentation regarding all material and non-material changes has been provided above in Section I.3.B.vii.

(a) Non-Material Changes

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

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

Not Applicable. No incentive arrangements exist with the CMDP.

B. Withhold Arrangements

Not Applicable. No withhold arrangement exists with the CMDP.

C. Risk-Sharing Mechanisms

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Risk-Sharing Mechanisms

Not Applicable. In prior years, AHCCCS included a risk corridor on the PPC rate cell due to its volatility and level of uncertainty. For CYE 19, since all Prospective and PPC experience has been combined into one rate cell, no risk corridor will be applied.

(b) Description of Medical Loss Ratio

The contract does not include a remittance/payment requirement for being above/below a specified medical loss ratio (MLR). This section is not applicable.

(c) Description of Reinsurance Requirements

(i) Reinsurance Requirements

AHCCCS provides a reinsurance program to the CMDP for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what one would see in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than the CMDP paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical expense. One could view the reinsurance offset as a premium.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with General Fund for State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the CMDP for covered services incurred above the deductible. The deductible is the responsibility of the CMDP. There has been no change to the deductible or coinsurance factors since the last rate setting period.

The actual reinsurance case amounts are paid to the CMDP whether the actual amount is above or below the reinsurance offset in the capitation rates. This can result in a loss or gain by the CMDP based on actual reinsurance payments versus expected reinsurance payments.

The table in Appendix 7 includes the projected reinsurance payments assumed in the CYE 19 capitation rate.

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

(ii) Effect on Development of Capitation Rates

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical expense PMPM

calculated for the rate setting period. It is a separate calculation and does not affect the methodologies for development of the gross medical capitation PMPM rate.

(iii) Development in Accordance with Generally Accepted Actuarial Principles and Practices

Projected reinsurance offsets are developed in accordance with generally accepted actuarial principles and practices.

(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset

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

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Delivery System and Provider Payment Initiatives

(i) Description

The Differential Adjusted Payment (DAP) initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 10%, depending on the provider type.

(ii) Amount

The total amount of DAP payments before premium tax, admin or underwriting gain included as an adjustment to the capitation rate is approximately $19,500 per calendar quarter ($78,000 annualized) or $0.45 PMPM.

(iii) Providers Receiving Payment

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for a 0.5% increase), other hospitals and inpatient facilities (eligible for a 0.5% increase), nursing facilities (eligible for up to 2% increase), integrated clinics (eligible for a 10% increase on a limited set of codes), physicians, physician assistants, and registered nurse practitioners (all eligible for a 1% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

(iv) Effect on Capitation Rate Development

Funding for DAP is included in the certified capitation rates. The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP was the FFY 16 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the FFY 18 time period, part of which falls within CYE 19 for CMDP rating purposes. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. AHCCCS describes the methodology, data and assumptions related the DAP within the approved 438.6(c) pre-print.

(v) Inclusion of Payments in the Capitation Rates

The DAP amounts included in the CYE 19 rate are shown in Appendix 6. The amounts represent the projected payments by the CMDP to providers in each COS during FFY 18, as described in subsection (iv), divided by the CMDP member months projected for that time period.

E. Pass-Through Payments

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

5. Projected Non-Benefit Costs

A. Rate Development Standards

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

B. Appropriate Documentation

i. Description of the Development of Projected Non-Benefit Costs

(a) Data, Assumptions, Methodology

The CMDP provides AHCCCS with an administrative expense request for funding that details employee compensation, data processing costs, management fees, interest charges, occupancy (rent/utilities), and other administrative expenses. The administrative expense request typically includes the most recent calendar year of administrative expense data and a projection of the administrative expenses for the upcoming contract year. These administrative expense requests are reviewed by AHCCCS for reasonableness by comparing against the financial statements submitted by the CMDP and against previous administrative expense requests. Once the reports are determined to be reasonable by AHCCCS, an administrative expense PMPM is calculated using the appropriate projected member months for the contract year. This is typically the methodology to develop the administrative expenses on a PMPM basis.

The administrative expense request used for the CYE 19 capitation rate for the CMDP included the actual administrative expenses for calendar year 2017 and a projection of administrative expenses for CYE 19. The projection for CYE 19 includes new staffing associated with incorporation of physical health services currently provided to CMDP members through the CRS program, as described in Section I.A.ii.(c)(i)(B). Most of the expenses for the new staffing are allocated to Care Management Expenses as described in subsection (b).

(b) Changes from the Previous Rate Certification

In preparation for future requirements around Medical Loss Ratio (MLR) reporting, DCS staff identified a subset of employees whose job duties entail care management for CMDP members. The projected compensation amount for those employees, as well as a proportional amount of projected expenditures for occupancy and other operating expenditures, is presented in Appendix 7 as "Care Management Expenses PMPM." The remainder of the CMDP's administrative request is shown as "Administrative Expenses PMPM." Note that risk contingency and premium tax are distinguished as separate items in the rate development.

(c) Any Other Material Changes

No other material adjustments were applied to the projected non-benefit expenses included in the capitation rate.

ii. Projected Non-Benefit Costs by Category

(a) Administrative Costs

The administrative component of the CYE 19 capitation rate for the CMDP is described above in Section I.5.B.i.(a). The PMPM amounts assumed can be found in Appendix 7.

(b) Taxes and Other Fees

The CYE 19 capitation rate for the CMDP includes a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. No other taxes, fees, or assessments are applicable for this filing.

(c) Contribution to Reserves, Risk Margin, and Cost of Capital

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

(d) Other Material Non-Benefit Costs

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

iii. Health Insurance Provider's Fee

(a) Address if in Rates

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

6. Risk Adjustment and Acuity Adjustments

This section of the 2019 Guide is not applicable to the CMDP. The CMDP does not utilize risk adjustments or acuity adjustments. This is not anticipated to change.

Section II Medicaid Managed Care Rates with Long-Term Services and Supports

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

Section III New Adult Group Capitation Rates

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

Appendix 1: Actuarial Certification

I, Matthew C. Varitek, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established the Actuarial Standards Board.

The capitation rate included with this rate certification is considered actuarially sound according to the following criteria from 42 CFR § 438.4 at 81 FR 27858:

- § 438.4 (a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4 (b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4 (b) (1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- § 438.4 (b) (2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
- § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
- § 438.4 (b) (5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4 (b) (6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4 (b) (7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b) (8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.

Additionally, the term actuarially sound is Actuarial Standard of Practice (ASOP) 49, “Medicaid Managed Care Capitation Rate Development and Certification,” as:

> “Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected

reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

The data, assumptions, and methodologies used to develop the CYE 19 capitation rate for the CMDP have been documented according to the guidelines established by CMS in the 2019 Guide. The CYE 19 capitation rate for the CMDP is effective for the 12-month time period from July 1, 2018 through June 30, 2019.

The actuarially sound capitation rate is based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rate, I have relied upon data and information provided by AHCCCS and the CMDP. I have relied upon AHCCCS and the CMDP for the accuracy of the data and I have accepted the data without audit, after checking the data for reasonableness and consistency.

SIGNATURE ON FILE	May 15, 2018
Matthew C. Varitek	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rate

Rate Cell	Projected CYE 19 Member Months	Updated CYE 18 Capitation Rate	CYE 19 Capitation Rate	Percentage Impact
Statewide	167,674	$226.52	$279.18	23.2%

The Updated CYE 18 Capitation Rate shown here is an average of the Prospective and PPC capitation rates effective January 1, 2018, weighted by the distribution of Prospective and PPC member months projected for CYE 19.

Appendix 3: Fiscal Impact Summary

Rate Cell	Projected CYE 19 Member Months	Updated CYE 18 Capitation Rate	CYE 18 Projected Expenditures	CYE 19 Capitation Rate	CYE 19 Projected Expenditures	Dollar Impact	Percentage Impact
Statewide	167,674	$226.52	$37,981,653	$279.18	$46,811,198	$8,829,546	23.2%

Appendix 4: Base Data and Base Data Adjustments

Calendar Year 2015					
Service Category	Unadjusted Base Data PMPMs	Reimb Changes	Supplemental Encounter Files	DAP PMPM Removed	Adjusted Base Data
Professional	$78.97	1.0057	1.0001	$0.00	$79.43
Pharmacy	$27.21	1.0000	1.0000	$0.00	$27.21
Dental	$21.18	1.0035	1.0000	$0.00	$21.25
Inpatient & NF	$16.09	1.2799	1.0000	$0.00	$20.59
Outpatient	$24.84	1.0007	1.0000	$0.00	$24.86
Total	**$168.29**	**1.0300**	**1.0001**	**$0.00**	**$173.34**

Calendar Year 2016					
Service Category	Unadjusted Base Data PMPMs	Reimb Changes	Supplemental Encounter Files	DAP PMPM Removed	Adjusted Base Data
Professional	$81.76	1.0054	1.0267	$0.00	$84.39
Pharmacy	$27.58	1.0000	1.0012	$0.00	$27.62
Dental	$20.34	1.0007	1.1954	$0.00	$24.33
Inpatient & NF	$19.20	1.1641	1.3843	-$0.02	$30.92
Outpatient	$15.62	1.0047	1.3749	-$0.02	$21.56
Total	**$164.50**	**1.0268**	**1.1181**	**-$0.04**	**$188.82**

Calendar Year 2017					
Service Category	Unadjusted Base Data PMPMs	Reimb Changes	Supplemental Encounter Files	DAP PMPM Removed	Adjusted Base Data
Professional	$83.32	1.0000	1.1217	-$0.05	$93.41
Pharmacy	$21.73	1.0000	1.0006	$0.00	$21.74
Dental	$25.28	1.0000	1.2796	$0.00	$32.35
Inpatient & NF	$25.14	1.0547	1.1276	-$0.11	$29.79
Outpatient	$17.07	1.0000	1.8666	-$0.08	$31.79
Total	**$172.54**	**1.0075**	**1.2041**	**-$0.23**	**$209.08**

Appendix 5: Projected Benefit Cost Trends

Service Category	Annualized Trend Rates		
	Utilization	Unit Cost	PMPM
Professional	0.0%	5.7%	5.7%
Pharmacy	0.0%	-3.8%	-3.8%
Dental	3.0%	3.4%	6.5%
Inpatient & NF	-2.0%	7.3%	5.2%
Outpatient	4.1%	1.5%	5.7%

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

Service Category	Adj Base Data PMPM	Assumed Trend	DAP Effective 7/1/2018	CYE 19 Proj GME PMPM
Professional	$93.41	5.70%	$0.29	$101.80
Pharmacy	$21.74	-3.80%	$0.00	$20.52
Dental	$32.35	6.50%	$0.00	$35.56
Inpatient & NF	$29.79	5.15%	$0.09	$32.21
Outpatient	$31.79	5.66%	$0.06	$34.59

Appendix 7: Projected CYE 19 Capitation Rate Development

Component	Amount
Gross Medical Expense PMPM	$224.67
Less Reinsurance PMPM	-$9.33
Less TPL PMPM	$0.00
Net Claim Cost PMPM	$215.34
Care Management Expenses PMPM	$17.71
Administrative Expenses PMPM	$37.75
Underwriting Gain PMPM	$2.80
Premium Tax Rate	2.00%
Effective Capitation PMPM	$279.18
Percent Change from 1/1/18 Rates	23.25%