SOLICITATION #:
2017000265

Appendix DD
Rocky Mountain PRIME Capitation Rate Development

April 28, 2016

Shane Mofford
Payment Reform Section Manager
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

PROPRIETARY AND CONFIDENTIAL

Subject: Rocky Mountain PRIME Capitation Rate Development for July 1, 2016 – June 30, 2017

Dear Shane:

Thank you for the opportunity to assist the Department of Health Care Policy and Financing (HCPF) with the development of the Rocky Mountain PRIME Capitation rate ranges. It was a pleasure to work with the HCPF team throughout this project. The following report summarizes the methodology used to develop the Rocky Mountain PRIME capitation rate ranges, effective July 1, 2016 – June 30, 2017. We have also provided our actuarial certification for these rate ranges, compliant with CMS guidelines and requirements. Please contact me if you have any questions. I can be reached at zachary.aters@Optumas.com or 480.588.2495.

Sincerely,

Zachary Aters, ASA, MAAA
Senior Actuary

CC: John Bartholomew, HCPF
Steve Schramm, **Optumas**
Cassie Williams, **Optumas**
Stephanie Taylor, **Optumas**

State of Colorado

Rocky Mountain PRIME Actuarial Certification

July 1, 2016 – June 30, 2017 Capitation Rate Ranges

Table of Contents

1. Background

This report provides documentation and actuarial certification for the Rocky Mountain Health Plan (RMHP) PRIME Program capitation rate range development for rates effective July 1, 2016 – June 30, 2017 (SFY17).

The 1281 Program is a pilot program that began in SFY15. The program covers most adult populations within Regional Care Collaborative Organization (RCCO) Region 1 counties: Mesa, Montrose, Garfield, Gunnison, Pitkin and Rio Blanco. RCCO Region 1 is one of 7 RCCO regions that are part of the Medicaid Accountable Care Collaborative (ACC) in the state of Colorado.

The Medicaid ACC, initiated in the spring of 2011, is a Medicaid program designed to improve the quality and cost effectiveness of health care in Colorado through the use of coordinated, client-centered systems. ACC members receive the full Medicaid benefit package and are assigned to a specific regulated region, called a RCCO. RMHP is RCCO 1 of the 7 medically-managed organizations within the state.

A capitation payment rate range has been developed for the target populations within the RCCO 1 area. The aged, disabled, prenatal and adults with dependent children currently in the RMHP Prepaid Inpatient Health Plans (PIHP) are eligible for the PRIME program. The target population of eligible members also includes expansion adults who qualify on the basis of income, disability and full-benefit Medicaid-Medicare categories. The PRIME Program proposal, included in Appendix I, provides more background on the target populations and services covered under the pilot.

Rocky Mountain proposed the 1281 payment reform pilot in response to the HCPF request for RCCOs to create and implement a pilot program that establishes new payment methodologies in the Medicaid ACC Program. The proposed program included reform initiatives designed to improve health outcomes and quality of care, as well as reduce cost for Medicaid patients. The model covers the full scope of covered physical health services and combines data from HCPF and RMHP for clients in the following adult eligibility groups: OAP-A, OAP-B, AND/SSI, AFDC, Expansion parents (61-133% FPL), BC Women, AwDC, and Adult Buy-in. The idea behind this approach is to achieve sustainability and create continuity of care as members move into managed care.

HCPF requested that **Optumas** set a capitated rate for the PRIME Program under managed care using a full-risk capitated payment model. This model includes risk corridor arrangements surrounding the Adults without Dependent Children (AwDC) and Expansion Parent populations. Additionally, there is an MLR requirement of 89% for the entire program after the risk corridor reconciliation. To the extent RMHP meets certain quality metrics set by HCPF, the 89% MLR requirement has the potential to be reduced to 85%.

As the consulting actuaries to HCPF, **Optumas** ensured that the methodology used to develop the SFY17 PRIME Program rate ranges complied with the Centers for Medicare & Medicaid Services (CMS) guidance, 42 CFR 438.6(c). In addition, the final capitation rates were developed using all of the applicable Actuarial Standards of Practice (ASOPs) and adhere to the 2016 CMS Consultation Guide. Appendix II(B) provides a summary of the guidance with compliance to each section noted.

2. Rate Development Process

2.01 Overview

In developing the SFY17 rate ranges, **Optumas** developed a methodology that adheres to guidance provided by CMS in accordance with 42 CFR 438.6(c), the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

In addition, **Optumas** ensured that all applicable Actuarial Standards of Practice were followed. This includes, but is not limited to:

- ASOP 5 – Incurred Health and Disability Claim
- ASOP 23 – Data Quality
- ASOP 41 – Actuarial Communications
- ASOP 49 – Medicaid Managed Care Capitation Rate Development and Certification

Optumas applied the above criteria within the development of the methodology for calculating capitation rate ranges for the SFY17 contract period. Appendix II(A) provides a brief summary of the CMS rate setting checklist with compliance to each section noted. Appendix II(B) provides a summary of the 2016 CMS Consultation guide with compliance to each section noted.

The base data used to develop the SFY17 PRIME Program rate ranges was comprised of RMHP encounter data with service dates from November 1, 2014 through September 30, 2015, paid through January 2016. This is a major change from the previous rate development cycle where supplemental data, such as ASO, RCCO, and FFS data, was used as the base data, since there was not any actual PRIME experience available.

Capitation data from the same time period was provided by HCPF and used to calculate member months.

The State and **Optumas** worked in partnership to determine the necessary adjustments required to ensure that the adjusted base data was an appropriate proxy for the expected experience in the contract period. These adjustments are presented below in Figure 1.

Figure 1. Rate Development Process Adjustments

Adjustment	Overview
Base Data	Historical data used as the starting point for rate range development.
Mass Adjustment	Adjusts the base data unit cost to reflect the RMHP provider fee schedules and policy changes in effect during the contract period.
IBNR	Estimate of the claims that have been incurred in the base data time period but have yet to be paid.
Provider Sub-Capitations	Incorporates sub-capitated expenditures reported by RMHP outside of the base encounter data.
Supplemental Payments	Accounts for other covered medical expenditures that were processed outside of the encounter data.
ACA 1202 Program Change	Reduction to the ACA 1202 bump which enhanced reimbursement for a set of professional service procedure codes.
FQHC/RHC Repricing	Reprices all FQHC/RHC encounters at the latest encounter rate and accounts for the sub-capitated expenditures for FQHC/RHC services not included in the base data.
Prospective Medical Trends	Accounts for the forecasted change in utilization and unit cost from the base to the contract period.
Copay Adjustment	Removes copayments from the rate development for applicable cohorts and services.
Non-Medical Loading	Administrative load to account for non-medical expenditures incurred by a MCO as well as a profit margin.
Health Insurer Providers Fee	Includes the HIPF for the second half of CY16.

The remainder of this report provides further detail on each of the adjustment categories listed above.

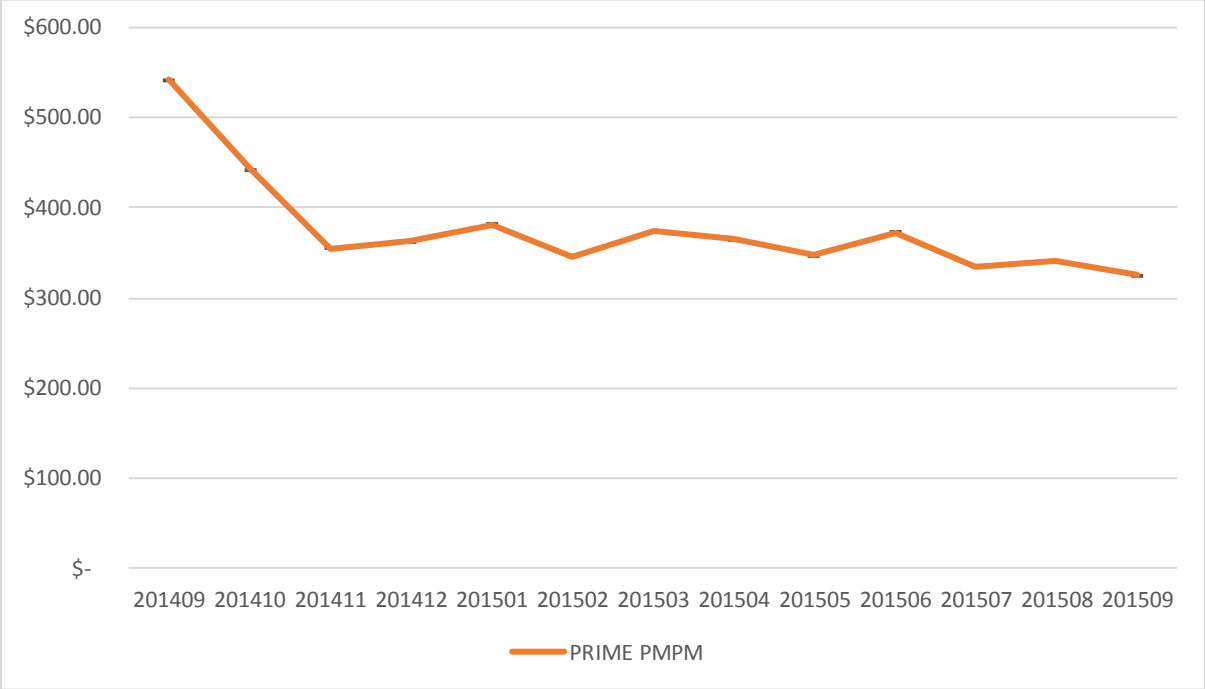
2.02 Base Data

Data Reporting

The base data used for the PRIME Program rate range development is comprised of eleven months of encounter data with incurred dates November 1, 2014 to September 30, 2015, paid through January 2016. **Optumas** used the paid amount plus the copay amount reported on the RMHP encounters as the reimbursement underlying the rate development.

The program started September 1, 2014 however, upon review of the reported encounters for the thirteen months of RMHP emerging encounter data experience, September 1, 2014 – September 30, 2015, **Optumas** identified outliers in the first couple months of the program (See Figure 2 below).

Figure 2. Emerging RMHP Experience – Aggregate PMPM by Month



Enrollment into the PRIME program was done in stages, meaning certain groups of members were enrolled into the program in September 2014, the first month of the program, and others in the remaining months. Specifically, ASO members who are a higher risk population, were the first to enroll in the program, which contributes to the higher costs per member seen in the initial months of the emerging PRIME experience (see Figure 2 above). After discussions with the State and RMHP, it was agreed upon that the underlying population starting in November 2014 is indicative of the risk of the target population moving into the contract period of FY17, therefore the base data time period chosen by **Optumas** as the base data for rate setting is November 2014 – September 2015.

Enrollment data from HCPF's capitation file was used to calculate member months for the same base data time period, November 2014 – September 2015.

To ensure compliance with ASOP 23 – Data Quality, **Optumas** conducted data validation analyses and benchmarked the data to the base data used for prior cycles of PRIME Program rate development as well as to the reported financials for the time period September 2014 to September 2015. Benchmarking the encounters to the reported financial template for the same time periods allowed **Optumas** to ensure that there were no missing encounters.

The data validation analyses included:

1. Referential Integrity Checks – ensured that all encounters included in base data were incurred by a member with a valid capitation that coincided with the incurred date associated with the specific encounter.
2. Volume Checks – **Optumas** checked both volume of encounters and total expenditures by category of service by looking at totals longitudinally. This ensured that any gaps or spikes in the data were identified and addressed before creating the base data.
3. Benchmark Comparison – **Optumas** compared summarized data to other base data summaries used in prior rate setting cycles for RMHP as well as to the reported financials.

Covered Services

The Rocky Mountain PRIME Program covers a range of medically necessary acute care services to the eligible members. The covered medical services are shown in Appendix II(C).

This is the first cycle where the PRIME Program has emerging experience from which to base the rates on. **Optumas** made a few adjustments to the rate cells describing the categories of service the PRIME Program covers. The specific changes to the categories of services consist of:

1. Removal of Non-Emergency Medical Transportation, Skilled Nursing Facility, Hospice, and Dental rate cells since these services are not covered by the PRIME Program.
2. Dialysis and Mental Health/Substance Abuse services are no longer explicitly broken out into their own category of service like they were in the FY16 PRIME certification letter.

Covered Populations

In past rate setting cycles, the data was divided into twelve rate cells. This cycle, the cohorts have been collapsed into nine rating groups as the State of Colorado begins to align all of their managed care programs and create more credible cohorts for the populations with lower membership. The following changes in rating categories of aid have been introduced this rate cycle:

1. The BUYIN cohort has been combined with the AND/AB SSI cohort to bolster credibility since there was very low membership within the BUYIN cohort alone.
2. OAP-A members have been combined into one cohort regardless of Dual status.
3. OAP-B members and AND/AB SSI members are aggregated into either OAP-B & AND/AB SSI Nondual or OAP-B & AND/AB SSI Dual based on their Dual status.

Although combining Dual and Nondual populations introduces mix risk, it is assumed that these populations are stable and that the membership mix will remain constant in the contract period. The purpose of the aggregated rate cells is to group similar risk together in order to create credible and homogenous cohorts that assist in better matching payment to risk with regards to developing capitation rates. Actuarially sound rate ranges are developed for each of the nine rate cells shown in Appendix II(D).

After the base data, service categories, and rating cohorts were finalized, various adjustments, described in the remainder of this document, were made to develop prospective rate ranges and associated payment rates. The base data used to develop prospective rate ranges and associated payment rates is shown in Appendix II(E).

2.03 Mass Adjustment

When setting rates, **Optumas** received two sets of RMHP encounter data extracts. The first was RMHP encounter data prior to an internal RMHP mass adjustment. The second data extract, used as the base data for rate setting, was the encounter data extract after the RMHP mass adjustment was applied. The purpose of the RMHP mass adjustment was to assign encounters a financial amount that reflects the provider fee schedules and all applicable reimbursement policy and program changes effective at the time the services were incurred.

However, the encounters incurred during the first quarter of SFY16, July 2015 – September 2015, were not adjusted to reflect the policy and reimbursement effective at the time. **Optumas** worked closely with RMHP and HCPF to perform the mass adjustment to this portion of the base data in order to reprice the encounters incurred during the first quarter of SFY16 and ensure all of the encounter data was on the same basis before moving forward with rate development.

In order to calculate the impact of the mass adjustment on the July 2015 – September 2015 encounter data, **Optumas** arrayed both the initial RMHP encounter data, prior to any mass adjustment, and the final encounter base data after the mass adjustment, longitudinally by category of aid and category of service. **Optumas** then compared the reimbursement amounts pre and post RMHP mass adjustment. The aggregate impact by category of service for the SFY15 time period was applied to the SFY16 encounter base data. The aggregate impact of the reimbursement adjustment by cohort and the variation by category of service can be seen in Appendix II (F).

2.04 IBNR Adjustment

Estimates for the incurred but not yet reported (IBNR) medical expenditures were developed for the base data after **Optumas** applied the mass adjustment in order to not distort the IBNR estimates by using an outdated reimbursement amount. As previously mentioned, the base data used to develop the PRIME rate ranges was paid through January 2016. IBNR factors are shown in Appendix II(G).

2.05 Provider Sub-Capitations

RMHP provided a supplemental data file which included their sub-capitation amounts by member by month. These sub-capitation amounts are primarily for professional services and FQHC/RHC services.

Optumas reviewed the PMPM rate for sub-capitated contracts as well as the aggregate unit cost of such services after the inclusion of the sub-capitated amounts and considered the amounts reasonable for the services provided. Although RMHP has sub-capitated arrangements for professional as well as FQHC/RHC services, **Optumas** included only the professional services in this adjustment as FQHC/RHC services will be repriced at the most recent encounter rate in a later adjustment.

The impact of adding in the professional sub-capitated amounts are shown in Appendix II(H).

2.06 Supplemental Payments

Optumas reviewed additional medical expenditures that RMHP reported on financials for expenses processed outside of the RMHP encounter data, but incurred during the base data time period. These medical expenditures are for eligible members and include the following types of payments:

1. RMHP payment to HCPF for hospital services that HCPF paid in error due to system issues.
2. Offline RMHP provider payments for contractual variances identified in the capitation payment.
3. Medically qualified quality expenses, such as CPC payments and shared savings.
4. Miscellaneous offline provider payments for doctors on call and case management services.

The additional dollars associated with supplemental payments are shown in Appendix II(I).

2.07 ACA 1202 Program Change

Section 1202 of the Affordable Care Act (ACA) states that certain evaluation and management (E&M) services and immunization administration services provided by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine will be paid at a rate no less than 100 percent of the Medicare rate. Colorado extended the temporary fee increase created by ACA 1202 through SFY16 and removed the corresponding physician type requirement.

The ACA 1202 bump is inherent in the underlying reimbursement of the RMHP base data used for rate setting. Current State policy does not include further continuation of the ACA 1202 fee increase during the contract period, SFY17, at 100% of the Medicare fee schedule. The State instead has selected a subset of the ACA 1202 procedure codes to reimburse at 87.3% of Medicare, while the remaining codes are adjusted back to the SFY15 fee schedule. **Optumas** was provided the applicable fee schedule and adjusted all ACA 1202 procedure codes to either 87.3% of Medicare reimbursement or the SFY15 fee schedule as indicated by the State.

The impact of reducing the enhanced reimbursement for the set of procedure codes affected by the ACA 1202 bump is shown in Appendix II(J).

2.08 FQHC/RHC Repricing

The FQHC/RHC repricing adjustment is applied to account for FQHC/RHC PPS rate changes. **Optumas** adjusted the FQHC/RHC encounter rates inherent in the base data to be commensurate with the rate schedule that will be effective during the contract period. Additionally, the

FQHC/RHC sub-capitated services discussed in Section 2.05 have been repriced at the appropriate encounter rate.

The impact of repricing the FQHC/RHC encounters is shown in Appendix II(K).

2.09 Prospective Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by major service category from the midpoint of the base period to the midpoint of the SFY17 contract period. Annual trend rates are listed in Appendix II(L).

2.10 Copay Adjustment

As mentioned in Section 2.02, **Optumas** used dollar amounts that were inclusive of patient liability in order to capture the true cost of services. This is necessary to ensure that adjustment values that impact the cost of an entire service, such as unit cost trend and public policy reimbursement changes, are applied accurately.

As part of the rate range development, **Optumas** built up the rate range with and without a copay adjustment to account for the populations, such as the Native American population, that are not required to pay copayments. The final rate range developed is the intersection of the upper and lower bound of including and excluding this adjustment. The adjustment across all rating cohorts and categories of service can be found in Appendix II(M).

2.11 Non-Medical Loading

The non-medical load accounts for expenses associated with administration, profit, risk, and contingencies, and is expressed as a percentage of the capitation rate. **Optumas** utilized RMHP's actual reported administrative cost to develop the non-medical load on both a PMPM and percentage basis. **Optumas** identified the risk contingency/profit margin separately, which is a 1.0% load. The resulting non-medical load ranges are listed in Appendix II(N).

2.12 Health Insurer Providers Fee

Optumas worked with the HCPF and RMHP to build in the second half of the CY16 Health Insurance Providers Fee (HIPF) within the rate ranges for SFY17. The 2017 Moratorium on Health Insurance Provider Fee, released by CMS, states that health insurance issuers are not required to pay the HIPF in 2017. Thus, no prospective estimates for a CY17 HIPF have been built into the SFY17 rates. However, the second half of the estimated CY16 HIPF has been incorporated into the SFY17 rates. Because the State chose a single rate per cohort for SFY17, the cost associated with the CY16 fee is spread across the entire fiscal year, even though the fee only applies to the CY16 portion of the fiscal year.

Optumas loaded half of the estimated CY16 HIPF into the rate ranges for the first half of SFY17 (July 1, 2016 – December 31, 2016). Please see the Certification Letter Addendum, dated January 13, 2016, for more information.

In order to calculate the tax amount on a percentage basis, **Optumas** started with RMHP's rates that are effective in CY2015. **Optumas** determined the latest known membership, September 2015, and multiplied the CY15 rates by this membership projection. The results yield an addition to premium of $1,859,045. For RMHP, the amount added to the rates for July 1, 2016 – December 31, 2016 to account for the second half of the CY16 HIPF is $929,522, half of the full addition to premium quoted above. The State will operationalize the HIPF amount as a withhold. Upon receipt of the actual CY16 HIPF owed to the Internal Revenue Service, the State will calculate the actual rate and will reimburse RMHP once the actual membership for FY17 is known.

The overall impact of the HIPF is roughly a 0.6% increase to the rate ranges. The final rates with the HIPF can be seen in Appendix III(B).

2.13 Development of Rate Ranges and Payment Rates

In developing the capitation rates by rate cell, **Optumas** relied on multiple actuarial assumptions. These assumptions are estimates of the impacts of various components of the rate development methodology. Multiple sources of program-specific information, industry information, and in-house proprietary actuarial tools were relied upon to ensure that these assumptions were well-informed, unbiased, and as accurate as possible. Per the CMS rate-setting checklist, **Optumas**' approach to developing actuarially sound rate ranges required a review of all of the assumptions and adjustments used in the rate development process in order to determine PMPM costs at specific points in the rate ranges, including the lower and upper bounds.

The upper and lower bounds of the rate range are intended to represent amounts at which an appropriately managed MCO would be able to meet the access to care and quality of care standards as described in their contract. **Optumas** examined variations in each component of the rate development process to determine these specific points in the range. These variations, examined in isolation as well as in combination, resulted in a series of capitation rates that, when combined, defined the rate ranges.

To develop the rate ranges, **Optumas** varied the utilization trend (+/-1.0%), unit cost trend (+/-1.0%), and administration (+/-1.0%). Additional detail related to the variations can be found in Appendix II(O).

Each assumption was not developed in isolation, but instead were developed to reflect the interaction between actuarial assumptions. For example, if **Optumas** assumed a lower trend then that assumption was coupled with a higher administrative assumption knowing that more medical management efforts would be needed to achieve the lower trend and managed care savings.

As discussed in Section 2.10, **Optumas** developed a rate range both gross and net of copayments, because there are populations that are not required to pay copayments. The final rate range developed is the intersection of the upper bound of the rate range net of copayments and the lower bound of the rate range gross of copayments.

The payment rates and intersection of rate ranges are shown in Appendix III(A).

2.14 Expansion Parent and AwDC Risk Corridor

As a result of the unknown risk level associated with the emerging Expansion Parent and AwDC populations, the State has developed a risk corridor as a risk-mitigation strategy. To the extent that the selected rate, net of the administrative load, is overstated or understated by certain barrier points, dollars would be paid to the MCO from the State or paid back to the State from the MCO respectively. The details of the risk corridor are included in Appendix IV(A)- Appendix IV(C).

3. Actuarial Certification

I, Zachary Aters, Senior Actuary at **Optumas** and Member of the American Academy of Actuaries (MAAA), am certifying the calculation of the rate ranges shown in Appendix III. 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 provided with this certification are considered actuarially sound for purposes of the 42 CFR 438.6(c), according to the following criteria:

- The capitation rate ranges have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rate ranges are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rate ranges meet the requirements of 42 CFR 438.6(c).

Appendix II(A) contains a crosswalk between the CMS rate setting checklist and this certification letter.

The actuarially sound rate ranges that are associated with this certification are effective July 1, 2016 through June 30, 2017 for Colorado's PRIME Program.

The actuarially sound capitation rate ranges are based on a projection of future events. Actual experience will vary from the experience assumed in any rate picked within the rate ranges. The capitation rates offered may not be appropriate for any specific MCO. An individual MCO should review the rates in relation to the benefits that it is obligated to provide to the covered population. The MCO should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit requirements prior to agreeing to contract with the State. The MCO may require rates above, within, or below the actuarially sound rate range associated with this certification.

Should you have questions on any of the above, please feel free to contact me at 480.588.2495 for any additional information.

Sincerely,

Zachary Aters, ASA, MAAA
Senior Actuary

4. Appendices

Appendix I. Rocky Mountain 1281 Initial Proposal Language

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.
Accountable Care Collaborative

Executive Summary

On behalf of our community partners in western Colorado, and throughout the Accountable Care Collaborative, Rocky Mountain Health Plans (RMHP) is pleased to submit the enclosed proposal for a payment reform pilot, pursuant to HB 12-1281 (C.R.S. § 25-5.5-415). We have created a Global Budget, Global Payment, reporting and gainsharing model that 1) encompasses the full scope of covered *physical health, behavioral health and substance use disorder services*; and, 2) aggregates data shared by the Department, the SDAC, the BHO and Rocky Mountain Health Plans – across the entire population below 250 percent of the Federal Poverty Level – without regard to coverage type. This structure will enable the Sponsors to achieve sustainability and create continuity of care as clients transition between Medicaid and private, subsidized coverage (a.k.a. "churn"). The Pilot will operate in seven RCCO 1 counties: **Mesa, Montrose, Delta, Gunnison, Pitkin, Garfield** and **Rio Blanco.**

Budget Neutrality and Savings

Our proposal is unequivocally **budget neutral** and will create **savings** for the Department in both **Year 1** and **Year 2** of the proposed Pilot. Beyond minimum savings attributable to the administrative simplification proposed by RMHP, there is significant additional savings potential for the Department associated with the Sponsors' interventions, logic model, Global Payment and gainsharing model.

The Sponsors' ability to produce budget neutrality and savings for the Department (as well as sustainability for themselves) is grounded upon: 1) An approach to patient activation, behavior change and self-management that reflects a large body of experience and evidence; 2) A logical re-alignment of enrollment, contracts, and payments, as follows:

	Pilot Year 1 (2014)	Pilot Year 2 (2015)	Combined Savings
Minimum Department Savings	$1,714,546	$3,135,668	$4,850,214
Potential Additional Department Savings for Target Population (Gainsharing)	$ 361,302	$ 590,714	$ 952,013
Potential Additional Department Savings in PCCM ("RCCO 1.0")	$2,140,782	$1,694,779	$3,835,561
Total Potential Department Savings	$4,216,630	$5,421,161	$9,637,791

Executive Committee

Principal RCCO partners in this effort include two community mental health centers - Colorado West Regional Mental Health Center and Midwestern Colorado Mental Health Center, both of which have been collaborating actively within the Region 1 RCCO since its inception, with support from Colorado Health Partnerships, the BHO. These partners have formed an **Executive Committee** to provide leadership and oversight for the project, which will also include the following members: a consumer, a Federally-Qualified Health Center (FQHC), a privately-practicing PCMP, a local public health department (LPHA), a hospital and a behavioral health

Executive Summary
Page 2 of 2

integration expert with the University of Colorado Department of Family Medicine (hereinafter referred to as "The Sponsors").

Enrollment and Payment

Target Population – The Target Population includes expansion adults who qualify on the basis of income, disability and full-benefit Medicaid-Medicare categories ("RCCO 2.0"). The Target Population accounts for 16% of the total enrollment in RMHP's existing PIHP agreement.

Broader Population – All other categories will be transitioned into the existing RCCO PCCM structure ("RCCO 1.0"). These categories currently account for 84% of the total population currently enrolled in RMHP's PIHP agreement. The Sponsors' planned interventions will encompass both the Target and the broader population, even though Global Payments will be made only for the Target Population. Consolidation of the PIHP population within the RCCO also assures compliance with the UPL requirement.

Global Payment, Gainsharing and Value - The RCCO will receive full-risk Global Payments from the Department for the Target Population. The Department will spend no more than 100% of FFS for Covered Services, and make lower administrative payments than it does under current contracts. BHO payment and contractual arrangements with the Department will remain unchanged. If actual costs for Covered Services in the Global Budget are lower than payments, 30% of the difference will be returned to the Department. The Sponsors will retain remaining gains - if and only if specific quality metrics are achieved. If costs are reduced but minimum quality targets are not achieved, 100% of the difference between projected and actual costs for Covered Services will be returned to the Department.

Primary Care - PCMPs will receive significantly enhanced PMPM payments, on a risk-adjusted basis, at a baseline equivalent to 125% of Medicaid FFS payments. Payments will be higher for patients with more complex needs to ensure that "cherry picking" does not occur. An additional 5% will be paid, contingent upon meeting quality targets (independently of cost). Further, 30% of any gains between Global Payments to the RCCO and actual costs for Covered Services will be paid to PCMPs. A 5% cost-accountability recoupment will be applied by the RCCO if actual costs exceed targets in the Global Budget for attributed patients. Enhancements above 100% of FFS will be made by RMHP, not financed by the Department through Global Payment.

Community Mental Health - CMHCs will receive direct payments via the RCCO for workforce development, as well as payments from PCMPs (financed by the RCCO, but controlled by the PCMPs) for integrated behavioral health services. Additionally, CMHCs will receive 30% of any gains, as outline above, and will carry risk for failure to achieve performance targets that is proportionate to their total share of the Global Budget.

Specialty Care - In order to ensure appropriate access and coordination, RMHP will make enhanced payments to specialists (equivalent to Medicaid + 30%) through a mix of fee and non-encounter payments for communication and co-management with PCMPs.

ROCKY MOUNTAIN HEALTH PLANS
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Accountable Care Collaborative

Description of Organization

Rocky Mountain Health Plans (RMHP) is honored to serve as the contracting Regional Care Collaborative Organization for Region 1 of the Accountable Care Collaborative (ACC). We fully support the Department's efforts to undertake an innovative approach to Medicaid reform. More importantly, we understand that sustainable reform is possible only through the creation of a collaborative structure, which promotes local leadership and data-driven accountability. RMHP supports the ACC because we know from experience that flexible partnerships among multiple public and private organizations operating with direct accountability to each other, as well as the communities they serve, is necessary to achieve the Triple Aim: better care and better health at lower costs.

Over the past three years, RMHP and several committed leaders have worked to promote a shared vision of *Community Integration*, in which we collectively invest in the development of new skills, tools and operating arrangements that are fundamental to the creation of value for both large purchasers and individual consumers alike. Our core principle in this work is simple: *walk the talk*. By investing in each other, holding ourselves to high standards, learning from our experiences and from others who share our vision, we have been able to create a tremendously valuable community infrastructure, which is essential to the successful execution of the enclosed proposal. This proposal includes:

- **Broad-based practice transformation, collaborative learning and measurement:** RMHP and its partners have been honored to receive national recognition for our role as a Beacon Community sponsor operating under a Cooperative Agreement with U.S. HHS/ONC. Further, in addition to being deemed an *Aligned Payer* within the Comprehensive Primary Care initiative, we are contracted to serve as a technical assistance provider on behalf of the CMS Innovation Center for western Colorado primary care practices – most of which are now also contracted as PCMPs within the ACC.

- **Advanced technology, data aggregation and use at the point of care:** RMHP and local physician groups, hospitals and community agencies have invested in and continue to expand data sharing relationships with Quality Health Network. QHN's infrastructure is producing very powerful results for PCMPs and the RCCO alike, as recently recognized by *Healthcare Informatics* with a 2013 Innovators Award for our work to make advanced patient engagement and risk stratification tools available to Medicaid PCMPs – at the point of care in regular clinical workflows.

- **Payment for behavioral health integration:** RMHP is investing heavily in behavioral health integration, and actively working to promote seamless care for both the body and mind. We recognize that evidence-based supports for *behavior change, patient activation and self-management* must be available to all individuals – not just people -as well as those with mental health diagnoses. As such, we are participating in the SHAPE (Sustaining Health Care across Integrated Primary Care Efforts) payment reform evaluation, in partnership with the Colorado Health Foundation, the Collaborative Family Health Care Association, and the University of Colorado Department of Family Medicine.

None of these efforts, however, will be sustainable without robust payment reform. To that end, we have created a diverse, but focused, **Executive Committee** to oversee implementation of our proposed pilot (as described in detail within the enclosed executive summary, and Attachment I – Business Structure). The Committee will provide monthly monitoring of the proposed Global Budget, and quarterly reports to the Department, with the expectation that our progress will be monitored closely and shared publicly with other stakeholders to accelerate learning throughout the Colorado ACC.

Appendix II. Rate Development Components

Appendix II(A) CMS Checklist

CMS Item #	Subject	Compliance	SFY17 RMHP Capitation Development
Subsection AA. 1 - General			
AA.1.0	Overview of rates being paid under the contract	✓	Appendix III
AA.1.1	Actuarial Certification	✓	Section 3
AA.1.2	Projection of expenditures	✓	This is part of waiver documents.
AA.1.3	Risk contracts	✓	N/A
AA.1.4	Modifications	✓	The rates certified in this report are effective July 1, 2016 to June 30, 2017. No modifications are planned during the rate period.
AA.1.5	N/A	N/A	There is no item AA.1.5 in the CMS Checklist
AA.1.6	Limit on payment to other providers	✓	N/A
AA.1.7	Risk and Profit	✓	Section 2.11
AA.1.8	Family Planning enhanced match	✓	N/A
AA.1.9	Indian Health Service (IHS) Facility enhanced match	✓	N/A
AA.1.10	Newly eligible enhanced match	✓	Expansion populations have their own rating cohorts, Section 2.02.
AA.1.11	Retroactive adjustments	✓	State will adhere to the 2-year stipulation mentioned in the checklist.
Subsection AA. 2 – Base Year Utilization and Cost Data			
AA.2.0	Based only upon services covered under the State plan	✓	The base data has been adjusted to reflect only those services covered in the contract period. See covered services in Section 2.02
AA.2.1	Provided under the contract to Medicaid-eligible individuals	✓	Only populations covered under this program were included in rate setting. See covered populations in Section 2.02

CMS Item #	Subject	Compliance	SFY17 RMHP Capitation Development
AA.2.2	Data sources	✓	Section 2.02
Subsection AA. 3 – Adjustments to the Base Year Data			
AA.3.0	Adjustments to the base year data	✓	Section 2.03 – Section 2.10
AA.3.1	Benefit differences	✓	The base data has been adjusted to reflect only those services covered in the contract period. See covered services in Section 2.02
AA.3.2	Administrative cost allowance calculations	✓	Section 2.11
AA.3.3	Special populations' adjustments	✓	Only populations covered under this program were included in rate setting. See covered populations in Section 2.02
AA.3.4	Eligibility adjustments	✓	Only populations covered under this program were included in rate setting. See covered populations in Section 2.02
AA.3.5	Third Party Liability (TPL)	✓	Section 2.10
AA.3.6	Indian Health Care provider payments	✓	N/A
AA.3.7	DSH payments	✓	N/A
AA.3.8	FQHC and RHC reimbursement	✓	Section 2.08
AA.3.9	Graduate Medical Education (GME)	✓	N/A
AA.3.10	Copayments, coinsurance, and deductibles in capitated rates	✓	Section 2.10
AA.3.11	Medical cost/Trend inflation	✓	Section 2.09
AA.3.12	Utilization adjustments	✓	Section 2.03 – Section 2.10
AA.3.13	Utilization and cost assumptions	✓	Section 2.03 – Section 2.10
AA.3.14	Post-Eligibility Treatment of Income (PETI)	✓	N/A
AA.3.15	Incomplete data adjustment	✓	Section 2.04
AA.3.16	Primary Care Rate Enhancement	✓	Section 2.07
AA.3.17	Health Homes	✓	N/A
Subsection AA. 4 – Establish Rate Category Groupings			
AA.4.0	Establish rate category groupings	✓	Section 2.02
AA.4.1	Eligibility categories	✓	Section 2.02
AA.4.2	Age	✓	Section 2.02

CMS Item #	Subject	Compliance	SFY17 RMHP Capitation Development
AA.4.3	Gender	✓	Section 2.02
AA.4.4	Locality/Region	✓	Section 2.02
AA.4.5	Risk adjustments	✓	N/A
Subsection AA. 5 – Data Smoothing, Special Populations and Catastrophic Claims			
AA.5.0	Data smoothing	✓	Section 2.02
AA.5.1	Cost-neutral data smoothing adjustment	✓	Section 2.02
AA.5.2	Data distortion assessment	✓	Outlier experience was reviewed and population-level distortion was addressed to the extent necessary.
AA.5.3	Data smoothing techniques	✓	Section 2.02
AA.5.4	Risk-Adjustment	✓	N/A
Subsection AA. 6 – Risk Sharing: Stop Loss Limits, Corridors, Reinsurance			
AA.6.0	Stop loss, reinsurance, or risk-sharing arrangements	✓	N/A
AA.6.1	Commercial reinsurance	✓	N/A
AA.6.2	Stop-loss program	✓	N/A
AA.6.3	Risk corridor program	✓	Section 2.14
Subsection AA. 7 – Incentive Arrangements			
AA.7.0	Incentive arrangements	✓	N/A
AA.7.1	Electronic Health Records (EHR) incentive payments	✓	N/A

Appendix II(B) 2016 Managed Care Rate Setting Consultation Guide

Section	Subject	SFY17 RMHP Capitation Development
	Section I. Medicaid Managed Care Rates	
General Information		
	Letter from the certifying actuary	Section 3
	Final and certified capitation rates or rate ranges for all rate cells and regions	Appendix III
	If rate ranges are certified, assurances that the capitation rate for each rate cell is within the certified rate range	Appendix III
	Specific state Medicaid managed care programs covered by certification	Section 2.02
	Rating periods covered by certification	Section 3
	Medicaid populations covered through managed care programs for which the certification applies	Section 2.02
	Any eligibility or enrollment criteria that could have a significant influence on the specific population to be covered within the managed care program	N/A
	General description or list of the benefits that are required to be provided by the managed care plan or plans, particularly noting any benefits that are carved out of the managed care program or that are new to the managed care program in that rating period covered	Section 2.02
Data		
	Types of data used	Section 2.02
	Age or time periods of all data used	Section 2.02
	Sources of all data used	Section 2.02

Section	Subject	SFY17 RMHP Capitation Development
	Description of the data received from subcapitated plans or providers	Section 2.05
	Description of how the historical costs related to subcapitated arrangements were developed or verified	Section 2.05
	Information related to the availability and the quality of the data used for rate development	Section 2.02
	Steps taken by the actuary or others to validate the completeness, quality, and accuracy of the data	Section 2.02
	Summary of the actuary's assessment of the data	Section 2.02
	Any other concerns that the actuary has over the availability or quality of the data	Section 2.02
	If fee-for service claims or managed care encounter data are not used, an explanation of why that data was not used and why the data used in the rate development is appropriate for setting capitation rates for the populations and services to be covered	N/A
	If the managed care program is considered mature and has been in operation for more than three years, but managed care encounter data was not used in the rate development, an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data	N/A
	If there is any reliance or use of a data book in the rate development, the details of the template and relevant instructions used in the data book	N/A
	Rate certification must thoroughly describe any significant adjustments, and the basis for the	

Section	Subject	SFY17 RMHP Capitation Development
	adjustments, that are made to the data, including but not limited to adjustments for:	
	(a) Credibility of the data	Section 2.02
	(b) Completion Factors	Section 2.04
	(c) Errors found in the data	N/A
	(d) Changes in the program between the time period from which the data is obtained and the rating period	N/A
	(e) Exclusions of certain payments or services from the data	N/A
Projected benefit costs		
	Description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs	Section 2.03 – Section 2.10
	Any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last certification must be described	Section 2.02
	Any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions	Section 2.03 – Section 2.10
	Methodologies used to develop projected benefit trends	Section 2.09
	Any comparisons to historical benefit cost trends, or other program benefit costs trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.	Trends are developed by observing historical trends and benchmarking to other states.
	Projected benefit cost trends separated into changes in price and changes in utilization	Appendix II(L)

Section	Subject	SFY17 RMHP Capitation Development
	If the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary must describe and justify the method(s) used to develop projected benefit cost trends	N/A
	Projected cost trends may include other components as applicable and used by the actuary in developing rates	Section 2.09
	Variations in the projected benefit cost trends by Medicaid populations, rate cells, or subsets of benefits within a category of services	Appendix II(L)
	Any material adjustments to projected benefit cost trends, including a description of the data, assumptions, and methodologies used to determine those adjustments	Section 2.09
	Description of any other adjustments to the projected benefit costs trends, including the impact of managed care on the utilization and the unit costs of health care services or changes to projected benefit cost trends in the rating period outside of regular changes in utilization or unit cost of services	N/A
	Categories of service that contain in lieu of services	N/A
	Percentage of costs that in lieu of services represent in each category of service	N/A
	How the in lieu of services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service	N/A
	Describe how retrospective eligibility periods are accounted for in rate development	The base data reflects retroactive time periods consistent with the State's policy.

Section	Subject	SFY17 RMHP Capitation Development
	Clearly document the final projected benefit costs by relevant level of detail	Appendix III
	Clearly document the impact on projected costs for all material changes to covered benefits or services since the last rate certification	N/A
	Estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.	Rates are rebased each contract period.
Pass Through Payments		
	Any amount that the State requires a managed care plan to pay providers	N/A
	Any amount added by the State or any amount required by the State to be added, to the payments from the plans to the providers that is not included in the contracted payment rates between the plans and the providers for a health care service/benefit	N/A
	Description of the pass-through payment	N/A
	Amount of the pass-through payments, both in total and on a per member per month basis	N/A
	Providers receiving the pass-through payments	N/A
	Financing mechanism for the pass-through payment	N/A
	Amount of pass-through payments made to providers in previous years.	N/A

Section	Subject	SFY17 RMHP Capitation Development
	Description of the supplemental payments	Section 2.06
	Total amount of the supplemental payments	Appendix II(I)
	Providers receiving the supplemental payments	Section 2.06
	Methodology that the actuary used to incorporate the supplemental payment into the capitation rates	Section 2.06
	Payment mechanisms associated with incorporating the supplemental payment into the capitation rates	Section 2.06
	Analysis and certification that the payment mechanisms) is consistent with 'Projection Non-Benefit Costs'	Section 2.06
Projected Non-Benefit Costs		
	Description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs	Section 2.11
	Any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification	N/A
	Rate certification must thoroughly describe any significant adjustments, and the basis for the adjustments, that are made to the data, including but not limited to adjustments for:	
	(a) Administrative costs	Section 2.11
	(b) Care coordination and care management	Section 2.11, care coordination is considered part of administrative costs.

Section	Subject	SFY17 RMHP Capitation Development
	(c) Provision for operating or profit margin	Appendix II(N)
	(d) Taxes, fees, and assessments	Section 2.12
	(e) Other material non-benefit costs	N/A
	Non-benefit costs developed as a per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates	Appendix II(N)
	Specifically address how Health Insurance Providers Fee (HIPF) is incorporated into capitation rates	Section 2.12
	If the HIPF is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification	Section 2.12
	Description of how the amount of the HIPF was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known	Section 2.12
	If the HIPF is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee	N/A
	If the capitation rates include benefits as described in 26 CFR 57.2(h)(2)(ix), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed	N/A

Section	Subject	SFY17 RMHP Capitation Development
Rate Range Development		
	Any assumptions for which values vary in order to develop rate ranges	Section 2.13
	Values of each of the assumptions used to develop the minimum, the mid-point or best estimate, and the maximum of the rate ranges	Section 2.13 and Appendix II(O)
	Description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point or best estimate, and the maximum of the rate ranges	Section 2.12 and Appendix II(O)
	Description of other information related to projected benefit costs	N/A
Risk Mitigation, Incentives and Related Contractual Provisions		
	Rate certification and supporting documentation must describe any risk mitigation, incentives, or similar contractual provisions that may affect the rates, rate ranges, or the final net payments to the health plans under the applicable contract.	N/A
	Risk adjustment model(s) being used to calculate risk scores	N/A
	Specific data, including the sources(s) of the data, being used by the risk adjustment model(s)	N/A
	Any changes that are made to the risk adjustment model(s)	N/A
	How frequently the risk scores are calculated	N/A

Section	Subject	SFY17 RMHP Capitation Development
	How the risk scores are being used to adjust the capitation rates	N/A
	Attestation that the risk adjustment model is cost neutral. (See 42 CFR 438.6(c)(1)(C)(iii) and 438.6(c)(3)(iv).)	N/A
	Reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment	N/A
	Risk adjustment or acuity adjustment model(s) being used to calculate acuity adjustment scores	N/A
	Specific data, including the source(s) of the data, being used by the risk adjustment or acuity adjustment model(s)	N/A
	Relationship and potential interactions between the acuity adjustment and the risk adjustment	N/A
	How frequently the acuity adjustment scores are calculated	N/A
	Description of how the acuity adjustment scores are being used to adjust the capitation rates	N/A
	Supporting documentation detailing any other risk-sharing arrangements, such as a risk corridor or a large claims pool	Section 2.14
	Detailed description of, or citation for, the methodology used to calculate the medical loss ratio	Section 1
	Description of the consequences for having a medical loss ratio below the minimum requirements	Section 1
	Provide a detailed description of any reinsurance requirements under the contract associated with the rate certification, including a description of any effect that the reinsurance requirements have on the development of the capitation rates	N/A

Section	Subject	SFY17 RMHP Capitation Development
	Certification that the incentive payments will not exceed 105% of the certified rates being paid under the contract	N/A
	Description of the percentage of the certified capitation rates being withheld through withhold arrangements	N/A
	Estimate of the percentage of the withheld amount through a withhold arrangement that is expected to be returned and the basis for that determination	N/A
	Description of any effect that the incentive or withhold arrangements have on the development of the capitation rates	N/A
Other Rate Development Considerations		
	All adjustments to the capitation rates, or to any portion of the capitation rates, must reflect reasonable, appropriate, and attainable costs in the actuary's judgement and must be included in the rate certification	N/A
	Adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.6(c)	N/A
	Final contracted rates 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	Appendix III
Section II. Medicaid Managed Care Rates with Long-Term Services and Support		

Section	Subject	SFY17 RMHP Capitation Development
Managed Long-Term Services and support		
	For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the actuarial rate certification must provide the information described in Section I of this guidance that is specific to MLTSS	N/A
	Specifically address the following considerations for MLTSS programs or for programs that include MLTSS as part of the covered benefits: (a) Structure of the capitation rates and rate cells or rating categories (b) Structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach.	N/A
	Describe the expected effect that managing LTSS has on the utilization and unit costs of services. The certification must describe any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives	N/A
	Projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification shall describe how the projected non-benefit costs were developed for populations receiving these services	N/A

Section	Subject	SFY17 RMHP Capitation Development
	Provide information on historical experience, analysis, and other sources used to develop the assumptions used for rate setting	N/A
Section III. New adult population capitation rates		
Data		
	Describe any data used to develop new adult group rates	Section 2.02 – Section 2.10
	Any new data that is available for use in 2016 rate setting	Section 2.02
	How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults	Section 2.02
	How actual experience and costs in 2014 and/or 2015 have differed from assumptions and expectations in previous rate certifications	Section 2.02
	How differences between projected and actual experience in 2014 and/or 2015 have been used to adjust the 2016 rates	Appendix III
Projected Benefit Costs		
	Any data and experience specific to newly eligible adults covered in 2014 and/or 2015 that was used to develop projected benefit costs for capitation rates	Section 2.02 – Section 2.10
	Any changes in data sources, assumptions, or methodologies used to develop projected benefit costs for capitation rates since the last certification	Section 2.02
	How assumptions changed from the 2014 and/or 2015 rate certification on the following issues: (a) Acuity or health status adjustments (b) Pent-up demand (c) Adverse selection	Section 2.02 – Section 2.10

Section	Subject	SFY17 RMHP Capitation Development
	(d) Demographics of newly eligible adults (e) Differences in provider reimbursement rates or provider networks (f) Other material adjustments to newly eligible adults projected benefit costs	
	Describe any changes to the benefit plan offered to the new adult group	N/A
	Describe any other material changes or adjustments to projected benefit costs	N/A
Projected Non-Benefit Costs		
	For states that covered the new adult group in Medicaid managed care plans in 2014 and/or 2015, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification	N/A
	How assumptions changed from the 2014 and/or 2015 rate certification on the following issues:	
	(a) Administrative costs	Section 2.11
	(b) Care coordination and care management	Section 2.11
	(c) Provision for operating or profit margin	Section 2.11
	(d) Taxes, fees, and assessments	Section 2.12
	(e) Other material non-benefit costs	Section 2.11
Final Certified Rates or Rate Ranges		
	Comparison to the final certified rates or rate ranges in the previous rate certification	The SFY16 rates/rate ranges cannot be compared to the SFY17 rates by cohort, as the cohort structure has changed.
	Description of any other material changes to the capitation rates or the rate development process not	N/A

Section	Subject	SFY17 RMHP Capitation Development
	otherwise addressed in the other sections of this guidance	
Risk Mitigation Strategies		
	Describe the risk mitigation strategy specific to the new adult group rates	Section 2.14
	Any changes in the risk mitigation strategy from those used during 2014 and/or 2015;	N/A
	Rationale for making the change in the risk mitigation strategy	N/A
	Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during 2014 and/or 2015	N/A

Appendix II(C) Covered Medical Services

COS
IP
ER
OP
HOME HEALTH
PCP-HOSP
PCP-OFFICE
PCP-ER
SPECIALIST
FQHC/RHC
EMT
DME
LAB/RAD
Rx
OTHER

Appendix II(D) Rate Cells

Cohort
AFDC F
AFDC M
AwDC
BC Pregnant Women
Expansion Parent F
Expansion Parent M
OAP-A
OAP-B & AND/AB SSI Dual
OAP-B & AND/AB SSI Nondual

Appendix II(E) Base Data

	November 2014 – September 2015 Base Data			
Cohort	MMs	Util/K	UC	PMPM
AFDC F	69,296	25,596	$135.42	$288.86
AFDC M	28,155	15,990	$164.36	$219.01
AwDC	127,397	24,804	$160.07	$330.88
BC Pregnant Women	7,646	35,862	$291.30	$870.56
Expansion Parent F	31,226	21,424	$137.94	$246.27
Expansion Parent M	14,906	12,645	$148.70	$156.70
OAP-A	13,249	26,405	$55.27	$121.61
OAP-B & AND/AB SSI Dual	13,190	25,833	$48.12	$103.59
OAP-B & AND/AB SSI Nondual	27,468	67,274	$167.74	$940.38
Total	**332,533**	**27,227**	**$150.86**	**$342.30**

Appendix II(F) Mass Adjustment

	Mass Adjustment	
Cohort	UC %	PMPM
AFDC F	0.23%	$289.52
AFDC M	0.06%	$219.14
AwDC	0.10%	$331.19
BC Pregnant Women	0.88%	$878.21
Expansion Parent F	0.21%	$246.79
Expansion Parent M	0.05%	$156.77
OAP-A	0.30%	$121.98
OAP-B & AND/AB SSI Dual	0.08%	$103.67
OAP-B & AND/AB SSI Nondual	0.06%	$940.94
Total	**0.16%**	**$342.86**

	Mass Adjustment	
COS	UC %	PMPM
IP	0.01%	$54.81
ER	-2.04%	$33.65
OP	-1.52%	$59.35
HOME HEALTH	0.04%	$0.65
PCP-HOSP	3.25%	$8.93
PCP-OFFICE	4.66%	$11.58
PCP-ER	5.47%	$7.05
SPECIALIST	3.34%	$18.00
FQHC/RHC	0.99%	$15.22
EMT	0.04%	$1.34
DME	0.49%	$9.21
LAB/RAD	0.75%	$7.26
Rx	0.00%	$102.61
OTHER	1.44%	$13.20
Total	**0.16%**	**$342.86**

Appendix II(G) IBNR

	IBNR Adjustment	
Cohort	IBNR Factor	PMPM
AFDC F	0.977	$296.40
AFDC M	0.981	$223.49
AwDC	0.973	$340.33
BC Pregnant Women	0.974	$901.49
Expansion Parent F	0.974	$253.40
Expansion Parent M	0.976	$160.58
OAP-A	0.980	$124.44
OAP-B & AND/AB SSI Dual	0.981	$105.69
OAP-B & AND/AB SSI Nondual	0.976	$963.73
Total	**0.975**	**$351.55**

	IBNR Adjustment	
COS	IBNR Factor	PMPM
IP	0.973	$56.32
ER	0.990	$33.98
OP	0.990	$59.97
HOME HEALTH	0.917	$0.71
PCP-HOSP	0.965	$9.26
PCP-OFFICE	0.972	$11.92
PCP-ER	0.982	$7.18
SPECIALIST	0.954	$18.87
FQHC/RHC	1.000	$15.22
EMT	1.000	$1.34
DME	0.984	$9.37
LAB/RAD	0.950	$7.65
Rx	0.964	$106.40
OTHER	0.986	$13.39
Total	**0.975**	**$351.55**

Appendix II(H) Provider Sub-Capitations

	Provider Caps	
Cohort	Additional PMPM	PMPM
AFDC F	$6.94	$303.35
AFDC M	$4.33	$227.82
AwDC	$4.27	$344.60
BC Pregnant Women	$4.90	$906.40
Expansion Parent F	$6.25	$259.65
Expansion Parent M	$3.97	$164.55
OAP-A	$23.33	$147.77
OAP-B & AND/AB SSI Dual	$32.30	$137.99
OAP-B & AND/AB SSI Nondual	$22.84	$986.57
Total	**$8.42**	**$359.98**

	Provider Caps	
COS	Additional PMPM	PMPM
IP	$0.00	$56.32
ER	$0.00	$33.98
OP	$0.00	$59.97
HOME HEALTH	$0.00	$0.71
PCP-HOSP	$2.22	$11.48
PCP-OFFICE	$3.75	$15.67
PCP-ER	$2.45	$9.64
SPECIALIST	$0.00	$18.87
FQHC/RHC	$0.00	$15.22
EMT	$0.00	$1.34
DME	$0.00	$9.37
LAB/RAD	$0.00	$7.65
Rx	$0.00	$106.40
OTHER	$0.00	$13.39
Total	**$8.42**	**$359.98**

Appendix II(I) Supplemental Payments

	Supplemental Payments	
Cohort	Additional PMPM	PMPM
AFDC F	$4.52	$307.86
AFDC M	$2.90	$230.72
AwDC	$4.52	$349.12
BC Pregnant Women	$24.54	$930.94
Expansion Parent F	$3.89	$263.54
Expansion Parent M	$2.19	$166.74
OAP-A	$1.56	$149.33
OAP-B & AND/AB SSI Dual	$1.07	$139.07
OAP-B & AND/AB SSI Nondual	$9.65	$996.22
Total	**$4.85**	**$364.83**

	Supplemental Payments	
COS	Additional PMPM	PMPM
IP	$1.17	$57.48
ER	$0.71	$34.69
OP	$1.25	$61.21
HOME HEALTH	$0.00	$0.71
PCP-HOSP	$0.54	$12.03
PCP-OFFICE	$0.47	$16.14
PCP-ER	$0.42	$10.06
SPECIALIST	$0.03	$18.90
FQHC/RHC	$0.03	$15.24
EMT	$0.00	$1.34
DME	$0.02	$9.38
LAB/RAD	$0.01	$7.66
Rx	$0.18	$106.58
OTHER	$0.02	$13.41
Total	**$4.85**	**$364.83**

Appendix II(J) ACA 1202 Program Change

	1202 Adjustment	
Cohort	UC %	PMPM
AFDC F	-2.6%	$299.78
AFDC M	-2.4%	$225.14
AwDC	-2.1%	$341.65
BC Pregnant Women	-1.1%	$920.73
Expansion Parent F	-2.3%	$257.58
Expansion Parent M	-2.3%	$162.84
OAP-A	-4.1%	$143.15
OAP-B & AND/AB SSI Dual	-4.6%	$132.71
OAP-B & AND/AB SSI Nondual	-1.7%	$979.51
Total	**-2.2%**	**$356.95**

	1202 Adjustment	
COS	UC %	PMPM
IP	0.0%	$57.48
ER	-6.8%	$32.34
OP	-0.1%	$61.18
HOME HEALTH	0.0%	$0.71
PCP-HOSP	-9.0%	$10.94
PCP-OFFICE	-7.7%	$14.90
PCP-ER	-17.6%	$8.29
SPECIALIST	-5.9%	$17.78
FQHC/RHC	0.0%	$15.24
EMT	0.0%	$1.34
DME	0.0%	$9.38
LAB/RAD	-0.5%	$7.62
Rx	0.0%	$106.58
OTHER	-1.8%	$13.17
Total	**-2.2%**	**$356.95**

Appendix II(K) FQHC/RHC Repricing

	FQHC/RHC Adjustment	
Cohort	UC %	PMPM
AFDC F	2.2%	$306.37
AFDC M	2.0%	$229.58
AwDC	3.3%	$353.02
BC Pregnant Women	0.3%	$923.06
Expansion Parent F	2.2%	$263.36
Expansion Parent M	2.6%	$167.07
OAP-A	0.5%	$143.91
OAP-B & AND/AB SSI Dual	0.0%	$132.69
OAP-B & AND/AB SSI Nondual	1.3%	$992.54
Total	**2.2%**	**$364.95**

	FQHC/RHC Adjustment	
COS	UC %	PMPM
IP	0.0%	$57.48
ER	0.0%	$32.34
OP	0.0%	$61.18
HOME HEALTH	0.0%	$0.71
PCP-HOSP	0.0%	$10.94
PCP-OFFICE	0.0%	$14.90
PCP-ER	0.0%	$8.29
SPECIALIST	0.0%	$17.78
FQHC/RHC	52.5%	$23.24
EMT	0.0%	$1.34
DME	0.0%	$9.38
LAB/RAD	0.0%	$7.62
Rx	0.0%	$106.58
OTHER	0.0%	$13.17
Total	**2.2%**	**$364.95**

Appendix II(L) Prospective Trend

Cohort	Trend Midpoint Assumptions			
	Util/K Trend	UC Trend	PMPM Trend	PMPM
AFDC F	4.0%	-0.7%	3.3%	$324.10
AFDC M	4.1%	-0.3%	3.8%	$244.62
AwDC	4.2%	-0.4%	3.7%	$375.82
BC Pregnant Women	2.8%	-0.8%	2.0%	$954.85
Expansion Parent F	4.1%	-0.6%	3.4%	$278.75
Expansion Parent M	4.2%	-0.6%	3.6%	$177.45
OAP-A	2.2%	0.6%	2.8%	$150.97
OAP-B & AND/AB SSI Dual	2.2%	0.8%	3.0%	$139.51
OAP-B & AND/AB SSI Nondual	2.6%	1.5%	4.2%	$1,064.83
Total	**3.6%**	**0.0%**	**3.6%**	**$387.82**

COS	Trend Midpoint Assumptions		
	Util/K Trend	UC Trend	PMPM Trend
IP	2.4%	0.1%	2.5%
ER	1.9%	0.0%	1.9%
OP	1.3%	0.0%	1.2%
HOME HEALTH	2.0%	0.0%	2.0%
PCP-HOSP	1.0%	0.0%	1.0%
PCP-OFFICE	2.0%	0.0%	2.0%
PCP-ER	1.9%	0.0%	2.0%
SPECIALIST	2.2%	-0.1%	2.1%
FQHC/RHC	2.0%	0.0%	2.0%
EMT	0.0%	0.0%	0.0%
DME	3.1%	-0.1%	3.0%
LAB/RAD	1.5%	0.0%	1.5%
Rx	5.2%	2.4%	7.8%
OTHER	1.6%	0.0%	1.7%
Total	**3.6%**	**0.0%**	**3.6%**

Appendix II(M) Copay Adjustment

	Copay Adjustment		
Cohort	PMPM	Copay PMPM	Net Copay
AFDC F	$324.10	$2.43	$321.67
AFDC M	$244.62	$1.71	$242.91
AwDC	$375.82	$2.80	$373.02
BC Pregnant Women	$954.85	$0.33	$954.52
Expansion Parent F	$278.75	$2.14	$276.61
Expansion Parent M	$177.45	$1.39	$176.06
OAP-A	$150.97	$3.38	$147.59
OAP-B & AND/AB SSI Dual	$139.51	$2.92	$136.59
OAP-B & AND/AB SSI Nondual	$1,064.83	$7.13	$1,057.71
Total	**$387.82**	**$2.83**	**$384.99**

	Copay Adjustment		
COS	PMPM	Copay PMPM	Net Copay
IP	$59.95	$0.34	$59.61
ER	$33.39	$0.01	$33.38
OP	$62.48	$0.32	$62.16
HOME HEALTH	$0.73	$0.00	$0.73
PCP-HOSP	$11.13	$0.01	$11.12
PCP-OFFICE	$15.42	$0.04	$15.38
PCP-ER	$8.57	$0.00	$8.57
SPECIALIST	$18.42	$0.16	$18.26
FQHC/RHC	$24.04	$0.05	$23.99
EMT	$1.34	$0.00	$1.34
DME	$9.86	$0.05	$9.81
LAB/RAD	$7.82	$0.02	$7.79
Rx	$121.13	$1.70	$119.43
OTHER	$13.55	$0.13	$13.42
Total	**$387.82**	**$2.83**	**$384.99**

Appendix II(N) Non-Medical Load

	Midpoint Non-Medical Load		
Cohort	Load %	Net Copay	Gross Copay
AFDC F	11%	$361.43	$364.16
AFDC M	11%	$272.93	$274.86
AwDC	11%	$419.13	$422.27
BC Pregnant Women	11%	$1,072.50	$1,072.87
Expansion Parent F	11%	$310.80	$313.20
Expansion Parent M	11%	$197.82	$199.38
OAP-A	11%	$165.83	$169.63
OAP-B & AND/AB SSI Dual	11%	$153.47	$156.75
OAP-B & AND/AB SSI Nondual	11%	$1,188.44	$1,196.44
Total	**11%**	**$432.57**	**$435.76**

Appendix II(O) Rate Range Assumption Variations

Cohort	Util/K Trend	UC Trend	Admin Load
AFDC F	+/- 1.0%	+/- 0.5%	+/- 1.0%
AFDC M	+/- 1.0%	+/- 0.5%	+/- 1.0%
AwDC	+/- 1.0%	+/- 0.5%	+/- 1.0%
BC Pregnant Women	+/- 1.0%	+/- 0.5%	+/- 1.0%
Expansion Parent F	+/- 1.0%	+/- 0.5%	+/- 1.0%
Expansion Parent M	+/- 1.0%	+/- 0.5%	+/- 1.0%
OAP-A	+/- 1.0%	+/- 0.5%	+/- 1.0%
OAP-B & AND/AB SSI Dual	+/- 1.0%	+/- 0.5%	+/- 1.0%
OAP-B & AND/AB SSI Nondual	+/- 1.0%	+/- 0.5%	+/- 1.0%
Total	**+/- 1.0%**	**+/- 0.5%**	**+/- 1.0%**

Appendix III. July 1, 2016 – June 30, 2017 Rate Ranges and Rate Selection

Appendix III(A) Rate Range and Rate Selection

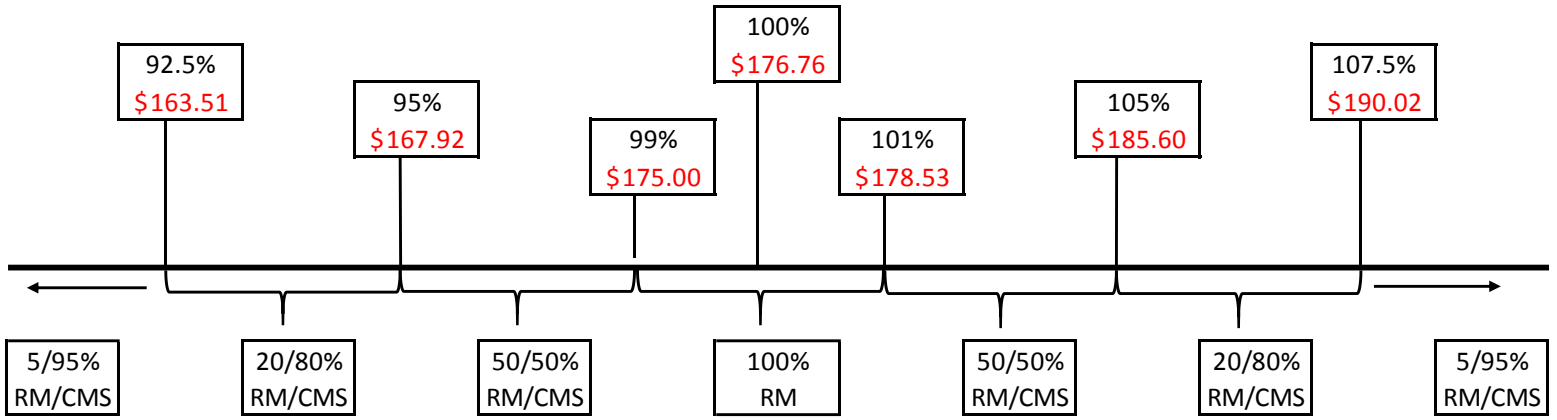
		Final Rate Range – Intersection of Net and Gross Rate Ranges			
Cohort	MMs	LB (Gross Copay)	MID	UB (Net Copay)	Rate Selection
AFDC F	69,296	$359.13	$362.81	$366.49	$362.81
AFDC M	28,155	$271.08	$273.91	$276.74	$273.91
AwDC	127,397	$416.47	$420.72	$424.97	$420.72
BC Pregnant Women	7,646	$1,057.85	$1,072.74	$1,087.64	$1,080.19
Expansion Parent F	31,226	$308.88	$312.02	$315.15	$312.02
Expansion Parent M	14,906	$196.63	$198.61	$200.58	$198.61
OAP-A	13,249	$167.27	$167.73	$168.19	$167.73
OAP-B & AND/AB SSI Dual	13,190	$154.57	$155.11	$155.64	$155.38
OAP-B & AND/AB SSI	27,468	$1,179.96	$1,192.49	$1,205.01	$1,192.49
Total	**332,533**	**$429.75**	**$434.18**	**$438.62**	**$434.36**

Appendix III(B) Rate Range Gross Health Insurer Provider Fee

		Rate Ranges Gross HIPF				
Cohort	MMs	HIT PMPM	Adjusted LB	Adjusted MID	Adjusted UB	Adjusted Rate
AFDC F	69,296	$2.22	$361.35	$365.03	$368.71	$365.03
AFDC M	28,155	$1.68	$272.76	$275.59	$278.42	$275.59
AwDC	127,397	$2.58	$419.04	$423.30	$427.55	$423.30
BC Pregnant Women	7,646	$6.58	$1,064.42	$1,079.32	$1,094.22	$1,086.77
Expansion Parent F	31,226	$1.91	$310.79	$313.93	$317.06	$313.93
Expansion Parent M	14,906	$1.22	$197.85	$199.83	$201.80	$199.83
OAP-A	13,249	$1.03	$168.30	$168.76	$169.22	$168.76
OAP-B & AND/AB SSI Dual	13,190	$0.95	$155.53	$156.06	$156.60	$156.33
OAP-B & AND/AB SSI	27,468	$7.31	$1,187.27	$1,199.80	$1,212.32	$1,199.80
Total	**332,533**	**$2.66**	**$432.41**	**$436.84**	**$441.28**	**$437.03**

Appendix IV. Risk Corridors

Appendix IV(A) Expansion Parent Male Risk Corridor



Example 1:

Net Medical Rate	$	176.76
Actual Cost Experience	$	187.37

MCO Bears Losses For:

Inner Corridor (100-101%)	($178.53-$176.76)*100%	$ 1.77
Middle Corridor (101-105%)	($185.60-$178.53)*50%	$ 3.54
Outer Corridor (105-107.5%)	($187.37-$185.60)*20%	$ 0.35
Tota Losses for MCO:	**$1.77+$3.54+$0.35=$5.66**	**$5.66**

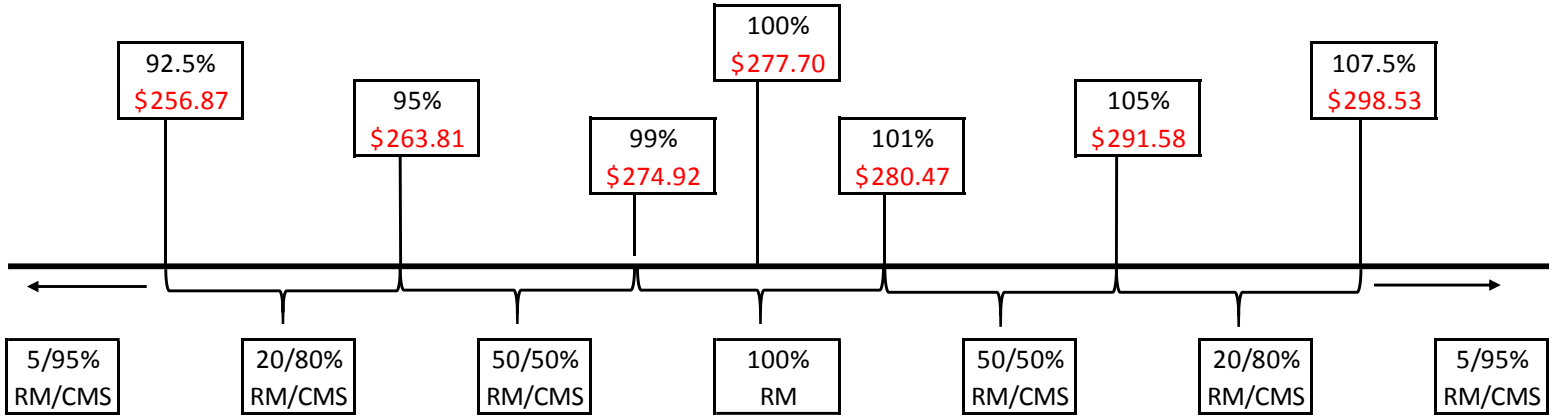
Example 2:

Net Medical Rate	$	176.76
Actual Cost Experience	$	173.23

MCO Gains For:

Inner Corridor (100-99%)	($176.76-$175.00)*100%	$ 1.77
Middle Corridor (99-95%)	($175.00-$173.23)*50%	$ 0.88
Tota Gains for MCO:	**$1.77+$0.88=$2.65**	**$2.65**

Appendix IV(B) Expansion Parent Female Risk Corridor



Example 1:

Net Medical Rate	$	277.70
Actual Cost Experience	$	287.42

MCO Bears Losses For:

Inner Corridor (100-101%)	($280.47-$277.70)*100%	$ 2.78
Middle Corridor (101-105%)	($287.42-$280.47)*50%	$ 3.47
Tota Losses for MCO:	**$2.78+$3.47=$6.25**	**$6.25**

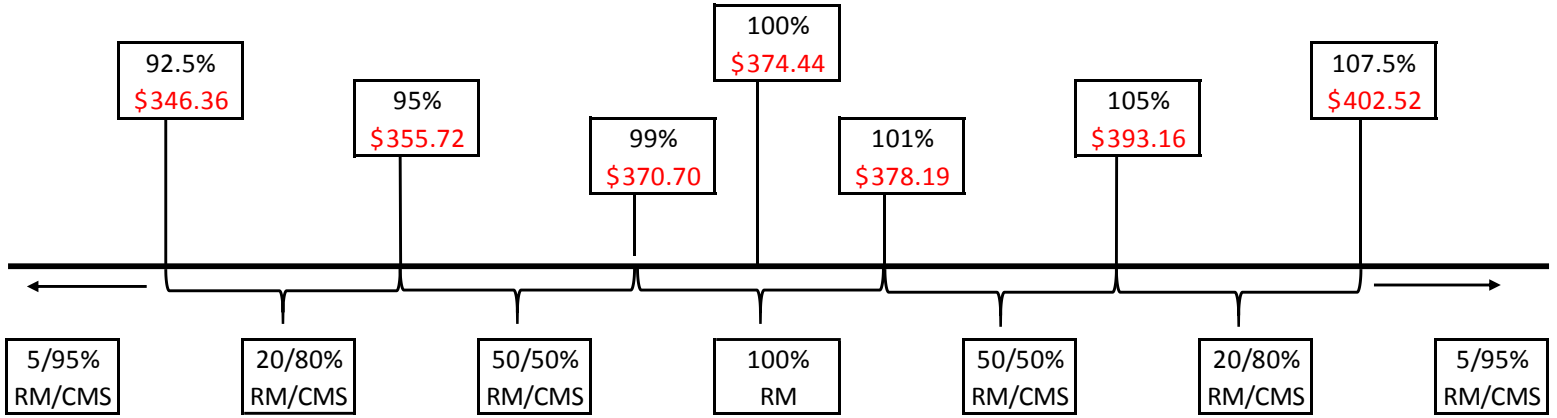
Example 2:

Net Medical Rate	$	277.70
Actual Cost Experience	$	258.26

MCO Gains For:

Inner Corridor (100-99%)	($277.70-$274.92)*100%	$ 2.78
Middle Corridor (99-95%)	($274.92-$263.81)*50%	$ 5.55
Outer Corridor (95 – 92.5%)	($263.81-$258.26)*20%	$ 1.11
Tota Gains for MCO:	**$2.78+$5.55+$1.11=$9.44**	**$9.44**

Appendix IV(C) AwDC Risk Corridor



Example 1:

Net Medical Rate	$	374.44
Actual Cost Experience	$	400.65

MCO Bears Losses For:

Inner Corridor (100-101%)	($378.19-$374.44)*100%	$ 3.74
Middle Corridor (101-105%)	($393.16-$378.19)*50%	$ 7.49
Outer Corridor (105-107.5%)	($400.65-$393.16)*20%	$ 1.50
Tota Losses for MCO:	**$3.74+$7.49+$1.50=$12.73**	**$ 12.73**

Example 2:

Net Medical Rate	$	374.44
Actual Cost Experience	$	359.46

MCO Gains For:

Inner Corridor (100-99%)	($374.44-$370.70)*100%	$ 3.74
Middle Corridor (99-95%)	($370.70-$359.46)*50%	$ 5.62
Tota Gains for MCO:	**$3.74+$5.62=$9.36**	**$ 9.36**

September 16, 2016

Shane Mofford
Payment Reform Section Manager
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

PROPRIETARY AND CONFIDENTIAL

Subject: **State of Colorado Addendum to Actuarial Certification for July 1, 2016 – June 30, 2017 Capitation Rate Ranges**

Dear Mr. Mofford:

Thank you for the opportunity to assist the Department of Health Care Policy and Financing (HCPF) with the development of the Rocky Mountain PRIME Capitation rate ranges. It was a pleasure to work with the HCPF team throughout this project. The following report summarizes the changes that were made from the original certification letter, dated April 28, 2016. We have also provided our actuarial certification for these updated rate ranges, compliant with the updated 2016 CMS guidelines and requirements. Please contact me if you have any questions at zachary.aters@Optumas.com or 480.588.2495.

Sincerely,

Zachary Aters, ASA, MAAA
Senior Actuary

CC: John Bartholomew, HCPF
Steve Schramm, **Optumas**
Cassie Williams, **Optumas**
Stephanie Taylor, **Optumas**

State of Colorado

Rocky Mountain PRIME Actuarial Certification Addendum

July 1, 2016 – June 30, 2017 Capitation Rate Ranges

Table of Contents

1. Executive Summary

The purpose of this report is to provide documentation and amended actuarial certification for the State of Colorado's Rocky Mountain PRIME Program. This addendum to the original actuarial certification, dated April 28, 2016, is effective for the period July 1, 2016 – June 30, 2017 (SFY17).

HCPF updates member date of death information within the MMIS system on a semi-annual basis. After discussions with HCPF, **Optumas** was informed that the January 2016 date of death update was not implemented. As such, the data that was used to set rates for the PRIME program inappropriately included member months for deceased members. The remainder of this addendum discusses the results of removing these members from the base data and the corresponding updated rate ranges.

As the consulting actuaries to the HCPF, **Optumas** ensured that the methodology used to develop the amended rate ranges for SFY17 complied with the Centers for Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rate ranges. The methodology and assumptions utilized when updating the rate ranges are consistent with the documentation included in the original certification.

Optumas worked with HCPF to identify the rate development components for the rating period, accounting for the covered services as described in the MCO contracts. The final results were developed according to actuarially sound principles and reasonably reflect the experience projected for the SFY17 contract period.

2. Rate Range Updates

The purpose for this addendum to the actuarial certification, dated April 28, 2016 is to remove deceased members from the base data membership underlying the rate ranges. HCPF updates date of death information within the MMIS system on a semi-annual basis, however, the January 2016 date of death update was not implemented. As such, the data used to set rates for the PRIME program inappropriately included member months for deceased members.

HCPF provided **Optumas** with a supplemental file containing each members' date of death. Using this information, **Optumas** was able to quantify the impact of removing these member months from the base data used for rate setting. Since the base data used for the PRIME program rate range development was comprised of eleven months of encounter data with incurred dates of November 1, 2014 through September 30, 2015, the impact of removing member months for deceased members has a material effect on the PRIME rate development, particularly on the OAP-A cohort.

A comparison of the original rate ranges from the April 28, 2016 certification and the revised rate ranges, net of the Health Insurer Tax (HIT), can be found in Appendix I. The updated payment rates, net of HIT and gross of HIT are shown in Appendix II and Appendix III, respectively.

3. Actuarial Certification

I, Zachary Aters, Senior Actuary at **Optumas**, Member of the American Academy of Actuaries (MAAA), am certifying the calculation of the rate ranges shown in Appendices III. 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 provided with this certification are considered actuarially sound for purposes of the 42 CFR 438.6(c), according to the following criteria:

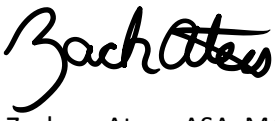
- The capitation rate ranges have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rate ranges are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rate ranges meet the requirements of 42 CFR 438.6(c).

The actuarially sound rate ranges that are associated with this certification are effective July 1, 2016 through June 30, 2017 for Colorado's RMHP PRIME Program.

The actuarially sound capitation rate ranges are based on a projection of future events. Actual experience will vary from the experience assumed in any rate picked within the rate ranges. The capitation rates offered may not be appropriate for any specific MCO. An individual MCO should review the rates in relation to the benefits that it is obligated to provide to the covered population. The MCO should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit requirements prior to agreeing to contract with the State. The MCO may require rates above, within, or below the actuarially sound rate range associated with this certification.

Should you have questions on any of the above, please feel free to contact me at 480.588.2495 for any additional information.

Sincerely,



Zachary Aters, ASA, MAAA
Senior Actuary

4. Appendices

Appendix I. Rate Range Comparison – Net HIT

	Original Rate Ranges – Net HIT			Revised Rate Ranges – Net HIT			% Difference		
Cohort	**MMs**	**LB**	**UB**	**MMs**	**LB**	**UB**	**MMs**	**LB**	**UB**
AFDC F	69,296	$359.13	$366.49	69,278	$359.21	$366.57	0.0%	0.0%	0.0%
AFDC M	28,155	$271.08	$276.74	28,137	$271.24	$276.91	-0.1%	0.1%	0.1%
AwDC	127,397	$416.47	$424.97	127,003	$417.75	$426.28	-0.3%	0.3%	0.3%
BC Pregnant Women	7,646	$1,057.85	$1,087.64	7,646	$1,057.78	$1,087.57	0.0%	0.0%	0.0%
Expansion Parent F	31,226	$308.88	$315.15	31,213	$309.00	$315.27	0.0%	0.0%	0.0%
Expansion Parent M	14,906	$196.63	$200.58	14,897	$196.75	$200.70	-0.1%	0.1%	0.1%
OAP-A	13,249	$167.27	$168.19	13,055	$169.75	$170.69	-1.5%	1.5%	1.5%
OAP-B & AND/AB SSI Dual	13,190	$154.57	$155.64	13,164	$154.88	$155.95	-0.2%	0.2%	0.2%
OAP-B & AND/AB SSI Nondual	27,468	$1,179.96	$1,205.01	27,374	$1,183.99	$1,209.12	-0.3%	0.3%	0.3%
Total	**332,533**	**$429.75**	**$438.62**	**331,767**	**$430.73**	**$439.62**	**-0.2%**	**0.2%**	**0.2%**

Appendix II. Payment Rate Comparison – Net HIT

	Original Rate Selections – Net HIT			Revised Rate Selections – Net HIT		
Cohort	**LB**	**UB**	**Rate Selection**	**LB**	**UB**	**Rate Selection**
AFDC F	$359.13	$366.49	$362.81	$359.21	$366.57	$362.81
AFDC M	$271.08	$276.74	$273.91	$271.24	$276.91	$273.91
AwDC	$416.47	$424.97	$420.72	$417.75	$426.28	$420.72
BC Pregnant Women	$1,057.85	$1,087.64	$1,080.19	$1,057.78	$1,087.57	$1,080.19
Expansion Parent F	$308.88	$315.15	$312.02	$309.00	$315.27	$312.02
Expansion Parent M	$196.63	$200.58	$198.61	$196.75	$200.70	$198.61
OAP-A	$167.27	$168.19	$167.73	$169.75	$170.69	$170.22
OAP-B & AND/AB SSI Dual	$154.57	$155.64	$155.38	$154.88	$155.95	$155.38
OAP-B & AND/AB SSI Nondual	$1,179.96	$1,205.01	$1,192.49	$1,183.99	$1,209.12	$1,192.49
Total	**$429.75**	**$438.62**	**$434.36**	**$430.73**	**$439.62**	**$434.47**

Appendix III. Payment Rate – Gross HIT

	Updated Rate Ranges – Gross HIT				
Cohort	**MMs**	**HIT PMPM**	**Adj. LB**	**Adj. UB**	**Adj Rate**
AFDC F	69,278	$2.22	$361.43	$368.80	$365.03
AFDC M	28,137	$1.68	$272.92	$278.58	$275.59
AwDC	127,003	$2.58	$420.32	$428.85	$423.30
BC Pregnant Women	7,646	$6.58	$1,064.36	$1,094.15	$1,086.77
Expansion Parent F	31,213	$1.91	$310.91	$317.18	$313.93
Expansion Parent M	14,897	$1.22	$197.97	$201.91	$199.83
OAP-A	13,055	$1.03	$170.78	$171.71	$171.25
OAP-B & AND/AB SSI Dual	13,164	$0.95	$155.83	$156.90	$156.33
OAP-B & AND/AB SSI Nondual	27,374	$7.31	$1,191.30	$1,216.43	$1,199.80
Total	**331,767**	**$2.66**	**$433.39**	**$442.28**	**$437.13**

January 20, 2017

Shane Mofford
Payment Reform Section Manager
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

PROPRIETARY AND CONFIDENTIAL

Subject: **State of Colorado Addendum to Actuarial Certification for October 1, 2016 – June 30, 2017 Capitation Rate Ranges**

Dear Mr. Mofford:

Thank you for the opportunity to assist the Department of Health Care Policy and Financing (HCPF) with the development of the Rocky Mountain PRIME Capitation rate ranges. It was a pleasure to work with the HCPF team throughout this project. The following report summarizes the changes that were made from the original certification letter, dated April 28, 2016 and the prior addendum, dated September 16, 2016. We have also provided our actuarial certification for these updated rate ranges, compliant with the updated 2017 Centers for Medicare & Medicaid Services (CMS) guidelines and requirements. Please contact me if you have any questions at zachary.aters@Optumas.com or 480.588.2495.

Sincerely,

Zachary Aters, ASA, MAAA
Senior Actuary

CC: John Bartholomew, HCPF
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State of Colorado

Rocky Mountain PRIME Actuarial Certification Addendum

October 1, 2016 – June 30, 2017 Capitation Rate Ranges

Table of Contents

1. Executive Summary

The purpose of this report is to provide documentation and amended actuarial certification for the State of Colorado's Rocky Mountain PRIME Program. This addendum to the original actuarial certification, dated April 28, 2016, and prior addendum, dated September 16, 2016, is effective for the period October 1, 2016 – June 30, 2017.

Effective October 1, 2016, the State of Colorado changed the reimbursement structure for Hepatitis C drug treatments within Medicaid. After discussions with CMS, the State of Colorado elected to pay all drugs related to the treatment of Hepatitis C via direct invoicing rather than under the managed care capitation rates. In other words, Rocky will still cover the Hepatitis C drugs, but these services will be removed from the at-risk contract and will be reimbursed by HCPF via a Fee-for-Service payment model. Since the Hepatitis C related drugs are to be paid via direct invoicing, these services must be removed from the base data underlying the original and amended PRIME capitation rates for the October 1, 2016 – June 30, 2017 time period. The remainder of this addendum discusses the results of removing the Hepatitis C drugs from the base data and the corresponding updated rate ranges, effective October 1, 2016.

As the consulting actuaries to HCPF, **Optumas** ensured that the methodology used to develop the amended rate ranges for October 1, 2016 – June 30, 2017 complied with the 2017 CMS guidance for the development of actuarially sound rate ranges. The methodology and assumptions utilized when updating the rate ranges are consistent with the documentation included in the original certification and previous addendum regarding the date of death membership sweep.

Optumas worked with HCPF to identify the rate development components for the rating period, accounting for the covered services as described in the MCO contracts. The final rates were developed according to actuarially sound principles and reasonably reflect the experience projected for the October 1, 2016 – June 30, 2017 portion of the SFY17 contract period.

2. Rate Range Updates

The purpose of this addendum to the actuarial certification and prior addendum is to remove drugs related to the treatment of Hepatitis C from the base data claims underlying the rate ranges, as these services will no longer be covered by the managed care capitation rates. Since the change in payment methodology for these drugs is effective October 1, 2016, the number of prospective trend months is adjusted to trend from the midpoint of the base data (November 1, 2014 – September 30, 2015) to the midpoint of October 1, 2016 – June 30, 2017, rather than the midpoint of contract year SFY17. This adjustment results in approximately 22 months of trend applied to the base data rather than 20.5 months used in the original rates.

HCPF provided **Optumas** with the list of NDC codes that will be paid via direct invoicing. Using this information, **Optumas** quantified the impact of removing these Hepatitis C NDCs from the base data used for rate setting. The impact of removing these claims from the base data had a material effect on the Pharmacy category of service within certain cohorts of the PRIME rate development. A comparison of the original base data and the updated base data, adjusted for the removal of Hepatitis C related scripts, can be found in Appendix I.

The revised rate ranges, updated to reflect effective dates of October 1, 2016 – June 30, 2017, net of the Health Insurer Tax (HIT), can be found in Appendix II. The final updated payment rates, net of HIT and gross of HIT are shown in Appendix III and Appendix IV, respectively.

3. Actuarial Certification

I, Zachary Aters, a Senior Actuary at **Optumas**, Member of the American Academy of Actuaries (MAAA), am certifying the calculation of the rate ranges shown in Appendices III. 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 provided with this certification are considered actuarially sound for purposes of the 42 CFR 438.4, according to the following criteria:

- The capitation rate ranges have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rate ranges are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rate ranges meet the requirements of 42 CFR 438.4.

The actuarially sound rate ranges that are associated with this certification are effective October 1, 2016 through June 30, 2017 for Colorado's RMHP PRIME Program.

The actuarially sound capitation rate ranges are based on a projection of future events. Actual experience will vary from the experience assumed in any rate picked within the rate ranges. The capitation rates offered may not be appropriate for any specific MCO. An individual MCO should review the rates in relation to the benefits that it is obligated to provide to the covered population. The MCO should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit

requirements prior to agreeing to contract with the State. The MCO may require rates above, within, or below the actuarially sound rate range associated with this certification.

Should you have questions on any of the above, please feel free to contact me at 480.588.2495 for any additional information.

Sincerely,

Zachary Aters, ASA, MAAA
Senior Actuary

4. Appendices

Appendix I. Base Data Comparison

	Original Base Data		Revised Base Data – Hep C NDCs Removed		% Difference	
Cohort	**MMs**	**PMPM**	**MMs**	**PMPM**	**MMs**	**PMPM**
AFDC F	69,278	$288.93	69,278	$287.67	0.0%	-0.4%
AFDC M	28,137	$219.15	28,137	$199.34	0.0%	-9.0%
AwDC	127,003	$331.90	127,003	$318.40	0.0%	-4.1%
BC Pregnant Women	7,646	$870.56	7,646	$870.56	0.0%	0.0%
Expansion Parent F	31,213	$246.37	31,213	$246.37	0.0%	0.0%
Expansion Parent M	14,897	$156.79	14,897	$151.17	0.0%	-3.6%
OAP-A	13,055	$123.41	13,055	$123.41	0.0%	0.0%
OAP-B & AND/AB SSI Dual	13,164	$103.79	13,164	$103.79	0.0%	0.0%
OAP-B & AND/AB SSI Nondual	27,374	$943.61	27,374	$906.11	0.0%	-4.0%
Total	**331,767**	**$343.09**	**331,767**	**$332.63**	**0.0%**	**-3.0%**

Appendix II. Rate Range Comparison – Net HIT

	Original Rate Ranges – Net HIT			Revised Rate Ranges – Net HIT			% Difference		
Cohort	**MMs**	**LB**	**UB**	**MMs**	**LB**	**UB**	**MMs**	**LB**	**UB**
AFDC F	69,278	$359.21	$366.57	69,278	$358.47	$367.16	0.0%	-0.2%	0.2%
AFDC M	28,137	$271.24	$276.91	28,137	$246.71	$252.64	0.0%	-9.0%	-8.8%
AwDC	127,003	$417.75	$426.28	127,003	$401.01	$410.60	0.0%	-4.0%	-3.7%
BC Pregnant Women	7,646	$1,057.78	$1,087.57	7,646	$1,058.52	$1,092.40	0.0%	0.1%	0.4%
Expansion Parent F	31,213	$309.00	$315.27	31,213	$309.76	$317.22	0.0%	0.2%	0.6%
Expansion Parent M	14,897	$196.75	$200.70	14,897	$190.09	$194.58	0.0%	-3.4%	-3.0%
OAP-A	13,055	$169.75	$170.69	13,055	$170.05	$171.63	0.0%	0.2%	0.6%
OAP-B & AND/AB SSI Dual	13,164	$154.88	$155.95	13,164	$155.17	$156.84	0.0%	0.2%	0.6%
OAP-B & AND/AB SSI Nondual	27,374	$1,183.99	$1,209.12	27,374	$1,140.19	$1,168.43	0.0%	-3.7%	-3.4%
Total	**331,767**	**$430.73**	**$439.62**	**331,767**	**$418.28**	**$428.42**	**0.0%**	**-2.9%**	**-2.5%**

Appendix III. Payment Rate Comparison – Net HIT

	Original Rate Selections – Net HIT			Revised Rate Selections – Net HIT		
Cohort	**LB**	**UB**	**Rate Selection**	**LB**	**UB**	**Rate Selection**
AFDC F	$359.21	$366.57	$362.81	$358.47	$367.16	$362.81
AFDC M	$271.24	$276.91	$273.91	$246.71	$252.64	$249.67
AwDC	$417.75	$426.28	$420.72	$401.01	$410.60	$405.80
BC Pregnant Women	$1,057.78	$1,087.57	$1,080.19	$1,058.52	$1,092.40	$1,080.19
Expansion Parent F	$309.00	$315.27	$312.02	$309.76	$317.22	$312.02
Expansion Parent M	$196.75	$200.70	$198.61	$190.09	$194.58	$192.34
OAP-A	$169.75	$170.69	$170.22	$170.05	$171.63	$170.22
OAP-B & AND/AB SSI Dual	$154.88	$155.95	$155.38	$155.17	$156.84	$155.38
OAP-B & AND/AB SSI Nondual	$1,183.99	$1,209.12	$1,192.49	$1,140.19	$1,168.43	$1,154.31
Total	**$430.73**	**$439.62**	**$434.47**	**$418.28**	**$428.42**	**$423.27**

Appendix IV. Payment Rate – Gross HIT

	Updated Rate Ranges – Gross HIT				
Cohort	**MMs**	**HIT PMPM**	**Adj. LB**	**Adj. UB**	**Adj Rate**
AFDC F	69,278	$2.22	$360.69	$369.39	$365.03
AFDC M	28,137	$1.68	$248.38	$254.32	$251.35
AwDC	127,003	$2.58	$403.59	$413.18	$408.38
BC Pregnant Women	7,646	$6.58	$1,065.10	$1,098.98	$1,086.77
Expansion Parent F	31,213	$1.91	$311.67	$319.13	$313.93
Expansion Parent M	14,897	$1.22	$191.31	$195.80	$193.55
OAP-A	13,055	$1.03	$171.07	$172.65	$171.25
OAP-B & AND/AB SSI Dual	13,164	$0.95	$156.13	$157.79	$156.33
OAP-B & AND/AB SSI Nondual	27,374	$7.31	$1,147.50	$1,175.74	$1,161.62
Total	**331,767**	**$2.66**	**$420.95**	**$431.08**	**$425.93**