Contract Year Ending 2024
Capitation Rate Certification
Comprehensive Health Plan Program

October 1, 2023 through September 30, 2024

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Business and Finance

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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rate for Contract Year Ending 2024 (CYE 24) for the Arizona Comprehensive Health Plan (CHP) Program. Programs under AHCCCS and their respective contracts have been aligned with the federal fiscal year since October 1, 2018. All contract years referenced below cover the timeframe from October 1 of one year through September 30 of the following year (e.g., CYE 24 covers the timeframe between October 1, 2023, through September 30, 2024).

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 rate contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rate represents projections of future events. Actual results may vary from the projections.

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 applicable to this rate certification, the 2023-2024 Medicaid Managed Care Rate Development Guide (2024 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2024 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 2024 Guide to help facilitate the review of this rate certification 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(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

- § 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 differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations. CMS may require a State to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or 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.

- § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

The actuary has followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), CMS, and federal regulations. In particular, the actuary referenced the below during the development of the actuarially sound capitation rate:

- Actuarial Standards of Practice (ASOPs) applicable to Medicaid managed care rate setting which were effective before the start date of the rating period:
  - ASOP No. 1 - Introductory Actuarial Standard of Practice,
  - ASOP No. 5 - Incurred Health and Disability Claims,
  - ASOP No. 12 - Risk Classification (for All Practice Areas),
  - ASOP No. 23 - Data Quality,
  - ASOP No. 25 – Credibility Procedures,
  - ASOP No. 41 - Actuarial Communications,
  - ASOP No. 45 - The Use of Health Status Based Risk Adjustment Methodologies,
  - ASOP No. 49 - Medicaid Managed Care Capitation Rate Development and Certification, and
  - ASOP No. 56 - Modeling.
- The 2016 and 2020 Medicaid and CHIP Managed Care Final Rules (CMS-2390-F and CMS-2408-F)
- FAQs related to payments to MCOs and PIHPs for IMD stays
- The 2023-2024 Medicaid Managed Care Rate Development Guide (2024 Guide) published by CMS

Throughout this actuarial certification, the term “actuarially sound” will be defined as in ASOP 49 (consistent with the definition at 42 CFR § 438.4(a)):

> “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 and 3 of the 2024 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.

I.1. General Information

This section provides documentation for the General Information section of the 2024 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Standards and Documentation for Rate Ranges

This section of the 2024 Guide notes that standards and documentation expectations are not different for capitation rates and capitation rate ranges, except where otherwise stated.

I.1.A.ii. Rating Period

The CYE 24 capitation rate for the CHP Program is effective for the 12-month time period from October 1, 2023, through September 30, 2024.

I.1.A.iii. Required Elements

I.1.A.iii.(a) Letter from Certifying Actuary

The actuarial certification letter for the CYE 24 capitation rate for the CHP Program, signed by Erica Johnson, ASA, MAAA, is in Appendix 1. Ms. Johnson meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 which 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.

Ms. Johnson certifies that the CYE 24 capitation rate for the CHP Program contained in this rate certification is actuarially sound and meets the standards within the applicable provisions of 42 CFR Part 438.

I.1.A.iii.(b) Final and Certified Capitation Rates

The final and certified capitation rate is located in Appendix 2. Additionally, the CHP Program contract includes the final and certified capitation rate in accordance with 42 CFR § 438.3(c)(1)(i). The CHP Program contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell when identifying a population at the certified capitation rate level (as shown in Appendix 2, Appendix 7, and Appendix 8b) to be consistent with the applicable provisions of 42 CFR Part 438 and the 2024 Guide and will use the term risk group when identifying a population not at the certified capitation rate level, such as when discussing the development of impacts where modeling was done for multiple programs.

I.1.A.iii.(c) Program Information

This section of the rate certification provides a summary of information about the CHP Program.

I.1.A.iii.(c)(i) Summary of Program

I.1.A.iii.(c)(i)(A) Type and Number of Managed Care Plans

The CHP Program 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. Effective April 1, 2021, the CHP Program subcontracted with an external health plan, Mercy Care, to deliver integrated services covered under this contract.

I.1.A.iii.(c)(i)(B) General Description of Benefits

The CHP Program covers integrated physical and behavioral health services for all CHP members, with the exception of the first 24 hours of crisis intervention services which are covered under the AHCCCS Complete Care – Regional Behavioral Health Agreement (ACC-RBHA) contracts for all Arizona Medicaid members. Additional information regarding covered services can be found in the CHP contract.

For the CYE 24 rating period, the projected expenses associated with the administration of COVID-19 vaccines are not included in the capitation rate; all COVID-19 vaccine costs in the base data period were removed as part of rate development, described below in Section I.2.B.iii.(d). AHCCCS Contractors are responsible for these expenses and will be reimbursed for these expenses on a non-risk basis via periodic cost-settlement payments based upon adjudicated/approved encounter data subject to the two-year claiming rule, as noted in contract and below in Section I.1.B.x.(c).

I.1.A.iii.(c)(i)(C) Areas of State Covered and Length of Time Program in Operation

The health plan under DCS was formed in July 1970 by state law under Arizona Revised Statute (A.R.S.) § 8-512. The integrated CHP Program operates on a statewide basis.

I.1.A.iii.(c)(ii) Rating Period Covered

The rate certification for the CYE 24 capitation rate for the CHP Program is effective for the 12-month time period from October 1, 2023, through September 30, 2024.

I.1.A.iii.(c)(iii) Covered Populations

The populations covered under the CHP Program are children under the age of 18 who are:

- Placed in a foster home;
- In the custody of DCS 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 CHP contract.

I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria

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 CHP Program and notify the CHP Program of the child's AHCCCS enrollment. The CHP Program is responsible for timely notification to AHCCCS if a

member no longer meets the criteria for the CHP Program 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 CHP Program contract.

Under the maintenance of effort (MOE) requirements included in the Families First Coronavirus Response Act (FFCRA), with a few exceptions as noted in the law, members who were eligible at the beginning of the COVID-19 public health emergency (PHE), or who became eligible during the PHE, remained treated as eligible for such benefits through March 31, 2023, or later, based on the Arizona renewal plan submitted to CMS. Under the Consolidated Appropriations Act, 2023 (CAA) which ended the Medicaid continuous coverage protection as of March 31, 2023, states were allowed to resume disenrollment of people who are no longer eligible for Medicaid eligibility after a complete redetermination of each person's eligibility for all categories of Medicaid, with the timeline expected for all renewals to be completed within 14 months of the start of the state's renewal plan. In practice, enrollment in the CHP Program is predicated upon being a child under the age of 18 and part of the foster care system, and if a child is no longer part of the foster care system, their eligibility for Medicaid will transition to another AHCCCS program, which in most cases is the AHCCCS Complete Care Program. Children who stopped being eligible for the CHP Program during the PHE will have their eligibility for Medicaid redetermined under the AHCCCS program they are enrolled with at the time their redetermination is processed during the unwinding of the PHE. As such, the unwinding of the PHE is not expected to have any impact on the CHP Program enrollment.

There have been policy changes implemented by DCS, unrelated to the COVID-19 PHE or the related unwinding, which have reduced the number of children entering the foster care system, with the effect that the children entering the system have health needs in several areas, both physical and mental, that are greater than the historical average needs of new CHP members. Additional information on the policy changes and the impacts on the capitation rate development are included below in Section I.3.B.ii.(a).

I.1.A.iii.(c)(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. The special contract provisions related to payment included in the CYE 24 capitation rate are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1))
- Reinsurance Arrangement (42 CFR § 438.6(b)(1))
- Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) (42 CFR § 438.6(c)(1)(iii)(A))
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(C))
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(C))
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(C))
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(C))

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

I.1.A.iii.(c)(vi) Retroactive Capitation Rate Adjustments – Not Applicable

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

I.1.A.iv. Rate Development Standards and Federal Financial Participation (FFP)

The CYE 24 capitation rate for the CHP Program is based on valid rate development standards and is not based on the rate of FFP for the populations covered under the CHP Program.

I.1.A.v. Rate Cell Cross-subsidization

The capitation rate was developed as one statewide rate cell.

I.1.A.vi. Effective Dates of Changes

The effective dates of changes to the CHP Program are consistent with the assumptions used to develop the CYE 24 capitation rate for the CHP Program.

I.1.A.vii. Minimum Medical Loss Ratio

The certified capitation rate was developed so the CHP Program would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 24.

I.1.A.viii. Conditions for Certifying Capitation Rate Range – Not Applicable

Not applicable. The actuary is not certifying capitation rate ranges.

I.1.A.ix. Certifying Actuarially Sound Capitation Rate Range – Not Applicable

Not applicable. The actuary is not certifying capitation rate ranges.

I.1.A.x. Generally Accepted Actuarial Principles and Practices

I.1.A.x.(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.

I.1.A.x.(b) Rate Setting Process

Adjustments to the rate 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.

I.1.A.x.(c) Contracted Rates

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 24 capitation rate certified in this report represents the final contracted rate.

I.1.A.xi. Rates from Previous Rating Periods – Not Applicable

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 24 capitation rate for the CHP Program.

I.1.A.xii. Evaluation of COVID-19 PHE and Unwinding

This section of the 2024 Guide includes CMS recommendations for risk mitigation strategies for rating periods impacted by the PHE and continuing after the end of the PHE until enrollment is expected to stabilize. All risk mitigation strategies are addressed in the contract and below in Section I.4.C. and will be submitted to CMS prior to the start of the rating period in accordance with the specific documentation requirements under 42 CFR § 438.6(b)(1).

This section also requests description of evaluations conducted, and the rationale for any applicable assumptions included or not included in rate development related to the COVID-19 PHE and related unwinding within the rate certification. Information on all assumptions included in the rate development, based on the available and applicable state specific, as well as nationally and regionally applicable, data (outlined below in Section I.1.B.x.(a)), to address the direct and indirect impacts of the COVID-19 PHE and related unwinding are described in each of the sections below:

- I.1.A.iii.(c)(i)(B) General Description of Benefits
- I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria
- I.1.B.viii.(a) Comparison to Previous Rate Certification
- I.1.B.x.(a) Available Applicable Data
- I.1.B.x.(b) Accounting for Direct and Indirect Impacts
- I.1.B.x.(c) COVID-19 Costs Paid Outside of Capitation Rates (Non-Risk)
- I.1.B.x.(d) Risk Mitigation Strategies
- I.2.B.ii.(b)(ii) Actuary's Assessment of the Data
- I.2.B.ii.(c) Appropriate Data for Rate Development
- I.2.B.iii.(d) Changes in the Program
- I.2.B.iii.(e) Exclusions of Payments or Services
- I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies
- I.3.B.iii.(a)(i) Projected Benefit Cost Trends Data
- I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons

Additional evaluation conducted related to the COVID-19 PHE and related unwinding which did not result in adjustments to the rate development for CYE 24 varies by program. The CHP Program was not impacted by the MOE requirements of the PHE based on the specific requirements for enrollment in the CHP Program, described above in Section I.1.A.iii.(c)(iv), and will not be impacted by the end of the Medicaid continuous coverage protection effective March 31, 2023. Additionally, while there are data adjustments included in the rate development for some categories of service based on reduced utilization during the base year associated with COVID-19 waves, not all categories of service were impacted to the point of being unreasonable for use as the base data without adjustment. For example, pharmacy data was not adjusted, because this category of service was not disrupted in a material way. The level of COVID-19 vaccinations within the CHP membership was evaluated and did not result in adjustments to the rate development. Changes in Arizona COVID-19 case rates were reviewed both in general and with respect to the different COVID-19 variants in the base data time period and more recently, but no adjustments for expected new variants were included in capitation rate development.

I.1.A.xiii. Rate Certification Procedures

I.1.A.xiii.(a) Timely Filing for Claiming Federal Financial Participation

This section of the 2024 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

I.1.A.xiii.(b) CMS Rate Certification Requirement for Rate Change

This is a new rate certification that documents that the CHP Program capitation rate is changing effective October 1, 2023.

I.1.A.xiii.(c) CMS Rate Certification Requirement for No Rate Change – Not Applicable

Not applicable. This rate certification will change the CHP Program capitation rate effective October 1, 2023.

I.1.A.xiii.(d) CMS Rate Certification Circumstances

This section of the 2024 Guide provides information on when CMS would not require a new rate certification, which includes increasing or decreasing capitation rates up to 1.5% for certified rates per rate cell, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.4(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract in accordance with 42 CFR § 438.7(b)(5)(iii).

I.1.A.xiii.(e) 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 state will submit a contract amendment to CMS as required.

I.1.A.xiii.(f) CMS Contract and Rate Amendment Requirement for Changes in Law

CMS requires a contract amendment and capitation rate amendment in the event that any State Medicaid program feature is invalidated by a court of law, or a change in federal statute, regulation, or approval. The rate amendment adjusting the capitation rates must remove costs specific to any program or activity no longer authorized by law, taking into account the effective date of the loss of program authority.

I.1.B. Appropriate Documentation

I.1.B.i. Capitation Rates or Rate Ranges

The actuary is certifying a statewide capitation rate for the CYE 24 CHP Program.

I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 24 capitation rate for the CHP Program.

I.1.B.iii. Capitation Rate Cell Assumptions

This section of the 2024 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell.

All such assumptions and adjustments are described in the rate certification.

I.1.B.iv. Capitation Rate Range Assumptions – Not Applicable

Not applicable. The actuary did not develop capitation rate ranges.

I.1.B.v. 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 relevant section numbers from the 2024 Guide. Sections of the 2024 Guide that do not apply will be marked as "Not Applicable"; any section wherein all subsections are not applicable will be collapsed to the section heading.

I.1.B.vi. Assurance Rate Assumptions Do Not Differ by Federal Financial Participation

All proposed differences in the assumptions, methodologies, or factors used to develop the certified CYE 24 capitation rate for the covered populations under the CHP Program are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

I.1.B.vii. 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 CHP Program receive the regular FMAP.

I.1.B.viii. Comparison to Prior Rates

I.1.B.viii.(a) Comparison to Previous Rate Certification

The 2024 Guide requests a comparison to the final certified rates in the previous rate certification. This comparison is included in Appendix 3.

The 2024 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. As in past years, the AHCCCS Division of Business and Finance (DBF) Actuarial Team has defined any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year as a negative change in the rate. Neither of these conditions apply for the certified CYE 24 capitation rate for the CHP Program.

I.1.B.viii.(b) Material Changes to Capitation Rate Development

There have been no material changes since the last rate certification other than those described elsewhere in the certification.

I.1.B.viii.(c) *De Minimis* Changes to Previous Period Capitation Rates

The state did not adjust the actuarially sound capitation rate in the previous rating period by a *de minimis* amount using the authority in 42 CFR § 438.7(c)(3).

I.1.B.ix. Future Rate Amendments

There are no known, or expected, future amendments to the CHP capitation rate.

I.1.B.x. Addressing COVID-19 PHE and Unwinding Impacts

I.1.B.x.(a) Available Applicable Data

The AHCCCS DBF Actuarial Team and AHCCCS DBF financial analysts have reviewed data, regulations, and information from a variety of applicable sources to address the COVID-19 PHE and related unwinding in rate setting. For CYE 24 rate development, AHCCCS DBF Actuarial Team has incorporated information regarding the end date of the Medicaid continuous coverage protection, including Arizona's plan for renewals as submitted to CMS, and disenrollment information available through June. The progress of redeterminations and subsequent disenrollments for ineligibility will continue to be monitored by the AHCCCS DBF Actuarial Team. Further details about state specific and national data sources are listed below.

- State Data Sources
    - AHCCCS historical and current encounter data including utilization and costs by category of service, risk group, GSA, and program
    - AHCCCS telehealth utilization and cost data by risk group, GSA, and program
    - AHCCCS non-emergency transportation (NEMT) utilization and cost data by risk group, GSA, and program
    - AHCCCS historical and current enrollment by risk group, GSA, and program
    - Historical and ongoing COVID-19 case rates for Arizona (not restricted to Medicaid populations)
    - AHCCCS COVID-19 testing by risk group, GSA, and program
    - AHCCCS COVID-19 vaccination rates by risk group, GSA, and program
    - AHCCCS child and adolescent well-care visit rates
    - Arizona Medicaid eligibility information, provided by the AHCCCS Division of Member and Provider Services (DMPS), which identified members who, if not for the MOE, would have been determined ineligible and disenrolled
- National Data Sources
    - Daily case rate, death rate, and vaccination rate data for Arizona collated and cleaned by the Centers for Disease Control
    - Consumer and Producer price inflation data published by the Bureau of Labor Statistics

- National webinars discussing various impacts of the response to the COVID-19 PHE and the end of continuous coverage protections
- Policy memoranda and newsletters related to available PHE unwinding flexibilities and considerations published by various universities and government agencies (examples below):
  - State Health Official Letter 23-002
  - Princeton University State Health and Value Strategies (SHVS):
    - Planning for the end of the Continuous Coverage Requirement
    - Best Practices for Publicly Reporting State Unwinding Data
    - State Reporting to Monitor the Unwinding of the Medicaid Continuous Coverage Requirement
  - CMS Policy Guidance FAQ dated May 12, 2023, on unwinding the continuous enrollment requirement
  - State Medicaid Director Letter 23-004

I.1.B.x.(b) Accounting for Direct and Indirect Impacts

The list above in I.1.A.xii. details the sections of the certification which describe assumptions included in the rate development to address the direct and indirect impacts of the COVID-19 PHE and related unwinding. A brief narrative summary of how the capitation rates account for the direct and indirect impacts of the COVID-19 PHE and related unwinding through the incorporation of the assumptions in the rate development, described in those sections of the certification, is provided below.

The CYE 24 capitation rate accounts for the direct and indirect impacts of the COVID-19 PHE and related unwinding by adjusting the base data to revise the impacts of depressed utilization of specific services in response to the winter and summer COVID-19 surges in CYE 22, by removing COVID-19 vaccine costs from the base data since AHCCCS has a non-risk based cost settlement with the Contractors for COVID-19 vaccines, and by removing COVID-19 test experience from the base data period and modeling projected COVID-19 testing costs for the rating period. The CYE 24 capitation rate also accounts for the impacts of the COVID-19 PHE and related unwinding by using a base data experience period that reflects changes in service delivery expected to continue beyond the pandemic, such as increased telehealth usage.

As noted above in Section I.1.A.iii.(c)(iv), the MOE requirements under the FFCRA did not impact the membership under the CHP Program as eligibility for the CHP Program is predicated upon being a child under the age of 18 and part of the foster care system, so under the MOE requirements a child leaving the foster care system, and thus the CHP Program, would have had their Medicaid eligibility continued under another AHCCCS program. Because of this unique aspect of eligibility for the CHP Program, there are not measurable changes in the acuity of the membership due to the PHE, the ending of the PHE, or the ending of the continuous coverage protections effective March 31, 2023, so no acuity adjustment was necessary.

I.1.B.x.(c) COVID-19 Costs Outside of Capitation Rates (Non-Risk)

Costs for COVID-19 vaccines and administration of COVID-19 vaccines are covered on a non-risk basis outside of the capitation rate. Covering these COVID-19 costs on a non-risk basis outside of the capitation rate required removing related costs from the base data period, as described in Section I.2.B.iii.(d).

I.1.B.x.(d) Risk Mitigation Strategies

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 24 contract will continue AHCCCS' long-standing program policy and will include risk corridors. For the CYE 24 rating period, AHCCCS is continuing the cost-settlement for administration of COVID-19 vaccines and carving these costs out of the capitation rate. This is the only risk mitigation strategy utilized specifically for COVID-19.

I.2. Data

This section provides documentation for the Data section of the 2024 Guide.

I.2.A. Rate Development Standards

I.2.A.i. Compliance with 42 CFR § 438.5(c)

AHCCCS actuaries have followed the rate development standards related to base data in accordance with 42 CFR § 438.5(c). The data types, sources, validation methodologies, material adjustments and other information related to the documentation standards required by CMS are documented in the subsections of I.2.B.

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

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

I.2.B.ii. Data Used for Rate Development

I.2.B.ii.(a) Description of Data

I.2.B.ii.(a)(i) Types of Data Used

The primary data sources used or reviewed for the development of the CYE 24 capitation rate for the CHP Program were:

- Adjudicated and approved encounter data submitted by the CHP Contractor and the prior behavioral health Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2018 through February 2023, and
  - Adjudicated and approved through the second February 2023 encounter cycle.
- Supplemental data files for all services provided by CHP from October 2018 through March 2021, paid through March 2023
- Reinsurance payments made to the CHP Program for services
  - Incurred from October 2018 through September 2022 paid through April 2023
- Enrollment data for the CHP Program and the prior behavioral health Programs from the AHCCCS PMMIS mainframe
  - October 2018 through February 2023
- Annual and quarterly financial statements submitted by the CHP and prior behavioral health Contractors and reviewed by the AHCCCS DBF Finance & Reinsurance Team
  - October 2018 through December 2022
- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DBF Rates & Reimbursement Team
- Data from AHCCCS DBF Rates & Reimbursement Team related to DAP, see Section I.4.D

- Data from AHCCCS DBF financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership provided by the Contractors.
- Detailed administrative expense data and projections from the CHP, the previous behavioral health Contractors, and the CHP integrated subcontractor, Mercy Care.
- Projected CYE 24 enrollment data provided by AHCCCS DBF Budget Team.
- Monthly operational outcomes report composed by DCS, accessible from their website.
- Any additional data used and not identified here will be identified in their applicable sections below.

I.2.B.ii.(a)(ii) Age of Data

The age of the data are listed above in Section I.2.B.ii.(a)(i).

I.2.B.ii.(a)(iii) Sources of Data

The sources of the data are listed above in Section I.2.B.ii.(a)(i).

I.2.B.ii.(a)(iv) Sub-capitated Arrangements

AHCCCS Contractors, including the CHP integrated subcontractor, sometimes use sub-capitated/block purchasing arrangements for some services. The sub-capitated/block purchase arrangements between the Contractors and their providers require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated/block purchased encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there are repricing methodologies (i.e., formulas) for sub-capitated/block purchased encounters to estimate a health plan valued amount in place of the health plan paid amount of zero. Different repricing methodologies have historically been used for different services based on comparisons between total reported medical expenses on the Contractor financial statements and the total encounters available to the actuaries, as submitted through the system for both regular and sub-capitated/block purchased services after completion factors. The units of service data from the encounters and the estimated health plan valued amounts were used for the basis of calculating utilization and unit cost values associated with the sub-capitated/block purchase encounters.

I.2.B.ii.(a)(v) Base Data Exception – Not Applicable

Not applicable. No exception to the base data requirements was necessary for capitation rate development.

I.2.B.ii.(b) Availability and Quality of the Data

I.2.B.ii.(b)(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. This process occurs for both regular and sub-capitated encounters.

The AHCCCS DBF 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 DBF Actuarial Team reports the findings to the AHCCCS Information Services Division (ISD) Data Management and Oversight (DMO) Team, who then works with the CHP to identify causes. In addition, the AHCCCS ISD DMO Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

AHCCCS Contractors know 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 Contractors 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 Contractors 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.

I.2.B.ii.(b)(i)(A) Completeness of the Data

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

I.2.B.ii.(b)(i)(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.

The AHCCCS DBF Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe. The AHCCCS DBF Actuarial Team ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 24 capitation rates for the CHP Program. Additionally, the AHCCCS DBF Actuarial Team ensured that only services covered under the state plan were included.

I.2.B.ii.(b)(i)(C) Consistency of the Data

The AHCCCS DBF Actuarial Team compared the CYE 22 encounter data to the aggregated CHP quarterly financial statement data. The encounter data was also compared to the data request which the Contractors fill out each year providing additional information regarding claims runout, revisions to financial statements for prior period adjustments, and administrative cost details. After adjustments to the encounter data for completion, the financial statements, the AHCCCS encounter data, and the annual data request amounts were judged to be consistent for capitation rate setting.

I.2.B.ii.(b)(ii) Actuary's Assessment of the Data

As required by ASOP No. 23, the AHCCCS DBF Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the Contractors and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the Contractors and reviewed by the AHCCCS DBF Finance & Reinsurance Team. The AHCCCS DBF 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 the following:

- data provided by the AHCCCS DBF Rates & Reimbursement Team with regard to DAP and fee schedule impacts,
- data provided by the AHCCCS DBF financial analysts with regard to some program changes,
- data provided by Milliman consultants with regard to the HEALTHII program,
- information and data provided by DMPS with regard to membership eligibility data,
- data provided by the CHP Program and the CHP integrated subcontractor, Mercy Care, on projected administrative costs,
- data provided by the CHP Contractor, the integrated subcontractor, and the prior behavioral health Contractors in the yearly supplemental data request regarding claims runout, revisions to financial statements for prior period adjustments, and administrative cost details, and
- data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

The actuary has found the encounter data in total, after adjustments for data concerns, to be appropriate for the purposes of developing the CYE 24 capitation rate for the CHP Program.

I.2.B.ii.(b)(iii) Data Concerns

The AHCCCS DBF Actuarial Team identified an issue with the financial statement reporting of sub-capitated/block purchased service costs, which led to the discovery of an additional issue with the methodologies for repricing sub-capitated/block purchased encounters. The actuary has made a specific adjustment in the development of the capitation rates which addresses the issue for CYE 24 and will be considering different methods for future rate development cycles. Other concerns related to potential fraud, waste, and abuse being included within the encounter data were identified, and specific adjustments to address those concerns have also been made within the rate development process. More detail on these concerns and adjustments are included below in Section I.2.B.iii.(d). There were no other material concerns identified with the availability or quality of the data.

I.2.B.ii.(c) Appropriate Data for Rate Development

The AHCCCS DBF Actuarial Team determined that the CYE 22 encounter data in total, after adjustments noted in I.2.B.ii.(b)(iii) and adjustments for depressed utilization related to COVID-19, described below in Section I.2.B.iii.(d), was appropriate to use as the base data for developing the CYE 24 capitation rate for the CHP Program.

I.2.B.ii.(c)(i) Not using Encounter or Fee-for-Service Data – Not Applicable

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 24 capitation rate for the CHP Program.

I.2.B.ii.(c)(ii) Not using Managed Care Encounter Data – Not Applicable

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 24 capitation rate for the CHP Program.

I.2.B.ii.(d) Use of a Data Book – Not Applicable

Not applicable. The AHCCCS DBF Actuarial Team did not rely on a data book to develop the CYE 24 capitation rate for the CHP Program.

I.2.B.iii. Adjustments to the Data

This section describes adjustments made to the CYE 22 encounter data that was used as the base data for developing the CYE 24 capitation rate for the CHP Program.

I.2.B.iii.(a) Credibility of the Data – Not Applicable

Not applicable. No credibility adjustments were made to the CYE 22 encounter data.

I.2.B.iii.(b) Completion Factors

Adjustments were made to the data to reflect the level of completion (including adjustments to encounters incurred prior to the base data year for the purposes of trend development).

AHCCCS calculated completion factors using the development method with monthly encounter data from October 2018 through February 2023, by major category of service. The major categories of service are based upon the AHCCCS form type, which indicates the type of form used to submit a claim. AHCCCS has six form types: Professional and Other Services (form type A), Prescription Drug (form type C), Dental Services (form type D), Inpatient Hospital (form type I), Nursing Facility (form type L), and Outpatient Hospital (form type O). The Dental Services form type (2.46% of CYE 22 payments) was combined with the Professional and Other Services form type (63.09% of CYE 22 payments). The Outpatient Hospital (5.04% of CYE 22 payments) and the Nursing Facility form types (0.00% of CYE 22 payments) were combined with the Inpatient Hospital form type (23.76% of CYE 22 payments). The monthly completion factors were applied to the encounter data on a monthly basis. Aggregated CYE 22 completion factors by detailed category of service are shown in Appendix 4.

I.2.B.iii.(c) Errors Found in the Data

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

I.2.B.iii.(d) Changes in the Program

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2021, through September 30, 2022) are described below. Additional adjustments to address specific impacts of COVID-19 in the base period and the concerns noted by the actuary in Section I.2.B.ii.(b)(iii) are also described in this section. All other program and fee schedule changes which occurred or are effective on or after October 1, 2022, are described in Section I.3.B.ii.(a).

Except for non-material adjustments, the impact of each adjustment to the base data is shown separately as part of Table 1 below. If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the capitation rate, that adjustment was deemed non-material and has been grouped into the Other Base Data Adjustments line in Table 1. Totals may not add up due to rounding. The impacts by category of service are shown in Appendix 4.

Some of the impacts for base data adjustment changes described below (indicated by an asterisk *) were developed by AHCCCS DBF financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS Division of Health Care Services (DHCS) Clinical Quality Management (CQM) Team and the Office of the Director's Chief Medical Officer. The actuary relied upon the professional judgment of the AHCCCS DBF financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuary met with the AHCCCS DBF financial analysts to understand at a high level how the estimated amounts were derived, and the data used for the amounts. The actuary was unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

Adjustment to Base Data for COVID-19

There were winter and summer COVID-19 surges during the base period which reduced utilization in some categories of service. Most adjustments made to account for the reduced utilization were developed by comparing CYE 22 data to CYE 19 data and modifying specific months of reduced utilization in CYE 22 to loosely resemble the seasonality patterns from the pre-pandemic period.

Removal of Crisis Services from Base Data

While the CHP Program covers most behavioral health services for its members, the CHP Program is not responsible for the first 24 hours of crisis intervention services. The first 24 hours of crisis intervention services for all Arizona Medicaid members are included as part of the ACC-RBHA contract. With the integration of CHP mid-way through CYE 21 (which was the base year for CYE 23 rate development), in order to ensure all appropriate expenses were included in the development of the capitation rates, expenses from the prior behavioral health contractors were included in the base data query. This was inadvertently repeated with the CYE 22 base data query, so an explicit adjustment to remove the crisis expenses which are the responsibility of the ACC-RBHA Contractors in CYE 24 is included for transparency.

Removal of Differential Adjusted Payments from Base Data

CYE 22 capitation rates for the CHP Program funded DAP made from October 1, 2021, through September 30, 2022, to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health and reduce cost of care growth. As these payments expired September 30, 2022, AHCCCS has removed the impact of CYE 22 DAP from the base period. To remove the impact, the AHCCCS DBF Actuarial Team requested provider IDs for the qualifying providers for the CYE 22 DAP by specific measure from the AHCCCS DBF Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 22 were then adjusted downward by the appropriate percentage bump specific to the DAP measure.

Removal of COVID-19 Tests from Base Data

As part of monitoring experience throughout the PHE, the AHCCCS DBF Actuarial Team has reviewed utilization associated with COVID-19 testing each month. Similar to CYE 23 capitation rate development, this review indicated that it would be more appropriate to model these specific services as a COVID-19 specific adjustment than including the utilization and costs in the base data and proceeding as if no further adjustment would be needed to accurately project costs in the rating period. To that end, as part of the rate development process, all utilization and expenses associated with COVID-19 tests were removed from the base data, as well as from the data used to develop trends, and analyzed separately. The impact of the specific adjustment for including COVID-19 tests in the rating period is addressed below in Section I.3.B.ii.(a).

Removal of Sub-capitated/Block Purchase Administrative Expense from Base Data

During CYE 24 capitation rate setting, the AHCCCS actuaries learned that some non-claims cost dollars which should have been reported as sub-capitated/block purchase administrative expenses per AHCCCS financial reporting guidelines and 42 CFR § 438.8(e)(2)(v)(A) were instead included in the medical expenses reported in the Contractors' historical financial statements. To adjust for this issue for CYE 24 rate development, the AHCCCS actuaries requested information from the Contractors on the total amounts that should have been reported as sub-capitated/block purchase administrative expenses in CYE 22 and compared those values to the amounts that were reported as sub-capitated/block purchase administrative expenses in CYE 22 to discern the magnitude of the non-claims costs dollars which were included as medical expenses in the CYE 22 financial statements and adjusted the base data for these amounts. The AHCCCS actuaries incorporated a corresponding adjustment to the administrative component to reflect the proper allocation of these expenses in the capitation rates, addressed in Section I.5.B.i.(a) below.

Table 1: Impacts of Base Data Adjustments

Base Data Adjustment	Dollar Impact	PMPM Impact
COVID-19 Normalization	$1,909,357	$16.10
Removal of Crisis Services	($2,743,107)	($23.12)
Removal of DAP	($1,753,175)	($14.78)
Removal of COVID-19 Tests	($507,030)	($4.27)
Removal of Sub-capitated/Block Purchase Administrative Expenses	($383,090)	($3.23)
Other Base Data Adjustments	($142,951)	($1.21)
Total Base Data Adjustments	**($3,619,995)**	**($30.52)**

Other Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component of the capitation rate, that adjustment was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the PMPMs for each non-material adjustment into an aggregate PMPM for display. The combined overall impact is illustrated above in Table 1. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- ***Fraud, Waste, and Abuse Adjustment***
  In May 2023, a multi-agency review and investigation of potential fraud, waste, and abuse (FWA) resulted in the suspension of dozens of providers of Medicaid services based on Credible Allegations of Fraud (CAF). Since that time, there have been additional CAF provider suspensions. The AHCCCS DBF Actuarial team has reviewed MCO encounters, with the exception of H0015 procedure codes, submitted by providers suspended as of June 23, 2023, per the Provider Terminations & Active Suspensions list, for unit cost and quantity characteristics which are substantially different from characteristics of encounters submitted by providers not identified on the publicly posted CAF list, and adjusted the irregular encounters to bring them into alignment with reasonable utilization and cost patterns. In response to concerns about abusive billing practices using the H0015 procedure code, AHCCCS set a specific fee schedule rate for H0015 in May 2023. Additional details about the development of the impact of the change for H0015 for all programs are provided below in Section I.3.B.ii.(a). More information about the investigation of potential fraud, waste, and abuse can be found on the AHCCCS website at https://azahcccs.gov/shared/News/PressRelease/PaymentSuspensions.html.
- ***N95 Masks ****
  In March 2022, AHCCCS advised Contractors that providers could bill and receive reimbursement for N95 masks issued to members with immunocompromised conditions.
- ***Pharmacy and Therapeutics Committee Recommendations ****
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 22 that impacted utilization and unit costs of Contractors' pharmacy costs in the base period. The P&T Committee evaluates scientific evidence on the relative safety,

efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

- ***Physician Administered Drugs (PADs) Repricing***
  Effective October 1, 2023, AHCCCS will implement quarterly rate adjustments for physician administered drugs (PADs) priced using the CMS Average Sales Price (ASP) file. The base data has been adjusted by repricing the PAD utilization in each quarter in the base year to the relevant ASP file for the same quarter.
- ***Removal of COVID-19 Vaccine Costs from Base Data***
  As noted above in Section I.1.B.x.(c), there is a separate mechanism to reimburse the Contractor for COVID-19 vaccines on a non-risk basis, so associated costs have been removed from the base encounter data.

I.2.B.iii.(e) Exclusions of Payments or Services

The AHCCCS DBF Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 24 capitation rates. Other base data adjustments which excluded services from the data (i.e., crisis removal and COVID-19 vaccine removal) are described above in Section I.2.B.iii.(d).

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2024 Guide.

I.3.A Rate Development Standards

I.3.A.i. Compliance with 42 CFR § 438.3(c)(1)(ii) and 42 CFR § 438.3(e)

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

I.3.A.ii. 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.

I.3.A.iii. In Lieu Of Services or Settings (ILOS) – Not Applicable

Not applicable. There are no in lieu of services or settings (ILOS) as defined at 42 CFR § 438.3(e)(2) included in the projected benefit costs.

I.3.A.iv. ILOS Cost Percentage – Not Applicable

Not applicable. There are no ILOS included in the projected benefit costs.

I.3.A.v. Institution for Mental Disease – Not Applicable

Not applicable. Institution for Mental Disease (IMD) payments in accordance with 42 CFR § 438.6(e) are for enrollees aged 21 to 64. The CHP Program only covers children under the age of 18. Therefore, no adjustment was made to encounter data or to the capitation rate.

I.3.B. Appropriate Documentation

I.3.B.i Projected Benefit Costs

The final projected benefit costs for the CHP Program are shown in Appendix 6.

I.3.B.ii. Projected Benefit Cost Developments

This section provides information on the projected benefit costs included in the CYE 24 capitation rate for the CHP Program.

I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies

The base data described in Section I.2.B.ii. was adjusted to reflect historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The adjusted base data per-member-per-month (PMPM) expenditures for each category of service (COS) were trended forward 24 months, from the midpoint of the CYE 22 time period to the midpoint of the CYE 24 rating period by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in Section I.3.B.iii.(a)(ii). The projected PMPMs were then adjusted for prospective program and reimbursement changes, described below. Appendix 4 contains the base data and base data

adjustments, and Appendix 5 contains the projected benefit cost trends. Appendix 6 contains the development of the gross medical expense from the adjusted base data, including all prospective programmatic and fee schedule changes, as well as the impact of the DAP. Appendix 7 contains the development of the certified capitation rate from the projected gross medical expense, including the reinsurance offset, administrative expense, case management expense, underwriting (UW) gain, and premium tax.

Except for non-material changes, the impact of each program change is shown separately as part of Table 2 below. If a program change had an impact of 0.2% or less on the gross medical component of the capitation rate, that program change was deemed non-material and has been grouped into the Combined Miscellaneous Program Changes line in Table 2. Totals may not add up due to rounding. The impacts by category of service are shown in Appendix 6.

Some of the impacts for projected benefits costs described below (indicated by an asterisk *) were developed by AHCCCS DBF financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS DHCS CQM Team and the Office of the Director's Chief Medical Officer. The actuary relied upon the professional judgment of the AHCCCS DBF financial analysts with regards to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuary met with the AHCCCS DBF financial analysts to understand at a high level how the estimated amounts were derived, and the data used for the amounts. The actuary was unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

AHCCCS FFS Fee Schedule Updates

AHCCCS typically makes annual updates to provider fee schedules used for AHCCCS FFS programs. The AHCCCS DBF Rates & Reimbursement Team and the AHCCCS DBF 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 except where authorized under applicable law, regulation or waiver, 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 through health plan surveys conducted by the AHCCCS DBF Finance & Reinsurance Team regarding health plan fee schedules.

Additionally, the contract has requirements that the Contractors reimburse FQHCs/RHCs at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates include adjustments to bring the base FQHC/RHC encounter data up to the projected CYE 24 FQHC/RHC PPS rates.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 24 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DBF Rates & Reimbursement Team used the CYE 22 encounter data to develop the impacts of fee schedule changes between the base year and the rating period. The AHCCCS DBF Rates & Reimbursement Team

applied AHCCCS provider fee schedule changes as a unit cost change to calculate the adjustment to the CYE 22 base data. The AHCCCS DBF Actuarial Team then reviewed the results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting category of service.

Beyond the regular provider fee schedule updates which are effective on October 1 of each year, the October 2022 fee schedule changes incorporated mandated increases for global OBGYN codes and for home and community based services (HCBS) and nursing facility (NF) providers passed by the legislature during the 2022 legislative session, and also increased the All Patients Refined Diagnosis Related Group (APR-DRG) base rate for rural hospitals.

AHCCCS also increases some fee schedule rates effective January 1 of each year to recognize the annual minimum wage increase resulting from the passing of Proposition 206. The increased costs for this change have been included with the fee schedule changes already discussed.

Effective May 1, 2023, AHCCCS set a fixed fee schedule rate for billing code H0015 of $157.86 for one unit of billable service, a change from the prior "by report" rate methodology which paid 58.66% of the billed amount. The AHCCCS DBF Actuarial Team worked with the Contractors to obtain information about which providers would be expected to see changes in their payments or payment structure based on contract status during the base period and/or the rating period. Using that information, the AHCCCS DBF Actuarial Team re-priced H0015 encounter data incurred during the base data year, at the health plan level, for those providers expected to see changes in their payments for the service based on the new fixed fee schedule rate and included the impact of the repricing with the other fee schedule adjustment changes.

Reduced Out-of-Home Placements

Specific adjustments were made to the data to account for changes in the characteristics of the population covered. While the population covered under the CHP contract is still children involved with the foster care system, DCS has made specific changes in policy with the aim of reducing the out-of-home foster care population. DCS' efforts to maintain this reduction have decreased the number of children entering the foster care system, but the impact of the reduced entry levels can be linked to changes, on average, in the characteristics and increased needs, in terms of both physical and mental health, of the children who are being placed outside of their homes. Additional information on these policies can be reviewed in DCS' Semi-Annual Benchmark Progress Report and the Semi-Annual Child Welfare Report (the latest rating period being the first half of State Fiscal Year 2023, July 2022 to December 2022), both of which can be viewed on the DCS Reports page (https://dcs.az.gov/reports). Per the Semi-Annual Benchmark Progress Report, the reduced out-of-home placements can be attributed to, but certainly not limited to, standardized process tools (case progress review checklists), safety discussion guides, and more training on effectively engaging with the related family members to keep the child safely in the home. Additionally, the goals of reunification have remained unchanged, so while fewer children have been entering the foster care system, similar numbers are still leaving the foster care system as in prior years. The combination of these policy changes has resulted in lessened numbers of children remaining in out-of-home placements, many of whom have increased behavioral and

physical health acuity. These children and youths' complex conditions require higher levels of care, services, and help to reach the goals of permanency than the historical population characteristics of children in foster care. The actuary has included adjustments to the categories of service with increased utilization or service mix changes that have been seen since the base year to recognize the expense increases that are expected to continue as the population in the foster care system changes based on policy goals and results. These adjustments have been developed through analysis of changes in expenses at similar durations of the different membership over time, as well as review of utilization and unit cost changes that are still evident in the data after including normalizations for fee schedule changes and trend assumptions.

Table 2: Impacts of Prospective Program and Reimbursement Changes

Prospective Program/Reimbursement Change	Dollar Impact	PMPM Impact
AHCCCS FFS Fee Schedule Updates	$1,967,592	$16.59
Reduced Out-of-Home Placements	$3,037,011	$25.60
Combined Miscellaneous Program Changes	$522,765	$4.41
Total Prospective Program and Reimbursement Changes	**$5,527,367**	**$46.60**

Combined Miscellaneous Program Changes

The rate development model includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component of the capitation rate, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the PMPMs for each non-material adjustment into an aggregate PMPM for display. The combined overall impact is illustrated above in Table 2. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- ***COVID-19 Tests***

  As noted above in Section I.2.B.iii.(d), the AHCCCS DBF Actuarial Team has reviewed utilization associated with COVID-19 testing each month. As part of the rate development process, the AHCCCS DBF Actuarial Team modeled projected utilization and costs for COVID-19 tests for the rating period. The projected utilization per 1000 was developed by reviewing utilization, unit costs, and distribution of tests by type during the CYE 22 base period and during the first quarter of CYE 23. The unit cost for different types of COVID-19 tests (lab/physician testing versus at-home test kits) was calculated with data specific to each type, and the distribution of tests by type provided the blend for an overall projected unit cost in the rating period. Combining projected utilization and unit cost into an overall PMPM for each program, the actuaries then applied utilization and unit cost relativities by each rate cell in the program to the overall PMPM to calculate appropriate PMPM adjustments for each rate cell. This modeling specifically incorporates more recent data than the base period in order to recognize that new variants and reduced public mitigation efforts have impacted the need for COVID-19 testing differently by population. No assumptions regarding vaccination rates were incorporated into the projections for use of tests.

- ***Pharmacy and Therapeutics Committee Recommendations ****
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 24. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.
- ***Child Depression Screening ****
  Effective October 1, 2022, the agency revised the AHCCCS Medical Policy Manual (AMPM) 430 to recommend depression and suicide risk screens be provided to children ages 12 to 20 years during EPSDT visits. The change aligned with screening recommendations from the American Academy of Pediatrics.
- ***Diabetes Self-Management Training ****
  Pursuant to HB2083, AHCCCS added 10 hours per year of diabetes self-management training as a covered service for diabetic members, effective October 1, 2022.
- ***Infant Dental Visits ****
  Effective October 1, 2022, AHCCCS revised AMPM 431 to expand coverage of preventive dental services to infants 6 – 12 months of age. The change is consistent with recommendations from Bright Futures and the American Academy of Pediatrics.
- ***Maternal Postpartum Depression Screening ****
  Effective October 1, 2022, the agency revised AMPM 430 to recommend postpartum depression screens be provided to caretakers during a child's EPSDT for 6 months following birth. The change aligned with screening recommendations from Bright Futures.
- ***Newborn Screening Fee ****
  Laws 2021, Chapter 409 required the Arizona Department of Health Services (ADHS) to expand the number of disorders screened for under the state's Newborn Screening Program. The law additionally authorized ADHS to increase fees charged for performing the expanded screening panel. The department consolidated the two prior fees ($101 combined) into one larger fee ($171) that is charged to the delivering provider following delivery. Effective October 1, 2022, AHCCCS increased hospital rates to incorporate the modification to ADHS fees.
- ***Unilateral Cochlear Implants ****
  AHCCCS has historically allowed either unilateral or bilateral cochlear devices to be implanted for those with bilateral hearing loss. Based on new research which indicated that this should be expanded to children with unilateral hearing loss, AHCCCS expanded cochlear device coverage to include this group of children effective October 1, 2022.
- ***Dental Cone Beam CT Capture ****
  AHCCCS began reimbursing for cone beam CT capture for dental imaging, effective January 1, 2023. Cone-beam CT capture emits an x-ray beam shaped like a cone as opposed to the conventional fan-shaped beam. This procedure is expected to be used for any tooth extraction as well as for endodontic procedures such as molar and premolar root canals. This type of

imaging would be done in addition to current X-ray imaging. AHCCCS requires prior authorization for fee-for-service coverage of cone beam CT capture.

- ***Long-Acting Reversible Contraception (LARC) ****
  Effective February 1, 2023, AHCCCS revised reimbursement rates for LARCs to equal the Wholesale Acquisition Cost (WAC) which reflects the costs providers pay for these medications.
- ***Community Health Workers/Community Health Representatives ****
  Effective April 1, 2023, AHCCCS implemented a new Community Health Worker (CHW)/Community Health Representative (CHR) benefit. A CHW/CHR is a frontline public health worker who is a trusted member of the community with a close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
- ***Back to School Initiative ****
  AHCCCS child and adolescent well-care visit rates have historically been lower than the CMS Medicaid median and these rates have declined as a result of the COVID-19 PHE. To address this issue, AHCCCS implemented a Back-to-School campaign beginning July 2023 to encourage child and adolescent well-care visits which is expected to raise awareness and increase child and adolescent well-care visits beyond the campaign.
- ***Dental Varnish ****
  Currently AHCCCS covers fluoride varnish for up to 4 times per year in Primary Care Physician (PCP) offices for children up to age 2. Effective October 1, 2023, AHCCCS will expand the use of fluoride varnishes in primary care offices beyond the currently eligible 0-2 year olds to include 3, 4 and 5 year old children in compliance with recommendations from the U.S. Preventive Services Task Force and the American Academy of Pediatrics.
- ***Diabetic Drug Class Utilization Changes***
  The AHCCCS DBF Actuarial Team reviewed all historical adjudicated and approved encounters for glucagon-like peptide-1 (GLP-1) receptor agonists, sodium-glucose co-transporter-2 inhibitors (SGLT2), and insulins, and determined that the changing utilization patterns of these drug classes was not fully accounted for by the projected trend assumptions, and have included a separate, specific adjustment to these drug classes as part of the capitation rate development.
- ***Group Prenatal Care ****
  Group prenatal care is an alternative model of prenatal care delivery where a small cohort of pregnant women with similar due dates participate in a structured prenatal care program facilitated by a clinician. Effective October 1, 2023, AHCCCS is adding this as an additional service available to its members.
- ***Sleep Study ****
  Effective October 1, 2022, AHCCCS is adding the WatchPAT system as a billable service, using CPT code 95800 (an unattended sleep study with analysis of airflow or peripheral arterial tone and recording of sleep time). The WatchPAT algorithm detects respiratory (apnea/hypopnea) events, sleep/wake status, and determines sleep stages.

- ***Adolescent SUD Screening ****
  The American Academy of Pediatrics encourages primary care clinicians to follow the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and recommends universal screening for substance use disorder (SUD) for adolescents. Effective October 1, 2023, AHCCCS will offer SUD screening for all 12 to 20 year-olds during EPSDT well-child visits.
- ***Rx Rebates Adjustment***
  An adjustment was made to reflect the impact of Rx Rebates reported within the integrated subcontractor, Mercy Care, financial statements for children covered under CHP, as pharmacy encounter data does not include these adjustments. The data that the AHCCCS DBF Actuarial Team reviewed was the CYE 20 and CYE 21 quarterly financial statement reports for Mercy Care as one of the previous behavioral health contractors and the CYE 22 and CYE 23 Q1 financial statement reports for Mercy Care as the integrated subcontractor for the CHP Program, as well as the CYE 20, CYE 21, and CYE 22 quarterly financial statements for the CHP Contractor. From this review, the AHCCCS DBF Actuarial Team determined that it would be reasonable to apply an adjustment to the projected CYE 24 Pharmacy (form type C) category of service.

I.3.B.ii.(b) Material Changes to the Data, Assumptions, and Methodologies

Any changes to the data, assumptions, or methodologies used to develop the projected benefit costs since the last rating period have been described within the relevant subsections of this certification.

I.3.B.ii.(c) Recoveries of Overpayments to Providers

AHCCCS Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base encounter data received and used as the primary data source to set the CYE 24 capitation rate therefore includes those adjustments.

I.3.B.iii. Projected Benefit Cost Trends

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

I.3.B.iii.(a) Requirements

I.3.B.iii.(a)(i) Projected Benefit Cost Trends Data

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2018 through January 2023, adjudicated and approved through the second February 2023 encounter cycle.

The trends were developed primarily from data specific to the CHP population.

I.3.B.iii.(a)(ii) Projected Benefit Cost Trends Methodologies

The encounter data was summarized by month and category of service, and by utilization per 1000, unit cost, and PMPM values. The encounter data for CYE 19, CYE 20, and first half of CYE 21 was adjusted for supplemental data received from the CHP Contractor for addressing encounter issues in those years, as described in prior rate certifications, and for monthly completion factors developed in the same manner described in Section I.2.B.iii.(b). The data was also adjusted to account for COVID-19 time periods which

had impacts on categories of service that are not anticipated to be continued into the rating period. Additionally, the encounter data was adjusted to normalize for previous program and reimbursement changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 22 (April 1, 2022) to the midpoint of the rating period for CYE 24 (April 1, 2024). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. 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 48-month linear regression results. The 36-month linear regression results were reviewed and discarded as inappropriate for comparison as CYE 20 data contained the bulk of the COVID-19 disruptions in service. Each category of service was analyzed in the same manner.

For the CHP Program, seven of the fifteen rate setting categories of service were aggregated with one or more other rate setting categories of service for the purposes of developing projected benefit cost trends. The aggregated trend categories of service are as follows: Outpatient and Emergency Facilities (Outpatient Facility, Emergency Facility), Other Professional Services (FQHC/RHC, Laboratory and Radiology, Other Professional Services), and Rehabilitation Services (Rehabilitation Services, Residential Services). The remaining eight rate setting categories of service were analyzed without further aggregation for projected benefit cost trend development.

I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons

The CYE 24 PMPM trend assumptions were aggregated and compared to similar aggregations of the PMPM trend assumptions for CYE 23 trend categories of service. The aggregated CYE 24 trend assumptions are higher than those assumed in the CYE 23 rate development; these increases are seen as reasonable for projection to the CYE 24 rating period given the changes in DCS policy which have led to increased health needs of the average CHP enrollee when comparing between the base period and the rating period.

I.3.B.iii.(a)(iv) Supporting Documentation for Trends

The 2024 Guide requires explanation of outlier or negative trends. As in past years, the AHCCCS DBF Actuarial Team has defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. There are no negative trend assumptions included in the CYE 24 CHP capitation rate development. The actuary has included an overall PMPM trend assumption of 7.1% for the Behavioral Health Inpatient and LTC category of service for the CYE 24 capitation rate development. This outlier trend is being driven by changes in DCS policy which have resulted in a higher percentage of children entering foster care with higher behavioral health needs than the members who were enrolled during the base data period. Additional information about the policy change and how the actuary has further adjusted for the change in the CYE 24 capitation rate development is included in Section I.3.B.ii.(a) above.

I.3.B.iii.(b) Projected Benefit Cost Trends by Component

I.3.B.iii.(b)(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.

I.3.B.iii.(b)(ii) Alternative Methods – Not Applicable

Not applicable. The projected benefit cost trends were developed using utilization per 1000 and unit cost components.

I.3.B.iii.(b)(iii) Other Components – Not Applicable

Not applicable. The projected benefit cost trends did not include other components.

I.3.B.iii.(c) Variation in Trend

Projected benefit cost trends do not vary except by category of service.

I.3.B.iii.(d) Any Other Material Adjustments

There were no other material adjustments made to the projected benefit cost trends.

I.3.B.iii.(e) Any Other Adjustments

There were no other adjustments made to the projected benefit cost trends.

I.3.B.iv. Mental Health Parity and Addiction Equity Act Compliance

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS DHCS Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. As of August 11, 2023, no additional services have been identified as necessary services to comply with MHPAEA.

I.3.B.v. ILOS – Not Applicable

Not applicable. There are no ILOS included in the projected benefit costs.

I.3.B.vi. Retrospective Eligibility Periods

I.3.B.vi.(a) Managed Care Plan Responsibility

AHCCCS provides prior period coverage (PPC) for the period of time prior to the member's enrollment during which the member is eligible for covered services. PPC 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 CHP Contractor. The CHP Contractor receives notification from AHCCCS of the member's enrollment. The CHP Contractor is responsible for payment of all claims for medically necessary services covered by the CHP Program and provided to members during prior period coverage.

I.3.B.vi.(b) Claims Data Included in Base Data

Encounter data related to PPC is included with the base data and is included in the capitation rate development process.

I.3.B.vi.(c) Enrollment Data Included in Base Data

Enrollment data related to PPC is included with the base data and is included in the capitation rate development process.

I.3.B.vi.(d) Adjustments, Assumptions, and Methodology

No specific adjustments are made to the CYE 24 capitation rate for the CHP Program for the PPC time frame, given that the encounter and enrollment data are already included within the base data used for capitation rate development.

I.3.B.vii. Impact of All Material Changes to Covered Benefits or Services

This section provides documentation on impacts to projected benefit costs made since the last rate certification.

I.3.B.vii.(a) Covered Benefits

Material adjustments related to covered benefits are discussed in Section I.3.B.ii. of this rate certification.

I.3.B.vii.(b) Recoveries of Overpayments

As noted in Section I.3.B.ii.(c), base period data was not adjusted to reflect recoveries of overpayments made to providers because Contractors are required to adjust encounters for recovery of overpayments, per the following contract requirement:

> "The Contractor shall void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters shall be submitted."

I.3.B.vii.(c) Provider Payment Requirements

Adjustments related to provider payment requirements under State Directed Payments are discussed in Section I.4.D of this rate certification.

I.3.B.vii.(d) Applicable Waivers

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

I.3.B.vii.(e) Applicable Litigation

There were no material changes made related to litigation.

I.3.B.viii. Impact of All Material and Non-Material Changes

All material and non-material changes have been included in the capitation rate development process and all requirements in this section of the 2024 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements – Not Applicable

Not applicable. No incentive arrangements exist with the CHP Program.

I.4.B. Withhold Arrangements – Not Applicable

Not applicable. No withhold arrangement exists with the CHP Program.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2024 Guide provides information on the requirements for risk-sharing mechanisms. For information on the COVID-19 costs covered on a non-risk basis, see Section I.1.B.x.(c).

In accordance with 42 CFR § 438.6(b)(1), all risk-sharing mechanisms have been developed in accordance with 42 CFR § 438.4, the rate development standards in 42 CFR § 438.5, and generally accepted actuarial principles and practices. Additionally, all risk-sharing mechanisms are documented in the contract and capitation rate certification for the rating period which will be submitted to CMS before the start of the rating period and will not be modified or added after the start of the rating period.

I.4.C.ii. Appropriate Documentation

I.4.C.ii.(a) Description of Risk-Sharing Mechanisms

The CYE 24 contract for the CHP Program will include a risk corridor.

I.4.C.ii.(a)(i) Rationale for Risk-Sharing Mechanisms

AHCCCS has a long-standing program policy of including risk corridors within many of the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 24 contract will continue AHCCCS' long-standing program policy and will include a risk corridor. This rate certification will use the term risk corridor to be consistent with the 2024 Guide. The CHP Contract refers to the risk corridor as a reconciliation.

I.4.C.ii.(a)(ii) Description of Risk-Sharing Mechanisms Implementation

The Subcontractor costs to reimbursement risk corridor will reconcile Subcontractor medical expenses to medical capitation paid to the Subcontractor in accordance with the CHP contract with the Subcontractor. The risk corridor with the Subcontractor provides for payment or recoupment outside a risk corridor as agreed to in the subcontract. CHP will submit the reconciliation for AHCCCS approval and AHCCCS will reconcile with CHP by reimbursing excess losses to be paid to the Subcontractor. The total amount of any excess profits to be recouped from the Subcontractor will be returned to AHCCCS.

Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically computed no sooner than 15 months after the contract year.

I.4.C.ii.(a)(iii) Effect of Risk-Sharing Mechanisms on Capitation Rates

The risk corridor did not have any effect on the development of the CYE 24 capitation rate for the CHP Program.

I.4.C.ii.(a)(iv) Development in Accordance with Generally Accepted Actuarial Principles and Practices

Risk-sharing mechanisms are developed in accordance with generally accepted actuarial principles and practices. The threshold amounts for the risk corridor were set using actuarial judgement with consideration of conversations and input between the AHCCCS DBF Actuarial Team, the AHCCCS DBF Finance & Reinsurance Team, the AHCCCS Office of the Director, and the CHP Program leadership.

I.4.C.ii.(a)(v) Risk-Sharing Arrangements Consistent with Pricing Assumptions

The inclusion of risk corridors as part of the contract is independent of the pricing assumptions used in capitation rate development. If the contract did not include risk corridors, the pricing assumptions used in capitation rate development would be unchanged.

Please see Section I.4.C.ii.(c) for documentation of reinsurance risk-sharing arrangements and the resulting impacts on capitation rate development.

I.4.C.ii.(a)(vi) Expected Remittance/Payment from Risk-Sharing Arrangements

If medical experience in the rating period aligns with pricing assumptions used in capitation rate development, there will be no remittance/payment between AHCCCS and the CHP Contractor associated with the risk corridor. The risk corridors protect the State against excessive Contractor profits and protect Contractors from excessive losses when experience in the rating period materially differs from the pricing assumptions.

See Section I.4.C.ii.(c) for reinsurance risk-sharing arrangements.

I.4.C.ii.(b) Remittance/Payment Requirements for Specified Medical Loss Ratio – Not Applicable

Not applicable. The CHP Program contract does not include a medical loss ratio remittance or payment requirement.

I.4.C.ii.(c) Reinsurance Requirements

I.4.C.ii.(c)(i) Description of Reinsurance Requirements

AHCCCS provides a reinsurance program to AHCCCS Contractors 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 a Catastrophic case type, including reinsurance for biologic drugs. Additionally, rather than the CHP

Contractor paying a premium, the capitation rate is 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 since 1982 and is funded with 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 CHP Contractor for covered services incurred above the deductible. The deductible is the responsibility of the CHP Contractor. The deductible for CYE 24 Regular reinsurance cases is $150,000, an increase from the CYE 23 Regular reinsurance deductible. The limit on High Dollar Catastrophic reinsurance is $1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

For additional information on the reinsurance program, refer to the Reinsurance section of the CHP Program contract.

I.4.C.ii.(c)(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 expense component of the capitation rate.

I.4.C.ii.(c)(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.

I.4.C.ii.(c)(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset

The methodology for setting the reinsurance offset has not changed from the CYE 23 capitation rates. The data used to develop the reinsurance offset amount are historical encounters incurred during CYE 22. The historical reinsurance payment data for catastrophic case types related to certain medical conditions and biologic/high cost specialty drugs were also used as a validation check to ensure encounters for members with those reinsurance cases were captured within the development of the reinsurance offset. The CYE 22 encounters were adjusted for historical programmatic and reimbursement changes as described above in Sections I.2.B.iii.(d) and I.3.B.(ii)(a) and trended to the CYE 24 rating period using the same trend factors described in Section I.3.B.iii.(a) above. These encounters were then evaluated against the applicable reinsurance rules, including deductible levels, for the CYE 24 rating period to determine calculated potential reinsurance case payments by member. These calculated reinsurance case payments were adjusted for an expected contractor reporting factor, representing the rate at which the contractor does not report reinsurance cases which would otherwise

merit reimbursement. The contractor reporting factor was developed from historical reinsurance payments as compared to aggregated encounters for individual members which would have triggered reinsurance payments in each historical contract year, using data under another AHCCCS program where the CHP integrated subcontractor also operates as an integrated subcontractor (the Arizona Long Term Care System – Developmental Disabilities Program). The decision to use data from another program and population for the contractor reporting factor is based on having less than two years of available experience for the integrated subcontractor under the CHP Program, the longer lag between medical expenses and reinsurance payments compared to encounter lag times, and the similarities of the services provided between the two programs by the integrated subcontractor (integrated physical and behavioral health services). The adjusted calculated reinsurance case payments were then summed and divided by the CYE 24 projected member months to develop the reinsurance offset. The reinsurance offset was then adjusted to account for changes to the covered biologics list after the base data period to get to the final reinsurance offset. This adjustment was calculated by taking the projected PMPM costs for CYE 24 for the new covered drugs for the CHP Program and applying a zero dollar deductible and coinsurance limit of 85%.

Appendix 7 displays the reinsurance offset PMPM included in the capitation rate.

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

This section of the 2024 Guide provides information on delivery system and provider payment initiatives (i.e., state directed payments) authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

I.4.D.ii.(a) Description of State Directed Payments

The only state directed payments addressed in this certification are the ones related to the CHP Program. The contract requires the adoption of a minimum fee schedule for FQHC/RHC providers using State plan approved rates, as defined in 42 CFR § 438.6(a), as allowed under 42 CFR § 438.6(c)(1)(iii)(A). This state directed payment for FQHC/RHC providers does not require written approval prior to implementation per 42 CFR § 438.6(c)(2)(ii). The state directed payments which require preprints for prior approval are DAP, APSI, PSI, and HEALTHII. The 2024 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

I.4.D.ii.(a)(i) Type and Description of Directed Payment Arrangements

Federally Qualified Health Centers and Rural Health Clinics

Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Medicaid State plan as a minimum fee schedule for FQHC/RHC providers. The Medicaid State plan describes the methodology for the calculation of PPS rates in Attachment 4.19-B starting on Page 3a.

Differential Adjusted Payments

The 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. All providers

were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP. The potential rate increases range from 0.5% to 20.0%, depending on the provider type.

Access to Professional Services Initiative

The APSI provides a uniform percentage increase of 75% to otherwise contracted rates for eligible practitioners, critical to professional training and education efforts, who deliver services to AHCCCS members. The uniform percentage increase is applicable only to services covered under the AHCCCS APSI policy. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Pediatric Services Initiative

The PSI provides a uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 licensed beds. The PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

Hospital Enhanced Access Leading to Health Improvements Initiative

The HEALTHII delivers a uniform percentage increase to hospitals for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The HEALTHII uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class's aggregate targeted pay-to-cost ratio for Medicaid Managed care services. The increase is intended to supplement, not supplant, payments to eligible providers.

I.4.D.ii.(a)(ii) Directed Payments Incorporated in Capitation Rates

The FQHC/RHC minimum fee schedule and the DAP initiative are the only directed payments incorporated in the capitation rates. The 2024 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

I.4.D.ii.(a)(ii)(A) Rate Cells Affected

The single rate cell for the CHP Program is affected by the FQHC/RHC minimum fee schedule state directed payment and the DAP initiative.

I.4.D.ii.(a)(ii)(B) Impact on the Rate Cells

The FQHC/RHC minimum fee schedule impact is included as part of the aggregate fee schedule changes shown in Appendix 6. See Appendix 8b for the total impact by rate cell for the FQHC/RHC minimum fee schedule. For DAP, see Appendix 6 for medical impact by rate cell and Appendix 8b for total impact by rate cell.

I.4.D.ii.(a)(ii)(C) Data, Assumptions, Methodology to Develop Directed Payment Adjustment

Federally Qualified Health Centers and Rural Health Clinics

The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates, described above in Section I.3.B.ii.(a).

Differential Adjusted Payments

The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 22 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DBF 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 CYE 24 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and risk group to the applicable categories of service to come to the final dollar impact for CYE 24 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DBF Actuarial Team then aggregated to the specific risk groups for each program).

I.4.D.ii.(a)(ii)(D) Preprint Acknowledgement

AHCCCS has submitted the DAP 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates were certified. The DAP payment arrangement accounted for in the capitation rates, and described in the preceding sections, is included in the capitation rates in a manner consistent with the preprint under CMS review.

I.4.D.ii.(a)(ii)(E) Maximum Fee Schedule – Not Applicable

Not applicable. None of the directed payments for the CHP Program are based on maximum fee schedules.

I.4.D.ii.(a)(iii) Directed Payments Under Separate Payment Arrangement

The APSI, PSI, and HEALTHII are not included in the CHP certified capitation rate and will be paid out via lump sum payments. The 2024 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

I.4.D.ii.(a)(iii)(A) Aggregate Amount

Access to Professional Services Initiative

Anticipated payments, including premium tax, for APSI are approximately $3.25 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Services Initiative

Anticipated payments, including premium tax, for PSI are approximately $2.06 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 24 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments, including premium tax, for HEALTHII are approximately $13.51 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 24 utilization will be used to redistribute the payments.

I.4.D.ii.(a)(iii)(B) Actuarial Certification of the Amount of the Separate Payment Term

Access to Professional Services Initiative

The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from estimates based on actual utilization, and once final amounts are known, a notification document will be sent to CMS with that information.

Pediatric Services Initiative

The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from estimates based on actual utilization, and once final amounts are known, a notification document will be sent to CMS with that information.

Hospital Enhanced Access Leading to Health Improvements Initiative

The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from estimates based on actual utilization, and once final amounts are known, a notification document will be sent to CMS with that information.

I.4.D.ii.(a)(iii)(C) Estimated Impact by Rate Cell

Appendix 8b contains estimated PMPMs, including premium tax, by rate cell for informational purposes only; these payments are not made on a PMPM basis.

I.4.D.ii.(a)(iii)(D) Preprint Acknowledgement

Access to Professional Services Initiative

AHCCCS has submitted the APSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Pediatric Services Initiative

AHCCCS has submitted the PSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Hospital Enhanced Access Leading to Health Improvements Initiative

AHCCCS has submitted the HEALTHII 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates

were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

I.4.D.ii.(a)(iii)(E) Future Documentation Requirements

Access to Professional Services Initiative

After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Pediatric Services Initiative

After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Hospital Enhanced Access Leading to Health Improvements Initiative

After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

I.4.D.ii.(b) Confirmation of No Other Directed Payments

There are not any additional directed payments in the program that are not addressed in the rate certification, including minimum fee schedules using State plan approved rates as defined in 42 CFR § 438.6(a).

I.4.D.ii.(c) Confirmation Regarding Required Reimbursement Rates

There are not any requirements regarding reimbursement rates the plans must pay to providers unless specifically specified in the certification as a state directed payment or authorized under applicable law, regulation, or waiver.

I.4.E. Pass-Through Payments – Not Applicable

Not applicable. There are no pass-through payments for the CHP Program.

I.5 Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2024 Guide provides information on the non-benefit component of the capitation rate.

I.5.B. Appropriate Documentation

I.5.B.i. Description of the Development of Projected Non-Benefit Costs

I.5.B.i.(a) Data, Assumptions, and Methodology

AHCCCS requested administrative expense information from the CHP Contractor and the integrated subcontractor for actual and projected expenses in CYE 22, CYE 23, and CYE 24. The requested information detailed projected employee compensation (including FTE counts for the CHP Contractor), care management costs, data processing costs, interest charges, occupancy (rent/utilities), and other administrative expenses for the current contract year and the upcoming contract year. The CYE 24 projections for the CHP Contractor and the integrated subcontractor include expenses associated with care management. Care management activities performed by the CHP Contractor and the integrated subcontractor help to ensure that members receive appropriate physical health services, including well-child examinations, screenings, immunizations, and follow-up care. Care management also ensures that members have access to high quality, comprehensive behavioral health services delivered in a timely manner and in the most appropriate setting.

The projected administrative and care management expenses were reviewed by AHCCCS for reasonableness by comparing the projections against previous administrative expense projections and reported administrative expenses from financial statements submitted by the CHP Contractor and the integrated subcontractor. Additional details were requested from DCS to understand some of the administrative cost increases requested by DCS for Health Care Quality Improvement activities and some smaller miscellaneous projects. After reviewing the requested information, the additional amounts were deemed reasonable and appropriate for inclusion in the overall administrative expense projections.

As a final adjustment to the administrative cost projections, the actuary incorporated adjustments developed from the non-claims costs dollars removed from the base data medical costs, as described in Section I.2.B.iii.(d). The actuary trended the amounts removed from the base data medical costs forward two years using an inflationary factor consistent with the other administrative cost projections and included the revised amounts as an increase to the overall administrative cost component included in the CHP capitation rate. This adjustment resolves the data concern the AHCCCS DBF Actuarial Team had with the noted misallocation issue in the financial statement reporting of sub-capitated/block purchase arrangements for the CYE 24 capitation rates.

The administrative expense PMPM was evaluated along with the projected gross medical expense, reinsurance offset, and care management expense PMPM amount to ensure compliance with the minimum 85 percent MLR requirement, as calculated under 42 CFR § 438.8.

The projected CYE 24 administrative expense components are shown in Appendix 7.

I.5.B.i.(b) Changes from the Previous Rate Certification

There were no methodology changes from the non-benefit cost development used in the CYE 23 rate, other than the adjustments described in the previous section.

I.5.B.i.(c) Any Other Material Changes

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

I.5.B.ii. Projected Non-Benefit Costs by Category

I.5.B.ii.(a) Administrative Costs

The administrative component of the CYE 24 capitation rate for the CHP Program is described above in Section I.5.B.i.(a). The PMPM amounts assumed can be found in Appendix 7.

I.5.B.ii.(b) Taxes and Other Fees

The CYE 24 capitation rate for the CHP Program includes a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

I.5.B.ii.(c) Contribution to Reserves, Risk Margin, and Cost of Capital

The CYE 24 capitation rates for the CHP Program include a provision (denoted as underwriting (UW) gain and expressed as a percentage) for contributions to reserves, risk margin, and cost of capital. The CYE 24 UW gain of 1.0% is unchanged from the CYE 23 capitation rates based on the expectation that the unwinding of the PHE is not going to impact the CHP Program to a measurable degree.

I.5.B.ii.(d) Other Material Non-Benefit Costs

No other material or non-material non-benefit costs not already addressed in previous sections are reflected in the CYE 24 capitation rate for the CHP Program.

I.5.B.iii. Historical Non-Benefit Costs

Historical non-benefit cost data is provided by the AHCCCS Contractors via financial statements and additional data requests. The audited financial statements can be found on the AHCCCS website at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/contractedhealthplan.html. Historical non-benefit cost data was considered and used in the non-benefit cost assumptions as described in Section I.5.B.i.(a) above.

I.6. Risk Adjustment – Not Applicable

Not applicable. The CYE 24 capitation rate for the CHP Program does not utilize risk adjustments.

I.7. Acuity Adjustments – Not Applicable

Not applicable. The CYE 24 capitation rate for the CHP Program does not include an acuity adjustment.

Section II Medicaid Managed Care Rates with Long-Term Services and Supports – Not Applicable

Section II of the 2024 Guide is not applicable to the CHP Program. Managed long-term services and supports, as defined at 42 CFR § 438.2, are not covered services under the CHP Program. The CHP Program 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 – Not Applicable

Section III of the 2024 Guide is not applicable to the CHP Program.

Appendix 1: Actuarial Certification

I, Erica Johnson, ASA, MAAA, am an employee of AHCCCS. I meet the qualification standards established by the American Academy of Actuaries and have followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries, the Actuarial Standards Board, CMS, and federal regulations.

The capitation rate included with this rate certification is considered actuarially sound according to the following criteria from 42 CFR § 438.4(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

- § 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 differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations. CMS may require a State to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or 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.
- § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

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."

The data, assumptions, and methodologies used to develop the CYE 24 capitation rate for the CHP Program have been documented according to the guidelines established by CMS in the 2024 Guide. The CYE 24 capitation rate for the CHP Program is effective for the twelve-month time period from October 1, 2023, through September 30, 2024.

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 teams at AHCCCS, the CHP Contractor, CHP's integrated subcontractor, and the previous behavioral health Contractors. I have relied upon AHCCCS and the Contractors 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	August 11, 2023
Erica Johnson	Date
Associate, Society of Actuaries	
Member, American Academy of Actuaries	

Appendix 2: Certified Capitation Rate

CHP Capitation Rate	
Effective October 1, 2023, through September 30, 2024	$1,322.09

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rate

Rate Cell	CYE 24 Projected MMs	CYE 23 Capitation Rate	CYE 23 Projected Expenses	CYE 24 Capitation Rate	CYE 24 Projected Expenses	Percentage Impact
CHP	118,621	$1,293.65	$153,454,742	$1,322.09	$156,828,310	2.20%

Appendix 4: Base Data and Base Data Adjustments

Appendix 4: Base Data and Base Data Adjustments

	I.2.B.ii.(a)	I.2.B.iii.(b)	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	Subtotal
Category of Service	Unadjusted Base PMPM	Completion	COVID-19 Base Data Normalization	Adjusted PMPM	Removal of Crisis	Removal of DAP	Removal of COVID-19 Tests	Subcap Admin Removal	Other Base Data Adjustments	Adjusted Base PMPM
Physical Health Inpatient and LTC	$50.63	0.9414	0.9471	$56.78	0.00%	(9.32%)	0.00%	0.00%	0.00%	$51.49
Behavioral Health Inpatient and LTC	$164.51	0.9353	0.9973	$176.36	0.00%	0.00%	0.00%	0.00%	0.00%	$176.36
Outpatient Facility	$27.32	0.9419	1.0000	$29.01	0.00%	(4.86%)	0.00%	0.00%	0.00%	$27.60
Emergency Facility	$18.55	0.9388	0.9914	$19.93	0.00%	0.00%	0.00%	0.00%	0.00%	$19.93
Pharmacy	$54.38	0.9966	1.0000	$54.56	0.00%	0.00%	(0.01%)	0.00%	(0.78%)	$54.13
Transportation	$23.27	0.9709	0.9731	$24.63	(0.08%)	0.00%	0.00%	(0.00%)	0.00%	$24.61
Dental	$20.50	0.9727	0.9275	$22.72	0.00%	(0.52%)	0.00%	(8.19%)	0.00%	$20.75
FQHC/RHC	$24.29	0.9701	1.0000	$25.04	0.00%	0.00%	(0.00%)	(0.95%)	(0.01%)	$24.79
Laboratory and Radiology Services	$8.62	0.9767	0.9801	$9.00	0.00%	0.00%	(47.40%)	(3.09%)	0.00%	$4.59
Other Professional Services	$105.72	0.9733	0.9578	$113.41	(18.92%)	(0.15%)	0.00%	(0.88%)	(0.00%)	$91.00
Physical Health Practitioners	$82.97	0.9719	0.9713	$87.89	0.00%	(0.01%)	0.00%	(0.15%)	(0.73%)	$87.11
Behavioral Health Practitioners	$75.51	0.9713	0.9844	$78.97	0.00%	(9.90%)	0.00%	(0.04%)	(0.00%)	$71.13
Case Management	$125.05	0.9729	0.9929	$129.45	(0.27%)	0.00%	0.00%	(0.02%)	(0.01%)	$129.07
Rehabilitation Services	$104.33	0.9723	1.0000	$107.31	0.00%	0.00%	0.00%	(0.00%)	(0.12%)	$107.17
Residential Services	$45.92	0.9740	0.9896	$47.64	(2.71%)	0.00%	0.00%	0.00%	0.00%	$46.35
Gross Medical	**$931.56**	**0.9637**	**0.9836**	**$982.70**	**(2.35%)**	**(1.54%)**	**(0.45%)**	**(0.34%)**	**(0.13%)**	**$936.09**

Appendix 5: Projected Benefit Cost Trends

Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
CHP	Physical Health Inpatient and LTC	0.0%	1.0%	1.0%
CHP	Behavioral Health Inpatient and LTC	4.0%	3.0%	7.1%
CHP	Outpatient and Emergency Facilities	2.0%	0.0%	2.0%
CHP	Pharmacy	3.0%	1.5%	4.5%
CHP	Transportation	2.0%	0.0%	2.0%
CHP	Dental	2.0%	0.0%	2.0%
CHP	Other Professional Services	0.5%	0.0%	0.5%
CHP	Physical Health Practitioners	2.5%	0.0%	2.5%
CHP	Behavioral Health Practitioners	6.0%	0.5%	6.5%
CHP	Case Management	3.5%	0.5%	4.0%
CHP	Rehabilitation Services	4.0%	0.0%	4.0%

Appendix 6: Development of Gross Medical Component

Appendix 6: Development of Gross Medical Component

	Appendix 4	I.3.B.iii.	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal
Category of Service	Adjusted Base PMPM	Trend	Aggregate Fee Schedule Changes	Reduced Out-of-Home Placements	Combined Misc. Changes	Gross Medical
Physical Health Inpatient and LTC	$51.49	1.00%	0.98%	3.04%	0.00%	$54.65
Behavioral Health Inpatient and LTC	$176.36	7.12%	0.00%	3.04%	0.00%	$208.54
Outpatient Facility	$27.60	2.00%	(0.13%)	3.04%	0.00%	$29.55
Emergency Facility	$19.93	2.00%	(0.13%)	3.04%	0.00%	$21.33
Pharmacy	$54.13	4.55%	0.00%	3.04%	(0.83%)	$60.46
Transportation	$24.61	2.00%	8.79%	0.00%	0.00%	$27.85
Dental	$20.75	2.00%	0.00%	0.00%	2.17%	$22.06
FQHC/RHC	$24.79	0.50%	13.56%	0.00%	0.00%	$28.44
Laboratory and Radiology Services	$4.59	0.50%	(1.64%)	0.00%	40.37%	$6.40
Other Professional Services	$91.00	0.50%	1.33%	0.00%	1.21%	$94.26
Physical Health Practitioners	$87.11	2.50%	(0.12%)	3.04%	1.23%	$95.36
Behavioral Health Practitioners	$71.13	6.53%	1.94%	3.04%	0.39%	$85.13
Case Management	$129.07	4.02%	2.45%	3.04%	0.00%	$147.43
Rehabilitation Services	$107.17	4.00%	2.50%	3.04%	0.00%	$122.43
Residential Services	$46.35	4.00%	2.50%	3.04%	0.00%	$52.95
Gross Medical	**$936.09**	**3.88%**	**1.60%**	**2.53%**	**0.42%**	**$1,056.83**

DAP PMPM	**$18.33**
Gross Medical Plus DAP PMPM	**$1,075.16**

Appendix 7: Capitation Rate Development

Appendix 7: Capitation Rate Development

	Appendix 6	I.4.C.ii.(c)	Subtotal	I.5.B.i.(a)	I.5.B.i.(a)	I.5.B.ii.(c)	I.5.B.ii.(c)	I.5.B.ii.(b)	Total
Rate Cell	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPM	Care Management PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
CHP	$1,075.16	($16.44)	$1,058.72	$105.85	$118.12	1.0%	$12.96	$26.44	$1,322.09

Appendix 8a: State Directed Payments – CMS Prescribed Tables

Appendix 8a: State Directed Payments - CMS Prescribed Tables

CMS Prescribed Table for I.4.D.ii.(a)(i)

Control name of the state directed payment	Type of payment - Section I.4.D.ii.(a)(i)(A)	Brief description - Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.D.ii.(a)(iii)
Federally Qualified Health Centers and Rural Health Clinics	Minimum Fee Schedule	Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Medicaid State plan as a minimum fee schedule for FQHC/RHC providers.	Rate Adjustment
AZ_Fee_IPH.OPH.PC.SP.NF.HSBS.BHI.BHO.D_Renewal_20231001-20240930 (DAP)	Uniform Percentage Increase	Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.	Rate Adjustment
AZ_Fee_AMC_Renewal_20231001-20240930 (APSI)	Uniform Percentage Increase	75% increase to otherwise contracted rates for professional services provided by eligible practitioners, applicable only to services covered under the AHCCCS APSI policy.	Separate Payment Term
AZ_Fee_IPH.OPH1_Renewal_20231001-20240930 (PSI)	Uniform Percentage Increase	Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 beds. The uniform percentage increase is based on a fixed total payment amount, and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_IPH.OPH2_Renewal_20231001-20240930 (HEALTHII)	Uniform Percentage Increase	Uniform percentage increase for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class' aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term

Appendix 8a: State Directed Payments - CMS Prescribed Tables

CMS Prescribed Table for I.4.D.ii.(a)(ii)

Control name of the state directed payment	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Impact - Section I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	The single rate cell for the CHP Program is affected.	See Appendix 8b for total impact by rate cell.	The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates. The AHCCCS DBF Rates & Reimbursement Team developed the impacts of bringing the base FQHC/RHC encounter data up to the projected CYE 24 FQHC/RHC PPS rates, by applying the change in PPS rates as a unit cost change to the CYE 22 base data. The AHCCCS DBF Actuarial Team then reviewed the FQHC/RHC results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting category of service as part of the overall fee schedule update.	Not applicable.	Not applicable.
AZ_Fee_IPH.OPH.PC.SP.NF.HSBS.BHI.BHO.D_Renewal_20231001-20240930 (DAP)	The single rate cell for the CHP Program is affected.	See Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell.	The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 22 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DBF 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 CYE 24 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 24 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DBF Actuarial Team then aggregated to the specific rate cells for each program).	AHCCCS has submitted the DAP §438.6(c) preprint to CMS but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the preprint under CMS review.	Not applicable.

Appendix 8a: State Directed Payments - CMS Prescribed Tables

CMS Prescribed Table for I.4.D.ii.(a)(iii)

Control name of the state directed payment	Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20231001-20240930 (APSI)	$3,247,482	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Access to Professional Services Initiative (APSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH1_Renewal_20231001-20240930 (PSI)	$2,058,376	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Pediatric Service Initiative (PSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The PSI payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH2_Renewal_20231001-20240930 (HEALTHII)	$13,507,162	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The HEALTHII payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Appendix 8b: State Directed Payments – Estimated PMPMs

CYE 24 Estimated PMPM				
State Directed Payment	Medical	UW Gain	Premium Tax	Total
FQHC/RHC	$4.55	$0.05	$0.09	$4.69
DAP	$18.33	$0.19	$0.38	$18.90
APSI	$26.83	$0.00	$0.55	$27.38
PSI	$17.01	$0.00	$0.35	$17.35
HEALTHII	$111.59	$0.00	$2.28	$113.87