

# Contract Year Ending 2021 CMDP Capitation Rate Certification

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## Table of Contents

INTRODUCTION AND LIMITATIONS .....	6
SECTION I MEDICAID MANAGED CARE RATES .....	8
I.1. GENERAL INFORMATION .....	10
I.1.A. RATE DEVELOPMENT STANDARDS .....	10
I.1.A.I. RATING PERIOD .....	10
I.1.A.II. REQUIRED ELEMENTS .....	10
I.1.A.II.(A) LETTER FROM CERTIFYING ACTUARY .....	10
I.1.A.II.(B) FINAL AND CERTIFIED CAPITATION RATES .....	10
I.1.A.II.(C) PROGRAM INFORMATION.....	10
I.1.A.II.(C)(I) SUMMARY OF PROGRAM .....	10
I.1.A.II.(C)(I)(A) TYPE AND NUMBER OF MANAGED CARE PLANS .....	10
I.1.A.II.(C)(I)(B) GENERAL DESCRIPTION OF BENEFITS.....	10
I.1.A.II.(C)(I)(C) AREAS OF STATE COVERED AND LENGTH OF TIME PROGRAM IN OPERATION .....	11
I.1.A.II.(C)(II) RATING PERIOD COVERED .....	11
I.1.A.II.(C)(III) COVERED POPULATIONS.....	11
I.1.A.II.(C)(IV) ELIGIBILITY OR ENROLLMENT CRITERIA IMPACTS .....	11
I.1.A.II.(C)(V) SUMMARY OF SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT .....	11
I.1.A.II.(C)(VI) RETROACTIVE CAPITATION RATE ADJUSTMENTS.....	12
I.1.A.III. RATE DEVELOPMENT STANDARDS AND FEDERAL FINANCIAL PARTICIPATION.....	12
I.1.A.IV. RATE CELL CROSS-SUBSIDIZATION .....	12
I.1.A.V. EFFECTIVE DATES OF CHANGES .....	12
I.1.A.VI. MINIMUM MEDICAL LOSS RATIO .....	12
I.1.A.VII. GENERALLY ACCEPTED ACTUARIAL PRINCIPLES AND PRACTICES.....	12
I.1.A.VII.(A) REASONABLE, APPROPRIATE, AND ATTAINABLE COSTS.....	12
I.1.A.VII.(B) RATE SETTING PROCESS .....	12
I.1.A.VII.(C) CONTRACTED RATES .....	12
I.1.A.VIII. RATES FROM PREVIOUS RATING PERIODS .....	12
I.1.A.IX. RATE CERTIFICATION PROCEDURES.....	12
I.1.A.IX.(A) TIMELY FILING FOR CLAIMING FEDERAL FINANCIAL PARTICIPATION (FFP).....	12
I.1.A.IX.(B) CMS RATE CERTIFICATION REQUIREMENT FOR RATE CHANGE.....	12
I.1.A.IX.(C) CMS RATE CERTIFICATION REQUIREMENT FOR NO RATE CHANGE .....	13
I.1.A.IX.(D) CMS RATE CERTIFICATION CIRCUMSTANCES.....	13
I.1.A.IX.(E) CMS CONTRACT AMENDMENT REQUIREMENT.....	13
I.1.A.IX.(F) CMS AMENDMENT REQUIREMENT FOR CHANGES IN LAW .....	13
I.1.B. APPROPRIATE DOCUMENTATION.....	13

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I.1.B.I. ELEMENTS .....	13
I.1.B.II. RATE ASSUMPTIONS.....	13
I.1.B.III. RATE CERTIFICATION INDEX .....	14
I.1.B.IV. DIFFERENCES IN FEDERAL MEDICAL ASSISTANCE PERCENTAGE .....	14
I.1.B.V. COMPARISON OF RATES .....	14
I.1.B.V.(A) COMPARISON TO PREVIOUS RATE CERTIFICATION .....	14
I.1.B.V.(B) MATERIAL CHANGES TO CAPITATION RATE DEVELOPMENT .....	14
I.1.B.VI. FUTURE RATE AMENDMENTS .....	14
I.2. DATA .....	15
I.2.A. RATE DEVELOPMENT STANDARDS .....	15
I.2.A.I. COMPLIANCE WITH 42 CFR § 438.5(C) .....	15
I.2.B. APPROPRIATE DOCUMENTATION .....	15
I.2.B.I. DATA REQUEST .....	15
I.2.B.II. DATA USED FOR RATE DEVELOPMENT .....	15
I.2.B.II.(A) DESCRIPTION OF DATA .....	15
I.2.B.II.(A)(I) TYPES OF DATA USED.....	15
I.2.B.II.(A)(II) AGE OF DATA.....	16
I.2.B.II.(A)(III) SOURCES OF DATA.....	16
I.2.B.II.(A)(IV) SUB-CAPITATED ARRANGEMENTS .....	16
I.2.B.II.(B) AVAILABILITY AND QUALITY OF THE DATA .....	17
I.2.B.II.(B)(I) DATA VALIDATION STEPS.....	17
I.2.B.II.(B)(I)(A) COMPLETENESS OF THE DATA.....	18
I.2.B.II.(B)(I)(B) ACCURACY OF THE DATA.....	18
I.2.B.II.(B)(I)(C) CONSISTENCY OF THE DATA .....	18
I.2.B.II.(B)(II) ACTUARY’S ASSESSMENT OF THE DATA.....	18
I.2.B.II.(B)(III) DATA CONCERNS.....	19
I.2.B.II.(C) APPROPRIATE DATA FOR RATE DEVELOPMENT .....	19
I.2.B.II.(C)(I) NOT USING ENCOUNTER OR FEE-FOR-SERVICE DATA .....	19
I.2.B.II.(C)(II) NOT USING MANAGED CARE ENCOUNTER DATA .....	19
I.2.B.II.(D) USE OF A DATA BOOK.....	19
I.2.B.III. ADJUSTMENTS TO THE DATA.....	19
I.2.B.III.(A) CREDIBILITY OF THE DATA .....	19
I.2.B.III.(B) COMPLETION FACTORS .....	19
I.2.B.III.(C) ERRORS FOUND IN THE DATA .....	19
I.2.B.III.(D) CHANGES IN THE PROGRAM .....	19
I.2.B.III.(E) EXCLUSIONS OF PAYMENTS OR SERVICES .....	21
I.3. PROJECTED BENEFIT COSTS AND TRENDS .....	22
I.3.A RATE DEVELOPMENT STANDARDS .....	22
I.3.A.I. COMPLIANCE WITH 42 CFR § 438.3(C)(1)(II) AND § 438.3(E) .....	22

I.3.A.II. VARIATIONS IN ASSUMPTIONS.....	22
I.3.A.III. PROJECTED BENEFIT COST TREND ASSUMPTIONS .....	22
I.3.A.IV. IN-LIEU-OF SERVICES .....	22
I.3.A.V. INSTITUTION FOR MENTAL DISEASE.....	22
I.3.B. APPROPRIATE DOCUMENTATION .....	22
I.3.B.I PROJECTED BENEFIT COSTS .....	22
I.3.B.II. PROJECTED BENEFIT COST DEVELOPMENT .....	22
I.3.B.II.(A) DESCRIPTION OF THE DATA, ASSUMPTIONS, AND METHODOLOGIES .....	22
I.3.B.II.(B) MATERIAL CHANGES TO THE DATA, ASSUMPTIONS, AND METHODOLOGIES.....	28
I.3.B.II.(C) OVERPAYMENTS TO PROVIDERS.....	28
I.3.B.III. PROJECTED BENEFIT COST TRENDS.....	28
I.3.B.III.(A) REQUIREMENTS.....	28
I.3.B.III.(A)(I) PROJECTED BENEFIT COST TRENDS DATA.....	28
I.3.B.III.(A)(II) PROJECTED BENEFIT COST TRENDS METHODOLOGIES.....	28
I.3.B.III.(A)(III) PROJECTED BENEFIT COST TRENDS COMPARISONS .....	29
I.3.B.III.(A)(IV) SUPPORTING DOCUMENTATION FOR TRENDS .....	29
I.3.B.III.(B) PROJECTED BENEFIT COST TRENDS BY COMPONENT.....	29
I.3.B.III.(B)(I) CHANGES IN PRICE AND UTILIZATION.....	29
I.3.B.III.(B)(II) ALTERNATIVE METHODS .....	29
I.3.B.III.(B)(III) OTHER COMPONENTS .....	29
I.3.B.III.(C) VARIATION IN TREND .....	29
I.3.B.III.(D) ANY OTHER MATERIAL ADJUSTMENTS .....	29
I.3.B.III.(E) ANY OTHER ADJUSTMENTS .....	29
I.3.B.IV. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT COMPLIANCE .....	30
I.3.B.V. IN-LIEU-OF SERVICES.....	30
I.3.B.VI. RETROSPECTIVE ELIGIBILITY PERIODS .....	30
I.3.B.VI.(A) MANAGED CARE PLAN RESPONSIBILITY .....	30
I.3.B.VI.(B) CLAIMS DATA INCLUDED IN BASE DATA.....	30
I.3.B.VI.(C) ENROLLMENT DATA INCLUDED IN BASE DATA.....	30
I.3.B.VI.(D) ADJUSTMENTS, ASSUMPTIONS, AND METHODOLOGY .....	30
I.3.B.VII. IMPACT OF ALL MATERIAL CHANGES TO COVERED BENEFITS OR SERVICES.....	30
I.3.B.VII.(A) COVERED BENEFITS.....	30
I.3.B.VII.(B) RECOVERIES OF OVERPAYMENTS.....	30
I.3.B.VII.(C) PROVIDER PAYMENT REQUIREMENTS .....	31
I.3.B.VII.(D) APPLICABLE WAIVERS.....	31
I.3.B.VII.(E) APPLICABLE LITIGATION .....	31
I.3.B.VIII. IMPACT OF ALL MATERIAL AND NON-MATERIAL CHANGES .....	31
I.4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT .....	32
I.4.A. INCENTIVE ARRANGEMENTS.....	32

I.4.A.II.(A)(I) TIME PERIOD.....	32
I.4.A.II.(A)(II) ENROLLEES, SERVICES, AND PROVIDERS COVERED.....	32
I.4.A.II.(A)(III) PURPOSE.....	32
I.4.A.II.(A)(IV) ATTESTATION TO LIMIT ON INCENTIVE PAYMENTS.....	32
I.4.A.II.(A)(V) EFFECT OF CAPITATION RATE DEVELOPMENT.....	32
I.4.B. WITHHOLD ARRANGEMENTS.....	32
I.4.C. RISK-SHARING MECHANISMS.....	32
I.4.C.I. RATE DEVELOPMENT STANDARDS.....	32
I.4.C.II. APPROPRIATE DOCUMENTATION.....	32
I.4.C.II.(A) DESCRIPTION OF RISK-SHARING MECHANISMS.....	32
I.4.C.II.(A)(I) RATIONALE FOR RISK-SHARING MECHANISMS.....	33
I.4.C.II.(A)(II) DESCRIPTION OF RISK-SHARING MECHANISM IMPLEMENTATION.....	33
I.4.C.II.(A)(III) EFFECT OF RISK-SHARING MECHANISMS ON CAPITATION RATES.....	33
I.4.C.II.(A)(IV) RISK-SHARING MECHANISMS DOCUMENTATION.....	33
I.4.C.II.(B) DESCRIPTION OF MEDICAL LOSS RATIO.....	33
I.4.C.II.(C) DESCRIPTION OF REINSURANCE REQUIREMENTS.....	33
I.4.C.II.(C)(I) REINSURANCE REQUIREMENTS.....	33
I.4.C.II.(C)(II) EFFECT ON DEVELOPMENT OF CAPITATION RATES.....	34
I.4.C.II.(C)(III) DEVELOPMENT IN ACCORDANCE WITH GENERALLY ACCEPTED ACTUARIAL PRINCIPLES AND PRACTICES.....	34
I.4.C.II.(C)(IV) DATA, ASSUMPTIONS, METHODOLOGY TO DEVELOP THE REINSURANCE OFFSET.....	34
I.4.D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES.....	35
I.4.D.I. RATE DEVELOPMENT STANDARDS.....	35
I.4.D.II. APPROPRIATE DOCUMENTATION.....	35
I.4.D.II.(A) DESCRIPTION OF DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES.....	35
I.4.D.II.(A)(I) TYPE AND DESCRIPTION OF DIRECTED PAYMENT ARRANGEMENTS.....	35
I.4.D.II.(A)(II) DIRECTED PAYMENTS INCORPORATED IN CAPITATION RATES.....	36
I.4.D.II.(A)(II)(A) RATE CELLS AFFECTED.....	36
I.4.D.II.(A)(II)(B) IMPACT ON THE RATE CELLS.....	36
I.4.D.II.(A)(II)(C) DATA, ASSUMPTIONS, METHODOLOGY TO DEVELOP DIRECTED PAYMENT ADJUSTMENT.....	36
I.4.D.II.(A)(II)(D) PRE-PRINT ACKNOWLEDGEMENT.....	36
I.4.D.II.(A)(II)(E) MAXIMUM FEE SCHEDULE.....	37
I.4.D.II.(A)(III) DIRECTED PAYMENTS UNDER SEPARATE PAYMENT ARRANGEMENT.....	37
I.4.D.II.(A)(III)(A) AGGREGATE AMOUNT.....	37
I.4.D.II.(A)(III)(B) ACTUARIAL CERTIFICATION OF THE AMOUNT OF THE SEPARATE PAYMENT TERM.....	37
I.4.D.II.(A)(III)(C) PROVIDERS RECEIVING PAYMENT.....	38
I.4.D.II.(A)(III)(D) DISTRIBUTION METHODOLOGY.....	38
I.4.D.II.(A)(III)(E) ESTIMATED IMPACT BY RATE CELL.....	39

<b>I.4.D.II.(A)(III)(G) FUTURE DOCUMENTATION REQUIREMENTS .....</b>	<b>39</b>
<b>I.4.D.II.(B) CONFIRMATION OF NO OTHER DIRECTED PAYMENTS.....</b>	<b>39</b>
<b>I.4.D.II.(C) CONFIRMATION REGARDING REQUIRED REIMBURSEMENT RATES .....</b>	<b>40</b>
<b>I.4.E. PASS-THROUGH PAYMENTS.....</b>	<b>40</b>
<b>I.5 PROJECTED NON-BENEFIT COSTS .....</b>	<b>40</b>
<b>I.5.A. RATE DEVELOPMENT STANDARDS .....</b>	<b>40</b>
<b>I.5.B. APPROPRIATE DOCUMENTATION.....</b>	<b>40</b>
<b>I.5.B.I. DESCRIPTION OF THE DEVELOPMENT OF PROJECTED NON-BENEFIT COSTS .....</b>	<b>40</b>
<b>I.5.B.I.(A) DATA, ASSUMPTIONS, AND METHODOLOGY .....</b>	<b>40</b>
<b>I.5.B.I.(B) CHANGES FROM THE PREVIOUS RATE CERTIFICATION .....</b>	<b>40</b>
<b>I.5.B.I.(C) ANY OTHER MATERIAL CHANGES .....</b>	<b>41</b>
<b>I.5.B.II. PROJECTED NON-BENEFIT COSTS BY CATEGORY.....</b>	<b>41</b>
<b>I.5.B.II.(A) ADMINISTRATIVE COSTS.....</b>	<b>41</b>
<b>I.5.B.II.(B) TAXES AND OTHER FEES .....</b>	<b>41</b>
<b>I.5.B.II.(C) CONTRIBUTION TO RESERVES, RISK MARGIN, AND COST OF CAPITAL.....</b>	<b>41</b>
<b>I.5.B.II.(D) OTHER MATERIAL NON-BENEFIT COSTS.....</b>	<b>41</b>
<b>I.5.B.III. HISTORICAL NON-BENEFIT COSTS.....</b>	<b>41</b>
<b>I.5.B.IV. HEALTH INSURANCE PROVIDER'S FEE .....</b>	<b>41</b>
<b>I.5.B.IV.(A) ADDRESS IF IN RATES.....</b>	<b>41</b>
<b>I.6. RISK ADJUSTMENT AND ACUITY ADJUSTMENTS .....</b>	<b>41</b>
<b>SECTION II MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS.....</b>	<b>42</b>
<b>SECTION III NEW ADULT GROUP CAPITATION RATES.....</b>	<b>42</b>
<b>APPENDIX 1: ACTUARIAL CERTIFICATION .....</b>	<b>43</b>
<b>APPENDIX 2: ACTUARIAL CERTIFIED CAPITATION RATES.....</b>	<b>45</b>
<b>APPENDIX 3: FISCAL IMPACT SUMMARY COMPARED TO CYE 20 .....</b>	<b>46</b>
<b>APPENDIX 4: UNADJUSTED AND ADJUSTED BASE DATA .....</b>	<b>47</b>
<b>APPENDIX 5: PROJECTED BENEFIT COST TRENDS.....</b>	<b>48</b>
<b>APPENDIX 6: PROJECTED CYE 21 CAPITATION RATE DEVELOPMENT.....</b>	<b>49</b>
<b>APPENDIX 7: PROJECTED DIRECTED PAYMENT ADJUSTMENT, PMPM.....</b>	<b>50</b>
<b>APPENDIX 8: PROJECTED DELIVERY SYSTEM AND PROVIDER PAYMENTS INITIATIVES, PMPM.....</b>	<b>51</b>

## Introduction and Limitations

### **Introduction**

Milliman, Inc. (Milliman) has been retained by the Arizona Health Care Cost Containment System to provide actuarial and consulting services related to the development of contract year ending 2021 capitation rates for the Arizona Comprehensive Medical and Dental Program.

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438 at 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies, used to develop the actuarially sound capitation rates effective October 1, 2020 for Arizona's Comprehensive Medical and Dental Program (CMDP). Hereafter, the term "CYE 21" will refer to the 12-month rating period ending September 30, 2021. Comparisons to prior rates in this certification refer to the previously submitted actuarial memorandum for capitation rates as signed by Matthew C. Varitek on August 14, 2019. This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

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 at 81 FR 27497 applicable to this rate certification, the 2021 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2021 Medicaid Managed Care Rate Development Guide (2021 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 2021 Guide to help facilitate the review of this rate certification by CMS.

### **Limitations**

The services for this project were performed under the terms of the September 30, 2019 Master Services Agreement for State of Arizona between GuideSoft, Inc. (dba Knowledge Services) and Milliman, Inc. and AHCCCS Task Order YH20-0084 approved March 23, 2020.

The information contained in this report has been prepared for the Arizona Health Care Cost Containment System (AHCCCS) to provide documentation of the development of the contract year ending 2021 actuarially sound capitation rates for the population served under the Arizona Comprehensive Medical and Dental Program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for AHCCCS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has relied upon certain data and information provided by AHCCCS and the participating Medicaid Contractors in the development of the contract year ending 2021 capitation rates. The information may not be appropriate for any other purpose. Milliman has relied upon AHCCCS and the Contractors for the accuracy of the data and accepted it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.



Milliman's data reliance includes eligibility and encounter data, Contractor-reported financial experience, AHCCCS provided adjustments for program changes, as well as information related to eligibility system and assignment of enrollees to rate cells.

Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual Medicaid Contractor. Results will differ if actual experience is different from the assumptions contained in the capitation rate setting documentation. AHCCCS and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

At the time of this rate certification, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on setting capitation rates, including whether the pandemic will increase or decrease costs in CYE 21. Given the lack of reliable and historical information for this unprecedented public health emergency, we made no attempt to predict rates of foregone care, deferred care, and pent-up demand. However, it is known that the COVID-19 pandemic could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this rate certification. 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. In times such as these, the risk-sharing arrangements are even more important to the stability of the system.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

## Section I Medicaid Managed Care Rates

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

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

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for all Practice Areas)); ASOP 23 (Data Quality); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2021 managed care program rating period.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.

Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

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

As stated on page 2 of the 2021 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 2021 Guide.

### I.1.A. Rate Development Standards

#### I.1.A.i. Rating Period

This rate certification documents rates for the CMDP are effective for the twelve month time period from October 1, 2020 through September 30, 2021.

#### I.1.A.ii. Required Elements

##### I.1.A.ii.(a) Letter from Certifying Actuary

The actuarial certification letter for the CYE 21 capitation rates for the CMDP, signed by Bradley B. Armstrong, FSA, MAAA, is in Appendix 1. Mr. Armstrong meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854 and is provided below for reference.

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

Mr. Armstrong certifies that the CYE 21 capitation rates for the CMDP contained in this rate certification is actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 at 81 FR 27497.

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

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

##### I.1.A.ii.(c) Program Information

###### I.1.A.ii.(c)(i) Summary of Program

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

The CMDP is the health plan within the Arizona Department of Child Safety (DCS) that is responsible for managing the health care needs for children in foster care. Effective April 1, 2021, CMDP will subcontract with an external health plan – Mercy Care – to deliver services covered under this contract. At that same time, CMDP intends to change its name to DCS Comprehensive Health Plan. However, the acronym CMDP will be used throughout this report to describe this same entity.

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

Services covered by the CMDP include physical health services, limited behavioral health services (i.e. treatment for ADHD, anxiety and depression when provided by the member's primary care physician) and Children's Rehabilitative Services (CRS) specialty care. Prior to October 1, 2018, CRS specialty care was provided through the CRS program to CMDP members who were diagnosed with a CRS-qualifying health condition. Since October 1, 2018, those CRS specialty services have been provided through the CMDP. Capitation rates reflect this program change.

Effective April 1, 2021, the CMDP will also begin covering behavioral health services for members. These services have historically been provided under a separate contract by three regional behavioral health authorities (RBHAs).

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

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

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

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

This rate certification documents rates for the CMDP are effective for the twelve month time period from October 1, 2020 through September 30, 2021.

Rates are being certified for two different six month time periods: one rate that is effective October 1, 2020 through March 31, 2021, and a second rate that is effective from April 1, 2021 through September 30, 2021. The second rate reflects the integration of behavioral health services into the CMDP contract effective April 1, 2021.

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

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

1. Placed in a foster home;
2. 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
3. In the custody of the Arizona Department of Juvenile Corrections or the Administrative Office of the Courts/Juvenile Probation Office and placed in foster care.

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

### I.1.A.ii.(c)(iv) Eligibility or Enrollment Criteria Impacts

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

Due to the public health emergency (PHE), and the maintenance of effort (MOE) requirements included in Families First Coronavirus Response Act, with a few exceptions as noted in the law, members who were eligible at the beginning of the PHE, or who become eligible during the PHE, will remain treated as eligible for such benefits through the end of the month in which the PHE ends. Given the lack of reliable and historical information for this unprecedented PHE, we did not attempt to predict rates of foregone care, deferred care, and pent-up demand.

Otherwise, there are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the populations to be covered under the CMDP during CYE 21.

### I.1.A.ii.(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 at 81 FR 27859. The special contract provisions related to payment included in the CYE 21 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Alternative Payment Model (APM) Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

### **I.1.A.ii.(c)(vi) Retroactive Capitation Rate Adjustments**

Not applicable. This rate certification does not cover retroactive adjustments.

### **I.1.A.iii. Rate Development Standards and Federal Financial Participation**

The CYE 21 capitation rates for the CMDP are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the CMDP.

### **I.1.A.iv. Rate Cell Cross-subsidization**

The capitation rates were developed as one statewide rate cell.

### **I.1.A.v. Effective Dates of Changes**

The effective dates of changes to the CMDP are consistent with the assumptions used to develop the CYE 21 capitation rates for the CMDP.

### **I.1.A.vi. Minimum Medical Loss Ratio**

The certified capitation rates allow the CMDP to reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 21.

### **I.1.A.vii. Generally Accepted Actuarial Principles and Practices**

#### **I.1.A.vii.(a) Reasonable, Appropriate, and Attainable Costs**

In the actuary's judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, 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.vii.(b) Rate Setting Process**

Adjustments to the capitation rates 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 capitation rates performed outside the rate setting process.

#### **I.1.A.vii.(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 21 capitation rates certified in this report represents the final contracted rates.

### **I.1.A.viii. Rates from Previous Rating Periods**

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 21 capitation rates for the CMDP.

### **I.1.A.ix. Rate Certification Procedures**

#### **I.1.A.ix.(a) Timely Filing for Claiming Federal Financial Participation (FFP)**

This section of the 2021 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.ix.(b) CMS Rate Certification Requirement for Rate Change**

This is a new rate certification that documents that the CMDP capitation rates are changing effective October 1, 2020, as well as an additional rate change effective April 1, 2021.

### I.1.A.ix.(c) CMS Rate Certification Requirement for No Rate Change

Not Applicable. This rate certification will change the CMDP capitation rates effective October 1, 2020. This rate certification also addresses the contract amendment which revises the covered services under the contract effective April 1, 2021. Additionally, AHCCCS will be including contract amendments with the submission of this rate certification which removes language which imposed an upper limit on administrative expenses for PBM subcontractors, the capitation rates certified herein were developed without the specified upper limit.

### I.1.A.ix.(d) CMS Rate Certification Circumstances

This section of the 2021 Guide provides information on when CMS would not require a new rate certification, which includes increasing or decreasing capitation rates up to 1.5% per rate cell in accordance with 42 CFR § 438.7(c)(3) 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.ix.(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 to reflect the CMDP capitation rates changing effective October 1, 2020. The state will also submit a contract amendment which revises the covered services under the contract effective April 1, 2021. Additionally, AHCCCS will be including contract amendments with the submission of this rate certification which removes language which imposed an upper limit on administrative expenses for Pharmacy Benefit Manager (PBM) subcontractors, the capitation rates certified herein were developed without the specified upper limit.

### I.1.A.ix.(f) CMS Amendment Requirement for Changes in Law

CMS requires a 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. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 21 capitation rates for the CMDP.

### I.1.B.ii. Rate Assumptions

This section of the 2021 Guide notes that it is not permissible to certify rate ranges, and the actuary must be responsible for all assumptions and adjustments underlying the certified capitation rates, and the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell.

To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for the variation.

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

### I.1.B.iii. 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 2021 Guide. Sections 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.iv. Differences in Federal Medical Assistance Percentage

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

### I.1.B.v. Comparison of Rates

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

The comparisons between the most recent certified CYE 20 CMDP capitation rates and the CYE 21 capitation rates being certified in this actuarial rate certification are available in Appendix 3.

Since the certified rate effective April 1, 2021 reflects the integration of behavioral health services that have historically been provided under a separate contract by the RBHAs, this rate is being compared to the sum of the CYE 20 CMDP capitation rate and the CYE 20 composite rate paid to the three RBHAs.

The 2021 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. For the purposes of the CYE 21 certified capitation rates, the actuary 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 was a negative change in the rate. For the CMDP rate effective October 1, 2020, there were no large or negative changes in rates from the previous rating period. For the CMDP rate effective April 1, 2021, there was a rate change larger than 10% primarily due to increases in behavioral health base data, new program changes, and an increased care management allowance as compared to the CYE 20 rates.

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

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

### I.1.B.vi. Future Rate Amendments

There are no known amendments anticipated to be provided to CMS in the future which would impact capitation rates.



## I.2. Data

This section provides documentation for the Data section of the 2021 Guide.

### I.2.A. Rate Development Standards

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

We 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

We worked with the appropriate teams at AHCCCS to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) at 81 FR 27858. Descriptions of the data used are detailed in section I.2.B.ii. of this report.

#### 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 21 capitation rates for the CMDP were:

- Adjudicated and approved encounter data submitted by the CMDP, the CRS Contractor, and the RBHAs
  - a. Incurred from October 2016 through March 2020
  - b. Paid and reported through March 2020 (CMDP and CRS data)
  - c. Paid and reported through June 2020 (RBHA data)
- Pended encounter data submitted by the CMDP
- Reinsurance payments made to CMDP for services
  - a. Incurred from October 2016 through September 2019, paid through March 2020
- Enrollment data for the CMDP, the CRS program, and the RBHAs from the AHCCCS PMMIS mainframe
- Quarterly and annual financial statements submitted by the CMDP, the CRS Contractor, and the RBHAs
  - a. October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17)
  - b. October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
  - c. October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19)
  - d. October 1, 2019 through March 31, 2020 (CYE 20 or FFY 20)
- Supplemental encounter data files for services provided by the CMDP that had not been submitted for processing by the AHCCCS data warehouse.
- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement Team related to DAP, see Section I.4.D
- Data from AHCCCS DHCM 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:

- Detailed administrative expense data and projections from the CMDP, the RBHAs, and Mercy Care
- Projected CYE 21 enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
- 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 CMDP encounter data serving as the base experience in the capitation rate development process was incurred during October 1, 2018 to September 30, 2019, and paid through March 2020. For claims that were historically paid by the RBHAs, we utilized encounters incurred during October 1, 2018 to September 30, 2019, and paid through June 2020. For the purposes of developing trend assumptions applied for the CYE 21 capitation rates, we also reviewed encounter data from October 1, 2016 through September 30, 2018.

The historical enrollment data for CMDP members aligned with the encounter data time periods of October 1, 2016 through September 30, 2019.

The financial statement data reviewed as part of the rate development process included financial statements for CYE 19 and CYE 20 time periods.

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

The enrollment and encounter data were provided from the AHCCCS PMMIS mainframe. The financial statement data were provided by the AHCCCS DHCM Finance & Reimbursement Team. The projected enrollment data for CYE 21 was provided by the AHCCCS DBF Budget Team. The supplemental encounter data files and detailed administrative expense data were provided by the CMDP.

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

While the CMDP has not historically had sub-capitated contracts with providers, the encounter data for CRS specialty services provided to children with CRS-eligible health conditions does contain sub-capitated payment amounts. The CRS contractor stopped providing these services effective September 30, 2018, so this encounter data was not used in the base data development of the CYE 2021 CMDP rates. However, this data was analyzed as part of reviewing historical trends in the program.

The CRS Contractor used a sub-capitated/block purchasing arrangement for some professional services. The sub-capitated/block purchasing arrangements between the CRS Contractor and its providers still required 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 encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05, and health plan paid of zero (i.e. sub-capitated)) encounters to estimate a health plan valued amount for these encounters. 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.

The historical data for the behavioral health services previously covered by RBHAs has approximately 35.9% of expenditures in sub-capitation and block purchase payment arrangements (sub-cap/block payments) for CMDP. A block purchase payment arrangement is defined by AHCCCS as a payment arrangement methodology where a contracted amount for a block of services is divided by 12 and paid in monthly installments to the provider. The encounter data includes encounters for sub-cap/block payment arrangements; however, they are populated with a "HP Paid Amount" (HP standing for health plan) of zero. To use the sub-cap/block payment encounters for rate development, a methodology has been developed and tested for repricing the expenditures for these encounters.

The repricing methodology uses the payment field "HP Allowed Amount" in the AHCCCS PMMIS mainframe which the RBHAs populate on sub-cap/block payment encounters with the payment amount the RBHA would have paid, had the encounter been FFS. This allowed amount field is used in the repricing methodology instead of the paid amount field to estimate the expenditures for the sub-cap/block payment encounters.

Figure 1 below provides a distribution of the CYE 19 behavioral health encounter data by sub-cap/block payments, non-sub-cap/block payments and by Category of Service (COS) for CMDP.

**Figure 1: CYE 19 Non-Subcap/Non-Block and Subcap/Block percentages by Category of Service**

Category of Service	Non-Subcap/ Non-Block Payments	Subcap/Block Payments
Behavioral Health Day Programs	94.4%	5.6%
Case Management	30.5%	69.5%
Dental Services	91.0%	9.0%
FQHC/RHC	99.9%	0.1%
Inpatient Behavioral Health	99.9%	0.1%
Inpatient Hospital	100.0%	0.0%
Medical Services	33.4%	66.6%
Nursing Facility Services	0.0%	0.0%
Other Services	80.4%	19.6%
Outpatient Hospital	83.6%	16.4%
Pharmacy	100.0%	0.0%
Rehabilitation Services	15.4%	84.6%
Residential Services	97.5%	2.5%
Support Services	77.3%	22.7%
Transportation	76.6%	23.4%
Treatment Services	41.6%	58.4%
<b>Total</b>	<b>64.1%</b>	<b>35.9%</b>

## 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 DHCM 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 DHCM Actuarial Team reports the findings to the AHCCCS Office of Data Analytics (ODA) Team, which then works with the CMDP to determine causal factors. In addition, the AHCCCS ODA Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

The CMDP, the RBHAs, and the CRS Contractor 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 CMDP, the CRS Contractor, and the RBHAs 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, pending and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters, but providing this file to the CMDP, the CRS Contractor, and the RBHAs 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.

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

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

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

The AHCCCS DHCM ODA 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.

Through review of the encounter data provided from the AHCCCS PMMIS mainframe, we ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 21 capitation rates for the CMDP. Additionally, we ensured that only services covered under the state plan were included.

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

The AHCCCS DHCM Actuarial Team reviewed the encounter data for all services provided by CMDP and the RBHAs to the annual financial statement data for the same entities for CYE 19.

The monthly encounter cycle of the AHCCCS data warehouse ensures that no duplicated encounters exist among the adjudicated and approved encounters. We further compared the pending and non-submitted encounters from the CMDP supplemental data files using the member ID, date of service, servicing provider ID, and paid amount to remove duplicated encounters from those sources so that the adjustment to base data would be accurate.

After inclusion of the validated and non-duplicate encounters from the supplemental data files, and after adjusting the data for completion, the combined encounter data was deemed 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, we disclose that the rate development process has relied upon encounter data submitted by the CMDP, the RBHAs, and the CRS Contractor and provided from the AHCCCS PMMIS mainframe as well as the supplemental encounter files provided by the CMDP. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the CMDP, the RBHAs, and the CRS Contractor and reviewed by the AHCCCS DHCM Finance & Reinsurance Team. We did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS DHCM Rates & Reimbursement Team with regard to DAP and fee schedule impacts, on data provided by the AHCCCS DHCM financial analysts with regard to some program changes, on information and data provided by Mercer consultants with regard to pharmacy reimbursement savings, on information and data provided by Milliman consultants with regard to HEALTHII program, on data provided by CMDP and Mercy Care in regard to administrative and underwriting gain components, and on data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

We found the encounter data, with adjustments for encounter issues as described in Section I.2.B.ii.(b)(i), to be appropriate for the purposes of developing the CYE 21 capitation rates for the CMDP.

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

We did not identify any material concerns with the availability or quality of the data, with the exception of the encounter issue noted in the previous section.

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

We determined that the CYE 19 encounter data was appropriate to use as the base data for developing the CYE 21 capitation rates for the CMDP with the encounter issue adjustment previously noted.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 21 capitation rates for the CMDP.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 21 capitation rates for the CMDP.

#### I.2.B.ii.(d) Use of a Data Book

Not applicable. We did not rely on a data book to develop the CYE 21 capitation rates for the CMDP.

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

The CMDP encounter data was adjusted as described in Section I.2.B.ii.(b)(i) for pending and non-submitted encounters. The CMDP, RBHA, and CRS encounter data was also adjusted for completion. Historical program and fee schedule changes were applied as described in Section I.2.B.iii.(d) to bring the historical data to current program and reimbursement levels.

#### I.2.B.iii.(a) Credibility of the Data

No credibility adjustment was necessary.

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

An adjustment was made to the encounter data to reflect the level of completion. We calculated annualized completion factors by category of service (COS) using the development method with monthly CMDP and CRS Contractor encounter data from October 1, 2016 through September 30, 2019, paid through March 2020. For the services historically paid by the RBHAs, we calculated annualized completion factors by COS using the development method with monthly RBHA encounter data from October 1, 2016 through September 30, 2019, paid through June 2020. The annualized completion factors were applied to the October 1, 2018 through September 30, 2019 base experience encounter data, for purposes of projection to the CYE 21 rating period. The annualized completion factors were applied to the October 1, 2016 through September 30, 2019 encounter data for purposes of trend development.

The aggregated FFY 19 completion factors applied to each 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, 2018 through September 30, 2019) are described below. Additional adjustments for program and fee schedule changes which occurred before April 1, 2021 are also included below. All program and fee schedule changes which occurred or are effective on or after April 1, 2021 are described in Section I.3.B.ii.(a).

Impacts for base data adjustment changes described below were developed by AHCCCS DHCM financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the DHCM Clinical Quality Management Team and the Office of the Director's Chief Medical Officer. The actuary relied upon the professional judgment of the 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 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.

Figure 2 summarizes the impacts for historical program and reimbursement changes described below. Totals may not add up due to rounding.

**Figure 2: Impacts of Historical Program/Reimbursement Changes**

Change	Physical Health		Integrated - PH & BH	
	Annual Dollar Impact	PMPM Impact	Annual Dollar Impact	PMPM Impact
Provider Fee Schedule Changes	\$ 0	\$ 0.00	\$ (69,036)	\$ (0.43)
DAP Removal	(577,343)	(3.57)	(629,382)	(3.89)
Combined Miscellaneous Program Changes	(12,603)	(0.08)	374,095	2.31
<b>Total Historical Program and Reimbursement Changes</b>	<b>\$ (589,946)</b>	<b>\$ (3.65)</b>	<b>\$ (324,323)</b>	<b>\$ (2.01)</b>

#### **Provider Fee Schedule Changes**

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Effective October 1, 2019, AHCCCS updated provider fee schedules for certain providers based on access to care needs, Medicare/ Arizona Department of Health Services (ADHS) fee schedule rate changes, and/or legislative mandates. The base data has been adjusted to reflect these fee schedule changes.

#### **Combined Miscellaneous Program Changes**

##### ***Pharmacy and Therapeutics Committee Recommendations – Base Year***

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 19 that impacted utilization and unit costs of Contractors' pharmacy costs in CYE 19. 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.

Since CYE 19 is the base data year, the actuaries have normalized utilization and unit cost data for the partial year before the P&T Committee changes were implemented to ensure the base year data is consistent with the current recommendations.

##### ***Substance Use Disorder Assessment***

Effective October 1, 2018, AHCCCS updated provider fee schedules to include a targeted increase to providers who conduct a computer-guided, structured interview utilizing American Society of Addiction Medicine (ASAM) software. The service enables providers to determine the appropriate level of treatment based upon a set of medically accepted criteria. Due to a slower-than-anticipated adoption of the ASAM software, impacts of the change in the base period encounters are limited. For October 1, 2020 rate development, additional impacts for the change are included above any base period encounters.

***Advanced Practice Nurse MAT***

The Federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) permits Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists to administer Buprenorphine for medication assisted treatment (MAT). The federal law is expected to increase use of MAT and costs to the program.

***Applied Behavior Analysis***

AHCCCS policy was updated effective November 1, 2019 to include clarifying language on the requirement for the AHCCCS Complete Care and Regional Behavioral Health Authority programs to provide covered Applied Behavior Analysis (ABA) services to children not receiving these services through another program. The policy clarification is consistent with CMS guidance dated July 7, 2014, which directs states to cover medically necessary services for treatment of autism spectrum disorder as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children under 21 years of age. The policy guidance is expected to gradually raise awareness and increase utilization of these covered ABA services in CYE 20 and CYE 21.

**Removal of DAP from Base Period**

CYE 19 capitation rates funded Differential Adjusted Payments (DAP) for Acute, HCBS, and NF expenses from October 1, 2018 through September 30, 2019 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, 2019, we removed the impact of CYE 19 DAP payments from the base period. To remove the impact, the AHCCCS DHCM Actuarial Team requested provider IDs for the qualifying providers for the CYE 19 DAP by specific measure from the AHCCCS Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 19 were then adjusted downward by the appropriate percentage bump specific to the DAP measure. The associated costs removed from the base data are displayed above in Figure 2, and also displayed in Appendix 4. Totals may not add up due to rounding.

See section I.4.D. below for information on adjustments included in CYE 21 rates for DAP that are effective from October 1, 2020 through September 30, 2021.

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

We ensured that all non-covered services were excluded from the encounter data used for developing the CYE 21 capitation rates.

## I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2021 Guide.

### I.3.A Rate Development Standards

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

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

#### I.3.A.ii. Variations in Assumptions

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

#### I.3.A.iii. Projected Benefit Cost Trend Assumptions

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

#### I.3.A.iv. In-Lieu-Of Services

The projected benefit costs may include costs for in-lieu-of services defined at 42 CFR § 438.3(e)(2), as the CMDP allows the following types of services as in-lieu-of services: home and community based services (HCBS) covered in lieu of a nursing facility and services in alternative inpatient settings licensed by ADHS/DLS in lieu of services in an inpatient hospital. These services are then included in the CMDP's capitation rate development categories of service. Encounters which are in-lieu-of services are not identified separately in the data, and are not repriced to the cost of the State plan service or setting, and are treated the same as all other data for rate development.

#### I.3.A.v. Institution for Mental Disease

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

### I.3.B. Appropriate Documentation

#### I.3.B.i Projected Benefit Costs

Appendix 6 contains the projected CYE 21 gross medical expenses PMPM on a statewide basis for use in the capitation rates.

#### I.3.B.ii. Projected Benefit Cost Development

This section provides information on the projected benefit costs included in the CYE 21 capitation rates for the CMDP.

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

The data described in Section I.2.B.ii.(a) was adjusted to reflect historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The adjusted base data per-member-per-month (PMPM) expenditures for each category of service (COS) were trended forward from the midpoint of the FFY 19 time period to the midpoint of the CYE 21 effective rate period by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a)(ii). For the October 2020 through March 2021 rates, this resulted in applying 21 months of trend.



For the April 2021 through September 2021 rates, this resulted in applying 27 months of trend. The projected PMPMs were then adjusted for prospective program changes that are described in this section. Appendix 4 contains the base data and base data adjustments, Appendix 5 contains the projected benefit cost trends, and Appendix 6 contains the prospective program changes. Additionally, Appendix 6 illustrates the capitation rate development, which includes the CYE 21 DAP, reinsurance offset, third party liability offset, administrative expense, care management expense, underwriting (UW) gain, and premium tax.

The capitation rates were adjusted for all program changes. If a program change had an impact of 0.2% of less on the statewide capitation rate, that program change was deemed non-material and has been grouped in the combined miscellaneous program changes subset below, along with a brief description of the non-material items.

Some of the impacts for projected benefits costs described below were developed by AHCCCS financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the DHCM Clinical Quality Management Team and the Office of the Director's Chief Medical Officer. The actuary relied upon the professional judgment of the 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 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.

Figure 3 summarizes the impacts for prospective program and reimbursement changes effective at any point during the CYE 21 rating period.

**Figure 3: Impacts of Prospective Program/Reimbursement Changes**

Change	Physical Health		Integrated - PH & BH	
	Annual Dollar Impact	PMPM Impact	Annual Dollar Impact	PMPM Impact
Provider Fee Schedule Changes	\$ 2,518,422	\$ 15.57	\$ 4,065,879	\$ 25.14
Pharmacy Reimbursement Savings	(333,018)	(2.06)	(687,004)	(4.25)
COVID19 (1115 Waiver) - Increase Respite Care Annual Cap	-	-	587,184	3.63
Net Impacts of Telehealth Growth	88,414	0.55	2,320,922	14.35
Influenza Vaccine - Medical Services	170,130	1.05	170,130	1.05
Combined Miscellaneous Program Changes	207,080	1.28	299,296	1.85
<b>Total Prospective Program and Reimbursement Changes</b>	<b>\$ 2,651,028</b>	<b>\$ 16.39</b>	<b>\$ 6,756,407</b>	<b>\$ 41.77</b>

### **Provider Fee Schedule Changes**

AHCCCS typically makes annual updates to provider fee schedules used for AHCCCS Fee-for-Service (FFS) programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts 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 DHCM Finance & Reinsurance Team regarding health plan fee schedules.

Additionally, the contract has requirements that the Contractors reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. The AHCCCS Fee-for-Service Fee Schedule Updates program change includes a fee schedule adjustment to bring the encounter base data from CYE 19 FQHC PPS rates up to projected CYE 21 FQHC PPS rates.

Effective October 1, 2020, AHCCCS will be updating provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes and/or legislative mandates. The CYE 21 capitation rates have

been adjusted to reflect these fee schedule changes. The AHCCCS DHCM Rates & Reimbursement Team use the CYE 19 encounter data to develop the adjustment to the CYE 21 capitation rates. The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program.

In March 2020, the Arizona Legislature passed and Governor Ducey signed into law HB 2668 (Laws 2020, Chapter 46) which establishes a new hospital assessment effective October 1, 2020. Monies from this assessment are to be deposited into the Health Care Investment Fund (HCIF) and used to make directed payments to hospitals, as well as increase base reimbursement rates for services reimbursed under the dental fee schedule and physician fee schedule, not including the physician drug fee schedule, to the extent necessary as determined by AHCCCS to restore provider rates to those in existence prior to reductions implemented in state fiscal year 2009. In order to implement this legislation, AHCCCS has included a provision in the CYE 21 contracts requiring the percentage increases associated with HCIF provider rate increases be implemented by the Contractors. The AHCCCS DHCM Rates & Reimbursement Team used the CYE 19 encounter data to develop the adjustment to the CYE 21 capitation rates. The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program.

CMS expanded the range of Medicare codes that may be billed for services provided by a resident without the direct supervision of a primary care physician, using the GE modifier. AHCCCS has aligned with CMS by expanding the set of codes for which resident-provided services can be billed using the GE modifier. The DHCM financial analysts applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program as part of the fee schedule changes as the change is non-material for the CMDP when considered alone.

A technical issue was identified in the setting of CYE 19 fee for service rates for various DME codes. The CYE 21 capitation rates include a correction to these DME fee for service rates. This correction is non-material for the CMDP when considered alone.

AHCCCS will additionally be increasing some fee schedule rates effective January 1, 2021 to recognize the next 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 as the minimum wage change is non-material for the CMDP when considered alone.

Effective January 1, 2020, the DRG adjustor for burns increased. The increased costs for this change have been included with the fee schedule changes already discussed as the DRG burn adjustor is non-material for the CMDP when considered alone.

The overall impact of the AHCCCS Fee-for-Service fee schedule updates is illustrated in Figure 3.

### **Pharmacy Reimbursement Savings**

Analysis of pharmacy claims for all AHCCCS managed care programs and AHCCCS Fee-for-Service (FFS) program identified significant variability across all Contractors, and analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to the lesser of Health Plan Paid amounts or AHCCCS FFS repriced amounts would result in an annual savings of \$68.2 million or 5.6% of pharmacy spend for FFY 18 across all programs. AHCCCS Contractors should reasonably be able to achieve pharmacy pricing that is at or near that achieved by the AHCCCS FFS program. However, AHCCCS recognized that the full savings amount may not be reasonably achievable in a single year, and for CYE 20 therefore adjusted the base pharmacy data of each program by 33% of the savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing.

Based on continued analysis, for CYE 21, AHCCCS is adjusting the base pharmacy data of each program by 66% of the savings identified in the analysis of CYE 18 pharmacy data. This is consistent with subsequent analysis of the CYE 19 pharmacy data.

The estimated impact on the CYE 2021 CMDP rates is displayed in Figure 3.

### **Increase to Annual Respite Hour Limit**

CMS approved AHCCCS' requested 1115 Waiver authority to increase the annual limit in covered respite care services that a member may receive from 600 hours to 720 hours a year. The authority is effective retroactively from March 1, 2020 until 60 days after the end of the federal emergency declaration. The estimates assume that the authority will extend for the twelve months of CYE 21. To estimate the impact of this change, the DHCM financial analysts first reviewed base period encounters of respite care services. In projecting the impact of this change, analysts made the assumption that members currently receiving the full 600 hours of services permitted during the base period would begin receiving the full 720 hours of respite services permitted under the expanded 1115 waiver authority during the contract period. Analysts further assumed that use of respite care services by all other members using respite care services during the base period would increase by 20%, which equals the percentage increase in the annual cap.

The estimated impact on the CYE 2021 CMDP rates is displayed in Figure 3.

### **Expanded Telehealth Use**

To ensure access to care during the public health emergency, AHCCCS has temporarily expanded coverage of telephonic codes and mandated that services delivered telephonically or through telehealth (TPTH) are reimbursed at the same rates as for in-person services, for both physical and behavioral health services. April and May 2020 data provided by Contractors indicates use of TPTH services has been essential for continued provision of services and represented annualized growth of 1,308% above base period use. Most growth in the use of these services during the public health emergency is expected to represent a cost-neutral shift from use of in-person services. Increased use of TPTH services are, however, expected to reduce the rate of missed appointments and lower use of non-emergency medical transportation (NEMT) and emergency department (ED) visits.

DHCM financial analysts reviewed Contractor-provided utilization of physical and behavioral health TPTH services for April and May 2020. It was projected that monthly use of TPTH for October 1, 2020 to March 31, 2021 of the contract period would equal the monthly use reported for April and May 2020. For purposes of projecting TPTH use for April 1, 2021 to September 30, 2021 of the contract period, DHCM financial analysts relied on a national projection developed by McKinsey & Co. of potential TPTH use following the public health emergency. The AHCCCS percent share of McKinsey's national projection was estimated to equal AHCCCS' percent share of 2017 National Health Expenditures. It was further assumed that use would be phased in at 33% of AHCCCS projected TPTH services during the first year following the public health emergency.

As more services shift from being provided in person to through TPTH, the rate of missed appointments is expected to decrease, resulting in additional program service use. Based on a literature review, it was assumed that the missed appointment rate for TPTH-eligible services was 25% during the base period. Based on findings from additional studies, it was assumed that TPTH-provided services could result in a 50% reduction in missed appointments compared to in-person appointments. Combining these assumptions, the DHCM financial analysts estimated that 14.3% of growth in TPTH during CYE 21 would represent new services.

Use of TPTH is expected to reduce the need for NEMT services. DHCM financial analysts determined that 11.0% of claims for in-person services of the most heavily used TPTH codes were accompanied by same day use of NEMT during the CYE 2019 base period. It was therefore, estimated that 11.0% of the increase to TPTH services in CYE 21 would result in a reduction in NEMT rides. Cost savings was calculated using the average trip and mileage costs of NEMT rides multiplied by the estimated reduction in rides.

Use of TPTH is additionally expected to reduce the use of low-to-moderate severity ED visits. The McKinsey & Co. national projection noted above assumed that 20% of all ED visits could transition to TPTH following the public health emergency. Consistent with the 33% first year phase-in assumption above for projected TPTH services following the public health emergency, DHCM financial analysts projected a 6.6% reduction (33% phase-in of a 20% reduction) in ED visits in CYE 2021 resulting from TPTH use. Cost savings from the change was calculated using the cost reduction of TPTH services relative to the cost of low-to-moderate severity ED visits, multiplied by the estimated reduction in ED visits.

The estimated impact on the CYE 2021 CMDP rates is displayed in Figure 3.

### **Flu Vaccine Initiative**

AHCCCS is implementing initiatives in the contract year to support use of influenza vaccinations during the COVID-19 outbreak. Effective September 1, 2020, the agency increased fee for service rates on influenza vaccination and administration codes and on administration codes for all Vaccine For Children (VFC) program vaccines by 10%. Effective September 1, 2020, AHCCCS also modified policy guidance to permit pharmacists to administer influenza vaccinations to children ages 3 - 18 years old and to permit qualified emergency medical service (EMS) providers to administer influenza vaccinations to members of all ages. Prior to the change, policy limited pharmacist-administered influenza vaccines to adults 19 years and older. Lastly, Contractors are providing a \$10 gift card to members that receive an influenza vaccination in the contract period, funded through the non-benefit portion of the capitation rate. AHCCCS anticipates this gift card incentive will increase member use of these services.

To estimate the impact of the initiatives, the DHCM financial analysts first identified influenza vaccine and administration utilization in the base period encounters. The data was then adjusted to account for fee schedule changes made subsequent to the base period. The impact of a 10% rate increase on influenza vaccine and administration codes was estimated using the adjusted base data.

A review of studies suggests that pharmacy interventions that expand scope of practice and public information of available services can increase vaccination rates. Modifying policy to permit pharmacists to administer influenza vaccines to children ages 3-18 years old is projected to increase flu vaccination rates of child members that use pharmacy services by 10% above base period use.

The DHCM financial analysts also analyzed data for the number of influenza vaccinations provided by EMS providers to Arizona residents in prior years. The data was used to project the number of influenza vaccinations that would be delivered by EMS providers to members during the contract year. Estimated vaccinations included growth above prior year data to reflect greater provider participation in response to AHCCCS reimbursement to EMS providers.

Another review of studies suggests that monetary incentives, such as gift cards, may increase demand for influenza vaccinations. The DHCM financial analysts projected that the incentive of a \$10 gift card would further increase total vaccinations by 33% during the contract period. Contractor costs to purchase and administer the gift cards are funded separately in the non-benefit portion of the CYE 21 capitation rates.

The estimated impact on the CYE 2021 CMDP rates is displayed in Figure 3.

### **Combined Miscellaneous Program Changes**

#### ***Pharmacy and Therapeutics Committee Recommendations – Post Base Year***

On the recommendations of the P&T Committee, AHCCCS adopted policy changes during CYE 20 that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 21. 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.

To estimate the impact of adopted P&T Committee changes, the DHCM financial analysts largely relied on projections of drug utilization prepared by Magellan Rx Management, the agency's provider of drug rebate administrative services. Magellan has a nationwide vantage point that was drawn from in projecting how recommendations would impact drug utilization by AHCCCS members. In instances where Magellan did not provide a projected impact of an adopted change, the actuaries relied upon the judgement of DHCM financial analysts to project the impact. For October 1, 2020 rate development, the aggregate impact of adopted changes was allocated across rate cells and GSAs using FFY 19 encounter data for the affected drug classes.

#### ***Cystic Fibrosis Drug Approval***

On October 21, 2019, the Food and Drug Administration (FDA) approved the cystic fibrosis transmembrane conductance regulator (CFTR) modulator drug Trikafta for treatment of cystic fibrosis in individuals aged 12 years and older. The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Trikafta on October 21, 2019. Effective October 1, 2020, all CFTR drugs (Trikafta, Symdeko, and Orkambi) are eligible for reinsurance.

#### ***Sickle Cell Drugs Approval***

In November 2019, the FDA approved the drugs Oxbritya and Adakveo for treatment of sickle cell disease. Collectively, the drugs are approved for treatment of individuals 12 years and older. The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Oxbritya and Adakveo on November 25, 2019 and November 20, 2019, respectively.

#### ***Duchenne Muscular Dystrophy Drug Approval***

On December 12, 2019, the FDA approved Vyondys 53 for treatment of Duchenne muscular dystrophy in individuals with a mutation that is amenable to exon 53 skipping. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Vyondys 53 on December 12, 2019.

#### ***Peanut Allergy Drug Approval***

On January 31, 2020, the FDA approved the immunotherapy drug Palforzia for treatment of peanut allergy in children 4 to 17 years of age. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in MDRP, AHCCCS began coverage of Palforzia on January 31, 2020.

#### ***Off Campus Hospital Outpatient Department Reimbursement***

Effective October 1, 2020, AHCCCS is reimbursing services billed at off campus hospital outpatient departments on a UB form with PO or PN modifiers according to the physician or ambulatory surgical center fee schedules. The change will represent a decrease in reimbursement relative to outpatient hospital fee schedule rates that providers billed before the change.

#### ***Outpatient Psychiatric Hospital Reimbursement***

Beginning October 1, 2020, AHCCCS is implementing an outpatient hospital fee schedule reimbursement methodology for outpatient services provided by psychiatric hospitals. Prior to this change, AHCCCS manually approved Contractor payments to psychiatric hospitals for outpatient services, which were not subject to a specific reimbursement methodology. To estimate the impact, the DHCM financial analysts repriced base period encounters at outpatient hospital fee schedule rates.

#### ***Increased Frequency of Dental Fluoride Visits***

Beginning February 1, 2020, AHCCCS increased the maximum number of dental fluoride varnish applications that members may receive, from 2 to 4 applications a year.

### **Supports During School Hours**

Member students receive medically necessary services that are specified in an Individualized Education Program (IEP) from school-based providers participating in the School Based Claiming (SBC) fee for service program. Due to virtual learning environments necessitated by the public health emergency, it may not be feasible for schools to provide in-person attendant care and nursing services through SBC. It is therefore anticipated that these services will transition to Contractor provider networks. To estimate the impact of this change, DHCM financial analysts reviewed base period use SBC attendant care and nursing procedure codes. It was assumed these services would transition to Contractor networks during CYE 2021 and would be reimbursed at Contractor rates. It was additionally assumed that school aged children 5 to 20 years of age that use attendant care or nursing services, but that do not receive services through the SBC program, would use additional in-home attendant care and nursing services to the same extent as SBC participants. These projected services were similarly priced at average Contractor rates.

### **Pay and Chase Guidance**

Federal regulation 42 CFR 433.139, Payment of Claims, requires agencies and their Contractors to pay and chase claims for preventive pediatric care services, including EPSDT services, regardless of the existence of third party liability at the time the claim is filed. Preventive pediatric care refers to screening and diagnostic services to identify congenital, physical, mental health routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infectious and communicable diseases from occurring in children under 21 years of age. As a result of questions to AHCCCS regarding coordination of benefits for members with Autism Spectrum Disorder, the agency provided additional clarification to Contractors in FFY 20 on preventive services that must be reimbursed on a pay and chase basis. This clarification is anticipated to increase costs of Contractors in situations in which they are unable to successfully recover funding from liable third parties.

### **Depression and Anxiety Screening Codes**

Effective August 1, 2020, AHCCCS began coverage of procedure code 96127 for brief emotional or behavioral assessments.

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

There were no material changes to the components of the capitation rates or the process of their development, other than those changes described elsewhere in the certification.

### **I.3.B.ii.(c) Overpayments to Providers**

The CMDP and the RBHAs are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuary to set the CYE 21 capitation rates therefore includes those adjustments.

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

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

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

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

Please see Section I.2.B.ii.(a) for the types of data that we relied upon for developing the projected benefit cost trends for the CYE 2021 CMDP rates.

All data used was specific to the CMDP population, the CRS specialty services provided to CMDP members with a CRS qualifying condition, and the behavioral health services provided to the CMDP population by the RBHAs.

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

Historical utilization, unit cost, and PMPM data for the non-CRS services, the CRS specialty services, and behavioral health services provided to CMDP members from FFY 17, FFY 18, and FFY 19 were combined, organized by incurred year and month and COS.

The three years of data were normalized for historical program and fee schedule changes. For the services provided to CMDP members, the trend rates were developed to adjust the base data (midpoint of April 1, 2019) forward 21 months to the midpoint of the October 2020 through March 2021 rating period (January 1, 2021), and forward 27 months to the midpoint of the April 2021 through September 2021 rating period (July 1, 2021),

Projected benefit cost trends were based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. No simple formulaic solution exists to determine future trend; actuarial judgment is required. Each category of service was analyzed in the same manner.

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

The PMPM trends by COS were compared to the CYE 20 rate development PMPM trends for the CMDP. The actuary judged the changes in PMPM trends to be reasonable for all categories of service.

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

The 2021 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuary defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. Two trend categories met the criteria for being considered outlier or negative trends: Behavioral Health Inpatient Hospital and Physical Health Inpatient Hospital.

Behavioral Health Inpatient Hospital benefit cost trend is 10.7%. This category has seen large, steady increases in utilization over the past few years, which continue to persist in recent months. The utilization trend used in calculating the benefit cost trend is 7.0%. Prior to FFY 19, the category has had relatively stable unit costs, with increases starting at the beginning of FFY 19. The increases seem to be persistent, though not as significant as the utilization trend. The unit cost trend used in calculating the benefit cost trend is 3.5%.

Physical Health Inpatient Hospital benefit cost trend is -1.0%. Throughout FFY 19, the utilization has seen overall decreases. The utilization trend used in calculating the benefit cost trend is -1.0%. Through FFY 17 to FFY 19, unit costs have been relatively stable, and seem to be stable beyond in the months following FFY 19. The unit cost trend used in calculating the benefit cost trend is 0.0%.

### **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 rates.

#### **I.3.B.iii.(b)(ii) Alternative Methods**

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**

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

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

Projected benefit cost trends vary by category of service.

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

No other material adjustments were made to the trend assumptions.

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

No other adjustments were made to the trend assumptions.

### 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 DHCM Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA.

### I.3.B.v. In-Lieu-Of Services

The following types of services can be provided as in-lieu-of-services: home and community based services (HCBS) covered in lieu of a nursing facility and services in alternative inpatient settings licensed by ADHS/DLS in lieu of services in an inpatient hospital. These services are then included in CMDP's capitation rate development categories of service. Encounters which are in-lieu-of-services are not identified separately in the data. Thus, the actuary cannot define the percentage of cost that in-lieu-of services represented in the capitation rate development categories of service. However, the in-lieu-of services are treated exactly the same as all other State Plan approved services in capitation rate development.

### I.3.B.vi. Retrospective Eligibility Periods

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

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

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

Encounter data related to prior period coverage 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 prior period coverage 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 21 capitation rates for the CMDP, given that the encounter and enrollment data are already included within the base data used for rate development.

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

This section of the 2021 Guide provides information on what must be documented for all material changes to covered benefits or services since the last rate certification.

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

Documentation of impacts for all material changes to covered benefits or services since the last rate certification has been provided above in Section I.3.B.ii.

#### 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 must 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 must be submitted."



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

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

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

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

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

There were no material changes since the last rate certification 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 2021 Guide are documented in Section I.3.B.ii.(a) above.

## I.4. Special Contract Provisions Related to Payment

### I.4.A. Incentive Arrangements

#### **APM Initiative – Performance Based Payments**

The CYE 21 capitation rates for CMDP include an incentive arrangement, as described under 42 CFR § 438.6(b)(2) at 81 FR 27589, called the Alternative Payment Model (APM) Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the CMDP Contractor may receive additional funds over and above the capitation rates by successfully meeting targets established by AHCCCS that are aimed at improving access to care.

#### I.4.A.ii.(a)(i) Time Period

The time period of the incentive arrangements described herein coincides with the rating period.

#### I.4.A.ii.(a)(ii) Enrollees, Services, and Providers Covered

##### **APM Initiative – Performance Based Payments**

Children will be covered by this incentive arrangement. All physical health covered services are eligible for inclusion.

#### I.4.A.ii.(a)(iii) Purpose

##### **APM Initiative – Performance Based Payments**

The purpose of the APM Initiative – Performance Based Payments incentive arrangement is to align incentives between AHCCCS and the Contractor related activities that support program initiatives as specified in the State's quality strategy.

#### I.4.A.ii.(a)(iv) Attestation to Limit on Incentive Payments

All CMDP incentive arrangements combined will not exceed 105% of the capitation payments to comply with 42 CFR § 438.6(b)(2).

#### I.4.A.ii.(a)(v) Effect of Capitation Rate Development

##### **APM Initiative – Performance Based Payments**

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 21 capitation rates for CMDP. Additionally, incentive payments for the APM Initiative – Performance Based Payments incentive arrangement had no impact on the development of the CYE 21 capitation rates for CMDP. The anticipated incentive payment amount will be paid by AHCCCS to the CMDP Contractor through lump sum payment during the CYE 21 contract year.

### I.4.B. Withhold Arrangements

Not Applicable. No withhold arrangement exists with the CMDP.

### I.4.C. Risk-Sharing Mechanisms

#### I.4.C.i. Rate Development Standards

This section of the 2021 Guide provides information on the requirements for risk-sharing mechanisms.

#### I.4.C.ii. Appropriate Documentation

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

The CYE 21 capitation rates for the CMDP will include risk corridors.

### 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 21 capitation rates are consistent with AHCCCS' long-standing program policy and will include a risk corridor for all services under the CMDP. This rate certification will use the term risk corridor to be consistent with the 2021 Guide. The CMDP Contract refers to the risk corridor as a reconciliation.

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

There will be two risk-sharing methodologies with the CMDP in CY21.

For October 1, 2020 through March 31, 2021, the risk corridor will reconcile the CMDP's medical cost expenses to the net capitation paid to the CMDP. Net capitation is equal to the capitation rates paid, less the premium tax and the administrative component, plus any reinsurance payments. The CMDP's medical cost expenses are equal to the fully adjudicated encounters with dates of service during the contract year. The risk corridor will limit the CMDP profits to 6% and losses to 2%. Additional information regarding the risk corridor for October 1, 2020 through March 31, 2021 can be found in the CMDP contract.

For April 1, 2021 through September 30, 2021, CMDP will reconcile its Subcontracted Health Plan medical expenses to medical capitation paid to the Subcontracted Health Plan in accordance with the CMDP's contract with the Subcontracted Health Plan. The risk corridor with the Subcontracted Health Plan provides for payment or recoupment outside a risk corridor as agreed to in the subcontract. The CMDP will submit the reconciliation for AHCCCS approval and AHCCCS will reconcile with the CMDP by reimbursing excess losses to be paid to the Subcontracted Health Plan. The total amount of any excess profits to be recouped from the Subcontracted Health Plan 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 capitation rates for the CMDP.

### I.4.C.ii.(a)(iv) Risk-Sharing Mechanisms Documentation

The threshold amounts for the risk corridor for October 1, 2020 through March 31, 2021 and the risk corridor for April 1, 2021 through September 31, 2021 were set using actuarial judgement with consideration of conversations and input between the AHCCCS DHCM Actuarial Team, the AHCCCS DHCM Finance & Reinsurance Team, the AHCCCS Office of the Director, and the CMDP leadership.

### I.4.C.ii.(b) Description of Medical Loss Ratio

Not applicable. The CMDP contract does not include a remittance/payment requirement.

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

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

AHCCCS provides a reinsurance program to the CMDP for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what one would see in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services.

Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than the CMDP paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical expense. One could view the reinsurance offset as a premium.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the CMDP for covered services incurred above the deductible. The deductible is the responsibility of the CMDP. There has been no change to the deductible or coinsurance factors applicable to the regular CMDP reinsurance program since the last rate setting period. Effective October 1, 2018, the threshold at which a reinsurance case becomes eligible for high-dollar catastrophic coverage was increased from \$650,000 to \$1 million. Once a reinsurance case hits this limit, the MCO is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

Effective October 1, 2018, CRS services for CMDP members, which previously accumulated toward a \$75,000 deductible associated with the CRS program, are combined with non-CRS services to accumulate towards the \$35,000 deductible associated with the CMDP.

Additionally, effective April 1, 2021, behavioral health services previously covered by the RBHAs will be covered by the CMDP and will also accumulate towards the \$35,000 deductible. However, services provided at mental health residential treatment centers and subacute facilities are not eligible for reinsurance reimbursement.

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

For additional information, including all deductibles and coinsurance amounts, on the reinsurance program refer to the Reinsurance section of the CMDP 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 data used to develop the reinsurance offset are calculated reinsurance payments to the CMDP for services provided to CMDP members and incurred during FFY 19, including services provided by the RBHAs. The calculated reinsurance payments were developed from CYE 19 encounters that were adjusted for historical programmatic and reimbursement changes and trended to the CYE 21 rating period using the same trend factors applied to the gross medical capitation rate by category of service (provided in Appendix 5). Calculated reinsurance payments were used to develop the CYE 21 reinsurance offset in order to align expected payments with the timing of incurred services and to reflect deductible leveraging through applying expense trends to the CYE 19 encounters. The reinsurance offset for the October 2020 through March 2021 rate was based on encounters for services provided by the CMDP in FFY 19. The development of the reinsurance offset for the April 2021 through September 2021 rate also included encounters for services provided by the RBHAs in FFY 19 in order to reflect that both physical health and eligible behavioral health services will accumulate towards a single deductible for each reinsurance case, effective April 1, 2021. The calculated payments are expressed as PMPMs in Appendix 6.

Changes to the reinsurance program from CYE 19 to CYE 21 included adding several drugs (Trikafta, Symdeko, Orkambi, Tecartus, and Evrysdi) to the list of drugs covered by the AHCCCS reinsurance program.

The projected costs of the additional drugs covered by the reinsurance program, noted above in Section I.3.B.ii.(a), was calculated by taking the projected costs for CYE 21 for those drugs and applying a zero dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset. The combined dollar impact to the reinsurance offsets for the CMDP is \$63,600.

## I.4.D. Delivery System and Provider Payment Initiatives

### I.4.D.i. Rate Development Standards

This section of the 2021 Guide provides information on delivery system and provider payment initiatives authorized under 42 CFR § 438.6(c).

### I.4.D.ii. Appropriate Documentation

#### I.4.D.ii.(a) Description of Delivery System and Provider Payment Initiatives

The only pre-prints addressed in this certification are the ones related to CMDP. Those pre-prints are FQHC Differential Adjusted Payments, Differential Adjusted Payments, Access to Professional Services Initiative, Pediatric Services Initiative, and Hospital Enhanced Access Leading to Health Improvements Initiative. This certification combines the FQHC Differential Adjusted Payments under the Differential Adjusted Payments language.

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

##### ***Differential Adjusted Payments***

The Differential Adjusted Payment (DAP) initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 20.0%, depending on the provider type.

##### ***Access to Professional Services Initiative***

The Access to Professional Services Initiative (APSI) seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the Contractors' rates for professional services provided by qualified physicians and non-physician professionals affiliated with designated hospitals who meet the following definition:

- A hospital facility with an ACGME-accredited teaching program and which is operated pursuant to the authority in Arizona Statute Title 48, Chapter 31; or,
- A hospital facility with:
  - An ACGME-accredited teaching program with a state university, and
  - AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2014; or,
- A freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than one hundred (100) licensed pediatric beds, excluding nursery beds.

The APSI provides a uniform percentage increase of 62% to otherwise contracted rates for qualified practitioners-for all claims for which AHCCCS is the primary payer. The rate increase is intended to supplement, not supplant, payments to eligible providers.

**Pediatric Services Initiative**

The Pediatric Services Initiative (PSI) seeks to provide enhanced support to ensure financial viability of the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds.

The PSI provides a uniform dollar increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

**Hospital Enhanced Access Leading to Health Improvements Initiative**

The Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) delivers a uniform percentage increase to hospitals for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. HEALTHII program 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. The increase is intended to supplement, not supplant, payments to eligible providers.

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

Differential Adjusted Payments are the only directed payments incorporated in the capitation rates.

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

The single rate cell is affected.

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

For Differential Adjusted Payments see Appendix 6 for medical impact by rate cell. See Appendix 7 for total impact by rate cell.

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

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.5% increase; up to 13.5% for select services), Critical Access Hospitals (eligible for up to 10.0% increase; up to 20.0% for select services), other hospitals and inpatient facilities (eligible for up to 4.5% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 7.0% increase on all services provided), physicians, physician assistants, registered nurse practitioners, dental providers (all eligible for up to 2.0% increase), home and community based services providers (eligible for up to 1.0% increase on specified services at specified places of service) and Federally Qualified Health Centers (FQHCs) (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 19 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

The amount of increased medical payments for the DAP included in the CYE 21 capitation rates for the CMDP are displayed below in Figure 4. These projected medical payments do not include underwriting gain or premium tax.

**Figure 4: CMDP Differential Adjusted Payments**

Change	Physical Health		Integrated - PH & BH	
	Annual Dollar Impact	PMPM Impact	Annual Dollar Impact	PMPM Impact
Differential Adjusted Payments Add-in	\$ 475,806	\$ 2.94	\$ 1,424,604	\$ 8.81

#### I.4.D.ii.(a)(ii)(D) Pre-Print Acknowledgement

The Differential Adjusted Payments which are accounted for in the capitation rates, and described in the preceding sections, are being made under an approved §438.6(c) pre-print in a manner consistent with the pre-print reviewed by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

#### I.4.D.ii.(a)(ii)(E) Maximum Fee Schedule

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

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

The Access to Professional Services Initiative, Pediatric Services Initiative, and Hospital Enhanced Access Leading to Health Improvements Initiative are not included in the CMDP certified capitation rates and will be paid out via lump sum payments.

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

##### **Access to Professional Services Initiative**

Anticipated payments including premium tax for APSI are approximately \$2.0 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. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

##### **Pediatric Services Initiative**

Anticipated payments including premium tax for PSI are approximately \$1.8 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 21 utilization will be used to redistribute the payments. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

##### **Hospital Enhanced Access Leading to Health Improvements Initiative**

Anticipated payments including premium tax for HEALTHII are approximately \$6.7 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 21 utilization will be used to redistribute the payments. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

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

##### **Access to Professional Services Initiative**

The actuaries certify to 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 actuaries certify to 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 actuaries certify to 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) Providers Receiving Payment*****Access to Professional Services Initiative***

The qualifying providers receiving the uniform percentage increase include the following practitioners: physicians, including doctors of medicine and doctors of osteopathic medicine; certified registered nurse anesthetists; certified registered nurse practitioners; physician assistants; certified nurse midwives; clinical social workers; clinical psychologists; dentists; optometrists; and other providers that bill under Form Type A (Form 1500) and D (Dental).

***Pediatric Services Initiative***

The qualifying providers receiving the uniform dollar increase for inpatient and outpatient hospital services are freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds.

***Hospital Enhanced Access Leading to Health Improvements Initiative***

The qualifying providers receiving the payments include hospitals providing contracted Medicaid Managed Care acute inpatient and ambulatory outpatient services.

**I.4.D.ii.(a)(iii)(D) Distribution Methodology*****Access to Professional Services Initiative***

The distribution methodology for the CYE 21 APSI payments will be based on members' utilization of services from APSI qualified providers. The 62 percent uniform percentage increase will be applied to eligible services performed by APSI qualified providers as defined in the pre-print. The estimated amount for CYE 21 APSI was developed by applying the 62 percent uniform increase to CYE 19 utilization of eligible services based on encounters for the CYE 19 APSI qualified providers. The same definition of eligible services was used to develop for the estimated amount. The APSI qualified providers were identified by Billing Provider Tax IDs in AHCCCS encounter system. The CYE 19 utilization is used as the basis for where to distribute the quarterly lump sum payments. The final lump sum payment will use CYE 21 encounter data for APSI qualified providers. The CYE 21 encounter data used to distribute the final lump sum payment amount will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 19, as well as the distribution used to make the quarterly lump sum payments.

***Pediatric Services Initiative***

The distribution methodology for PSI for CYE 21 will be based on members' utilization of inpatient and outpatient services at freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The uniform dollar increase will be applied to eligible services performed by providers eligible for the Pediatric Services Initiative (identified in the encounters by Servicing Provider Tax IDs). Eligible services are those submitted on UB-04 Inpatient Hospital and UB-04 Outpatient Hospital. Adjudicated and approved encounter data have been used to allocate the interim PSI payments by capitation rate cell. CYE 19 utilization is the basis for the initial distribution of interim quarterly lump sum payments. After the end of the contract year, with sufficient run out, PSI interim quarterly payments will be reconciled using CYE 21 encounter utilization data to re-distribute the interim lump sum payments in the appropriate amounts. The CYE 21 encounter data will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 19.



***Hospital Enhanced Access Leading to Health Improvements Initiative***

The distribution methodology for HEALTHII for CYE 21 will be based on the utilization of services by members with providers participating in the HEALTHII program. Adjudicated and approved encounter data have been used to allocate the interim HEALTHII payments by capitation rate cell. CYE 19 utilization is the basis for the initial distribution of the interim quarterly lump sum payments. After the end of the contract year, with sufficient run out, HEALTHII interim quarterly payments will be reconciled using CYE 21 encounter utilization data to re-distribute the interim lump sum payments in the appropriate amounts. The CYE 21 encounter data will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 19.

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

Appendix 8 contains estimated PMPMs including premium tax by rate cell.

**I.4.D.ii.(a)(iii)(F) Pre-Print Acknowledgement*****Access to Professional Services Initiative***

These payments are being made under the approved APSI §438.6(c) payment arrangement in a manner consistent with the pre-print reviewed by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

***Pediatric Services Initiative***

These payments are being made under the approved PSI §438.6(c) payment arrangement in a manner consistent with the pre-print reviewed by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

***Hospital Enhanced Access Leading to Health Improvements Initiative***

These payments are being made under the approved HEALTHII §438.6(c) payment arrangement in a manner consistent with the pre-print reviewed by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

**I.4.D.ii.(a)(iii)(G) 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 described in Section I.4.D.ii.(a)(iii)(D), 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 described in Section I.4.D.ii.(a)(iii)(D), 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 described in Section I.4.D.ii.(a)(iii)(D), 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 certification.

#### 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 directed payment or authorized under applicable law, regulation, or waiver.

AHCCCS will be including contract amendments with the submission of this rate certification which clarify the regulatory authority for any minimum fee schedule requirements which exist in contract language.

#### I.4.E. Pass-Through Payments

Not applicable. Pass-through payments, as defined in 42 CFR § 438.6(a) at 81 FR 27497, were not developed for the CYE 21 capitation rates for the CMDP.

### I.5 Projected Non-Benefit Costs

#### I.5.A. Rate Development Standards

This section of the 2021 Guide provides information on the non-benefit component of the capitation rates.

#### 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

The CMDP – as well as its new subcontractor Mercy Care – provided AHCCCS and us with an administrative expense request for funding that detailed projected employee compensation, data processing costs, management fees, interest charges, occupancy (rent/utilities), and other administrative expenses for the current contract year and the upcoming contract year. These estimates included expenses associated with care management. Care management activities performed by CMDP and the 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. These administrative expense requests were reviewed by AHCCCS and us for reasonableness by comparing against previous administrative expense requests. The requests were also compared against previous administrative requests from the CMDP RBHAs in order to consider what reasonable expenses would be after behavioral health services are integrated into the CMDP contract on April 1, 2021. Once the reports were determined to be reasonable by AHCCCS and us, an administrative expense PMPM was calculated using the appropriate projected member months for the contract year. Additional expenses were included in the projected administrative costs for requirements identified by AHCCCS for the upcoming year, inclusive of the administrative costs required to administer the flu vaccine gift card initiative, which were not reflected in the Contractor or subcontractor's original administrative expense requests. Separate administrative PMPMs were developed for the October 2020 through March 2021 rates and for the April 2021 through September 2021 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 21 administrative expense components are shown in Appendix 6.

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

The projection for CYE 20 rates included expected costs associated with issuing a Request for Proposal (RFP) for a contractor to provide administrative services for the CMDP. The CYE 2021 rates do not include these expected costs, but the April 2021 through September 2021 rates do include additional costs associated with the coverage of behavioral health services, which is effective April 1, 2021.

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

There were no other adjustments (material or non-material) to the projected non-benefit expenses included in the capitation rates.

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

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

The administrative component of the CYE 21 capitation rates for the CMDP is described above in Section I.5.B.i.(a). The PMPM amounts assumed can be found in Appendix 6.

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

The CYE 21 capitation rates for the CMDP include 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 21 capitation rates for the CMDP include a provision of 1% for margin (i.e. underwriting gain).

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

No other material or non-material non-benefit costs are reflected in the CYE 21 capitation rates for the CMDP.

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

Historical non-benefit cost data is provided by the plans 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.5.B.iv. Health Insurance Provider's Fee

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

#### I.5.B.iv.(a) Address if in Rates

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

## I.6. Risk Adjustment and Acuity Adjustments

This section of the 2021 Guide is not applicable to the CMDP. The CMDP does not utilize risk adjustments or acuity adjustments. This is not anticipated to change.

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

Section II of the 2021 Guide is not applicable to the CMDP. Managed long-term services and supports, as defined at 42 CFR § 438.2 at 81 FR 27855, are not covered services under the CMDP. The CMDP does cover nursing facility services, and related home and community based services, for 90 days of short-term convalescent care.

## Section III New Adult Group Capitation Rates

Section III of the 2021 Guide is not applicable to the CMDP.

## Appendix 1: Actuarial Certification

I, Bradley B. Armstrong, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established the Actuarial Standards Board. I have been retained by the Arizona Health Care Cost Containment System (AHCCCS) to perform an actuarial review and certification regarding the development of capitation rates for the Arizona Comprehensive Medical and Dental Program (CMDP) effective October 1, 2020. I am generally familiar the state specific Medicaid program, eligibility rules, and benefit provisions.

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

1. § 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.
2. § 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:
3. § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
4. § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
5. § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
6. § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
7. § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
8. § 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).
9. § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
10. § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
11. § 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 21 capitation rates for the CMDP have been documented according to the guidelines established by CMS in the 2021 Guide. The CYE 21 capitation rates for the CMDP are effective for the twelve-month time period from October 1, 2020 through September 30, 2021.

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

The capitation rates developed may not be appropriate for any specific Contractor. An individual Contractor will need to review the rates in relation to the benefits that it will be obligated to provide. The Contractor should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The Contractor may require rates above, equal to, or below the “actuarially sound” capitation rates that are associated with this certification.

At the time of this rate certification, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on setting capitation rates, including whether the pandemic will increase or decrease costs in CYE 21. Given the lack of reliable and historical information for this unprecedented public health emergency, we made no attempt to predict rates of foregone care, deferred care, and pent-up demand. However, it is known that the COVID-19 pandemic could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this rate certification. 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. In times such as these, the risk-sharing arrangements are even more important to the stability of the system.

SIGNATURE ON FILE

November 13, 2020

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Bradley B. Armstrong

Date

Fellow, Society of Actuaries  
Member, American Academy of Actuaries

## Appendix 2: Actuarial Certified Capitation Rates

CMDP Capitation Rates	
Effective October 1, 2020 through March 31, 2021	\$ 343.75
Effective April 1, 2021 through September 30, 2021	\$ 1,359.97

## Appendix 3: Fiscal Impact Summary Compared to CYE 20

CMDP	Services	Projected CYE 21 Member Months	CYE 20 Capitation Rate Effective 10/01/19 - 09/30/20	CYE 21 Capitation Rate Effective 10/01/20 - 09/30/21	CYE 21 Projected Expenditures (based on 10/01/19 rate)	CYE 21 Projected Expenditures (based on 10/01/20 rate)	Annual Dollar Impact	Percentage Impact
Statewide	Physical Health	161,747	\$ 325.55	\$ 343.75	\$ 52,656,379	\$ 55,601,337	\$ 2,944,957	5.6%
Statewide	Integrated - PH & BH	161,747	\$ 1,207.95	\$ 1,359.97	\$ 195,383,010	\$ 219,971,899	\$ 24,588,889	12.6%

**Notes:**

The CYE 2020 integrated rate reflects the sum of the individual CYE 2020 physical health and behavioral health rates.

The CYE 2021 integrated rate includes both physical health and behavioral health services, and is effective 4/1/2021 - 9/30/2021.

The Annual Dollar Impact illustrates the fiscal impact for the entire CYE 21 contract period.



## Appendix 4: Unadjusted and Adjusted Base Data

Gross Medical Expenses							
Service	Service Category	Unadjusted Base Data PMPMs	Supplemental Encounter Files	Completion Factors	Program/ Reimbursement Changes	DAP PMPM Removed	Adjusted Base Data
Physical Health	Professional	\$ 103.87	1.0123	0.9960	1.0000	\$ (0.38)	\$ 105.19
Physical Health	Pharmacy	18.33	1.1576	1.0000	0.9962	-	21.14
Physical Health	Dental	24.85	1.3110	0.9990	1.0000	-	32.61
Physical Health	Inpatient & NF	48.71	1.1389	0.9620	1.0000	(1.87)	55.79
Physical Health	Outpatient	36.29	1.0838	0.9970	1.0000	(1.32)	38.14
Behavioral Health	Behavioral Health Day Programs	0.67	1.0789	0.9487	1.0000	-	0.76
Behavioral Health	Case Management	146.43	1.0288	0.9581	1.0000	-	157.24
Behavioral Health	Dental Services	0.04	1.0000	0.9300	1.0000	-	0.04
Behavioral Health	FQHC/RHC	1.05	1.1154	1.0284	1.0000	(0.01)	1.13
Behavioral Health	Inpatient Behavioral Health	175.56	1.0017	0.9360	1.0000	(0.29)	187.59
Behavioral Health	Inpatient Hospital	12.14	1.0000	0.9239	1.0000	-	13.14
Behavioral Health	Medical Services	8.73	1.0327	0.9615	1.0001	(0.02)	9.36
Behavioral Health	Nursing Facility Services	-	1.0000	1.0000	1.0000	-	-
Behavioral Health	Other Services	0.05	1.0711	0.4104	1.0000	-	0.14
Behavioral Health	Outpatient Hospital	0.43	1.0000	0.9191	1.0000	(0.00)	0.47
Behavioral Health	Pharmacy	25.29	1.0000	0.9847	1.0504	-	26.97
Behavioral Health	Rehabilitation Services	76.96	1.0138	0.9667	1.0000	-	80.71
Behavioral Health	Residential Services	64.11	1.0692	0.9634	1.0000	-	71.15
Behavioral Health	Support Services	102.04	1.0372	0.9633	1.0000	-	109.88
Behavioral Health	Transportation	22.85	1.0377	0.9655	0.9826	-	24.13
Behavioral Health	Treatment Services	113.01	1.0439	0.9560	1.0089	-	124.49
<b>Total</b>	<b>Total</b>	<b>\$ 981.40</b>	<b>1.0426</b>	<b>0.9634</b>	<b>1.0018</b>	<b>\$ (3.89)</b>	<b>\$ 1,060.06</b>

## Appendix 5: Projected Benefit Cost Trends

Services	Service Category (Non-CRS and CRS Expenses)	Annualized Trend Rates		
		Utilization	Unit Cost	PMPM
Physical Health	Professional	(1.5%)	3.0%	1.5%
Physical Health	Pharmacy	2.0%	2.5%	4.6%
Physical Health	Dental	4.0%	0.5%	4.5%
Physical Health	Inpatient & NF	(1.0%)	0.0%	(1.0%)
Physical Health	Outpatient	(1.5%)	3.0%	1.5%
Behavioral Health	Inpatient Behavioral Health	6.8%	3.2%	10.2%
Behavioral Health	Inpatient Hospital	0.0%	0.0%	0.0%
Behavioral Health	Medical Services	0.0%	0.0%	0.0%
Behavioral Health	Pharmacy	0.5%	0.0%	0.5%
Behavioral Health	Residential Services	2.0%	1.0%	3.0%
Behavioral Health	Support Services	(1.0%)	3.5%	2.5%
Behavioral Health	Other Services	0.0%	5.0%	5.0%
Behavioral Health	Rehabilitation/Treatment Services	1.0%	0.0%	1.0%

## Appendix 6: Projected CYE 21 Capitation Rate Development

Projected Combined Gross Medical Expense							
Service Category	Adj Base Data PMPM	Trend	Program Change 10/1/20	Reimbursement Change 10/1/20 <sup>1</sup>	10/1/20 DAP	Projected GME PMPM (10/1/20-3/31/2021)	Projected GME PMPM (4/1/2021 - 9/30/2021)
Professional	\$ 105.19	1.46%	\$ 2.30	\$ 11.86	\$ 0.44	\$ 122.49	\$ 123.27
Pharmacy	21.14	4.55%	0.64	(2.06)	-	21.43	21.94
Dental	32.61	4.52%	0.02	3.47	0.19	38.91	39.69
Inpatient & NF	55.79	-1.00%	-	0.17	1.31	56.30	56.03
Outpatient	38.14	1.46%	(0.08)	0.07	1.00	40.10	40.39
Behavioral Health Day Programs	0.76	5.00%	-	-	-	-	0.85
Case Management	157.24	2.47%	-	-	-	-	166.09
Dental Services	0.04	5.00%	-	0.00	0.00	-	0.05
FQHC/RHC	1.13	5.00%	-	0.01	0.01	-	1.28
Inpatient Behavioral Health	187.59	10.21%	-	-	3.33	-	236.77
Inpatient Hospital	13.14	10.21%	-	-	0.25	-	16.60
Medical Services	9.36	0.00%	14.27	9.05	2.23	-	34.91
Nursing Facility Services	-	5.00%	0.03	-	-	-	0.03
Other Services	0.14	5.00%	0.00	0.65	0.00	-	0.80
Outpatient Hospital	0.47	5.00%	(0.00)	0.00	0.02	-	0.53
Pharmacy	26.97	0.50%	0.00	(2.80)	-	-	24.48
Rehabilitation Services	80.71	1.00%	-	-	-	-	82.54
Residential Services	71.15	3.02%	3.71	-	-	-	79.79
Support Services	109.88	2.47%	0.00	0.00	-	-	116.07
Transportation	24.13	2.47%	-	0.46	0.04	-	25.99
Treatment Services	124.49	1.00%	-	-	-	-	127.31
<b>Total</b>	<b>\$ 1,060.06</b>		<b>\$ 20.88</b>	<b>\$ 20.89</b>	<b>\$ 8.81</b>	<b>\$ 279.22</b>	<b>\$ 1,195.40</b>

1. The reimbursement change includes pharmacy reimbursement savings.

Service Category	Capitation build from Projected GME PMPM (10/1/2020 - 3/31/2021)	Capitation build from Projected GME PMPM (4/1/2021 - 9/30/2021)
<b>Total Gross Medical Expense</b>	279.22	1,195.40
Less Reinsurance PMPM	(16.89)	(46.04)
Less TPL PMPM	-	-
<b>Net Claim Cost PMPM</b>	<b>\$ 262.33</b>	<b>\$ 1,149.36</b>
Care Management PMPM	30.03	95.99
Administrative Expenses PMPM	40.98	73.63
Underwriting Gain PMPM	3.54	13.79
Premium Tax Rate	2.0%	2.0%
<b>Projected CYE 21 Capitation Rate</b>	<b>\$ 343.75</b>	<b>\$ 1,359.97</b>

## Appendix 7: Projected Directed Payment Adjustment, PMPM

Services	Rate Cell	DAP Non-FQHC	DAP FQHC	DAP Total
Physical Health	Statewide	\$ 2.91	\$ 0.12	\$ 3.03
Integrated - PH & BH	Statewide	8.95	0.13	9.08

Note: All amounts shown include underwriting gain and premium tax.

## Appendix 8: Projected Delivery System and Provider Payments Initiatives, PMPM

Provider Payment Initiative	Rate Cell	Physical Health	Integrated - PH & BH
Access to Professional Services Initiative	Statewide	\$ 11.87	\$ 12.53
Pediatric Services Initiative	Statewide	10.58	11.34
Hospital Enhanced Access Leading to Health Improvements Initiative	Statewide	34.42	47.90
<b>Total</b>	<b>Statewide</b>	<b>\$ 56.87</b>	<b>\$ 71.78</b>

Note: All amounts shown include premium tax.



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