MILLIMAN CLIENT REPORT

Contract Year Ending 2022 CHP Capitation Rate Certification

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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 2022 capitation rates for the Arizona Comprehensive Health Program (CHP), formerly the Comprehensive Medical and Dental Plan (CMDP).

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies, used to develop the actuarially sound capitation rates effective October 1, 2021 for Arizona's Comprehensive Health Program (CHP). Hereafter, the term "CYE 22" will refer to the 12-month rating period ending September 30, 2022. Comparisons to prior rates in this certification refer to the previously submitted actuarial memorandum for capitation rates as signed by Bradley B. Armstrong on November 13, 2020. 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 applicable to this rate certification, the 2021-2022 Medicaid Managed Care Rate Development Guide (2022 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2022 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 2022 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, as amended February 8, 2021.

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 2022 actuarially sound capitation rates for the population served under the Arizona Comprehensive Health 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 2022 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.

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 42 CFR § 438.4(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
  - § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations. CMS may require a State to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or the covered populations.
  - § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
  - § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
  - § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
  - § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
  - § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
  - § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
  - § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
  - § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs

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 CYE 22 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 and 3 of the 2022 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 2022 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Application of Expectations to Rate Ranges

Not applicable. There are no rate ranges being developed in the CYE 22 CHP rate development.

I.1.A.ii. Rating Period

This rate certification documents rates for the CHP are effective for the twelve month time period from October 1, 2021 through September 30, 2022.

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 22 capitation rates for the CHP, 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 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 22 capitation rate for the CHP contained in this rate certification is actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

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

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

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

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

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

The CHP 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, CHP subcontracted with an external health plan – Mercy Care – to deliver services covered under this contract. At this time, CHP also changed its name to DCS Comprehensive Health Plan, formerly Comprehensive Medical and Dental Plan (CMDP).

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

Services covered by the CHP include both physical and behavioral health services. Limited behavioral health services (i.e. treatment for ADHD, anxiety and depression) have always been provided by the member's primary care physician. Provision of other behavioral health services has changed as follows:

- Prior to October 1, 2018, and Children's Rehabilitative Services (CRS) specialty care was provided through the CRS program to CHP members who were diagnosed with a CRS-qualifying health condition. Since October 1, 2018, those CRS specialty services have been provided through the CHP.
- Effective April 1, 2021, the CHP capitation rate was expanded to include behavioral health services that were previously provided under a separate contract by three regional behavioral health authorities (RBHAs).

For the CYE 22 rating period, the projected expenses associated with the administration of COVID-19 vaccines are not included in the capitation rates. The CHP Contractor is responsible for these expenses and will be reimbursed for these expenses via periodic cost-settlement payments based upon adjudicated/approved encounter data subject to the two-year claiming rule.

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

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

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

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

This rate certification documents rates for the CHP are effective for the twelve month time period from October 1, 2021 through September 30, 2022.

A single rate is effective for the full contract year ending 2022 period, from October 1, 2021 through September 30, 2022.

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

The populations covered under the CHP 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 CHP contract.

I.1.A.iii.(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 CHP and notify the CHP of the child's AHCCCS enrollment. The CHP is responsible for timely notification to AHCCCS if a member no longer meets the criteria for the CHP coverage as set for in A.R.S. § 8-512. Additional information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the CHP contract.

Due to the public health emergency (PHE), and the maintenance of effort (MOE) requirements included in Families First Coronavirus Response Act (FFCRA), 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.

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 CHP during CYE 22.

I.1.A.iii.(c)(v) Summary of Special Contract Provisions Related to Payment

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6. The special contract provisions related to payment included in the CYE 22 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1))
- Reinsurance Arrangement (42 CFR § 438.6(b)(1))
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B))
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(B))
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(B))
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(B)

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

I.1.A.iii.(c)(vi) Retroactive Capitation Rate Adjustments

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

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

The CYE 22 capitation rates for the CHP are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the CHP.

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

The capitation rates were developed as one statewide rate cell.

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

The effective dates of changes to the CHP are consistent with the assumptions used to develop the CYE 22 capitation rates for the CHP.

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

The certified capitation rates allow the CHP to reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 22.

I.1.A.viii. Certifying Rate Ranges

Not applicable. There are no rate ranges being developed in the CYE 22 CHP rate development.

I.1.A.ix. Capitation Rates Within Rate Ranges

Not applicable. There are no rate ranges being developed in the CYE 22 CHP rate development.

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

I.1.A.x.(a) Reasonable, Appropriate, and Attainable Costs

In the actuary's judgment, all adjustments to the capitation 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.x.(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.x.(c) Contracted Rates

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 22 capitation rates certified in this report represents the final contracted rates.

I.1.A.xi. Rates from Previous Rating Periods

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 22 capitation rates for the CHP.

I.1.A.xii. COVID-19 PHE Risk Mitigation

This section of the 2022 Guide includes CMS recommendations for risk mitigation strategies for rating periods impacted by the PHE and reminds states of specific requirements related to risk mitigation strategies. All risk

mitigation strategies are addressed in the contract and below in Section I.4.C. and will be submitted to CMS prior to the start of the rating period.

I.1.A.xiii. Rate Certification Procedures

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

This section of the 2022 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

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

This is a new rate certification that documents that the CHP capitation rates are changing effective October 1, 2021.

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

Not Applicable. This rate certification will change the CHP capitation rates effective October 1, 2021.

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

This section of the 2022 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 for certified rates per rate cell, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.7(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract in accordance with 42 CFR § 438.7(b)(5)(iii).

I.1.A.xiii.(e) CMS Contract Amendment Requirement

CMS requires a contract amendment be submitted whenever capitation rates change for any reason other than application of an approved payment term (e.g. risk adjustment methodology) which was included in the initial managed care contract. The state will submit a contract amendment to CMS to reflect the CHP capitation rates changing effective October 1, 2021.

I.1.A.xiii.(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. Rates or Rate Ranges

The actuary is certifying a capitation rate – not a rate range – for the CYE 22 CHP rate development.

I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 22 capitation rates for the CHP.

I.1.B.iii. Rate Assumptions

This section of the 2022 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell.

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

I.1.B.iv. Certifying Rate Ranges

Not applicable. There are no rate ranges being developed in the CYE 22 CHP rate development.

I.1.B.v. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes relevant section numbers from the 2022 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.vi. Differences in Federal Medical Assistance Percentage

Variations in the assumptions used to develop the projected benefit costs for the covered populations were based on valid rate development standards and not based on the rate of Federal Medical Assistance Percentage (FMAP). The covered populations under the CHP receive the regular FMAP.

I.1.B.viii. Comparison of Rates

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

The comparisons between the most recent certified CYE 21 CHP capitation rates and the CYE 22 capitation rates being certified in this actuarial rate certification are available in Appendix 3.

Since the CYE 22 rate 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 CYE 21 CHP capitation rate effective April 1, 2021, which also reflected the integration of behavioral health services.

The 2022 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 22 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 CHP rate effective October 1, 2021, there was a negative change in the rate, primarily due to lower behavioral health trends and lower non-benefit expenses.

I.1.B.viii.(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.viii.(c) De minimis rate changes

The state did not adjust the CYE 21 CHP rates by a de minimis amount using the authority in 42 C.F.R. § 438.7(c)(3).

I.1.B.ix. Future Rate Amendments

The list of possible amendments which would impact capitation rates in the future are shown in Figure 1 below, along with the potential submission date, and the reason why the current certification cannot account for the changes anticipated to be made to the rates.

Figure 1: Possible Future Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
American Rescue Plan Act (ARPA) proposals	February 2022	AHCCCS has submitted ARPA proposals to CMS for review and approval. AHCCCS also needs approval from the Arizona State Legislature for implementation of any approved ARPA items.

I.1.B.x. Approach to Addressing Impact of COVID-19 PHE

I.1.B.x.(a) Available Applicable Data to Address COVID-19 PHE in Capitation Rate Setting

The AHCCCS Division of Health Care Management (DHCM) Actuarial Team and the Milliman consultants certifying these rates have read and discussed numerous articles (Health Affairs, Health Watch, KFF, Harvard, Science Alert, CMS FAQs, JAMA, etc.), attended several webinars discussing various aspects of the impacts of COVID-19 (enrollment mix changes, deferred versus foregone care, pandemic progression timelines, hospital utilization patterns, etc.), and monitored national trends and information such as unemployment reports published by the Bureau of Labor Statistics, emerging COVID-19 case rates, and projections of vaccine utilization. We continue to monitor national legislation and federal guidance on the public health emergency (PHE) end date and plan to analyze changes in acuity of members due to maintenance of effort (MOE) eligibility requirements in the Families First Coronavirus Response Act (FFCRA).

We have found the following data to be applicable for determining how to address the COVID-19 PHE in rate setting:

- Arizona Medicaid data (before and during the PHE)
- Arizona school closure data
- Arizona, regional, and national COVID-19 vaccination data
- Arizona Medicaid telehealth data along with national projections

I.1.B.x.(b) How Capitation Rates Account for COVID-19 PHE Impacts

The CYE 22 capitation rates account for the direct and indirect impacts of the COVID-19 PHE by including projected costs associated with expanding service and telehealth coverage, reimbursement for COVID-19 testing, and approved flexibilities under Appendix K authority and select 1115 waiver changes. Emerging experience during the PHE was also considered in projecting costs for CYE 22. The CYE 22 capitation rates do not include costs for administration of COVID-19 vaccines, as there is a new cost-settlement arrangement in place for CYE 22 for those expenses. AHCCCS will continue to monitor encounters and has plans to view member acuity.

I.1.B.x.(c) Risk Mitigation Strategies Utilized for COVID-19 PHE

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 22 capitation rates will continue AHCCCS' long-standing program policy and will include risk corridors. For the CYE 22 rating period, AHCCCS is adding a cost-settlement for administration of COVID-19 vaccines and carving these costs outside of the capitation rates. This is the only risk mitigation strategy utilized specifically for COVID-19 and is the only change from the prior rating period in terms of risk strategies being utilized.

I.2. Data

This section provides documentation for the Data section of the 2022 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). 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 22 capitation rates for the CHP were:

- Adjudicated and approved encounter data submitted by the CHP, the CRS Contractor, and the RBHAs
    a. Incurred from October 2017 through February 2021
    b. Paid and reported through February 2021 (CHP, CRS, and RBHA data)
- Pended encounter data submitted by the CHP
- Reinsurance payments made to CHP for services
    a. Incurred from October 2017 through September 2020, paid through February 2021
- Enrollment data for the CHP, the CRS program, and the RBHAs from the AHCCCS PMMIS mainframe
- Quarterly and annual financial statements submitted by the CHP, the CRS Contractor, and the RBHAs
    a. October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
    b. October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19)
    c. October 1, 2019 through September 31, 2020 (CYE 20 or FFY 20)
    d. October 1, 2020 through December 31, 2020 (CYE 21 or FFY 21)
- Supplemental encounter data files for services provided by the CHP 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 CHP, the RBHAs, and Mercy Care
- Projected CYE 22 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 CHP encounter data serving as the base experience in the capitation rate development process was incurred during January 1, 2019 to December 31, 2019, and paid through February 2021. Similarly, for claims that were historically paid by the RBHAs, we utilized encounters incurred during January 1, 2019 to December 31, 2019, and paid through February 2021. For the purposes of developing trend assumptions applied for the CYE 22 capitation rates, we also reviewed encounter data from October 1, 2017 through December 31, 2020.

The historical enrollment data for CHP members aligned with the encounter data time periods of October 1, 2017 through December 31, 2020.

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 22 was provided by the AHCCCS DBF Budget Team. The supplemental encounter data files were provided by the CHP. The detailed administrative expense data was provided by the CHP and Mercy Care.

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

While the CHP 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 2022 CHP 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 34.7% of expenditures in sub-capitation and block purchase payment arrangements (sub-cap/block payments) for CHP. 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 2 below provides a distribution of the CalYr19 behavioral health encounter data by sub-cap/block payments, non-sub-cap/block payments and by Category of Service (COS) for CHP.

Figure 2: CalYr19 Non-Subcap/Non-Block and Subcap/Block Percentages by Category of Service

Category of Service	Non-Subcap/ Non-Block Payments	Subcap/Block Payments
Inpatient Behavioral Health	99.9%	0.1%
Inpatient Hospital	100.0%	0.0%
Pharmacy	100.0%	0.0%
Rehabilitation Services	17.5%	82.5%
Treatment Services	40.8%	59.2%
Residential Services	98.7%	1.3%
Support Services	76.2%	23.8%
Transportation	77.4%	22.6%
Case Management	34.7%	65.3%
Medical Services	31.8%	68.2%
Total	**65.3%**	**34.7%**

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 CHP 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 CHP, 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 CHP, 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, pended and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters, but providing this file to the CHP, 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 CHP 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, Milliman 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 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 22 capitation rates for the CHP. Additionally, we ensured that only services covered under the state plan were included.

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

We reviewed the encounter data for all services provided by CHP and the RBHAs to the annual financial statement data for the same entities for CalYr19.

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 pended and non-submitted encounters from the CHP 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 CHP, the RBHAs, and the CRS Contractor and provided from the AHCCCS PMMIS mainframe as well as the supplemental encounter files provided by the CHP. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the CHP, 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 CHP 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 22 capitation rates for the CHP.

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 CalYr19 encounter data was appropriate to use as the base data for developing the CYE 22 capitation rates for the CHP 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 22 capitation rates for the CHP.

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 22 capitation rates for the CHP.

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

Not applicable. We did not rely on a data book to develop the CYE 22 capitation rates for the CHP.

I.2.B.iii Adjustments to the Data

The CHP encounter data was adjusted as described in Section I.2.B.ii.(b)(i) for pended and non-submitted encounters. The CHP, 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 CHP and CRS Contractor encounter data from October 1, 2017 through December 31, 2020, paid through February 2021. 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, 2017 through December 31, 2020, paid through February 2021. The annualized completion factors were applied to the January 1, 2019 through December 31, 2019 base experience encounter data, for purposes of projection to the CYE 22 rating period. The annualized completion factors were applied to the October 1, 2017 through December 31, 2020 encounter data for purposes of trend development.

The aggregated CalYr19 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 (January 1, 2019 through December 31, 2019) are described below. All program and fee schedule changes which occurred or are effective on or after January 1, 2020 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 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 historical program and reimbursement changes described below. Totals may not add up due to rounding.

Figure 3: Impacts of Historical Program/Reimbursement Changes

Change	Integrated - PH & BH	
	Annual Dollar Impact	PMPM Impact
Provider Fee Schedule Changes	$ 3,046,158	$ 18.82
DAP Removal	(1,033,564)	(6.39)
Combined Miscellaneous Program Changes	668,440	4.13
Total Historical Program and Reimbursement Changes	**$ 2,681,034**	**$ 16.57**

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 CalYr19 that impacted utilization and unit costs of Contractors' pharmacy costs in the base period. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

Since CalYr19 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.

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. 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. The impacts of adding reinsurance eligibility are discussed in section I.4.C.ii.(c)(iv).

Sickle Cell Drugs Approval

In November 2019, the FDA approved the drugs Oxbryta 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 Oxbryta and Adakveo on November 25, 2019 and November 20, 2019, respectively.

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. Slower-than-anticipated adoption of the ASAM software caused by compatibility issues with provider electronic health record systems limited use of ASAM in the base period. To raise adoption of the software during CYE 22,

AHCCCS is providing a differential adjusted payment for providers that submit a letter of intent to complete integration of ASAM with their EHR system. For CYE 22 rate development, additional impacts for the fee schedule change and incentivized adoption of ASAM are included above any base period encounters.

BHRF Personal Care Differential

Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team established a differentiated Fee For Service rate for Behavioral Health Residential Facilities (BHRF) that are licensed by ADHS to provide personal care services.

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 has gradually raised awareness and increased utilization of these covered ABA services.

Removal of DAP from Base Period

CYE 19 and CYE 20 capitation rates funded DAP made from October 1, 2018 through September 30, 2019 and from October 1, 2019 through September 30, 2020 to distinguish providers which 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 and September 30, 2020, AHCCCS has removed the impact of DAP from the base period CalYr19. To remove the impact, the AHCCCS DHCM Actuarial Team requested provider IDs for the qualifying providers for the CYE 19 and CYE 20 DAP by specific measure from the AHCCCS Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 19 and CYE 20 were then adjusted downward by the appropriate percentage bump specific to the DAP measure for each respective contract year. The associated costs removed from the base data are displayed in Figure 3. Totals may not add up due to rounding.

See Section I.4.D. for information on adjustments included in CYE 22 capitation rates for DAP that are effective from October 1, 2021 through September 30, 2022.

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 22 capitation rates.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2022 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) and 42 CFR § 438.3(e).

I.3.A.ii. Projected Benefit Cost Trend Assumptions

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

I.3.A.iii. In-Lieu-Of Services

There are no in lieu of services as defined at 42 CFR § 438.(e)(2) included in the projected benefit costs.

I.3.A.iv. 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 CHP 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 22 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 22 capitation rates for the CHP.

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

Following national and state emergency declarations in March 2020, AHCCCS has sought authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. As of this writing, Appendix K authorities are projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end while other select 1115 waiver changes are approved from March 1, 2020 until 60 days after the end of the federal emergency declaration. For October 1, 2021 rate development, the actuaries have incorporated projected impacts of these authorities and other AHCCCS responses to the COVID-19 outbreak for portions of the contract period, these are indicated by a ǂ symbol.

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 CalYr19 time period to the midpoint of the CYE 22 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 CYE 22 rates, this resulted in applying 33 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 22 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 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 4 summarizes the impacts for prospective program and reimbursement changes effective after the base data period.

Figure 4: Impacts of Prospective Program/Reimbursement Changes

Change	Integrated - PH & BH	
	Annual Dollar Impact	PMPM Impact
Provider Fee Schedule Changes	$ 365,729	$ 2.26
Pharmacy Reimbursement Savings	(618,924)	(3.82)
Expanded Telehealth Use‡	1,871,843	11.57
High Needs Therapeutic Foster Care Rates	1,912,498	11.82
Combined Miscellaneous Program Changes	80,462	0.50
Total Prospective Program and Reimbursement Changes	**$ 3,611,608**	**$ 22.32**

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules used for AHCCCS 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 FFS fee schedule updates program change includes a fee schedule adjustment to bring the encounter base data from CalYr19 FQHC PPS rates up to projected CYE 22 FQHC PPS rates.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 22 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DHCM Rates & Reimbursement Team used both the CYE 19 and CYE 20 encounter data to develop the impacts of the fee schedule changes on October 1, 2020 and October 1, 2021. The October 1, 2020 fee schedule changes also incorporated increased base reimbursement rates for services reimbursed under the dental fee schedule and physician fee schedule, not including the physician drug fee schedule, to restore provider rates to those in existence prior to reductions implemented in state fiscal year 2009, per Arizona State HB 2668 (Laws 2020, Chapter 46). 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 each time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the cumulative impacts to CalYr19 by program.

For the duration of the COVID-19 PHE, 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 AHCCCS DHCM Actuarial Team applied the impacts by program as part of the fee schedule changes as the change is non-material for each program and rate cell when considered alone.

Effective January 1, 2020, the All Patients Refined Diagnosis Related Group (APR-DRG) adjustor for burns increased. The increased costs for this change have been included with the fee schedule changes already discussed as the APR-DRG burn adjustor is non-material for each program and rate cell when considered alone.

In the 2021 legislative session, the legislature passed a general appropriations bill which included funding for CHP to implement HCBS and NF provider fee schedule increases. Consistent with the additional funding, the DHCM Rates and Reimbursement Team increased HCBS and NF provider reimbursement rates by 7.2% on October 1, 2021. The DHCM Actuarial Team similarly adjusted CYE 22 capitation rates to reflect AHCCCS' expectation that increased rates will be adopted by the Contractors.

AHCCCS will transition from version 34 to version 38 of the APR-DRG payment classification system on October 1, 2021. AHCCCS has used v34 APR-DRG national weights published by 3M since January 1, 2018 until present. In addition to updating to version 38, AHCCCS will rebase the inpatient system and update to APR-DRG v38 effective October 1, 2021. Rebasing involves updating the DRG grouper version, relative weights and DRG base rates via payment simulations modeling using more recent data. Guidehouse did the rebase of the AHCCCS DRG system. The rebase followed the same methodology as that used in the January 2018 rebase, included here for reference:

> "Rebasing calculations included updated base rates (both standardized amounts and wage indices), relative weights, and change of policy adjusters. Outlier identification and payment methodology has not changed nor has any other underlying claim pricing calculation (notwithstanding the above noted changes to factors, indices, and statewide standardized base rate)."

After adjusting the base rates and wage indices to maintain a budget neutral rebase, AHCCCS adjusted one service policy adjustor during the rebase to meet program funding goals. The high acuity pediatric policy adjustor was increased from 2.3 to 2.4 in this rebase process. The AHCCCS DHCM Actuarial Team relied upon Guidehouse and the AHCCCS DHCM Rates & Reimbursement Team for the reasonableness of the changes. The combined impact for the rebase and policy adjustor change has been included with the fee schedule changes already discussed.

AHCCCS also increases some fee schedule rates effective January 1 of each year to recognize the annual minimum wage increase resulting from the passing of Proposition 206. The increased costs for this change have been included with the fee schedule changes already discussed as the minimum wage change is non-material for the CHP Program when considered alone.

The overall impact of the AHCCCS Fee-for-Service fee schedule updates is illustrated below in Table 9l. Totals may not add up due to rounding.

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 AHCCCS FFS repriced amounts would result in an annual savings of $71.5 million or 4.8% of pharmacy spend for CalYr19 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. In past years, AHCCCS recognized

that the full savings amount identified in similar analyses may not be reasonably achievable in a single year. As a result, the base pharmacy data of each program was adjusted by 33% in CYE 20 and 66% in CYE 21 of the amount identified in the original CYE 18 analysis as savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing. Based on the updated analysis of CalYr19 which only considers savings based on AHCCCS FFS pricing and does not include savings based on a lesser of calculation, for CYE 22, AHCCCS is adjusting the base pharmacy data of each program by 90% of the savings identified in the analysis of CalYr19 pharmacy data for valuing claims data to AHCCCS FFS prices.

The overall impact of the change for CHP is displayed below in Figure 4. Totals may not add up due to rounding.

High Needs Therapeutic Foster Care Rates

Effective October 1, 2021, AHCCCS is establishing increased Fee for Services (FFS) rates for Therapeutic Foster Care (TFC) services provided in a licensed family setting to higher needs foster children under 18 years of age. Distinct rates will be set for TFC services provided to high-needs children with a) significant co-morbid behavioral and physical health conditions, b) behavioral health needs and cognitive impairment, or c) a primary psychotic disorder. The rate adjustments for TFC services are intended to ensure access to care to higher needs foster care populations.

To estimate the impact, the DHCM financial analysts first reviewed encounters to identify child members that used TFC services during FFY 19. The analysts then reviewed each of the members' FFY 19 encounters and compared their service use against clinical criteria for each of the three high needs categories. It was determined that 27% of TFC service users could be categorized into the three high-needs categories. Annual costs for these members were 29.9% to 113.7% greater than the average cost for all other child users of TFC services in FFY 19. Based on that analysis, FFS fee schedule rates for TFC services to the three high-needs populations were set to be 29.9% to 113.7% above the base rates for TFC services provided to other members. The Actuarial Team anticipates that Contractors will adopt similarly differentiated rates.

For CYE 22 rate development, the projected change was estimated using base period encounter data of TFC service use. The overall impact of the change for CHP is displayed in Figure 4. Totals may not add up due to rounding.

Expanded Telehealth Use‡

To ensure access to care during the COVID-19 public health emergency, AHCCCS expanded coverage of telephonic and telehealth (TPTH) codes and mandated that services delivered through TPTH be reimbursed at the same rates as for in-person services, for both physical and behavioral health services. A review of encounters from April 1, 2020 to December 31, 2020 indicates that use of TPTH services has been essential for continued provision of services and represented annualized growth of 1,049% above base period use. Most growth in the use of these services is expected to represent a cost-neutral shift from use of in-person services. Increased use of TPTH services in the rating period are, however, expected to reduce the rate of missed appointments and lower use of non-emergency medical transportation (NEMT), emergency department (ED) visits, and specialty visits.

For purposes of projecting TPTH use during the rating 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 2018 National Health Expenditures. It was further assumed that use would be phased in at 67% of long-run AHCCCS projected TPTH services during the rating period. The projection suggests that 76% of annualized TPTH service growth encountered between April 1, 2020 and December 31, 2020 would be maintained in CYE 22.

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 22 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 FFY 2019. It was therefore, estimated that 11.0% of the increase to TPTH services in CYE 22 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 67% phase-in assumption above for projected TPTH services, DHCM financial analysts projected a 13.4% reduction (67% phase-in of a 20% reduction) in ED visits in CYE 22 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.

For CYE 22 rate development, the projected impact of growth in TPTH services was estimated base period encounters of TPTH-eligible services, NEMT, and ED visits. The overall impact of the change for CHP is displayed below in Figure 4. Totals may not add up due to rounding.

Combined Miscellaneous Program Changes

EPSDT Visits and Developmental Screens

Effective October 1, 2021, AHCCCS is revising policy to better align Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits and developmental screening requirements with CMS Core Measures and recommendations from the American Academy of Pediatrics. The policy revisions require an additional EPSDT visit for child members at 30 months of age and two specialized developmental screens at the child member's 18-month and 24-month EPSDT visits.

Pharmacy and Therapeutics Committee Recommendations – Post Base Year

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 22. 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.

Dental Counseling Services

On the recommendation of the Office of the Director's Chief Medical Officer, AHCCCS began covering dental services for tobacco counseling effective October 1, 2020 and high-risk substance use counseling effective January 1, 2021. An estimated 26.1% of AHCCCS adults use tobacco while an estimated 17.7% of high-school aged AHCCCS members use electronic cigarettes. The CYE 22 capitation rates include adjustments for the projected use of these dental counseling services.

Bus Passes

Effective October 1, 2021, AHCCCS is revising policy to clarify that Contractors may reimburse public transport passes as non-emergency medical transport (NEMT). Passes would generally be billed with procedure code A0110. When offering a public transport pass, contractors should consider such things as location of the member, location of the member's provider, public transportation schedules, and member ability to travel alone. CYE 22 adjustments to rates include projected costs of bus passes and increased use of medical services due to greater members options for transport, partly offset by savings from reduced use of more expensive alternative forms of NEMT.

Genetic Testing for Cardiovascular Disorders

AHCCCS began covering genetic tests for rare inherited cardiovascular disorders effective October 23, 2020. The tests are primarily recommended for identification of Long QT syndrome (LQTS) in first degree relatives of individuals with the disorder. To estimate the impact of coverage, the DHCM financial analysts first reviewed FFY 19 encounters to identify members with an LQTS diagnosis. The analysts then projected the number of first-degree relatives of

those individuals that are also AHCCCS members and that would receive the tests. Lastly, the analysts applied FFS fee schedule pricing to the projected quantity of tests to estimate total cost of coverage.

COVID-19 Tests‡

Since February 2020, AHCCCS has covered a range of medically necessary diagnostic and antibody tests for detecting COVID-19. The DHCM Actuarial Team is adjusting CYE 22 rates to reflect the projected use of these tests, which were not covered during the base period.

Emergency Triage, Treat, and Transport

Effective October 1, 2021, AHCCCS will implement an Emergency Triage, Treat, and Transport (ET3) model that is similar to the ET3 program that Medicare began in FFY 21. Under the state's program, emergency service providers may begin billing for trips that result in delivery of on-site or telehealth services by a partner health professional or for trips to an outpatient non-emergency department provider. The DHCM financial analysts project that cost savings of diverting unnecessary emergency department visits to lower acuity settings under the ET3 model will be offset by additional costs of reimbursing emergency service providers for trips in which no or limited reimbursement was previously paid.

Vaxelis Immunizations

Effective January 1, 2021, AHCCCS began covering Vaxelis as a combination immunization for children ages 6 weeks through 4 years against diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B, and disease due to haemophiles influenzae type b. The vaccination is administered in a series of three shots and is anticipated to substitute for anywhere from 7 to 16 shots of the previously available vaccinations for the diseases above. The federal Vaccines for Children program funds costs of the vaccines while AHCCCS and its contractors reimburse for administration of the vaccines. The CYE 22 rates include a reduction for the projected decrease in vaccine shots that will be administered to children.

Cancer Profiling Tests

Effective July 1, 2021, AHCCCS began covering two medically necessary cancer profiling tests. The tests can assist providers in determining the most appropriate course of treatment for a patient's cancer.

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 two to four applications a year.

Inpatient Dental Hygienist Teeth Cleanings

As part of the 2019 Legislative session, the Arizona Legislature passed HB 2058 which permits dental hygienists to provide services in an inpatient hospital setting under supervision of a physician. The legislation is expected to increase provision of inpatient teeth cleanings for prevention of ventilator associated pneumonia.

Pay and Chase Guidance

Federal regulation 42 CRF 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.

Child Flu Shots at Pharmacies

Effective September 1, 2020, AHCCCS modified policy guidance to permit pharmacists to administer influenza vaccinations to children ages 3 to 18 years old. Prior to the change, policy limited pharmacist-administered influenza vaccines to adults 19 years and older.

Rate Increase for Vaccines for Children

Effective October 1, 2021, AHCCCS is increasing reimbursement for administration of Vaccine for Children (VFC) program vaccines to the maximum fee permitted to be reimbursed by the state under federal rule 77 FR 66669.

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 CHP 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 22 capitation rates therefore includes those adjustments.

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

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

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

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

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 22 CHP rates.

All data used was specific to the CHP population, the CRS specialty services provided to CHP members with a CRS qualifying condition, and the behavioral health services provided to the CHP 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 CHP members from FFY 18, FFY 19, FFY 20, and part of FFY 21 were combined, organized

by incurred year and month and COS. The historical data were normalized for historical program and fee schedule changes. For the services provided to CHP members, the trend rates were developed to adjust the base data (midpoint of July 1, 2019) forward 33 months to the midpoint of the October 2021 through September 2022 rating period (April 1, 2022).

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 21 rate development PMPM trends for the CHP. 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 2022 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%. No trend categories met the criteria for being considered outlier or negative PMPM trends.

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. As of August 11, 2021, no additional services have been identified as necessary services to comply with MHPAEA.

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

There are no in lieu of services as defined at 42 CFR § 438.(e)(2) included in the projected benefit costs.

I.3.B.vi. Retrospective Eligibility Periods

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

AHCCCS provides prior period coverage 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 CHP. The CHP receives notification from AHCCCS of the member's enrollment. The CHP is responsible for payment of all claims for medically necessary services covered by the CHP 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 22 capitation rates for the CHP, 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 2022 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 shall void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters shall be submitted."

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

Adjustments related to provider 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 2022 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

Not Applicable. No incentive arrangement exists with the CHP.

I.4.B. Withhold Arrangements

Not Applicable. No withhold arrangement exists with the CHP.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2022 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 22 capitation rates for the CHP Program will include a risk corridor. There is also a cost-settlement type arrangement for the administration of COVID-19 vaccines for the CYE 22 rating period.

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 22 capitation rates are consistent with AHCCCS' long-standing program policy and will include a risk corridor for all services under the CHP. This rate certification will use the term risk corridor to be consistent with the 2022 Guide. The CHP 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 CHP in CYE 22.

For October 1, 2021 through September 30, 2022, CHP will reconcile its Subcontracted Health Plan medical expenses to medical capitation paid to the Subcontracted Health Plan in accordance with the CHP'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 CHP will submit the reconciliation for AHCCCS approval and AHCCCS will reconcile with the CHP 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.

The cost-settlement will reimburse the CHP Contractor for the administration of COVID-19 vaccines via a periodic cost-settlement based upon adjudicated/approved encounter data subject to the two-year claiming rule.

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 CHP.

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

The threshold amounts for the risk corridor for October 1, 2021 through September 31, 2022 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 CHP leadership.

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

Not applicable. The CHP 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 CHP 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 CHP 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 since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the CHP for covered services incurred above the deductible. The deductible is the responsibility of the CHP. The deductible for CYE 22 Regular reinsurance cases is $50,000, an increase from previous years of the program. The limit on other catastrophic reinsurance is $1,000,000. Once a reinsurance case hits this limit, the CHP is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level. The actual reinsurance case amounts are paid to the CHP 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 CHP 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 CHP 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 CHP for services provided to CHP members and incurred during CalYr19, including services provided by the RBHAs. The calculated reinsurance payments were developed from CalYr19 encounters that were adjusted for historical programmatic and reimbursement changes and trended to the CYE 22 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 22 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 CalYr19 encounters. The reinsurance offset for the rating period was developed using encounters for services provided by both the CHP and the RBHAs in CalYr19 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 CalYr19 to CYE 22 included adding several drugs 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 22 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 CHP is $201,425.

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

This section of the 2022 Guide provides information on delivery system and provider payment initiatives (i.e., state directed payments) authorized under 42 CFR §438.6(c).

I.4.D.ii. Appropriate Documentation

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

The only pre-prints addressed in this certification are the ones related to CHP. Those pre-prints are DAP, APSI, PSI, and HEALTHII. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 9.

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

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. 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 potential rate increases range from 0.5% to 18.5%, depending on the provider type.

Access to Professional Services Initiative

The 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 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 percentage 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 PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

Hospital Enhanced Access Leading to Health Improvements Initiative

The HEALTHII delivers a uniform percentage increase to hospitals for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The HEALTHII uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class' 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

DAP are the only directed payments incorporated in the capitation rates. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 9.

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

The single rate cell for the CHP program is affected.

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

For DAP see Appendix 7 for the total impact in the CHP rate development. See Appendix 8 for the impacts of the other payments.

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 3.0% increase), Critical Access Hospitals (eligible for up to 10.5% increase), other hospitals and inpatient facilities (eligible for up to 5.0% 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 8.5% increase on all services provided), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), and HCBS providers (eligible for up to 1.0% increase on specified services for some provider types, and all services for other provider types). 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 20 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 22 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 22 (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

Figure 5: CHP Differential Adjusted Payments

Change	Integrated - PH & BH	
	Annual Dollar Impact	PMPM Impact
Differential Adjusted Payments Add-in	$ 2,463,254	$ 15.22

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

Differential Adjusted Payments

AHCCCS has submitted the DAP §438.6(c) pre-print to CMS but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described in the preceding sections, is included in the capitation rates in a manner consistent with the pre-print under CMS review.

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

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

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

The APSI, PSI, and HEALTHII are not included in the CHP certified capitation rates and will be paid out via lump sum payments. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 9.

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $2.1 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Services Initiative

Anticipated payments including premium tax for PSI are approximately $1.5 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 22 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments including premium tax for HEALTHII are approximately $8.6 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 22 utilization will be used to redistribute the payments.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

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

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

Access to Professional Services Initiative

AHCCCS has submitted the APSI § 438.6(c) pre-print to CMS but has not yet received approval. The payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

Pediatric Services Initiative

AHCCCS has submitted the PSI § 438.6(c) pre-print to CMS but has not yet received approval. The payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

Hospital Enhanced Access Leading to Health Improvements Initiative

AHCCCS has submitted the HEALTHII § 438.6(c) pre-print to CMS but has not yet received approval. The payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, 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.

I.4.E. Pass-Through Payments

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

I.5 Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2022 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 CHP – 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 CHP 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 CHP RBHAs in order to consider what reasonable expenses would be after behavioral health services were integrated into the CHP 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.

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 22 administrative expense components are shown in Appendix 6.

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

There were no methodology changes from the non-benefit cost development used in the CYE 21 rate.

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 22 capitation rates for the CHP 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 22 capitation rates for the CHP 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 22 capitation rates for the CHP include a provision of 1.0% 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 22 capitation rates for the CHP.

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.6. Risk Adjustment and Acuity Adjustments

This section of the 2022 Guide is not applicable to the CHP. The CHP 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 CHP. Managed long-term services and supports, as defined at 42 CFR § 438.2, are not covered services under the CHP. The CHP 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 2022 Guide is not applicable to the CHP.

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 Health Program (CHP) effective October 1, 2021. 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:

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations. CMS may require a State to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or the covered populations.
- § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
- § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
- § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
- § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

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

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

The data, assumptions, and methodologies used to develop the CYE 22 capitation rates for the CHP have been documented according to the guidelines established by CMS in the 2022 Guide. The CYE 22 capitation rates for the CHP are effective for the twelve-month time period from October 1, 2021 through September 30, 2022.

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 CHP. I have relied upon AHCCCS and the CHP 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.

Signature on File	August 11, 2021
Bradley B. Armstrong	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Actuarial Certified Capitation Rates

CHP Capitation Rates	
Effective October 1, 2021 through September 30, 2022	$ 1,322.22

Appendix 3: Fiscal Impact Summary Compared to CYE 21

CHP	Service	Projected CYE 22 Member Months	CYE 21 Capitation Rate Effective 4/01/21 - 09/30/21	CYE 22 Capitation Rate Effective 10/01/21 - 09/30/22	CYE 22 Projected Expenditures (based on 4/01/21 rate)	CYE 22 Projected Expenditures (based on 10/01/21 rate)	Annual Dollar Impact	Percent-age Impact
Statewide	Integrated - PH & BH	161,835	$ 1,359.97	$ 1,322.22	$ 220,091,551	$ 213,982,634	$ (6,108,916)	(2.8%)

Notes:

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

The CYE 2022 integrated rate includes both physical health and behavioral health services, and is effective 10/1/2021 - 9/30/2022.

The Annual Dollar Impact illustrates the fiscal impact for the entire CYE 22 contract period.

Appendix 4: Unadjusted and Adjusted Base Data

Service Category	Unadjusted Base Data PMPMs	Supplemental Encounter Files	Completion Factors	Program/ Reimbursement Changes	DAP PMPM Removed	Adjusted Base Data
Inpatient & NF	$ 50.81	1.1441	1.0000	1.0021	$ (3.23)	$ 55.02
Inpatient Behavioral Health	207.02	1.0000	0.9919	1.0000	(2.61)	206.09
Outpatient	39.38	1.0473	1.0000	1.0012	(0.00)	41.29
Pharmacy	45.53	1.0630	0.9998	1.0462	(0.25)	50.40
Rehabilitation Services	81.06	1.0000	0.9876	1.0063	(0.00)	82.59
Treatment Services	113.21	1.0000	0.9909	1.0000	-	114.25
Residential Services	67.73	1.0000	0.9933	1.0042	-	68.47
Support Services	105.58	1.0000	0.9928	1.0107	(0.11)	107.38
Transportation	23.55	1.0000	0.9911	1.0141	-	24.10
Case Management	155.37	1.0000	0.9903	1.0000	-	156.88
Dental	23.55	1.3889	0.9999	1.0777	(0.02)	35.23
Medical Services	115.67	1.0266	0.9991	1.1324	(0.17)	134.41
Total	**$ 1,028.45**	**1.0236**	**0.9936**	**1.0217**	**$ (6.39)**	**$ 1,076.11**

Appendix 5: Projected Benefit Cost Trends

Service Category (Non-CRS and CRS Expenses)	Annualized Trend Rates		
	Utilization	Unit Cost	PMPM
Inpatient & NF	(1.5%)	3.0%	1.5%
Inpatient Behavioral Health	1.0%	1.5%	2.5%
Outpatient	(0.5%)	1.0%	0.5%
Pharmacy	0.3%	1.0%	1.3%
Dental	0.5%	1.0%	1.5%
Medical Services	0.5%	1.0%	1.5%
Residential Services	3.0%	1.0%	4.0%
Support Services	0.0%	1.0%	1.0%
Rehabilitation/Treatment Services	2.0%	1.0%	3.0%

Appendix 6: Projected CYE 22 Capitation Rate Development

Projected Combined Gross Medical Expense						
Service Category	Adj Base Data PMPM	Trend	Program Change 10/1/21	Reimbursement Change 10/1/21[1]	10/1/21 DAP	Projected GME PMPM (10/1/21-9/30/2022)
Inpatient & NF	$ 55.02	1.46%	$ 0.00	$ 0.00	$ 0.00	$ 57.25
Inpatient Behavioral Health	206.09	2.52%	-	(1.69)	1.24	220.21
Outpatient	41.29	0.50%	-	-	-	41.85
Pharmacy	50.40	1.26%	0.01	(3.82)	-	48.35
Rehabilitation Services	82.59	3.02%	-	0.02	0.61	90.26
Treatment Services	114.25	3.02%	11.57	-	2.34	137.90
Residential Services	68.47	4.03%	-	0.01	-	76.33
Support Services	107.38	1.00%	11.82	2.71	0.21	125.10
Transportation	24.10	1.00%	0.27	0.03	-	25.07
Case Management	156.88	1.00%	-	-	-	161.23
Dental	35.23	1.51%	-	-	-	36.71
Medical Services	134.41	1.54%	0.22	1.19	10.81	152.40
Total	$ 1,076.11		$ 23.88	$ (1.56)	$ 15.22	$ 1,172.67

Notes:

1. The reimbursement change includes pharmacy reimbursement savings.

Service Category	Capitation build from Projected GME PMPM (10/1/2021 - 9/30/2022)
Total Gross Medical Expense	1,172.67
Less Reinsurance PMPM	(39.81)
Less TPL PMPM	-
Net Claim Cost PMPM	$ 1,132.86
Care Management PMPM	86.59
Administrative Expenses PMPM	63.37
Underwriting Gain PMPM	12.96
Premium Tax Rate	2.0%
Projected CYE 22 Capitation Rate	**$ 1,322.22**

Appendix 7: Differential Adjusted Payment, PMPM

Services	Rate Cell	DAP Total
Integrated - PH & BH	Statewide	$15.69

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

Appendix 8: Estimated State Directed Payments, PMPM

Provider Payment Initiative	Rate Cell	Integrated - PH & BH
Access to Professional Services Initiative	Statewide	$ 12.99
Pediatric Services Initiative	Statewide	9.57
Hospital Enhanced Access Leading to Health Improvements Initiative	Statewide	52.98
Total	**Statewide**	**$ 75.54**

Note: All amounts shown include premium tax.

Appendix 9: State Directed Payments, CMS Prescribed Tables

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

Control name of the state directed payment	Type of payment - Section I.4.D.ii.(a)(i)(A)	Brief description - Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.d.ii.(a)(iii)
AZ_Fee_IP.OP.PC_Renewal_20211001-20220931 (a.k.a. DAP)	Uniform Percentage Increase	Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.	Rate Adjustment
AZ_Fee_AMC_Renewal_20211001-20220930 (a.k.a. APSI)	Uniform Percentage Increase	62% increase to otherwise contracted rates for professional services provided by qualified practitioners affiliated with designated hospitals.	Separate Payment Term
AZ_Fee_IP.OP1_Renewal_20211001-20220930 (a.k.a. PSI)	Uniform Percentage Increase	Uniform percentage 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 uniform percentage increase is based on a fixed total payment amount, and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_IP.OP2_Renewal_20211001-20220930 (a.k.a. HEALTHII)	Uniform Percentage Increase	Uniform percentage increase for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class' aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term

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

Control name of the state directed payment	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Impact - Section I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
AZ_Fee_IP.OP.PC_Renewal_20211001-20220931 (a.k.a. DAP)	The single rate cell for the CHP program is affected.	$2,463,254	The qualifying providers receiving the payments include: Hospitals subject to APR-DRG reimbursement (eligible for up to 3.0% increase), Critical Access Hospitals (eligible for up to 10.5% increase), Other Hospitals and Inpatient Facilities (eligible for up to 5.0% 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 8.5% increase on all services provided), Physicians, Physician Assistants, and Registered Nurse Practitioners (eligible for up to 3.5% increase), Behavioral Health Providers (eligible for up to 1.0% increase), Dental Providers (eligible for up to 2.0% increase), and HCBS Providers (eligible for up to 1.0% increase on specified services for some provider types, and all services for other provider types). 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 20 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 22 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 22 (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).	AHCCCS has submitted the Differential Adjusted Payments (DAP) §438.6(c) pre-print to CMS, but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the pre-print under CMS review.	Not applicable.

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

Control name of the state directed payment	Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20211001-20220930 (a.k.a. APSI)	$2,102,525	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	$12.99	AHCCCS has submitted the Access to Professional Services Initiative (APSI) §438.6(c) pre-print to CMS, but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IP.OP1_Renewal_20211001-20220930 (a.k.a. PSI)	$1,549,217	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	$9.57	AHCCCS has submitted the Pediatric Service Initiative (PSI) §438.6(c) pre-print to CMS, but has not yet received approval. The PSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IP.OP2_Renewal_20211001-20220930 (a.k.a. HEALTHII)	$8,573,508	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	$52.98	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) §438.6(c) pre-print to CMS, but has not yet received approval. The HEALTHII payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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