Contract Year Ending 2022 Regional Behavioral Health Authority Program Capitation Rate Certification

October 1, 2021 through September 30, 2022

Prepared for:
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Prepared by:
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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the October 1, 2021 through September 30, 2022 (Contract Year Ending 2022 (CYE 22), or alternatively, Federal Fiscal Year 2022 (FFY 22)) actuarially sound capitation rates for Arizona's Regional Behavioral Health Authority (RBHA) Program.

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 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.

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.

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

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

As stated on pages 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. Standards and Documentation for Rate Ranges

This section of the 2022 Guide notes that standards and documentation expectations are not different for capitation rates and capitation rate ranges, except where otherwise stated.

I.1.A.ii. Rating Period

The CYE 22 capitation rates for the RBHA Program are effective for the 12-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 RBHA Program, signed by Erica Johnson ASA, MAAA and Windy J. Marks FSA, MAAA, is in Appendix 1. Ms. Johnson and Ms. Marks meet the requirements for the definition of an Actuary described at 42 CFR § 438.2 which is provided below for reference.

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

Ms. Johnson and Ms. Marks certify that the CYE 22 capitation rates for the RBHA Program contained in this rate certification are 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 by rate cell are located in Appendix 2. Additionally, the RBHA Program contracts include the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The RBHA Program contracts use the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 and the 2022 Guide.

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

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

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

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

The RBHA Program has three managed care organizations. The managed care organization is referred to as a RBHA. The RBHA Program has three Geographic Service Areas (GSAs) and one RBHA operating in

each GSA. The three GSAs, along with the three RBHAs and their respective effective dates are listed below.

- Central GSA – Mercy Maricopa Integrated Care (MMIC), effective April 1, 2014
    - Effective October 1, 2018, MMIC is known as Mercy Care - RBHA
- North GSA – Health Choice Integrated Care (HCIC), effective October 1, 2015
    - Effective October 1, 2018, HCIC became known as Steward Health Choice Arizona - RBHA
    - Effective December 31, 2019, Steward Health Choice Arizona - RBHA is known as Health Choice Arizona - RBHA
- South GSA – Cenpatico Integrated Care (CIC), effective October 1, 2015
    - Effective October 1, 2018, CIC is known as Arizona Complete Health - Complete Care Plan - RBHA (AZCH-CCP - RBHA)

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

The three RBHAs provide integrated care (that is, both physical and behavioral health services) for most Arizona Medicaid members diagnosed with a Serious Mental Illness (SMI), and the first 24 hours of crisis intervention services to all Arizona Medicaid populations (including those whose behavioral health services are provided by other programs) through a Crisis 24 Hour Group rate cell. This is a change from the previous year, when there were two Crisis rate cells (Crisis Adult, Crisis Child). It has been determined that the RBHAs do not contract differently based on age, so the distinction by age has been removed for CYE 22. All tables which do not specifically state otherwise are restricted to the SMI population and do not include any impacts to the Crisis 24 Hour Group rate cell. When there are impacts to the Crisis 24 Hour Group rate cell, the tables will note that the Crisis 24 Hour Group rate cell is included. The Central GSA RBHA began providing integrated care for members with SMI in April 2014, and the North and South GSA RBHAs followed suit in October 2015.

The following list is a general description of behavioral health services covered under the RBHA Program.

- Treatment Services
- Rehabilitation Services
- Medical Services
- Support Services
- Inpatient Behavioral Health
- Behavioral Health Residential
- Behavioral Health Day Programs
- Prevention Services
- Pharmacy
- Crisis Intervention Services (Crisis 24 Hour Group rate cell)

The following list is a general description of physical health services for members with SMI covered under the RBHA Program.

- Hospital Inpatient
- Hospital Outpatient
- Physician Services
- Emergency Services
- Pharmacy
- Dental for members less than 21 years of age
- Emergency dental for adults
- Durable Medical Equipment
- Transportation
- Laboratory and Radiology

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 RBHAs are 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 RBHA Program contracts.

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

The RBHA Program has operated in the State of Arizona since 1992 and was administered by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS) until July 1, 2016. On July 1, 2016, the administration of the RBHA Program was moved from ADHS/DBHS to AHCCCS. Capitation rates for the RBHA Program prior to July 1, 2016 were developed and paid from AHCCCS to ADHS/DBHS. These historical capitation rates were developed by AHCCCS at the RBHA level and then grossed up to reflect additional expenses for ADHS/DBHS administration, additional vendor expenses to determine whether a member has SMI, and additional expenses to cover Tribal Fee-for-Service (FFS) claims. After the July 1, 2016 move of ADHS/DBHS into AHCCCS, these additional expenses were no longer required to be added to the capitation rates because the administration of the RBHA Program was under AHCCCS. As of October 1, 2018, the AHCCCS Complete Care (ACC) Program integrated behavioral health and physical health services for most Arizona Medicaid members through the ACC Contractors. As of October 1, 2019, the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Program integrated behavioral health and physical health services for their members. Effective April 1, 2020, the Arizona Department of Child Safety (DCS) integrated behavioral health with the physical health services that the DCS Comprehensive Medical and Dental Program (CMDP) was already providing for their members (Arizona children living in foster care) under the DCS Comprehensive Health Plan (DCS CHP), ending the RBHAs' responsibility for behavioral health services for the CMDP Child rate cell.

The RBHA Program is a statewide program with three GSAs. The three GSAs are defined by county and zip code:

- Central GSA – Maricopa, Pinal (includes zip codes 85120, 85140, 85143, 85220)
- North GSA – Apache, Coconino, Gila (excludes zip codes 85542, 85192, 85550), Mohave, Navajo, and Yavapai
- South GSA – Cochise, Gila (includes zip codes 85542, 85192, 85550), Graham, Greenlee, La Paz, Pima, Pinal (excludes zip codes 85120, 85140, 85143, 85220), Santa Cruz, and Yuma

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

The rate certification for the CYE 22 capitation rates for the RBHA Program is effective for the 12-month time period from October 1, 2021 through September 30, 2022.

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

Table 1 below displays the rate cells and a brief description of the covered populations within each rate cell. The SMI rate cell receives behavioral health services through the RBHA Program, along with physical health services for most AHCCCS members with SMI (some SMI members have opted out of integration, either by choosing the American Indian Health Plan (AIHP) for those who are American Indian, or by choosing an ACC plan for those who are not). The SMI rate cell covers the same population as in the previous rating period. In contrast to the SMI rate cell, the population covered under the other rate cell for the RBHA Program has changed as crisis intervention services for all populations (adults and children) are now in the single Crisis 24 Hour Group rate cell. The single Crisis 24 Hour Group rate cell covers crisis intervention services for all Arizona Medicaid populations, including the SMI population. More information about the populations covered under the RBHA Program can be found in the Eligibility Categories section of the RBHA Program contracts.

Table 1: Covered Populations by Rate Cell

Rate Cell	Covered Populations
SMI	Title XIX eligible adults diagnosed with a Serious Mental Illness who may additionally receive physical health services under the RBHA Program
Crisis 24 Hour Group	Title XIX/Title XXI eligible adults and children

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

AHCCCS operates as a mandatory managed care program. Additional information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the RBHA Program contracts.

Due to the COVID-19 public health emergency (PHE), and the maintenance of effort 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.

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))
- Alternative Payment Model (APM) Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B))
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(B))
- Pediatric Services Initiative (PSI) (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

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

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

Proposed differences among the CYE 22 capitation rates for the RBHA Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the RBHA Program.

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

The CYE 22 capitation rates for the RBHA Program were developed at the rate cell level. There is no cross-subsidization of payments between the rate cells in the RBHA Program.

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

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

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

The capitation rates were developed so each RBHA would 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. Conditions for Certifying Capitation Rate Range – Not Applicable

Not applicable. The actuaries are not certifying capitation rate ranges.

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

Not applicable. The actuaries are not certifying capitation rate ranges.

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

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

In the actuaries' judgement, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To the actuaries' 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 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 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 represent the contracted rates by rate cell.

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

Not Applicable. Capitation rates from previous rating periods are not used in the development of the CYE 22 capitation rates for the RBHA Program.

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

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 RBHA Program capitation rates are changing effective October 1, 2021.

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

Not applicable. This rate certification will change the RBHA Program 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 include 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.

I.1.A.xiii.(f) CMS Contract and Rate Amendment Requirement for Changes in Law
CMS requires a contract amendment and capitation rate amendment in the event that any State Medicaid program feature is invalidated by a court of law, or a change in federal statute, regulation, or approval. The rate amendment adjusting the capitation rates must remove costs specific to any program or activity no longer authorized by law, taking into account the effective date of the loss of program authority.

I.1.B. Appropriate Documentation

I.1.B.i. Capitation Rates or Rate Ranges
The actuaries are certifying capitation rates for each rate cell.

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 RBHA Program.

I.1.B.iii. Capitation Rate Cell 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. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for the variation.

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

I.1.B.iv. Capitation Rate Range Assumptions – Not Applicable
Not applicable. The actuaries did not develop capitation rate ranges.

I.1.B.v. Rate Certification Index
The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2022 Guide. Sections of the 2022

Guide that do not apply will be marked as "Not Applicable;" any section wherein all subsections are not applicable will be collapsed to the section heading.

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

All proposed differences in the assumptions, methodologies, or factors used to develop the certified CYE 22 capitation rates for the RBHA Program's covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

I.1.B.vii. Differences in Federal Medical Assistance Percentage

The RBHA Program includes populations for which the State receives a different Federal Medical Assistance Percentage (FMAP).

The percentages of costs by the various populations for January 1, 2019 through December 31, 2019 (CalYr19) for the RBHA Program are provided below in Table 2, along with the associated FMAP for the time period of January 1, 2021 through September 30, 2021. The FMAPs shown do not incorporate the increased FMAP associated with the PHE.

Table 2: Percentage of Costs by Population and Associated FMAP

Population	Percentage of Costs	FMAP
Adult Expansion	2.49%	90.00%
Child Expansion	0.04%	79.01%
Childless Adult Restoration	37.82%	90.00%
KidsCare (Title XXI)	0.00%	79.01%
Breast and Cervical Cancer	0.01%	79.01%
Populations not listed above	59.64%	70.01%

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

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

The 2022 Guide requests a comparison to the final certified rates in the previous rate certification. That comparison, for the SMI rate which did not change in terms of populations served, is available in Appendix 3a.

The 2022 Guide also 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 actuaries

defined any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year as a negative change in the rate.

The negative change to the South SMI rate cell is driven by the change in the time period for the base encounter data and the reduction in the encounter data adjustment applied to the new time period. The CYE 21 capitation rate development included an $8.4M adjustment to account for delayed processing of claim payments by the South RBHA due to claims payment system issues related to the ACC integration in the first six months of CYE 19 (October 1, 2018 through March 31, 2019). The CYE 22 capitation rate development continues this data adjustment for the first three months of CalYr19 (January 1, 2019 through March 31, 2019), but at a decreased amount due to additional run-out. The data adjustment included for CYE 22 rate development is $1.1M. After accounting for data adjustments and completion factors for both data periods, the base data decreased from CYE 19 to CalYr19 by $8.6M as reported by the South RBHA, and by $7.8M as determined by AHCCCS. This decrease as a PMPM based on CalYr19 member months is $47.27. This decrease is only partially offset by increased trends, and other programmatic changes.

The Crisis 24 Hour Group rate cell has changed in terms of covered populations from the previous rate certification. In CYE 21, there were two Crisis-only rate cells, Crisis Adult and Crisis Child. The CYE 22 rate development combined the populations from the Crisis Adult and Child cells since the RBHAs report that they do not contract differently based on the age of members receiving crisis intervention services. The Crisis 24 Hour Group rate cell capitation rate is not compared to the prior year Crisis Adult and Crisis Child rate cells capitation rates due to this change. The actuaries have included in Appendix 3b a restatement of the projected CYE 21 dollars, using the same CYE 21 projected membership included in the CYE 21 certification, in alignment with the changes to the populations and projections for this year. Additional detail regarding changes in projected expenses for the Crisis 24 Hour Group rate cell for CYE 22 are addressed in Section I.2.B.ii.(c).

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

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

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

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

I.1.B.ix. Future Rate Amendments

The list of possible amendments which would impact capitation rates in the future are shown in Table 3 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.

Table 3: Possible Future Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
Targeted Investments (TI)	February 2022	AHCCCS has requested an extension of the TI program with submission of its Section 1115 Demonstration Waiver Renewal Request; continuation of the TI program is subject to CMS approval.
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. COVID-19 PHE Impacts

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 has 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. The AHCCCS DHCM Actuarial Team continues to monitor national legislation and federal guidance on the public health emergency (PHE) end date and plans to analyze changes in acuity of members due to maintenance of effort eligibility requirements in the FFCRA.

The AHCCCS DHCM Actuarial Team has 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. 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)

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

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

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 RBHA Program include the following:

- Adjudicated and approved encounter data submitted by the RBHAs and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2016 through early March 2021
  - Adjudicated and approved through the first encounter cycle in March 2021
- Reinsurance payments made to the RBHAs for services
  - Incurred from October 2018 through September 2020 paid through April 2021
- Enrollment data for the RBHA Program provided from the AHCCCS PMMIS mainframe
  - October 2016 through early March 2021
- Annual audited financial statements submitted by the RBHAs and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17)
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
  - October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19)
  - October 1, 2019 through September 30, 2020 (CYE 20 or FFY 20)

- Quarterly financial statements submitted by the RBHAs and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
  - October 1, 2016 through September 30, 2020 (quarterly financials from CYEs 17, 18, 19 and 20)
  - October 1, 2020 through December 31, 2021 (CYE 21 Q1)
- AHCCCS FFS fee schedules developed and maintained by the AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement Team related to DAP, see Section 1.4.D.
- Data from AHCCCS DHCM financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)
- Data regarding contracted block payments for crisis intervention services provided by the RBHAs

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership for current and previous rate cells provided by the RBHAs
- Supplemental data regarding crisis intervention services cost projections and historical costs provided by the RBHAs
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CalYr19
- Historical and projected enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
  - Projections for CYE 22
  - Historical enrollment from mid CYE 21 and earlier
- Any additional data used and not identified here will be identified in their applicable sections below

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

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

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

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

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

The RBHA Program has approximately 24.6% of expenditures in sub-capitation and block purchase payment arrangements (sub-cap/block payments) for the main SMI population. 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 reimbursed on a FFS basis by the RBHA. 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.

Table 4 below provides a distribution of the CalYr19 encounter data by sub-cap/block payments, non-sub-cap/block payments and by category of service for the main SMI population. The Crisis 24 Hour Group rate cell is approximately 91.1% sub-cap/block payments for crisis intervention services.

Table 4: CalYr19 Non-Subcap/Non-Block and Subcap/Block percentages by Category of Service

Category of Service	Non-Subcap/Non-Block Payments	Subcap/Block Payments
Behavioral Health Day Programs	34.8%	65.2%
Case Management	25.4%	74.6%
Dental Services	94.3%	5.7%
FQHC/RHC	99.0%	1.0%
Inpatient Behavioral Health	87.4%	12.6%
Inpatient Hospital	100.0%	0.0%
Medical Services	69.8%	30.2%
Nursing Facility (Short-term)	100.0%	0.0%
Other Services	92.0%	8.0%
Outpatient Hospital	100.0%	0.0%
Pharmacy	100.0%	0.0%
Rehabilitation Services	6.2%	93.8%
Residential Services	92.1%	7.9%
Support Services	23.0%	77.0%
Transportation	85.4%	14.6%
Treatment Services	46.4%	53.6%
Total	**75.4%**	**24.6%**

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 RBHAs to identify causes. 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 RBHAs 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 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 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.

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.

The AHCCCS DHCM Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe. The AHCCCS DHCM Actuarial Team ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 22 capitation rates for the RBHA Program. Additionally, the AHCCCS DHCM Actuarial Team ensured that only services covered under the state plan were included.

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

The AHCCCS DHCM Actuarial Team compared the CalYr19 encounter data for the SMI rate cell, excluding crisis intervention services, to the RBHAs financial statement data, excluding crisis intervention services, for CalYr19. The actuaries also compared the CalYr19 encounter data for the SMI and Crisis 24 Hour Group rate cells to the yearly supplemental data request from the RBHAs which requires the RBHAs to

report their FFS and block payment expenses as well as reporting their record of encounters priced at their fee schedule amounts for encounters submitted under block payment agreements. This allowed the actuaries to determine multiple things: that the encounters that have been adjudicated and approved through the PMMIS system (adjusted for completion and outstanding encounter issues) were consistent with the RBHAs' figures, as well as confirming the repricing methodology described in Section I.2.B.ii.(a)(iv) is valuing the subcap/block encounters consistently with the RBHAs' approach. After adjustments to the encounter data for completion and encounter issues, the comparisons showed that the financial statements, the AHCCCS encounter data, and the RBHAs' reported encounter data were consistent.

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

As required by ASOP No. 23, the AHCCCS DHCM Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the RBHAs and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the RBHAs and reviewed by the AHCCCS DHCM Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data and the rate development is dependent upon this reliance. The actuaries 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 the HEALTHII program, on data provided by the AHCCCS DBF Budget Team with regard to projected enrollment, on data provided by the RBHAs in the yearly supplemental data request with regard to historical and projected administrative costs, and contracted block payment amounts and cost projections for the crisis intervention category of service.

The AHCCCS DHCM Actuarial Team found the encounter data, with adjustments for encounter issues, in conjunction with the additional data on contracted block payments for crisis intervention services to be appropriate for the purposes of developing the CYE 22 capitation rates for the RBHA Program. The development of the encounter issue adjustments are described below in Section I.2.B.iii.(c).

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

The AHCCCS DHCM Actuarial Team has not identified any other concerns with the quality or availability of the data, with the exception of the encounter issues noted in Section I.2.B.ii.(b)(i)(C).

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

The actuaries determined that the CalYr19 encounter data was appropriate to use as the base data for developing the CYE 22 capitation rates for the SMI population of the RBHA Program with the encounter issue adjustment previously noted. The actuaries determined that the CalYr19 encounter data, contracted block payment information for CYE 19, CYE 20, CYE 21, and CYE 22, with one specific revision in the South GSA, were appropriate to use as the data for developing the CYE 22 capitation rates for the Crisis 24 Hour Group rate cell covering all Arizona Medicaid populations for the RBHA Program.

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

As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 22 capitation rates for the main SMI population for the RBHA Program.

For the Crisis 24 Hour Group rate cell, both encounter data and contracted block payment amounts are used for the development of the CYE 22 capitation rates. The inclusion of data other than encounters for developing the CYE 22 capitation rates is due to the nature of the crisis intervention service model. Crisis intervention services are based on a "firehouse" model, in which costs are incurred for staffing 24/7 crisis telephone lines, 24/7 crisis mobile teams, and 24/7 crisis stabilization units, whether or not there are services provided. The RBHAs therefore contract and pay for these staffing costs through block payment arrangements, which keeps the system running smoothly, since the numbers of people seeking crisis in any given year can be very different and trying to price fee schedules to account for those differences could under or over fund the services in any given year if the projections turn out different than reality. The actuaries reviewed contracts and projected expenses for the block payments for the various crisis intervention services. In this review, it was noted that the South RBHA is using a related party for their crisis telephone service and paying nearly twice as much as the Central RBHA is paying to a non-related party for covering a much larger membership base. The actuaries are taking a phased approach to recognizing savings for the crisis telephone component by reducing the included funding for crisis telephone services in the South GSA to match the projected block payment dollars of the Central region for crisis telephone services. The actuaries believe that this revised amount is more than adequate based on membership, and the reduced funding is reasonable, appropriate, and attainable.

The projected expenses for crisis intervention services for CYE 22 are close to the same amounts projected in CYE 21, with the adjustment for the South crisis telephone expenses making up much of the difference. This is due to the "firehouse" model where block payment projections make up approximately 91% of the capitation rate, and the expenses of staffing 24/7 crisis telephone lines, 24/7 crisis mobile teams, and 24/7 crisis stabilization units don't grow at the same level of membership growth, especially when membership growth is occurring primarily due to maintenance of effort requirements with respect to the COVID-19 PHE. Membership growth does not (in most instances) impact the expense projections for providing 24/7 access to crisis intervention services. It does not generally cost more to staff crisis telephone lines, stabilization units, and mobile teams 24/7 for 1.8M Arizonans than it does to staff 24/7 for 2M Arizonans.

The projections for additional ancillary crisis services which are provided alongside crisis telephone lines, crisis stabilization units, and crisis mobile teams were developed using the base period encounters and base period membership, so the ancillary services PMPM amounts, when applied across greater membership, take into consideration the additional membership growth.

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

Not applicable. As described above in Section I.2.B.ii.(c)(i), managed care encounters are used in the rate development for all rate cells in the CYE 22 capitation rates for the RBHA Program.

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

Not applicable. The AHCCCS DHCM Actuarial Team did not rely on a data book to develop the CYE 22 capitation rates for the RBHA Program.

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

This section describes adjustments made to the CalYr19 encounter data that was used as the base data for developing the CYE 22 capitation rates for the RBHA Program.

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

Not applicable. No credibility adjustments were made to the CalYr19 encounter data.

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

Completion Factors

The AHCCCS DHCM Actuarial Team developed completion factors to apply to the CalYr19 encounter data. Completion factors were calculated using the development method with monthly encounter data incurred from October 2016 through early March 2021 and adjudicated and approved through early March 2021. The completion factors were developed by GSA, major category of service, and by month of service. The major categories of service are based upon the AHCCCS form type, which indicates the type of form used to submit a claim. AHCCCS has six form types: Professional and Other Services (form type A), Prescription Drug (form type C), Dental Services (form type D), Inpatient Hospital (form type I), Nursing Facility (form type L), and Outpatient Hospital (form type O). Dental Services (0.07% of CalYr19 encounters) were combined with Professional and Other Services and Nursing Facility Services (0.66% of CalYr19 encounters) were combined with Inpatient Hospital. The monthly completion factors for CalYr19 were applied to the CalYr19 encounter data. Table 5a below displays the aggregate completion factors for CalYr19 by GSA and major category of service. Table 5b below displays the aggregate impact of completion by GSA.

Table 5a: CalYr19 Completion Factors for Encounters by GSA

GSA	Professional and Other Services (Form Types A and D)	Pharmacy (Form Type C)	Inpatient Hospital and Nursing Facility (Form Types I and L)	Outpatient Hospital (Form Type O)	Total
Central	0.9836	0.9997	0.9472	0.9629	0.9787
North	0.9947	0.9999	0.9360	0.9844	0.9856
South	0.9792	0.9996	0.9174	0.9382	0.9684
Total	**0.9837**	**0.9997**	**0.9394**	**0.9588**	**0.9770**

Table 5b: Impact of Completion Factors by GSA

GSA	Before Completion	After Completion	Impact
Central	$2,049.55	$2,094.59	2.2%
North	$1,302.24	$1,321.57	1.5%
South	$1,260.30	$1,301.87	3.3%
Total	**$1,691.25**	**$1,731.58**	**2.4%**

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

Encounter Issue Adjustment Factors

During the rate development process, the Central RBHA was determined to have missing encounters due to a delay in encounter submission for the last four months of CalYr19 for the SMI rate cell. To correct for the missing encounters, the actuaries calculated factors (by form type) which averaged the first eight months of completed encounter data for the year divided by the average of the last four months and applied those factors to the last four months of the contract year to bring them up to a reasonable level. The actuaries then compared the revised amounts against supplemental data from the RBHA regarding paid claims by month to confirm the reasonability of the approach and magnitude of correction. The other encounter issue corrected for had to do with delayed processing of claim payments by the South RBHA due to claims payment system issues related to the ACC integration. The completion factors for the South RBHA corrected for some of this delay; however, after review of completed encounters by month across the past three years, the actuaries could see that the completion factors were not fully correcting for this issue in the first three months of CalYr19, and as a result, the actuaries used a similar methodology as that described above, by calculating factors by form type which increased the first three months of CalYr19 encounters. The reasonability of the adjustments was assessed by comparing the revised totals to the financials and viewing the adjusted months in line with the monthly data used in the trend model. The actuaries were confident in the suitability of the data in aggregate after these adjustments. Table 6 below displays the aggregate impact of the encounter issue factors for CalYr19 by GSA.

Table 6: Impact of Encounter Issue Factors by GSA

GSA	Before Adjustment	After Adjustment	Impact
Central	$2,094.59	$2,144.39	2.4%
North	$1,321.57	$1,321.57	0.0%
South	$1,301.87	$1,308.68	0.5%
Total	**$1,731.58**	**$1,760.59**	**1.7%**

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), with the exception of the October 1, 2019 fee schedule changes, are described below, or in Section I.3.A.iv. for base data adjustments required with respect to IMD in-lieu-of services. All program changes which occurred or are effective on or after January 1, 2020 are described in Section I.3.B.ii.(a). All fee schedule changes which occurred on or after October 1, 2019 are also described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less for every individual rate cell, that adjustment was deemed non-material and has been grouped in the combined miscellaneous base data adjustment subset below along with a brief description of each adjustment. Some of the impacts for base data adjustment changes described below (indicated by an asterisk *) were developed by AHCCCS DHCM financial analysts with oversight from the AHCCCS DHCM Clinical Quality Management (CQM)

Team and the Office of the Director's Chief Medical Officer. As noted above in Section I.2.B.ii.(b)(ii), the actuaries relied upon the professional judgment of the AHCCCS DHCM financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuaries met with the AHCCCS DHCM financial analysts to understand at a high level how the estimated amounts were derived, and the data used for the amounts. The actuaries were unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

Removal of Differential Adjusted Payments from Base Data

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 below in Table 7a. 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.

Table 7a: Removal of DAP from Base Data

GSA	Dollar Impact	PMPM Change
Central	($4,997,518)	($15.41)
North	($635,210)	($8.02)
South	($1,652,343)	($9.17)
Total	**($7,285,072)**	**($12.48)**

Removal of Access to Professional Services Initiative

CYE 19 capitation rates funded APSI fee schedule increases for claim payments made from October 1, 2018 through September 30, 2019. The enhanced fee schedule was used 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. As these enhanced fee schedule payments expired September 30, 2019, AHCCCS has removed the impact of CYE 19 APSI from the base period CalYr19. To remove the impact, the AHCCCS DHCM Actuarial Team extracted adjudicated and approved encounter data (submitted on form CMS-1500s and dental encounters) for the qualifying providers, identified by Billing Provider Tax ID, excluded any sub-capitated/block purchasing arrangements (identified by CN1 Code 05 on the encounters) and any encounters for which AHCCCS was not the primary payer, and

calculated the increase due to the enhanced fee schedule to remove from the base data. The encounter data included relevant rate cell and program information to be able to distribute into the individual rate cells. The associated costs removed from the base data are displayed below in Table 7b. Totals may not add up due to rounding.

Table 7b: Removal of APSI from Base Data

GSA	Dollar Impact	PMPM Change
Central	($1,261,060)	($3.89)
North	($42,342)	($0.53)
South	($1,571,029)	($8.72)
Total	**($2,874,430)**	**($4.92)**

Pharmacy Reimbursement Savings

Analysis of pharmacy claims for all AHCCCS managed care programs and AHCCCS 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 amount of the base data adjustment for pharmacy reimbursement savings for the RBHA Program is displayed below in Table 7c. Totals may not add up due to rounding.

Table 7c: Pharmacy Reimbursement Savings

GSA	Dollar Impact	PMPM Change
Central	($10,850,078)	($33.45)
North	($1,945,291)	($24.57)
South	($934,320)	($5.19)
Total	**($13,729,689)**	**($23.52)**

Pharmacy Benefit Manager (PBM) Administrative Spread Removal

In July 2019, AHCCCS provided additional guidance on several contract requirements that aim to increase transparency and cost-effectiveness. One requirement provided guidance on how the PBM pass-through pricing model was to be implemented and administrative expenses reported. In accordance with contract requirements, the AHCCCS DHCM Actuarial Team has incorporated savings to

medical expense costs associated with the removal of administrative spread from CalYr19 base period encounters. The percentages used to adjust pharmacy encounters for the removal of PBM administrative spread from the base data encounters were developed based on additional data provided by the RBHAs through surveys, supplemental data requests, and additional clarifying communications between AHCCCS and the RBHAs. The non-benefit costs reflected in the CYE 22 capitation rates reflect the requirements for transparency in reporting PBM administrative expenses.

The amount of the base data adjustment for PBM administrative spread removal for the RBHA Program is shown below in Table 7d by GSA. Totals may not add up due to rounding.

Table 7d: PBM Administrative Spread Removal

GSA	Dollar Impact	PMPM change
Central	($1,673,369)	($5.16)
North	$0	$0.00
South	($1,432,617)	($7.95)
Total	**($3,105,986)**	**($5.32)**

Combined Miscellaneous Base Data Adjustments

- **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.
- **Pharmacy and Therapeutics Committee Recommendations – Base Year ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy and drug coverage 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.
- **3D Mammography ***
  Effective June 1, 2019, upon recommendation of the AHCCCS CQM Team, AHCCCS began covering digital breast tomosynthesis (3D mammograms) for preventive screening and diagnosis of adults 21 years of age and older. The AHCCCS CQM Team made the recommendation in recognition of studies that find use of 3D mammograms in addition to or in place of 2D services

has at times improved detection of breast cancer in some populations. Contractors are permitted to use prior authorization criteria in evaluating medical necessity of 3D services for members.

- **Behavioral Health Residential Facilities (BHRF) Personal Care Differential ***
  Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team established a differentiated FFS rate for Behavioral Health Residential Facilities (BHRF) that are licensed by ADHS to provide personal care services.
- **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 CalYr19 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.

The aggregate amount of the costs of the miscellaneous non-material base data adjustments are displayed by GSA below in Table 7e. Totals may not add up due to rounding.

Table 7e: Combined Misc. Base Data Adjustments

GSA	Dollar Impact	PMPM change
Central	$310,148	$0.96
North	($6,314)	($0.08)
South	$103,312	$0.57
Total	**$407,146**	**$0.70**

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

The AHCCCS DHCM Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 22 capitation rates for the RBHA Program.

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 allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an Institution for Mental Disease (IMD) in lieu of services in an inpatient hospital. For enrollees aged 21-64, for inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.6(e), and this is described below in Section I.3.A.iv.

I.3.A.iv. Institution for Mental Disease

The projected benefit costs include costs for members aged 21-64 that have a stay of no more than 15 cumulative days in a month in an IMD in accordance with 42 CFR § 438.6(e).

Costs Associated with an Institution for Mental Disease Stay

The AHCCCS DHCM Actuarial Team adjusted the base data to remove the costs associated with stays in an IMD for enrollees aged 21-64 in accordance with 42 CFR § 438.6(e). The AHCCCS DHCM Actuarial Team repriced all utilization of an IMD at the cost of the same services through providers included under the State plan, regardless of length of stay. The AHCCCS DHCM Actuarial Team then removed costs for members aged 21-64 for stays in an IMD exceeding 15 cumulative days in a month, whether through a single stay or multiple within the month. Additionally, the AHCCCS DHCM Actuarial Team removed all associated medical costs that were provided to the member during the IMD stay(s) that exceeded 15 cumulative days in a month.

The data used to determine the base data adjustment was the CalYr19 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CalYr19 encounter data, the AHCCCS DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the Non-IMD price-per-day. The Non-IMD price-per-day used in the analysis was $890.14 and was derived from the CalYr19 encounter data for similar IMD services that occurred within a Non-IMD setting. The encounter

data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a Non-IMD setting, which may not be fully captured within the AHCCCS FFS fee schedule per diem rate. The costs associated with an institutional stay at an IMD that were repriced in the base data are displayed below in Table 8a. Totals may not add up due to rounding.

Table 8a: Reprice of Costs for all IMD Stays by GSA

GSA	Repriced IMD Dollars Added	Repriced IMD PMPM Added
Central	$4,076,389	$12.57
North	$151,179	$1.91
South	$1,136,949	$6.31
Total	$5,364,516	$9.19

The AHCCCS DHCM Actuarial Team identified all members aged 21-64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed below in Table 8b. Totals may not add up due to rounding.

Table 8b: Removal of Repriced Stays More Than 15 Days in a Month by GSA

GSA	Repriced IMD Dollars Removed	Repriced IMD PMPM Removed
Central	($7,376,645)	($22.74)
North	($422,010)	($5.33)
South	($1,891,039)	($10.50)
Total	($9,689,694)	($16.60)

Once a member was identified as having an IMD stay(s) greater than 15 cumulative days in a month, all encounter data for the member was pulled for the timeframe(s) they were in the IMD in order to remove those additional medical service costs from rate development. The associated costs removed from the base data are displayed below in Table 8c. Totals may not add up due to rounding.

Table 8c: Removal of Related Costs for IMD Stays of More Than 15 Days in a Month by GSA

GSA	Related Cost Dollars Removed	Related Cost PMPM Removed
Central	($1,832,446)	($5.65)
North	($87,995)	($1.11)
South	($358,790)	($1.99)
Total	($2,279,231)	($3.90)

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

The final projected benefit costs by GSA and rate cell are detailed in Appendix 6.

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

The section provides information on the projected benefit costs included in the CYE 22 capitation rates for the RBHA Program.

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

The base data described in Section I.2.B.ii. was summarized by GSA and rate cell. Adjustments were made to the base data to reflect completion, and all base data changes described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in I.3.A.iv. The SMI rate cells' adjusted base data PMPMs were trended forward 33 months, from the midpoint of the CalYr19 time period to the midpoint of the CYE 22 rating period The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below. Appendix 4 contains the base data and base data adjustments by GSA and rate cell, Appendix 5 contains the projected benefit cost trends by GSA and rate cell, and Appendix 6 contains the prospective program changes by GSA and rate cell. Additionally, Appendix 6 illustrates the capitation rate development by GSA and rate cell, which includes the DAP, reinsurance offset, administrative expense, underwriting (UW) gain, and premium tax.

The capitation rates were adjusted for all program and reimbursement changes. The rate development process includes every individual program change as a separate adjustment. However, if a program or reimbursement change had an impact of 0.2% or less for every individual rate cell, that program or reimbursement change was deemed non-material and has been grouped in the combined miscellaneous subset below.

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

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 CYE 22 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 ‡ symbol.

Pharmacy & Therapeutics Committee Decisions – January 2020 and forward*

On the recommendations of the 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.

To estimate the impact of adopted P&T Committee changes, the AHCCCS DHCM financial analysts largely relied on projections of drug utilization prepared by Magellan Rx Management, the agency's provider of drug rebate administrative services. Magellan has a nationwide vantage point that was drawn from in projecting how recommendations would impact drug utilization by AHCCCS members. In instances where Magellan did not provide a projected impact of an adopted change, the actuaries relied upon the judgement of AHCCCS DHCM financial analysts to project the impact. For CYE 22 rate development, the aggregate impact of adopted changes was allocated across risk cells and GSAs using CalYr19 encounter data for the affected drug classes.

For CYE 22 rate development for the RBHA program, the actuaries additionally included the impact of removing substance use remission requirements before receiving Hepatitis C direct acting antiviral medications, with the P&T Committee recommendations, as this change was immaterial when considered alone.

The combined impacts to the RBHA Program of the adopted P&T Committee recommendations are displayed by GSA below in Table 9a. Totals may not add up due to rounding.

Table 9a: P&T Committee Decisions

GSA	Dollar Impact	PMPM change
Central	($385,238)	($1.19)
North	($36,901)	($0.47)
South	($25,777)	($0.14)
Total	**($447,916)**	**($0.77)**

Expanded Telehealth Use *‡

To ensure access to care during the COVID-19 PHE, 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, AHCCCS DHCM financial analysts relied on a national projection developed by McKinsey & Co. of potential TPTH use following the PHE. 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 AHCCCS 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. AHCCCS 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 19. 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 PHE. Consistent with the 67% phase-in assumption above for projected TPTH services, AHCCCS DHCM financial analysts projected a 13.4% reduction (67% phase-in of a 20% reduction) in ED visits in CYE 2022 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 allocated across rate cells and GSAs using base period encounters of TPTH-eligible services, NEMT, and ED visits. The overall impact of the change by GSA is displayed below in Table 9b. Totals may not add up due to rounding.

Table 9b: Net Impacts of Expanded Telehealth Use

GSA	Dollar Impact	PMPM change
Central	$3,019,604	$9.31
North	$368,538	$4.66
South	$1,917,124	$10.64
Total	**$5,305,266**	**$9.09**

AHCCCS FFS Fee Schedule Updates

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. For CYE 22 capitation rate development, the actuaries used data provided by the AHCCCS DHCM Rates & Reimbursement Team to determine the impact of the annual October 1 fee schedule changes which should be applied to the base data year CalYr19. The impacts applied are the October fee schedule changes for 2019 through 2021. The CalYr19 data required nine months of the October 2019 change, and the full year impacts of the October 2020 and October 2021 fee schedule changes, to bring the data to the rating period. Additional detail on specific changes within the fee schedules are addressed below.

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.

The October 1, 2020 fee schedule changes 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).

In the 2021 legislative session, the legislature passed a general appropriations bill which included funding for the RBHA program to implement HCBS and NF provider fee schedule increases. Consistent with the additional funding, the AHCCCS DHCM Rates and Reimbursement Team increased HCBS and NF provider reimbursement rates by 7.2% effective October 1, 2021.

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 to the RBHA Program when considered alone.

The overall impact of the AHCCCS FFS fee schedule updates by GSA is illustrated below in Table 9c. Totals may not add up due to rounding.

Table 9c: Impact of Aggregate AHCCCS FFS Fee Schedule Updates

GSA	Dollar Impact	PMPM change
Central	$16,108,033	$49.66
North	$2,356,243	$29.77
South	$5,846,271	$32.45
Total	**$24,310,548**	**$41.65**

Combined Miscellaneous Program Changes

- **Opioid Treatment Program Reimbursement ***
  Pursuant to final rule 2019-24086, Medicare began reimbursing Opioid Treatment Programs (OTPs) for opioid use disorder (OUD) treatment services provided to individuals with Medicare Part B insurance on and after January 1, 2020. Under the change, reimbursement of OTP services and Medication Assisted Treatment (MAT) drugs to members dually enrolled in Medicare and Medicaid for treatment of OUD are shifting from AHCCCS Contractors and Medicare Part D to Medicare Part B. Medicare OTP services on and after January 1, 2020 are not subject to the traditional Medicare Part B 20% coinsurance during the rating period.
- **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.
- **COVID-19 Tests *ǂ**
  Since February 2020, AHCCCS has covered a range of medically necessary diagnostic and antibody tests for detecting COVID-19. The AHCCCS DHCM Actuarial Team is adjusting CYE 22 rates to reflect the projected use of these tests, which were not covered during the base period.
- **Depression and Anxiety Screening Codes ***
  Effective August 1, 2020, AHCCCS began coverage of procedure code 96127 for brief emotional or behavioral assessments.
- **Adult Hepatitis C Screening Recommendation ***
  On March 2, 2020, the U.S. Preventive Services Task Force (USPSTF) published a final recommendation that all adults 19 to 79 years of age be screened for hepatitis C. This represents an expansion of recommended screening from the previous guidance that adults born between 1945 and 1965 be screened. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the USPSTF final recommendation on hepatitis screenings for adults.
- **Adult Human Papillomavirus Immunization Guidance ***
  On August 16, 2019, the CDC Advisory Committee on Immunizations (ACIP) released a recommendation that adults 27 to 45 years of age at risk of contracting human papillomavirus

immunization (HPV) are vaccinated. This represents an expansion to previous guidance, which recommended HPV immunizations for adults 19 to 26 years of age. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the ACIP recommendation on HPV immunizations for adults.

- **Off Campus Hospital Outpatient Department Reimbursement ***
  Effective October 1, 2020, AHCCCS is reimbursing services billed at off campus hospital outpatient departments on a UB-04 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 AHCCCS DHCM financial analysts repriced base period encounters at outpatient hospital fee schedule rates.
- **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.
- **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.
- **Cell-Free DNA Testing ***
  Effective March 1, 2021, AHCCCS began covering cell-free DNA tests for pregnant women at high risk of delivering a baby with chromosomal abnormalities. These tests are generally more extensive, accurate, and expensive than covered fetal nuchal translucency (NT) test.
- **Alzheimer's Drug Approval ***
  On June 7, 2021, the FDA gave accelerated approval to Aduhelm for the treatment of patients with mild cognitive impairment or mild dementia stage of Alzheimer's disease (AD). Continued approval of the drug is contingent on additional trials that show clinical benefit of the drug. 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 Aduhelm on June 15, 2021.

- **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.
- **Bus Passes ***
  Effective October 1, 2021, AHCCCS is revising policy to clarify that Contractors may reimburse public transport passes as 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.
- **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-ED provider. The AHCCCS DHCM financial analysts project that cost savings of diverting unnecessary ED 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.
- **Rx Rebates Adjustment**
  An adjustment was made to reflect the impact of Rx Rebates reported within the RBHA Program financial statements, as pharmacy encounter data does not include these adjustments. The data reviewed to develop the impact was the CYE 17, CYE 18, CYE 19, CYE 20, and CYE 21 Q1 financial statement reports. From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment to the projected CYE 22 Pharmacy category of service to reflect the levels of reported Rx Rebates by GSA.

The aggregate amount of the costs of the miscellaneous non-material interim and prospective adjustments are displayed by GSA below in Table 9d. Totals may not add up due to rounding.

Table 9d: Combined Miscellaneous Program Changes

GSA	Dollar Impact	PMPM change
Central	($1,470,384)	($4.53)
North	($287,553)	($3.63)
South	($360,397)	($2.00)
Total	**($2,118,334)**	**($3.63)**

Adjustments to Crisis Intervention

As noted above in Section I.2.B.ii.(c)(i), for the Crisis 24 Hour Group rate cell, both encounter data and contracted block payment amounts are used for the development of the CYE 22 capitation rates. The inclusion of data other than encounters for developing the CYE 22 capitation rates is due to the nature of the crisis intervention service model. Crisis intervention services are based on a "firehouse" model, in which costs are incurred for staffing 24/7 crisis telephone lines, 24/7 crisis mobile teams, and 24/7 crisis stabilization units, whether there are services provided or not. The RBHAs therefore contract and pay for these staffing costs through block payment arrangements, which keeps the system running smoothly, since the numbers of people seeking crisis in any given year can be very different, and trying to price fee schedules to account for those differences could under or over fund the services in any given year if the projections turn out different than reality. This "always on" model of care is the most efficient way to ensure that members in crisis have access to crisis intervention services at all times without needing to go to the ED, reducing costs, increasing access, and providing care to members in their most vulnerable states.

Due to the "firehouse" model, the actuaries have included additional costs for crisis intervention services above what is in the encounter base data. This is a continuation of the methodology from the CYE 21 capitation rate development which used a discrete adjustment to crisis intervention services, having a similar effect as that of an under-reporting factor for a single category of service. The amount of dollars added to the crisis encounter data are based on the difference between the completed base year encounters, and the CYE 22 contracted block payment arrangements for each of the three types of crisis intervention services (crisis telephone lines, crisis mobile teams, and crisis stabilization units) between the RBHAs and the service providers. The RBHA CYE 22 contracted block payments for crisis intervention services, with the adjustment described in Section I.2.B.ii.(c)(i), plus ancillary crisis base encounter data completed and trended forward most accurately reflect anticipated reasonable, appropriate, and attainable costs for the rating period.

Ancillary crisis services, such as NEMT to a crisis stabilization unit and laboratory services provided in the first 24 hours of a crisis episode, continue to be the responsibility of the RBHAs for CYE 22. The AHCCCS DHCM Actuarial team pulled encounter data related to ancillary crisis services provided by the RBHAs within 24 hours of a crisis episode, added completion, adjusted for a policy change effective October 1, 2020 which clarifies that emergency transportation as well as NEMT (unless such NEMT is to a crisis stabilization unit) is the responsibility of the plan of enrollment for physical health services, added 33 months of trend (midpoint to midpoint), and added those amounts to the RBHA Crisis 24 Hour Group rate cell capitation rate development.

The overall impact of the additional dollars for crisis intervention services over the base encounter data, including the impact of the additional ancillary encounters, is shown below in Table 9e. Totals may not add due to rounding. Note that the PMPM and dollar impacts for the GSAs expressed in this table are calculated on the Crisis 24 Hour Group rate cell where impacts expressed elsewhere within this section are specific to and calculated across the SMI population.

Table 9e: Adjustments to Crisis 24 Hour Group Rate Cell

GSA	Crisis 24 Hour Group Dollars	Crisis 24 Hour Group PMPM
Central	$42,518,716	$3.28
North	$6,803,271	$2.22
South	$22,709,093	$3.55
Total	**$72,031,080**	**$3.21**

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

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

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

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 actuaries 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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2016 through December 2019 and adjudicated and approved through the first encounter cycle in March 2021. The data was truncated to avoid including any COVID-19 time period which had large and varied impacts on most categories of service which are not anticipated to be continued into the rating period, making the COVID-19 time period data inappropriate for use in developing trend projections. The trend was developed primarily with actual experience from the Medicaid population.

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

The encounter data was summarized by GSA, rate cell, month, and major category of service, and by utilization per 1000, unit cost, and PMPM values. The encounter data was adjusted for completion, the encounter issues described in Section I.2.B.iii.(c), and to normalize for previous program changes. Projected benefit cost trends were developed to project the base data forward 33 months, from the midpoint of CalYr19 (July 1, 2019) to the midpoint of the rating period for CYE 22 (April 1, 2022). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. Projected benefit cost trends were based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages and with 12-month, 24-month, and 36-month linear regression results for the SMI population rate cell.

Projected benefit cost trends were developed at the major category of service level of detail for the SMI rate cell within each GSA. There was no trend applied to the crisis intervention services encounters

(specified procedure codes which define crisis) for the Crisis 24 Hour Group rate cell due to the adjustment to align CYE 22 projections with anticipated crisis spend (block payment contract amounts and non-block cost projections) from the RBHAs for those services, as noted in Section I.3.B.ii.(a). The trend applied to the ancillary crisis encounters was 2.01% PMPM, for all three RBHAs.

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

No comparisons were made against other AHCCCS programs due to the unique aspects of the RBHA Program. Comparisons were made against the trends used in the previous rating period, and the change in trends by categories of service was deemed reasonable considering the change in the base data time period, the rating period, and the intervening COVID-19 pandemic. Trends were also compared between GSAs and variances were determined to be reasonable and appropriate.

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 actuaries defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%.

There are two PMPM trends which crossed the outlier threshold. For Central SMI, the Inpatient Behavioral Health category of service PMPM trend is 7.9%, driven by large, sustained utilization increases in this category of service. For North SMI, the Residential Services category of service PMPM trend is 7.6%, also driven by large, sustained utilization increases in this category of service.

The actuaries assumed negative unit cost trends in the South GSA for the SMI rate cell for the Medical Services and Residential Services categories of service. Each of these negative unit cost trend assumptions was 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. For all negative unit cost trend assumptions, all regression lines for the rate cell's category of service unit cost data are negatively sloped and the negative slopes are more extreme than the unit cost trend rates assumed in capitation rate development.

Where the direction of linear regression results varied by time frame, the actuaries used actuarial judgement with all data available, including feedback from the RBHAs obtained before rate development began, to make individual assumptions by category of service.

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

I.3.B.iii.(b)(i) Changes in Price and Utilization

The projected benefit cost trends by GSA, rate cell, and major category of service for utilization per 1000, unit cost, and PMPM values are included in Appendix 5. The aggregate annualized projected benefit cost trends for the SMI rate cell by GSA for utilization per 1000, unit cost, and PMPM values are included below in Table 10.

Table 10: CYE 22 Annualized Trends

GSA	Util/1000	Unit Cost	PMPM
Central	0.36%	2.54%	2.92%
North	0.40%	2.80%	3.21%
South	0.76%	2.03%	2.81%
Total	**0.45%**	**2.46%**	**2.92%**

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

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

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

The projected benefit cost trends were developed by GSA, implicitly addressing regional differences in utilization and unit cost data.

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

Variations within the projected benefit cost trends are driven by the underlying utilization and unit cost data for each GSA and rate cell.

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

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

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

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

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS 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 allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an Institution for Mental Disease (IMD) in lieu of services in an inpatient hospital. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the capitation rate development has complied with the requirements of 42 CFR § 438.6(e), and this is described above in Section I.3.A.iv.

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 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 RBHA. The RBHA receives notification from AHCCCS of the member's enrollment. The RBHA is responsible for payment of all claims for medically necessary behavioral health services and integrated health covered services, provided by the RBHA, provided to members during prior period coverage.

I.3.B.vi.(b) Claims Incorporated 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 Incorporated 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 RBHA Program for the prior period time frame, given that the encounter and enrollment data are already included within the base data used for capitation rate development.

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

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

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

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

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

As noted in Section I.3.B.ii.(c), base period data was not adjusted to reflect recoveries of overpayments made to providers because the RBHAs 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

Material adjustments related to provider payment requirements under State Directed Payments are discussed in Section I.4.D. of this rate certification. Additionally, provider payment requirements related to FQHCs are described in Section I.3.B.ii.

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

There were no material adjustments made related to waiver requirements or conditions.

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

There were no material adjustments made related to litigation.

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

All material and non-material changes have been included in the 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

I.4.A.i. Rate Development Standards

An incentive arrangement, as defined in 42 CFR § 438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract.

I.4.A.ii. Appropriate Documentation

I.4.A.ii.(a) Description of Any Incentive Arrangements

The CYE 22 capitation rates for the RBHA Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2), called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where a RBHA may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the RBHA that are aimed at quality improvement, such as reducing costs, improving health outcomes, or improving access to care. For reference, the RBHA Program CYE 21 APM Initiative – Performance Based Payment amounts are anticipated to be $7.8 million.

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

The time period of the incentive arrangement described herein is twelve months.

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

All enrollees, children and adults, may be covered by this incentive arrangement. Likewise, all network providers have the opportunity to participate in the APM arrangements and all covered services are eligible for inclusion. RBHAs are mandated to utilize the APM strategies in the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 3 and 4 as defined at https://hcp-lan.org/workproducts/apm-whitepaper.pdf. Their provider contracts must include performance measures for quality and/or cost efficiency.

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

The purpose of the APM Initiative – Performance Based Payments incentive arrangement is to align incentives between the RBHAs and providers to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality to achieve cost savings and quantifiable improved outcomes.

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

The total payments under the APM Initiative – Performance Based Payments incentive arrangement (i.e., capitation rate payments plus incentive payments) will not exceed 105% of the capitation payments to comply with 42 CFR § 438.6(b)(2).

I.4.A.ii.(a)(v) Effect on Capitation Rate Development
Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 22 capitation rates and had no effect on the development of the capitation rates for the RBHA Program. The incentive payments will be paid by AHCCCS to the RBHAs through lump sum payments after the completion of the CYE 22 contract year.

I.4.B. Withhold Arrangements – Not Applicable
Not applicable. There are no withhold arrangements in the CYE 22 capitation rates for the RBHA Program.

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 RBHA Program will include a risk corridor across all rate cells and a separate risk corridor for members transitioning to Title XIX from RBHA non-Title XIX eligibility. 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 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 stability 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 a risk corridor. This rate certification will use the term risk corridor to be consistent with the 2022 Guide. The RBHA Program contracts refer to the risk corridors as either a reconciliation, or as limiting Contractor's profits and losses.

I.4.C.ii.(a)(ii) Description of Risk-Sharing Mechanism Implementation
There are two risk corridor type arrangements in the RBHA Program. The first is a reconciliation of costs to reimbursement and the second is a reconciliation of costs associated with members transitioning to Title XIX from RBHA non-Title XIX eligibility if a Non-Title XIX enrollment segment was created before Title XIX enrollment.

The first risk corridor, which is across all rate cells, will reconcile the RBHA's medical cost expenses to the net capitation paid to each RBHA. Net capitation is equal to the capitation rates paid less the administrative component and premium tax, plus any reinsurance payments. The RBHA's medical cost expenses are equal to the RBHA's fully adjudicated encounters and sub-cap/block payment expenses as

reported by the RBHA with dates of service during the contract year. 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. This risk corridor will limit the RBHA's profits to 4% and losses to 2%.

The second risk corridor, related to members transitioning to Title XIX from RBHA non-Title XIX eligibility, will be a payment made to the RBHA for Title XIX behavioral health covered service medical expenses provided during the prior period coverage timeframe to General Mental Health/Substance Abuse (GMH/SA) and non-CMDP child members who are initially eligible as Non-Title XIX and assigned to a RBHA who then transition to Title XIX eligibility. This risk corridor limits the RBHA's profits and losses to 0% for these services, and the reconciliation amounts (payments and expenses) are excluded from any other reconciliation on the RBHA's service expenses. The actuaries have calculated an estimate ($4.8 million) of the potential reconciliation by extracting encounter data for members transitioning to Title XIX from RBHA non-Title XIX eligibility. There is neither a capitation rate, nor a rate cell for members transitioning, as there is not a reasonable method to estimate how many members transition in a year, much less on a monthly basis.

The cost-settlement will reimburse the RBHAs 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.

Additional information regarding the risk corridors can be found in the RBHA Program contracts.

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

The risk corridors did not have any effect on the development of the CYE 22 capitation rates for the RBHA Program.

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

The threshold amounts for the risk corridors were set using actuarial judgment with consideration of conversations between the AHCCCS DHCM Actuarial Team, the AHCCCS DHCM Finance & Reinsurance Team, and the AHCCCS Office of the Director.

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

Not applicable. The RBHA Program contracts do not include a medical loss ratio remittance/payment requirement.

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

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

To better align integrated populations across programs, effective October 1, 2018, AHCCCS extended the reinsurance program it operates to the RBHA Program contracts for the SMI rate cell. AHCCCS provides a reinsurance program for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what you 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 biological drugs. Additionally, rather than the RBHAs paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical expenses. 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 will reimburse the RBHA Contractors for covered services incurred above the deductible. The deductible is the responsibility of the RBHA Contractors. 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 RBHA Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

For additional information on the reinsurance program, including all deductibles and coinsurance amounts and covered biological drugs, refer to the Reinsurance section of the RBHA Program contracts.

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 capitation PMPM 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, Methodologies to Develop the Reinsurance Offset

The methodology for setting the reinsurance offset has changed from the CYE 21 RBHA capitation rates, due to the base period CalYr19 crossing two contract years (reinsurance payments are made based on encounters in contract years, not calendar years) and the change in the regular reinsurance deductible for CYE 22. The data used to develop the reinsurance offset for CYE 22 are historical reinsurance payments to the RBHAs for services incurred during CYE 19 and CYE 20. The actuaries developed a

pseudo-calendar year set of data from these payments for each of the major reinsurance case types (Regular, Biological, and Catastrophic). For the Biological and Catastrophic reinsurance case types, these reinsurance payments were divided by the CalYr19 GSA specific SMI member months to develop a PMPM offset before completion. For the Regular reinsurance case type, the actuaries first repriced, at the case level, all reinsurance payments in the Regular reinsurance data set using the increase in deductible from $35,000 to $50,000. Reinsurance cases which were below the higher deductible threshold were removed, and reinsurance cases which were above the higher deductible were repriced. These revised regular reinsurance payments were then divided by the CalYr19 GSA specific SMI member months to develop a PMPM offset before completion. The reinsurance PMPMs were then completed and adjusted for any adjustments that impacted CalYr19 base encounter data as described above in Section I.2.B.iii.(d). The adjusted reinsurance PMPMs were trended forward to CYE 22 using medical trend rates for the appropriate categories. Regular reinsurance case type used the Inpatient Hospital category of service trend, Biological reinsurance case type used the Pharmacy category of service trend, and Catastrophic reinsurance case type used aggregated trend rates for the SMI rate cells by GSA across all categories of service.

The adjusted and trended reinsurance PMPMs were then further modified to account for changes to the reinsurance program from CalYr19 to CYE 22, to account for similar adjustments as those described above in Section I.3.B.(ii)(a), and for deductible leveraging to arrive at the CYE 22 reinsurance PMPMs. Other 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 drugs added to the Biological case type after the base period 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 RBHA Program is $70,000.

Appendix 6 displays the reinsurance offset PMPMs for each rate cell.

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 the RBHA Program. 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 7a.

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 from the pre-print:

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

I.4.D.ii.(a)(ii) Directed Payments Incorporated in Capitation Rates
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 7a.

I.4.D.ii.(a)(ii)(A) Rate Cells Affected
The SMI rate cell is affected.

I.4.D.ii.(a)(ii)(B) Impact on the Rate Cells
See Appendix 6 for medical impact by rate cell. See Appendix 7b for total impact by rate cell.

I.4.D.ii.(a)(ii)(C) Data, Assumptions, Methodology to Develop Directed Payment Adjustment
Differential Adjusted Payments
The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.0% 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).

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

AHCCCS has submitted the Differential Adjusted Payments §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

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

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

The APSI, PSI, and HEALTHII are not included in the RBHA 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 7a.

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $6.8 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 $37,000. 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 $77.6 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 actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from estimates based on actual utilization, and once final amounts are known, a notification document will be sent to CMS with that information.

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

The actuaries certify 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 7b 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

Not applicable. There are no pass-through payments for the RBHA 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, Methodology

The actuaries reviewed reported administrative expenses from the CYE 19 and CYE 20 audited annual financial statements and CYE 21 Q1 unaudited financial statements. In addition, the RBHAs were required to submit supplemental data which included administrative expenses by rate cell for CYE 20 and year-to-date CYE 21, administrative expense projections for the full year for CYE 21 and CYE 22, and actual and projected membership for those time frames. The supplemental data was then reviewed in conjunction with the non-benefit cost projections developed by the actuaries. Other sources of data reviewed and utilized in the development of the non-benefit cost projections were trends and forecasts for various Consumer Price Indices (CPI) and Employment Cost Indices (ECI) data from IHS Markit.

The actuaries developed and reviewed several methodologies for projecting administrative expenses for the RBHAs, comparing results to projections provided by the RBHAs, as well as reviewing the results as a percentage of pre-tax capitation. After reviewing all of the various results, the actuaries judged that the magnitude of requested administrative increases from CYE 21 to CYE 22 were not reasonable for two of the RBHAs (North and South), and instead built into the capitation rates PMPM amounts developed by adjusting either the CYE 20 or CYE 21 reported administrative expenses for growth in membership from the selected base, along with applying one or two years of inflation to wage related administrative categories of service, and then adding specific adjustments to account for additional contract requirements (NCQA accreditation, and CMS interoperability requirements). The actuaries also confirmed that the projected CYE 22 non-benefit expenses associated with the PBM category of service under the model was equal to or greater than the RBHA projections for that line item, due to contract changes between the base year and the projection year. The Central RBHA's CYE 22 projections were consistent with the model described above, and the actuaries therefore used the Central RBHA's projected PMPMs as the final PMPM included in each rate cell.

The total CYE 22 administrative expense PMPMs and percentage of the pre-tax capitation rates are displayed below in Table 11. Note that the aggregated PMPM impacts and percentages of pre-tax capitation for the GSAs expressed in this table are calculated across both the SMI and Crisis 24 Hour Group rate cells.

Table 11: CYE 22 Administrative Expenses and Percentage of Pre-tax Capitation

GSA	Admin PMPM	Percentage of Pre-tax Capitation
Central	$5.51	7.99%
North	$4.38	9.83%
South	$4.64	9.17%
Total	**$5.10**	**8.46%**

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

The data, assumptions, and methodology used to develop the CYE 22 projected administrative costs are different than the previous rating period and have been documented above. The previous methodology is documented in the CYE 21 actuarial rate certification.

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

No other material adjustments were applied to the projected non-benefit costs of the CYE 22 capitation rates for the RBHA Program.

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 RBHA Program is described above in Section I.5.B.i.(a).

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

The CYE 22 capitation rates for the RBHA Program include a provision of 2.0% for premium tax. 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 RBHA Program include a provision of 1.0% for UW gain.

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

No other material or non-material non-benefit costs not already addressed in the previous sections are reflected in the CYE 22 capitation rates for the RBHA Program.

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 – Not Applicable

Not applicable. The CYE 22 capitation rates for the RBHA Program do not include risk adjustment or acuity adjustment.

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

Section II of the 2022 Medicaid Managed Care Rate Development Guide is not applicable to the RBHA Program. Managed long-term services and supports, as defined at 42 CFR § 438.2, are not covered services under the RBHA Program. The RBHA Program does cover nursing facility services, and related HCBS, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates – Not Applicable

Section III of the 2022 Medicaid Managed Care Rate Development Guide is not applicable to the RBHA Program, as there have been no changes to the capitation rate development process in this regard.

AHCCCS expanded coverage for childless adults up to 100% of the federal poverty level (FPL) in 2000 under Proposition 204. In July 2011, this population was subject to an enrollment freeze. Effective January 1, 2014, AHCCCS opted to expand Medicaid eligibility for all adults up to 133% FPL (Adult Expansion) and restored coverage for the childless adults up to 100% FPL (Childless Adult Restoration) population. Collectively, these two populations will be referred to as the new adult group.

Prior to January 1, 2014, the RBHA Program did not have a separate rate cell for the childless adults up to 100% FPL population. This population would have been included in the various adult rate cells which existed at the time, without any delineation between the members based on their income. After January 1, 2014, the RBHA Program rate cell structure included the new adult group in the various adult rate cells which existed at the time, without any delineation between the members based on their income. The RBHA Program has never analyzed the new adult group separate of other members, and there are no data, assumptions, or methodologies specific to the new adult group within any rate cell. The CYE 22 capitation rates for the RBHA Program have continued this approach.

Appendix 1: Actuarial Certification

We, Erica Johnson, ASA, MAAA and Windy J. Marks, FSA, MAAA, are employees of Arizona Health Care Cost Containment System (AHCCCS). We meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

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

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 22 capitation rates for the RBHA Program have been documented according to the guidelines established by CMS in the 2022 Guide. The CYE 22 capitation rates for the RBHA Program are effective for the 12-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, we have relied upon data, information, and the professional judgment provided by teams at AHCCCS and the RBHAs. We have relied upon AHCCCS and the RBHAs for the accuracy of the data and we have accepted the data without audit, after checking the data for reasonableness and consistency unless stated otherwise.

SIGNATURE ON FILE	August 11, 2021
Erica Johnson Associate, Society of Actuaries Member, American Academy of Actuaries	Date

SIGNATURE ON FILE	August 11, 2021
Windy J. Marks Fellow, Society of Actuaries Member, American Academy of Actuaries	Date

Appendix 2: Certified Capitation Rates

Central GSA

Rate Cell	CYE 22 Capitation Rate
SMI	$2,593.76
Crisis 24 Hour Group	$7.04

North GSA

Rate Cell	CYE 22 Capitation Rate
SMI	$1,647.48
Crisis 24 Hour Group	$4.13

South GSA

Rate Cell	CYE 22 Capitation Rate
SMI	$1,618.86
Crisis 24 Hour Group	$7.46

Appendix 3: Comparisons and Fiscal Impact Summary

Appendix 3a: Comparison of Capitation Rates for Rate Cells with No Population Changes

Central GSA

Rate Cell	CYE 22 Capitation Rate	CYE 21 Capitation Rate	% Change
SMI	$2,593.76	$2,592.33	0.1%
Crisis 24 Hour Group[1]	$7.04	Population served by this rate cell has changed	

1) Crisis 24 Hour Group rate cell covers crisis intervention services for all Arizona Medicaid populations, including SMI

North GSA

Rate Cell	CYE 22 Capitation Rate	CYE 21 Capitation Rate	% Change
SMI	$1,647.48	$1,606.24	2.6%
Crisis 24 Hour Group[1]	$4.13	Population served by this rate cell has changed	

1) Crisis 24 Hour Group rate cell covers crisis intervention services for all Arizona Medicaid populations, including SMI

South GSA

Rate Cell	CYE 22 Capitation Rate	CYE 21 Capitation Rate	% Change
SMI	$1,618.86	$1,641.07	-1.4%
Crisis 24 Hour Group[1]	$7.46	Population served by this rate cell has changed	

1) Crisis 24 Hour Group rate cell covers crisis intervention services for all Arizona Medicaid populations, including SMI

Appendix 3b: Fiscal Impact Summary

Central GSA

Rate Cell	CYE 22 Projected MMs	CYE 22 Capitation Rate	CYE 22 Projected Expenses	CYE 21 Projected Dollars Restated[1]
SMI	324,379	$2,593.76	$841,360,240	$789,001,974
Crisis 24 Hour Group	12,945,351	$7.04	$91,130,403	$89,707,724

1) The CYE 21 rates separated crisis intervention services to Crisis Adult/Child respectively. The CYE 21 dollars shown here are not adjusted for membership growth and are a combination of the two separate Crisis Adult/Child rate cells from CYE 21.

North GSA

Rate Cell	CYE 22 Projected MMs	CYE 22 Capitation Rate	CYE 22 Projected Expenses	CYE 21 Projected Dollars Restated[1]
SMI	79,158	$1,647.48	$130,411,773	$127,132,674
Crisis 24 Hour Group	3,064,279	$4.13	$12,641,178	$11,382,142

1) The CYE 21 rates separated crisis intervention services to Crisis Adult/Child respectively. The CYE 21 dollars shown here are not adjusted for membership growth and are a combination of the two separate Crisis Adult/Child rate cells from CYE 21.

South GSA

Rate Cell	CYE 22 Projected MMs	CYE 22 Capitation Rate	CYE 22 Projected Expenses	CYE 21 Projected Dollars Restated[1]
SMI	180,164	$1,618.86	$291,659,785	$300,795,933
Crisis 24 Hour Group	6,398,834	$7.46	$47,738,577	$52,053,903

1) The CYE 21 rates separated crisis intervention services to Crisis Adult/Child respectively. The CYE 21 dollars shown here are not adjusted for membership growth and are a combination of the two separate Crisis Adult/Child rate cells from CYE 21.

Appendix 4: Base Data and Base Data Adjustments

GSA: Central
Rate Cell: SMI
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 276,426
Projection Period Member Months: 324,379

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.03	0.9836	0.9562	$0.03	$9.33	0.9836	0.9562	$9.92	$9.95	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$9.95
Case Management	$2.86	0.9836	0.9562	$3.05	$184.38	0.9836	0.9562	$196.05	$199.09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.37%	$199.83
Dental Services	$1.14	0.9836	0.8531	$1.35	$0.02	0.9836	0.8526	$0.02	$1.37	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.37
FQHC/RHC	$12.89	0.9836	0.9545	$13.74	$0.00	0.9836	1.0000	$0.00	$13.74	0.00%	0.00%	0.00%	-0.82%	0.00%	0.00%	0.00%	0.00%	$13.62
Inpatient Behavioral Health	$197.05	0.9526	0.9932	$208.26	$23.45	0.9630	0.9805	$24.84	$233.10	5.39%	-9.26%	0.00%	-1.77%	0.00%	0.00%	0.00%	0.00%	$218.97
Inpatient Hospital	$231.88	0.9472	1.0000	$244.81	$0.00	0.9472	1.0000	$0.00	$244.81	0.00%	0.00%	0.00%	-3.37%	0.00%	0.00%	0.00%	0.00%	$236.56
Medical Services	$100.22	0.9836	0.9562	$106.56	$74.94	0.9836	0.9562	$79.69	$186.25	0.00%	0.00%	-3.03%	-0.02%	-2.15%	0.00%	0.00%	0.03%	$176.73
Nursing Facility (Short-term)	$10.42	0.9472	1.0000	$11.00	$0.00	0.9472	1.0000	$0.00	$11.00	0.00%	0.00%	0.00%	-0.58%	0.00%	0.00%	0.00%	0.00%	$10.94
Other Services	$14.17	0.9836	0.9562	$15.07	$0.09	0.9836	0.9562	$0.10	$15.17	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$15.17
Outpatient Hospital	$93.89	0.9630	0.9998	$97.53	$0.01	0.9629	1.0000	$0.01	$97.54	0.00%	0.00%	0.00%	-3.06%	0.00%	0.00%	0.00%	0.00%	$94.55
Pharmacy	$468.72	0.9997	1.0000	$468.83	$0.00	0.9997	1.0000	$0.00	$468.83	0.00%	0.00%	0.00%	0.00%	0.00%	-7.13%	-1.18%	-0.02%	$430.14
Rehabilitation Services	$0.64	0.9836	0.9562	$0.68	$152.75	0.9836	0.9562	$162.41	$163.10	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$163.10
Residential Services	$136.36	0.9836	0.9562	$144.99	$5.24	0.9836	0.9562	$5.57	$150.56	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.13%	$150.76
Support Services	$3.73	0.9836	0.9562	$3.97	$82.59	0.9836	0.9562	$87.81	$91.78	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$91.78
Transportation	$124.98	0.9836	0.9562	$132.89	$17.55	0.9836	0.9562	$18.66	$151.55	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$151.55
Treatment Services	$25.53	0.9836	0.9562	$27.14	$74.68	0.9836	0.9562	$79.40	$106.55	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.04%	$106.59
Gross Medical	**$1,424.53**			**$1,479.91**	**$625.02**			**$664.47**	**$2,144.39**									**$2,071.62**

GSA: North
Rate Cell: SMI
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 71,812
Projection Period Member Months: 79,158

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.00	0.9947	1.0000	$0.00	$0.00	0.9947	1.0000	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Case Management	$1.28	0.9947	1.0000	$1.29	$81.52	0.9947	1.0000	$81.95	$83.24	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.45%	$83.62
Dental Services	$2.07	0.9947	1.0000	$2.08	$0.00	0.9947	1.0000	$0.00	$2.08	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.08
FQHC/RHC	$16.17	0.9947	1.0000	$16.25	$0.00	0.9947	1.0000	$0.00	$16.25	0.00%	0.00%	0.00%	-0.53%	0.00%	0.00%	0.00%	0.00%	$16.17
Inpatient Behavioral Health	$46.60	0.9462	1.0000	$49.25	$72.77	0.9409	1.0000	$77.34	$126.60	1.51%	-4.15%	0.00%	-1.27%	0.00%	0.00%	0.00%	0.00%	$121.62
Inpatient Hospital	$91.03	0.9360	1.0000	$97.26	$0.00	0.9360	1.0000	$0.00	$97.26	0.00%	0.00%	0.00%	-2.29%	0.00%	0.00%	0.00%	0.00%	$95.04
Medical Services	$80.06	0.9947	1.0000	$80.49	$28.39	0.9947	1.0000	$28.54	$109.03	0.00%	0.00%	-1.02%	-0.57%	-0.50%	0.00%	0.00%	0.06%	$106.83
Nursing Facility (Short-term)	$7.00	0.9360	1.0000	$7.48	$0.00	0.9360	1.0000	$0.00	$7.48	0.00%	0.00%	0.00%	-0.74%	0.00%	0.00%	0.00%	0.00%	$7.42
Other Services	$5.97	0.9947	1.0000	$6.00	$7.84	0.9947	1.0000	$7.89	$13.89	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.89
Outpatient Hospital	$108.76	0.9844	1.0000	$110.48	$0.12	0.9844	1.0000	$0.12	$110.60	0.00%	0.00%	0.00%	-3.15%	0.00%	0.00%	0.00%	0.00%	$107.11
Pharmacy	$285.00	0.9999	1.0000	$285.02	$0.00	0.9999	1.0000	$0.00	$285.02	0.00%	0.00%	0.00%	0.00%	0.00%	-8.62%	0.00%	-0.22%	$259.88
Rehabilitation Services	$1.85	0.9947	1.0000	$1.86	$75.69	0.9947	1.0000	$76.09	$77.95	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$77.95
Residential Services	$113.48	0.9947	1.0000	$114.08	$59.15	0.9947	1.0000	$59.46	$173.55	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$173.55
Support Services	$0.18	0.9947	1.0000	$0.18	$41.36	0.9947	1.0000	$41.58	$41.76	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$41.76
Transportation	$51.41	0.9947	1.0000	$51.69	$55.41	0.9947	1.0000	$55.70	$107.39	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$107.39
Treatment Services	$5.51	0.9947	1.0000	$5.54	$63.60	0.9947	1.0000	$63.93	$69.47	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.07%	$69.52
Gross Medical	**$816.39**			**$828.96**	**$485.85**			**$492.61**	**$1,321.57**									**$1,283.82**

GSA: South
Rate Cell: SMI
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 164,998
Projection Period Member Months: 180,164

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$8.92	0.9792	0.9903	$9.20	$0.69	0.9792	0.9903	$0.71	$9.91	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$9.91
Case Management	$116.73	0.9792	0.9903	$120.38	$4.99	0.9792	0.9903	$5.15	$125.53	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.48%	$126.14
Dental Services	$0.57	0.9792	0.9999	$0.58	$0.19	0.9792	1.0000	$0.20	$0.78	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.78
FQHC/RHC	$34.38	0.9792	0.9907	$35.44	$0.62	0.9792	1.0000	$0.64	$36.08	0.00%	0.00%	0.00%	-0.79%	0.00%	0.00%	0.00%	0.00%	$35.79
Inpatient Behavioral Health	$142.20	0.9273	0.9984	$153.59	$0.03	0.9611	0.9931	$0.03	$153.62	4.11%	-6.56%	0.00%	-1.05%	0.00%	0.00%	0.00%	0.00%	$147.86
Inpatient Hospital	$105.50	0.9174	1.0000	$114.99	$0.00	0.9174	1.0000	$0.00	$114.99	0.00%	0.00%	0.00%	-3.15%	0.00%	0.00%	0.00%	0.00%	$111.36
Medical Services	$123.07	0.9792	0.9903	$126.92	$1.48	0.9792	0.9903	$1.53	$128.45	0.00%	0.00%	-1.55%	-0.41%	-6.92%	0.00%	0.00%	0.01%	$117.23
Nursing Facility (Short-term)	$13.09	0.9174	1.0000	$14.26	$0.00	0.9174	1.0000	$0.00	$14.26	0.00%	0.00%	0.00%	-1.27%	0.00%	0.00%	0.00%	0.00%	$14.08
Other Services	$12.85	0.9792	0.9903	$13.25	$0.00	0.9792	1.0000	$0.00	$13.25	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.25
Outpatient Hospital	$86.16	0.9382	1.0000	$91.83	$0.00	0.9382	1.0000	$0.00	$91.83	0.00%	0.00%	0.00%	-3.24%	0.00%	0.00%	0.00%	0.00%	$88.85
Pharmacy	$255.34	0.9996	1.0000	$255.44	$0.00	0.9996	1.0000	$0.00	$255.44	0.00%	0.00%	0.00%	0.00%	0.00%	-2.03%	-3.18%	-0.05%	$242.19
Rehabilitation Services	$18.02	0.9792	0.9903	$18.58	$2.77	0.9792	0.9903	$2.86	$21.44	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$21.44
Residential Services	$111.81	0.9792	0.9903	$115.31	$0.00	0.9792	1.0000	$0.00	$115.31	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	$115.32
Support Services	$41.68	0.9792	0.9903	$42.99	$1.56	0.9792	0.9903	$1.61	$44.60	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$44.60
Transportation	$79.50	0.9792	0.9903	$81.99	$0.35	0.9792	0.9903	$0.36	$82.35	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$82.35
Treatment Services	$92.92	0.9792	0.9903	$95.82	$4.87	0.9792	0.9903	$5.03	$100.85	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.05%	$100.90
Gross Medical	**$1,242.73**			**$1,290.58**	**$17.56**			**$18.10**	**$1,308.68**									**$1,272.05**

Appendix 5: Projected Benefit Cost Trends

Central GSA

Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	6.0%	1.8%	7.9%
SMI	Inpatient Hospital	2.5%	0.2%	2.7%
SMI	Medical Services	0.0%	0.0%	0.0%
SMI	Other Services	1.0%	1.0%	2.0%
SMI	Pharmacy	1.5%	4.0%	5.6%
SMI	Rehabilitation/Treatment Services	0.0%	0.0%	0.0%
SMI	Residential Services	2.0%	0.8%	2.8%
SMI	Support Services	0.0%	1.0%	1.0%
Crisis 24 Hour Group	Other Services	1.0%	1.0%	2.0%

North GSA

Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	3.9%	0.0%	3.9%
SMI	Inpatient Hospital	3.0%	1.6%	4.6%
SMI	Medical Services	0.0%	0.0%	0.0%
SMI	Other Services	1.8%	0.0%	1.8%
SMI	Pharmacy	0.6%	5.0%	5.6%
SMI	Rehabilitation/Treatment Services	0.0%	0.5%	0.5%
SMI	Residential Services	5.5%	2.0%	7.6%
SMI	Support Services	0.0%	0.0%	0.0%
Crisis 24 Hour Group	Other Services	1.0%	1.0%	2.0%

South GSA

Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	3.0%	1.4%	4.4%
SMI	Inpatient Hospital	2.0%	0.0%	2.0%
SMI	Medical Services	1.0%	-1.0%	0.0%
SMI	Other Services	2.1%	0.0%	2.1%
SMI	Pharmacy	0.0%	5.5%	5.5%
SMI	Rehabilitation/Treatment Services	0.0%	1.6%	1.6%
SMI	Residential Services	5.0%	-0.4%	4.6%
SMI	Support Services	0.5%	0.5%	1.0%
Crisis 24 Hour Group	Other Services	1.0%	1.0%	2.0%

Appendix 6: CYE 22 Capitation Rate Development

GSA: Central
Rate Cell: SMI
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 276,426
Projection Period Member Months: 324,379

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions Jan20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$9.95	2.01%	0.00%	0.00%	0.99%	0.00%	$10.61
Case Management	$199.83	1.00%	0.00%	0.00%	0.00%	0.00%	$205.38
Dental Services	$1.37	2.01%	0.00%	0.00%	10.96%	0.02%	$1.61
FQHC/RHC	$13.62	2.01%	0.00%	0.00%	6.75%	0.00%	$15.36
Inpatient Behavioral Health	$218.97	7.91%	0.00%	0.00%	0.00%	0.00%	$269.95
Inpatient Hospital	$236.56	2.71%	0.00%	0.00%	0.00%	0.00%	$254.58
Medical Services	$176.73	0.00%	0.00%	3.53%	18.19%	-0.17%	$215.89
Nursing Facility (Short-term)	$10.94	2.01%	0.00%	0.00%	11.17%	0.00%	$12.84
Other Services	$15.17	2.01%	0.00%	0.00%	0.00%	0.00%	$16.02
Outpatient Hospital	$94.55	2.01%	0.00%	-0.92%	0.00%	-2.62%	$96.35
Pharmacy	$430.14	5.56%	-0.24%	0.00%	0.00%	-0.25%	$496.70
Rehabilitation Services	$163.10	0.00%	0.00%	3.35%	0.99%	0.56%	$171.19
Residential Services	$150.76	2.82%	0.00%	0.00%	0.99%	0.00%	$164.34
Support Services	$91.78	1.00%	0.00%	3.26%	6.97%	0.54%	$104.76
Transportation	$151.55	1.00%	0.00%	-5.22%	1.54%	-1.36%	$147.86
Treatment Services	$106.59	0.00%	0.00%	3.35%	0.99%	0.56%	$111.88
Gross Medical	**$2,071.62**	**2.92%**	**-0.05%**	**0.42%**	**2.21%**	**-0.20%**	**$2,295.32**

Total DAP	**$25.27**
Total Gross Medical PMPM	**$2,320.59**
Reinsurance Offset	**($12.49)**
Total Net Medical PMPM	**$2,308.10**

Non-benefit Expenses	PMPM
Admin	$208.36
Total Medical with Admin	$2,516.46
UW Gain	$25.42
Pre-tax Capitation PMPM	$2,541.88
Premium Tax	$51.88
Capitation PMPM	**$2,593.76**

GSA: Central
Rate Cell: Crisis 24 Hour Group
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 11,180,526
Projection Period Member Months: 12,945,351

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$3.07	0.9836	$3.12	N/A	$2.60	$5.72
Ancillary Crisis Services	$0.64	0.9836	$0.65	2.0%	$0.00	$0.69
Gross Medical	**$3.71**		**$3.77**			**$6.41**

Total Gross Medical PMPM	**$6.41**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$6.41**

Non-benefit Expenses	PMPM
Admin	$0.42
Total Medical with Admin	$6.83
UW Gain	$0.07
Pre-tax Capitation PMPM	$6.90
Premium Tax	$0.14
Capitation PMPM	**$7.04**

GSA: North
Rate Cell: SMI
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 71,812
Projection Period Member Months: 79,158

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions Jan20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$0.00	1.80%	0.00%	0.00%	0.45%	0.00%	$0.00
Case Management	$83.62	0.00%	0.00%	0.00%	0.00%	0.00%	$83.62
Dental Services	$2.08	1.80%	0.00%	0.00%	12.59%	0.04%	$2.46
FQHC/RHC	$16.17	1.80%	0.00%	0.00%	6.74%	0.00%	$18.12
Inpatient Behavioral Health	$121.62	3.90%	0.00%	0.00%	0.00%	0.00%	$135.11
Inpatient Hospital	$95.04	4.65%	0.00%	0.00%	3.35%	0.01%	$111.30
Medical Services	$106.83	0.00%	0.00%	3.70%	15.91%	0.08%	$128.51
Nursing Facility (Short-term)	$7.42	1.80%	0.00%	0.00%	10.90%	0.00%	$8.65
Other Services	$13.89	1.80%	0.00%	0.00%	0.00%	0.00%	$14.58
Outpatient Hospital	$107.11	1.80%	0.00%	-1.22%	0.00%	-2.34%	$108.52
Pharmacy	$259.88	5.63%	-0.15%	0.00%	0.00%	-0.39%	$300.48
Rehabilitation Services	$77.95	0.50%	0.00%	3.58%	0.45%	0.05%	$82.27
Residential Services	$173.55	7.61%	0.00%	0.00%	0.45%	0.00%	$213.29
Support Services	$41.76	0.00%	0.00%	3.63%	2.01%	0.05%	$44.17
Transportation	$107.39	0.00%	0.00%	-4.46%	3.50%	0.09%	$106.28
Treatment Services	$69.52	0.50%	0.00%	3.58%	0.45%	0.05%	$73.36
Gross Medical	**$1,283.82**	**3.21%**	**-0.03%**	**0.33%**	**2.12%**	**-0.26%**	**$1,430.73**

Total DAP	**$19.32**
Total Gross Medical PMPM	**$1,450.05**
Reinsurance Offset	**($12.18)**
Total Net Medical PMPM	**$1,437.86**

Non-benefit Expenses	PMPM
Admin	$160.53
Total Medical with Admin	$1,598.39
UW Gain	$16.15
Pre-tax Capitation PMPM	$1,614.53
Premium Tax	$32.95
Capitation PMPM	**$1,647.48**

GSA: North
Rate Cell: Crisis 24 Hour Group
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 2,794,829
Projection Period Member Months: 3,064,279

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$1.43	0.9947	$1.43	N/A	$1.92	$3.35
Ancillary Crisis Services	$0.28	0.9947	$0.29	2.0%	$0.00	$0.30
Gross Medical	**$1.71**		**$1.72**			**$3.65**

Total Gross Medical PMPM	**$3.65**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$3.65**

Non-benefit Expenses	PMPM
Admin	$0.35
Total Medical with Admin	$4.00
UW Gain	$0.04
Pre-tax Capitation PMPM	$4.04
Premium Tax	$0.08
Capitation PMPM	**$4.13**

GSA: South
Rate Cell: SMI
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 164,998
Projection Period Member Months: 180,164

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions Jan20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$9.91	2.10%	0.00%	0.00%	0.61%	0.00%	$10.56
Case Management	$126.14	1.00%	0.00%	0.00%	0.00%	0.00%	$129.65
Dental Services	$0.78	2.10%	0.00%	0.00%	13.73%	0.10%	$0.94
FQHC/RHC	$35.79	2.10%	0.00%	0.00%	6.42%	0.00%	$40.33
Inpatient Behavioral Health	$147.86	4.44%	0.00%	0.00%	0.00%	0.00%	$166.63
Inpatient Hospital	$111.36	2.00%	0.00%	0.00%	1.67%	0.00%	$119.56
Medical Services	$117.23	-0.01%	0.00%	7.98%	16.22%	0.12%	$147.26
Nursing Facility (Short-term)	$14.08	2.10%	0.00%	0.00%	12.02%	0.00%	$16.70
Other Services	$13.25	2.10%	0.00%	0.00%	0.00%	0.00%	$14.03
Outpatient Hospital	$88.85	2.10%	0.00%	-1.42%	0.00%	-2.90%	$90.05
Pharmacy	$242.19	5.50%	-0.05%	0.00%	0.00%	0.30%	$281.31
Rehabilitation Services	$21.44	1.60%	0.00%	6.97%	0.61%	0.20%	$24.15
Residential Services	$115.32	4.58%	0.00%	0.00%	0.61%	0.00%	$131.23
Support Services	$44.60	1.00%	0.00%	7.08%	1.53%	0.20%	$49.94
Transportation	$82.35	1.00%	0.00%	-11.25%	3.90%	-0.60%	$77.58
Treatment Services	$100.90	1.60%	0.00%	6.97%	0.61%	0.20%	$113.66
Gross Medical	**$1,272.05**	**2.81%**	**-0.01%**	**0.78%**	**2.35%**	**-0.14%**	**$1,413.57**

Total DAP	**$17.54**
Total Gross Medical PMPM	**$1,431.10**
Reinsurance Offset	**($5.04)**
Total Net Medical PMPM	**$1,426.06**

Non-benefit Expenses	PMPM
Admin	$144.56
Total Medical with Admin	$1,570.62
UW Gain	$15.86
Pre-tax Capitation PMPM	$1,586.48
Premium Tax	$32.38
Capitation PMPM	**$1,618.86**

GSA: South
Rate Cell: Crisis 24 Hour Group
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 5,657,068
Projection Period Member Months: 6,398,834

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$2.93	0.9792	$2.99	N/A	$2.95	$5.94
Ancillary Crisis Services	$0.55	0.9792	$0.56	2.0%	$0.00	$0.60
Gross Medical	**$3.48**		**$3.56**			**$6.54**

Total Gross Medical PMPM	**$6.54**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$6.54**

Non-benefit Expenses	PMPM
Admin	$0.70
Total Medical with Admin	$7.24
UW Gain	$0.07
Pre-tax Capitation PMPM	$7.31
Premium Tax	$0.15
Capitation PMPM	**$7.46**

Appendix 7: State Directed Payments

Appendix 7a: 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)	SMI	See Appendix 6 for medical impact by rate cell and Appendix 7b for total impact by rate cell. (Appendices 6 and 8b for ACC)	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)	$6,758,666	The actuary certifies to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 7b	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)	$36,888	The actuary certifies to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 7b	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)	$77,623,961	The actuary certifies to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 7b	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.

Appendix 7b: State Directed Payments Estimated PMPMs

Differential Adjusted Payments

	CYE 22 Estimated DAP PMPM[1]		
Rate Cell	Central	North	South
SMI	$26.05	$19.93	$18.08
Crisis 24 Hour Group	$0.00	$0.00	$0.00

1) The PMPMs here are inclusive of premium tax and UW gain. These PMPMs will not match the medical PMPMs in Appendix 6.

Access to Professional Services Initiative

	CYE 22 Estimated APSI PMPM[1]		
Rate Cell	Central	North	South
SMI	$11.80	$1.70	$15.53
Crisis 24 Hour Group	$0.00	$0.00	$0.00

1) The PMPMs here are inclusive of premium tax.

Pediatric Services Initiative

	CYE 22 Estimated PSI PMPM[1]		
Rate Cell	Central	North	South
SMI	$0.11	$0.01	$0.00
Crisis 24 Hour Group	$0.00	$0.00	$0.00

1) The PMPMs here are inclusive of premium tax.

Hospital Enhanced Access Leading to Health Improvements Initiative

	CYE 22 Estimated HEALTHII PMPM[1]		
Rate Cell	Central	North	South
SMI	$137.31	$125.55	$128.47
Crisis 24 Hour Group	$0.00	$0.00	$0.00

1) The PMPMs here are inclusive of premium tax.