



**Contract Year Ending 2023
Capitation Rate Certification
Comprehensive Health Plan Program**

October 1, 2022 through September 30, 2023

**Prepared for:
The Centers for Medicare & Medicaid Services**

**Prepared by:
AHCCCS Division of Health Care Management**

August 12, 2022

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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, 2022 through September 30, 2023 (Contract Year Ending 2023 (CYE 23), or alternatively, Federal Fiscal Year 2023 (FFY 23)) actuarially sound capitation rate for the Arizona Comprehensive Health Plan (CHP) 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 rate contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rate represents projections of future events. Actual results may vary from the projections.

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2022-2023 Medicaid Managed Care Rate Development Guide (2023 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2023 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 2023 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

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

- Actuarial Standards of Practice (ASOPs) applicable to Medicaid managed care rate setting which were effective before the start date of the rating period:
 - ASOP No. 1 - Introductory Actuarial Standard of Practice,
 - ASOP No. 5 - Incurred Health and Disability Claims,
 - ASOP No. 12 - Risk Classification (for All Practice Areas),
 - ASOP No. 23 - Data Quality,
 - ASOP No. 25 – Credibility Procedures,
 - ASOP No. 41 - Actuarial Communications,
 - ASOP No. 45 - The Use of Health Status Based Risk Adjustment Methodologies,
 - ASOP No. 49 - Medicaid Managed Care Capitation Rate Development and Certification, and
 - ASOP No. 56 – Modeling.
- The 2016 and 2020 Medicaid and CHIP Managed Care Final Rules (CMS-2390-F and CMS-2408-F)
- FAQs related to payments to MCOs and PIHPs for IMD stays
- The 2022-2023 Medicaid Managed Care Rate Development Guide (2023 Guide) published by CMS

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

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

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As stated on page 2 and 3 of the 2023 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 2023 Guide.

I.1.A. Rate Development Standards

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

This section of the 2023 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 23 capitation rate for the CHP Program are effective for the 12-month time period from October 1, 2022 through September 30, 2023.

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 23 capitation rate for the CHP Program, signed by Erica Johnson, ASA, MAAA, and Wenzhang Du, ASA, MAAA, is in Appendix 1. Ms. Johnson and Mr. Du 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 Mr. Du certify that the CYE 23 capitation rate for the CHP Program contained in this rate certification is actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

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

The final and certified capitation rate is located in Appendix 2. Additionally, the CHP Program contract includes the final and certified capitation rate in accordance with 42 CFR § 438.3(c)(1)(i). The CHP Program contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 and the 2023 Guide.

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

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

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

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

The CHP Program is the health plan within the Arizona Department of Child Safety (DCS) that is responsible for managing the health care needs for children in foster care. Effective April 1, 2021, the

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

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

Services covered by the CHP Program include integrated physical and behavioral health services effective April 1, 2021. Prior to the April 1, 2021 integration, physical health services along with limited behavioral health services (i.e. treatment for ADHD, anxiety and depression provided by the member's primary care physician) were covered by the CMDP, and, for dates after October 1, 2018, the CMDP was also responsible for all specialty services and behavioral health services for CMDP members with a Children's Rehabilitative Services (CRS) qualifying health condition. The balance of behavioral health services for CMDP members were provided under a separate contract/program until March 31, 2021. Since the April 1, 2021 integration, the CHP covers all physical and behavioral health services for all CHP members, with the exception of the first 24 hours of crisis intervention services which are covered under the AHCCCS Complete Care – Regional Behavioral Health Agreement (ACC-RBHA) contract for all Arizona Medicaid members. Additional information regarding covered services can be found in the CHP contract.

For the CYE 23 rating period, the actuaries have aligned the aggregation of encounter data into consistent detailed categories of service for all programs which do not cover long term services and supports (LTSS). Each program which does not cover LTSS includes further aggregation into less detailed categories of service for the purposes of setting capitation rates. The rate setting categories of service are shown in Appendix 4 and Appendix 6, and the further aggregated trend categories of service, are shown in Appendix 5.

For the CYE 23 rating period, the projected expenses associated with the administration of COVID-19 vaccines are not included in the capitation rate; all COVID-19 vaccine costs in the base data period were removed as part of rate development, described below in Section I.2.B.iii.(d). AHCCCS Contractors are responsible for these expenses and will be reimbursed for these expenses on a non-risk basis via periodic cost-settlement payments based upon adjudicated/approved encounter data subject to the two-year claiming rule, as noted in contract and below in Section I.1.B.x.(c).

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

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

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

The rate certification for the CYE 23 capitation rate for the CHP Program is effective for the 12-month time period from October 1, 2022 through September 30, 2023.

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

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

- Placed in a foster home;
- In the custody of DCS and placed with a relative, in a certified adoptive home prior to the final order of adoption, or in an independent living program as provided in A.R.S. § 8-512; or
- In the custody of the Arizona Department of Juvenile Corrections or the Administrative Office of the Courts/Juvenile Probation Office and placed in foster care.

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

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

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

Additional information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the CHP Program contract.

Due to the public health emergency (PHE), and the maintenance of effort (MOE) requirements included in the Families First Coronavirus Response Act (FFCRA), with a few exceptions as noted in the law, members who were eligible at the beginning of the 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. In practice, enrollment in the CHP program is predicated upon being a child under the age of 18 years of age and part of the foster care system, and if a child is no longer part of the foster care system, their eligibility will transition to another AHCCCS program, which in most cases is the AHCCCS Complete Care Program.

There are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the populations to be covered under the CHP Program during CYE 23.

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 23 capitation rate are:

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

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

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

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

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

The CYE 23 capitation rate for the CHP Program is based on valid rate development standards and is not based on the rate of FFP for the populations covered under the CHP Program.

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

The capitation rate was developed as one statewide rate cell.

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

The effective dates of changes to the CHP Program are consistent with the assumptions used to develop the CYE 23 capitation rate for the CHP Program.

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

The certified capitation rate was developed so the CHP Program would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 23.

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' judgment, all adjustments to the capitation rate, or to any portion of the capitation rate, reflects 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 rate that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR § 438.4. There are no adjustments to the rate performed outside the rate setting process.

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 23 capitation rate certified in this report represents the final contracted rate.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 23 capitation rate for the CHP Program.

I.1.A.xii. COVID-19 PHE Assumptions, Impacts, and Risk Mitigation

This section of the 2023 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.

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

- I.1.A.iii.(c)(i)(B) General Description of Benefits
- I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria
- I.1.B.viii.(a) Comparison to Previous Rate Certification
- I.1.B.x.(a) Available Applicable Data to Address COVID-19 PHE in Capitation Rate Setting
- I.1.B.x.(b) How Capitation Rates Account for COVID-19 PHE Impacts
- I.1.B.x.(c) COVID-19 Costs Not at Risk – Outside Capitation Rates
- I.1.B.x.(d) Risk Mitigation Strategies Utilized for COVID-19 PHE
- I.2.B.ii.(b)(ii) Actuary’s Assessment of the Data
- I.2.B.ii.(c) Appropriate Data for Rate Development
- I.2.B.iii.(d) Changes in the Program
- I.2.B.iii.(e) Exclusions of Payments or Services
- I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies
- I.3.B.iii.(a)(i) Projected Benefit Cost Trends Data
- I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons

Additional evaluation conducted related to the COVID-19 PHE which did not result in adjustments to the rate development for CYE 23 vary by program. The CHP Program is not impacted by the MOE requirements of the PHE in the same way that other AHCCCS programs are, as described above in Section I.1.A.iii.(c)(iv), which resulted in the evaluation of changes in acuity being negligible as stated below in I.1.B.x.(b), and so while the population was evaluated for acuity changes, no adjustments to the rate were made as they were unnecessary. Additionally, while there are data adjustments included in the rate development for some categories of service based on changes in utilization associated with the PHE, not all categories of service were impacted to the point of being unreasonable for use as the base data without adjustment. For example, pharmacy data was not adjusted, because this category of service was not disrupted in a material way. The level of COVID-19 vaccinations within the CHP membership was evaluated and did not result in adjustments to the rate development as the level of vaccination for COVID-19 in the CHP population has remained low, primarily due to the later timelines for Emergency Use Authorization of the various COVID-19 vaccines from the Food and Drug

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Administration for children at different ages. Changes in Arizona COVID-19 case rates were reviewed both in general and with respect to the different COVID-19 variants in the base data time period and more recently, but no adjustments for expected new variants were included in capitation rate development.

I.1.A.xiii. Rate Certification Procedures

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

This section of the 2023 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

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

This is a new rate certification that documents that the CHP Program capitation rate is changing effective October 1, 2022.

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

Not applicable. This rate certification will change the CHP Program capitation rate effective October 1, 2022.

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

This section of the 2023 Guide provides information on when CMS would not require a new rate certification, which includes increasing or decreasing capitation rates up to 1.5% per rate cell in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.4(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract in accordance with 42 CFR § 438.7(b)(5)(iii).

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

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

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

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

I.1.B. Appropriate Documentation

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

The actuaries are certifying a statewide capitation rate for the CYE 23 CHP Program.

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I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 23 capitation rate for the CHP Program.

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

This section of the 2023 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell.

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

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

Not applicable. The 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 relevant section numbers from the 2023 Guide. Sections of the 2023 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 23 capitation rate for the covered populations under the CHP Program are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

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

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

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

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

The 2023 Guide requests a comparison to the final certified rates in the previous rate certification. This comparison is included in Appendix 3.

The 2023 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. For the purposes of the CYE 23 capitation rate certification, the actuaries defined

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any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year was a negative change in the rate. For the CHP Program, the capitation rate has decreased from CYE 22 to CYE 23. The primary driver of this change is moving the base data year from Calendar Year 2019 (CalYr19) to CYE 21. These decreases can be attributed to multiple changes between the two years. CalYr19 data was prior to the integration of physical and behavioral health under the CHP Program when most behavioral health services for foster care children were covered under a separate contract with three separate Contractors across the state. CalYr19 data was also prior to the beginning of the PHE, and the system of care has changed dramatically in response to the PHE, including far more telehealth use which has reduced missed appointments and emergency room visits as well as reducing the need for non-emergency medical transportation. Additionally, post-integration, there have been changes with respect to some payment mechanisms; in particular, dental care was previously paid on a fee for service (FFS) basis and has since been shifted to primarily subcapitated payment arrangements with dental providers.

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

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

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

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

I.1.B.ix. Future Rate Amendments

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

Table 1: Future Rate Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
American Rescue Plan Act (ARPA) proposals	Early 2023	AHCCCS has received approval of various ARPA proposals from CMS and the Arizona State Legislature. However, the June 3, 2022 announcement of the extension of the timeline within which states can use ARPA funding means the spending plan is being revised, and has not yet been finalized.

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

Arizona specific data and information available to the AHCCCS Division of Health Care Management (DHCM) Actuarial Team and the AHCCCS DHCM financial analysts and applicable for determining how to address the COVID-19 PHE in rate setting is listed below:

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- AHCCCS historical and current encounter data including utilization and costs by category of service, risk group, GSA, and program
- AHCCCS telehealth utilization and cost data by risk group, GSA, and program
- AHCCCS non-emergency transportation (NEMT) utilization and cost data by risk group, GSA, and program
- AHCCCS historical and current enrollment by risk group, GSA, and program
- AHCCCS COVID-19 testing by risk group, GSA, and program
- AHCCCS COVID-19 vaccination rates by risk group, GSA, and program
- AHCCCS child and adolescent well-care visit rates
- Arizona Medicaid eligibility information, provided by the AHCCCS Division of Member and Provider Services (DMPS), which identified members who, if not for the MOE, would be ineligible, which was used in evaluating expected differences in acuity of the CHP Program population after the end of the COVID-19 PHE declaration
- Historical and ongoing COVID-19 case rates for Arizona (not just Medicaid population)

Since the beginning of the COVID-19 pandemic, the AHCCCS 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 data and trends with regard to unemployment and inflation reports published by the Bureau of Labor Statistics, as well as state and national COVID-19 case rates published by a variety of sources. The AHCCCS DHCM Actuarial Team continues to monitor national legislation which impacts Medicaid, as well as monitoring federal guidance on the PHE end date and, as mentioned in the bullets above, has analyzed changes in acuity of members due to MOE eligibility requirements in the FFCRA.

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

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

The CYE 23 capitation rate accounts for the direct and indirect impacts of the COVID-19 PHE by adjusting the base data to revise the impacts of depressed utilization of specific services in response to the November 2020 through February 2021 COVID-19 surge, by adjusting the base data to revise the impacts of depressed utilization which show reversion towards a more pre-pandemic level within the base data period, by removing COVID-19 vaccine costs from the base data since AHCCCS has a non-risk based cost settlement with the Contractors for COVID-19 vaccines, and by removing COVID-19 test experience from the base data period and modeling projected COVID-19 testing costs for the rating period. The CYE 23 capitation rate also accounts for the impacts of the COVID-19 PHE by using a base

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data experience period which reflects changes in service delivery that are expected to continue beyond the pandemic, such as increased telehealth usage.

As noted above in Section I.1.A.iii.(c)(iv), the MOE requirements under the PHE do not impact the membership under the CHP Program as a member stops being eligible for CHP by leaving the foster care system, and any member leaving the CHP Program will have their Medicaid eligibility continued under another AHCCCS program. Because of this unique aspect of eligibility for the CHP program, there are not measurable changes in the acuity of the membership due to the PHE and MOE requirement, so no acuity adjustment was necessary.

I.1.B.x.(c) COVID-19 Costs Not At Risk – Outside Capitation Rates

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

I.1.B.x.(d) Risk Mitigation Strategies 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 23 contract will continue AHCCCS' long-standing program policy and will include risk corridors. For the CYE 23 rating period, AHCCCS is continuing the cost-settlement for administration of COVID-19 vaccines and carving these costs out of the capitation rate. This is the only risk mitigation strategy utilized specifically for COVID-19.

I.2. Data

This section provides documentation for the Data section of the 2023 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 23 capitation rate for the CHP Program were:

- Adjudicated and approved encounter data submitted by the CHP, CRS, and the prior behavioral health Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
 - Incurred from October 2017 through February 2022
 - Adjudicated and approved through the second February 2022 encounter cycle
- Supplemental data files for all services provided by CHP from October 2017 through March 31, 2021, paid through March 2022
- Reinsurance payments made to the CHP Program for services
 - Incurred from October 2017 through September 2021 paid through April 2022
- Enrollment data for CHP, CRS, and prior behavioral health Programs from the AHCCCS PMMIS mainframe
 - October 2017 through February 2022
- Annual and quarterly financial statements submitted by the CHP, CRS, and prior behavioral health Contractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
 - 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)
 - October 1, 2020 through September 30, 2021 (CYE 21 or FFY 21)
 - October 1, 2021 through December 31, 2021 (CYE 22 or FFY 22, first quarter)

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- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement Team related to DAP, see Section I.4.D
- Data from AHCCCS DHCM Financial Analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership provided by the Contractors
- Detailed administrative expense data and projections from the CHP, the previous behavioral health Contractors, and the CHP integrated subcontractor, Mercy Care
- Projected CYE 23 enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
- Any additional data used and not identified here will be identified in their applicable sections below

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

The 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

Before the April 1, 2021 integration date, with the exception of the previous behavioral health Contractors, there were very few sub-capitated or block purchasing arrangements with providers for CHP services. After integration, the CHP integrated subcontractor has contracted with some providers under sub-capitated or block purchasing arrangements for CHP services. All such arrangements require that the CHP service providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated/block encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e., formula) for sub-capitated/block encounters to estimate a health plan valued amount in place of the health plan paid amount of zero. The repricing methodology for sub-capitated/block encounter data from the previous behavioral health Contractors uses the health plan allowed amount (i.e., the amount the Contractor would have paid, had the provider been reimbursed FFS), less any third party insurance amounts. The repricing methodology for sub-capitated/block encounter data for all other Contractors uses the minimum of the AHCCCS fee schedule, the health plan billed amount, and the health plan allowed amount, less any third party insurance amounts. These different repricing methodologies have been tested and found to be the most appropriate for capturing accurate costs for services provided under the various previous contracts. The units of service data from the encounters and the estimated health plan valued amounts were used for the basis of calculating utilization and unit cost values associated with the sub-capitated/block purchase encounters.

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The overall amount of sub-cap/block payment costs across all of the various responsible Contractors for the CHP population between October 1, 2020 and September 30, 2021 is 14.2% of the total data

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 DHCM Data Management and Oversight (DMO) Team, who then works with the CHP to identify causes. In addition, the AHCCCS DHCM DMO Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

AHCCCS Contractors know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides the Contractors with the “Encounter Monthly Data File” (aka the “magic” file) which contains the previous 36 months of encounter data. Data fields contained in this file include, but are not limited to, adjudication status, AHCCCS ID, Claim Reference Number (CRN), Provider ID and various cost amounts. The adjudication status has five types: adjudicated/approved, adjudicated/plan denied, adjudicated/AHCCCS denied, pending and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters but providing this file to the Contractors allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions.

All of these processes create confidence in the quality of the encounter data.

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

- The supplemental data files contained AHCCCS member IDs, service dates, paid dates, servicing provider AHCCCS IDs and NPIs, form types, procedure codes, revenue codes, billed amounts, paid amounts, and units, so that only finalized claims which were not duplicates to already received data were included as adjustments;

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- Because those informational fields were available, AHCCCS was able to make adjustments supported by medical expense data at a detailed category of service level that was not possible in the prior rate development cycle;
- The non-duplicated finalized claims were added as adjustments to the units and costs for each applicable category of service by month of service.

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

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

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

AHCCCS has an additional encounter process which ensures that each adjudicated and approved encounter contains a valid AHCCCS member ID for an individual who was enrolled on the date that the service was provided. The process also checks to ensure that each adjudicated and approved encounter is for a covered service under the state plan and contains the codes necessary to map it into one of the categories of service used in the rate development process.

Through review of 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 23 capitation rate for the CHP. 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 CYE 21 encounter and the additional non-duplicated finalized claims from the supplemental data for all services provided by CHP to the aggregated CHP quarterly financial statement data. The actuaries also compared the encounter data from the time frame before integration, October 1, 2020 through March 31, 2021, from the previous behavioral health contractors to the aggregated quarterly financial statement data for the same entities. The encounter and added supplemental data was also compared to the data request which the Contractors fill out each year providing additional information regarding claims runout, revisions to financial statements for prior period adjustments, and administrative cost details.

The monthly encounter cycle of the AHCCCS data warehouse ensures that no duplicated encounters exist among the adjudicated and approved encounters. AHCCCS further compared the information from the supplemental data files as described above in Section I.2.B.ii.(b)(i) to remove duplicated information so that the adjustment to base data would be accurate.

After inclusion of the validated and non-duplicate claims from the supplemental data files, the adjusted encounter data was deemed to be consistent for capitation rate setting.

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

As required by ASOP No. 23, the AHCCCS DHCM Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the CHP Program, the previous behavioral health Contractors, and the CRS Contractor and provided from the AHCCCS PMMIS mainframe as well as the



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supplemental data files provided by the CHP Contractor. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the same entities and reviewed by the AHCCCS DHCM Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on the following:

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

The AHCCCS DHCM Actuarial Team has found the encounter data, with adjustments based on supplemental data files as described in Section I.2.B.ii.(b)(i), and base data adjustments specific to reduced utilization attributable to COVID-19 and normalizing the base data time period to be reflective of the post-integration period and expected utilization patterns, as described in Section I.2.B.iii.(d), to be appropriate for the purposes of developing the CYE 23 capitation rate for the CHP Program.

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

The AHCCCS DHCM Actuarial Team did not identify any material concerns with the availability or quality of the data, after the adjustment to include the supplemental data noted in the previous section.

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

The AHCCCS DHCM Actuarial Team determined that the CYE 21 encounter data, adjusted by the non-duplicated finalized claims for the first six months of CYE 21 from the CHP Contractor, was appropriate to use as the base data for developing the CYE 23 capitation rate for the CHP Program as it was the most recently completed available contract year which included post-integration experience, as well as being reflective of ongoing changes due to the PHE, such as the increase in telehealth services. The base data was analyzed and adjusted as appropriate for utilization and cost changes related to COVID-19 and integration, described below in Section I.2.B.iii.(d).

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 23 capitation rate for the CHP Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 23 capitation rate for the CHP 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 23 capitation rate for the CHP Program.

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

This section describes adjustments made to the CYE 21 encounter data that was used as the base data for developing the CYE 23 capitation rate for the CHP Program.

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

Not applicable. No credibility adjustments were made to the CYE 21 encounter data.

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

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

Due to the mid-year integration, there were three sets of completion factors developed. The first set was developed from and applied to the October 2017 through March 2021 encounter data and supplemental data from DCS/CHP (including October 2017 through September 2018 encounter data from the CRS Contractor), the second set was developed from and applied to the October 2017 through March 2021 encounter data from the behavioral health Contractors, and the third set was developed from the aggregated October 2017 through February 2022 data for all services for CHP members, and was applied to the post-integration (April 2021 and forward) encounter data.

Each set of completion factors was calculated using the development method with monthly data from the time periods listed, by major category of service. The major categories of service are based upon the AHCCCS form type, which indicates the type of form used to submit a claim. AHCCCS has six form types: Professional and Other Services (form type A), Prescription Drug (form type C), Dental Services (form type D), Inpatient Hospital (form type I), Nursing Facility (form type L), and Outpatient Hospital (form type O). The Dental Services form type (2.93% of CYE 21 payments) was combined with the Professional and Other Services form type. The Outpatient Hospital form type (4.12% of CYE 21 payments) and the Nursing Facility form type (equal to zero in CYE 21 for the CHP Program) were combined with the Inpatient Hospital form type. The aggregated CYE 21 completion factors applied to each detailed category of service are shown in Appendix 4.

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

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

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2020 through September 30, 2021) are described below. Additional adjustments to

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address specific impacts of mid-year integration as well as COVID-19 in the base period are also described in this section. All other program and fee schedule changes which occurred or are effective on or after October 1, 2021 are described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the capitation rate, that adjustment was deemed non-material and has been grouped in the other base data adjustment subset below.

Some of the impacts for base data adjustment changes 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 Clinical Quality Management (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.

Adjustment to Base Data for COVID-19 and Integration

The base period spans the November 2020 through February 2021 COVID-19 surge which reduced utilization in some categories of service. The CYE 21 base data period also includes a 6-month pre-integration period where there were multiple Contractors providing different services for the foster care population, and a 6-month post-integration period where the integrated subcontractor provided all services for the CHP population. The actuaries have developed adjustments to the data to address the impacts of COVID-19 disruptions, and changes stemming from the mid-year integration and changing of Contractors. Most adjustments were developed by comparing the CYE 21 data to the CYE 19 data and CYE 18 data and modifying specific months of reduced utilization to loosely resemble the seasonality patterns from the pre-pandemic and pre-integration periods. There was also a downward adjustment to the Dental category of service to reflect the change from FFS to capitated payment arrangements, noted above in Section I.1.B.viii.(a), which repriced each of the first six months of CYE 21 dental encounters at the average unit cost of the services provided in the corresponding month from the second six months of CYE 21. The overall impact of these adjustments for COVID-19 disruptions and changes stemming from the mid-year integration are shown below in Table 2. Totals may not add up due to rounding. The impacts by category of service are shown in Appendix 4.

Removal of Crisis Services from Base Data

While the CHP program covers most behavioral health services for its members, the CHP Program is not responsible for the first 24 hours of crisis intervention services. The first 24 hours of crisis intervention services for all Arizona Medicaid members are included as part of the ACC-RBHA contract. Since the behavioral health Contractors also provided behavioral health services to CHP members in the base

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period before the April 2021 integration date, this adjustment removes the first 24 hours of crisis intervention services for CHP members from the base data. The associated costs removed from the base data are displayed below in Table 2. Totals may not add up due to rounding.

Removal of Differential Adjusted Payments from Base Data

CYE 21 capitation rates for the CHP program funded DAP made from October 1, 2020 through September 30, 2021 to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health and reduce cost of care growth. As these payments expired September 30, 2021, AHCCCS has removed the impact of CYE 21 DAP from the base period. To remove the impact, the AHCCCS DHCM Actuarial Team requested provider IDs for the qualifying providers for the CYE 21 DAP by specific measure from the AHCCCS Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 21 were then adjusted downward by the appropriate percentage bump specific to the DAP measure. The associated costs removed from the base data are displayed below in Table 2. Totals may not add up due to rounding.

Removal of COVID-19 Tests from Base Data

As part of the monitoring of experience for the PHE, the DHCM Actuarial Team has reviewed utilization associated with COVID-19 testing each month. This review led the actuaries to the decision that it would be more appropriate to model these specific services as a COVID-19 specific adjustment than including the utilization and costs in the base data and proceeding as if no further adjustment would be needed to accurately project costs in the rating period. To that end, as part of the rate development process, all utilization and expenses associated with COVID-19 tests were removed from the base data, as well as from the data used to develop trends, and analyzed separately. The associated costs removed from the base data are displayed below in Table 2. Totals may not add up due to rounding.

The impact of the specific adjustment for including projected expenses for COVID-19 tests in the rating period is addressed below in Section I.3.B.ii.(a).

Table 2: Impacts of Base Data Adjustments

Base Data Adjustment	Dollar Impact	PMPM Impact
COVID-19 and Integration Base Data Normalization	\$4,074,364	\$25.83
Removal of Crisis Services from Base Data	(\$2,354,262)	(\$14.54)
Removal of DAP from Base Data	(\$2,208,206)	(\$13.64)
Removal of COVID-19 Tests from Base Data	(\$725,934)	(\$4.48)
Other Base Data Adjustments	(\$11,378)	(\$0.07)
Total Base Data Adjustments	(\$1,113,370)	(\$7.06)

Other Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component of the capitation rate, that adjustment was deemed non-material for

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the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the PMPMs for each non-material adjustment into an aggregate PMPM for display. The combined overall impact is illustrated above in Table 2. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Removal of COVID-19 Vaccine Costs from Base Data**

As noted above in Section I.1.B.x.(c), there is a separate mechanism to reimburse the Contractor for COVID-19 vaccines on a non-risk basis, so associated costs have been removed from the base encounter data.

- **Pharmacy and Therapeutics Committee Recommendations**

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE21 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.

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 and supplemental data used for developing the CYE 23 capitation rate. Other base data adjustments which excluded services from the data (i.e., crisis removal and COVID-19 vaccine removal) are described above in Section I.2.B.iii.(d).

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2023 Guide.

I.3.A Rate Development Standards

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

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

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

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

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

There are no in lieu of services as defined at 42 CFR § 438.3(e)(2) included in the projected benefit costs.

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

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

I.3.B. Appropriate Documentation

I.3.B.i Projected Benefit Costs

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

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

This section provides information on the projected benefit costs included in the CYE 23 capitation rate for the CHP Program.

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

The base data described in Section I.2.B.ii. was adjusted to reflect historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The adjusted base data per-member-per-month (PMPM) expenditures for each category of service (COS) were trended forward 24 months, from the midpoint of the CYE 21 time period to the midpoint of the CYE 23 rating period by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a)(ii). The projected PMPMs were then adjusted for prospective program and reimbursement changes, described below. Appendix 4 contains the base data and base data adjustments, and Appendix 5 contains the projected benefit cost trends. Appendix 6 contains the development of the gross medical expense from the adjusted base data, including all prospective programmatic and fee schedule changes, as well as the impact of the DAP. Appendix 7 contains the

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development of the certified capitation rate from the projected gross medical expense, including the reinsurance offset, administrative expense, case management expense, underwriting (UW) gain, and premium tax.

The capitation rate was adjusted for all program and reimbursement changes. If a program change had an impact of 0.2% or less on the gross medical component of the capitation rate, that program change was deemed non-material and has been grouped in the combined miscellaneous program changes 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 regards 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.

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 FQHCs/RHCs at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates include adjustments to bring the base FQHC/RHC encounter data up to the projected CYE 23 FQHC/RHC PPS rates.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 23 capitation rate has been adjusted to reflect these fee schedule changes. The AHCCCS DHCM Rates & Reimbursement Team used the CYE 21 encounter data to develop the impacts of fee schedule changes between the base year and the rating period. The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to calculate the adjustment to the CYE 21 base data. The actuaries then reviewed the results and applied aggregated percentage impacts by program, rate setting category of service, and rate cell.

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

In the 2022 legislative session, the legislature passed a general appropriations bill which included funding for AHCCCS programs to implement HCBS and NF provider fee schedule increases. Consistent with the additional funding, the DHCM Rates and Reimbursement Team increased HCBS and NF provider reimbursement rates by 11% effective October 1, 2022. The HCBS and NF fee schedule increases from the 2022 legislative session are in addition to the fee schedule increases for the same services from the 2021 legislative session which were described in the CYE 22 CHP capitation rate certification.

The general appropriations bill passed by the legislature in the 2022 session also included funding to increase the four global OBGYN codes (59400, 59510, 59610, 59618) effective October 1, 2022.

Effective October 1, 2022, AHCCCS is increasing the All Patients Refined Diagnosis Related Group (APR-DRG) base rate for rural hospitals.

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

The changes included in the CYE 23 capitation rate reflects AHCCCS' expectation that the Contractors will continue to benchmark against the AHCCCS provider fee schedules. The overall impact of the AHCCCS Fee-for-Service fee schedule updates is shown below in Table 3. Totals may not add up due to rounding.

High Needs Therapeutic Foster Care Rates *

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

Impacts of the High Needs Therapeutic Foster Care Rates were included in the CYE22 capitation rate for the CHP program. The AHCCCS DHCM financial analysts reviewed the CYE22 estimates and determined that they are appropriate for use again in CYE 23 capitation rate. The estimate methodology is described in the CYE 22 CHP capitation rate certification submitted to CMS in August 2021. The overall impact of the change is displayed below in Table 3. Totals may not add up due to rounding.

COVID-19 Tests

As noted above in Section I.2.B.iii.(d), the AHCCCS DHCM Actuarial Team has reviewed utilization associated with COVID-19 testing each month. As part of the rate development process, the AHCCCS DHCM Actuarial Team modeled projected utilization and costs for COVID-19 tests for the rating period.

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The projected utilization per 1000 was developed by averaging the utilization from the base period with more recent utilization from June 2021 through May 2022. The unit cost for different types of COVID-19 tests (lab/physician testing versus at-home test kits) was calculated with data specific to each type, and the distribution of tests by type provided the blend for an overall projected unit cost in the rating period. The actuaries then combined projected utilization and unit cost into an overall PMPM for the CHP rate cell. This modeling specifically incorporates more recent data than the base period in order to recognize that new variants and reduced public mitigation efforts have impacted the need for COVID-19 testing differently by population. No assumptions regarding vaccination rates were incorporated into the projections for use of tests. The overall impact of the change is displayed below in Table 3. Totals may not add up due to rounding.

Table 3: Impacts of Prospective Program and Reimbursement Changes

Prospective Program/Reimbursement Change	Dollar Impact	PMPM Impact
Aggregate Fee Schedule Updates	\$2,535,655	\$16.07
High Needs Therapeutic Foster Care Rates	\$1,912,498	\$12.12
COVID-19 Tests	\$719,590	\$4.56
Combined Miscellaneous Program Changes	\$30,234	\$0.19
Total Prospective Program and Reimbursement Changes	\$5,197,977	\$32.95

Combined Miscellaneous Program Changes

The rate development model includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component of the capitation rate, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the PMPMs for each non-material adjustment into an aggregate PMPM for display. The combined overall impact is illustrated above in Table 3. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- ***Pharmacy and Therapeutics Committee Recommendations ****

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors’ pharmacy costs in CYE 23. 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.
- ***Vaxelis Immunizations ****

AHCCCS began covering Vaxelis, a combination immunization for children ages 6 weeks through 4 years against diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B, and disease due to haemophiles influenzae type b, effective January 1, 2021, but a review of the encounter data shows that adoption of the combination immunization did not begin in earnest until October 2021, after the end of the base data time period. The vaccination is administered in a series of three shots and is anticipated to substitute for anywhere from 7 to 16 shots of the previously available vaccinations for the diseases above. The federal Vaccines for Children program funds costs of the vaccines while

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AHCCCS and its contractors reimburse for administration of the vaccines. The CYE 23 rate includes a reduction for the projected decrease in vaccine shots that will be administered to children.

- **Bus Passes ***

Effective October 1, 2021, AHCCCS revised AMPM 310-BB to clarify that Contractors may reimburse public transport passes as non-emergency medical transport (NEMT). Passes are generally 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 23 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.

- **EPSDT Visits and Developmental Screens ***

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

- **Emergency Triage, Treat, and Transport ***

Effective October 1, 2021, AHCCCS implemented 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 bill for trips that result in delivery of on-site or telehealth services by a partner health professional or for trips to an outpatient non-emergency department provider. The AHCCCS DHCM financial analysts project that cost savings of diverting unnecessary emergency department visits to lower acuity settings under the ET3 model will be offset by additional costs of reimbursing emergency service providers for trips in which no or limited reimbursement was previously paid.

- **N95 Masks ***

In March 2022, AHCCCS advised Contractors that providers could bill and receive reimbursement for N95 masks issued to members with immunocompromised conditions.

- **Child Depression Screening ***

Effective October 1, 2022, the agency is revising the AHCCCS Medical Policy Manual (AMPM) 430 to recommend depression and suicide risk screens be provided to children ages 12 to 20 years during EPSDT visits. The change aligns with screening recommendations from the American Academy of Pediatrics. To estimate the impact, DHCM financial analysts reviewed EPSDT visit and depression screening utilization for the CYE 2021 base period. It was assumed that all members ages 12 to 20 years that had not received a depression screen during their EPSDT visits would receive 1 screen during CYE 2023. The analysts then assumed that the difference in the rate of depression diagnosis between screened and previously unscreened individuals in the base period would be reduced by 20% in CYE 2023. Costs of the additional screens and subsequent mental health services were priced using per user service costs observed during the base period.

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- **Diabetes Self-Management Training**

Pursuant to HB2083, AHCCCS is adding 10 hours per year of diabetes self-management training as a covered service for diabetic members, effective October 1, 2022. To estimate the impact, DHCM financial analysts first reviewed data of diabetes prevalence among members. Based on findings from a literature review of studies on diabetes self-management training programs, it was assumed that 6% of diabetic members would utilize the covered service. It was assumed that each utilizing member would receive 5 hours of services a year. The total cost of the visits was then estimated using the AHCCCS fee for service rate schedule for outpatient diabetes self-management training. The resulting cost impact was allocated across rate cells using member prevalence of diabetes diagnoses during FFY 2021.
- **Infant Dental Visits**

Effective October 1, 2022, AHCCCS is revising AMPM 431 to expand coverage of preventive dental services to infants 6 – 12 months of age. The change is consistent with recommendations from Bright Futures and the American Academy of Pediatrics.
- **Maternal Postpartum Depression Screening**

Effective October 1, 2022, the agency is revising AMPM 430 to recommend postpartum depression screens be provided to caretakers during a child’s EPSDT for 6 months following birth. The change aligns with screening recommendations from Bright Futures.
- **Newborn Screening Fee ***

Laws 2021, Chapter 409 requires the Arizona Department of Health Services (ADHS) to expand the number of disorders screened for under the state’s Newborn Screening Program. The law additionally authorizes ADHS to increase fees charged for performing the expanded screening panel. The department intends to consolidate the two prior fees (\$101 combined) into one larger fee (\$171) that will be charged to the delivering provider following delivery. Effective October 1, 2022, AHCCCS will increase hospital rates to incorporate the modification to ADHS fees.
- **Dental Cone Beam CT Capture ***

AHCCCS will reimburse for cone beam CT capture for dental imaging, beginning January 1, 2023. Cone-beam CT capture emits an x-ray beam shaped like a cone as opposed to the conventional fan-shaped beam. This procedure is expected to be used for any tooth extraction as well as for endodontic procedures such as molar and premolar root canals. This type of imaging would be done in addition to current X-ray imaging. AHCCCS estimates that 85-90% of conventional X-rays prior to extractions and 80% of root canals would be augmented by cone beam imaging to confirm results. AHCCCS will require prior authorization for fee-for-service coverage of cone beam CT capture.
- **Back to School Initiative ***

AHCCCS child and adolescent well-care visit rates have historically been lower than the CMS Medicaid median and these rates have declined as a result of the COVID-19 Public Health Emergency. To address this issue, AHCCCS will implement a Back-to-School campaign beginning July 2023 to encourage child and adolescent well-care visit rates.

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- **Rx Rebates Adjustment**

An adjustment was made to reflect the impact of Rx Rebates reported within the integrated subcontractor, Mercy Care, financial statements for children covered under CHP, as pharmacy encounter data does not include these adjustments. The data that the AHCCCS DHCM Actuarial Team reviewed was the CYE 19, CYE 20 and CYE 21 quarterly financial statement reports for Mercy Care as one of the previous behavioral health contractors and the CYE21 and CYE 22 Q1 financial statement reports for Mercy Care as the integrated subcontractor for the CHP Program, as well as the CYE 19, CYE 20, and CYE 21 quarterly financial statements for the CHP Contractor. From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment to the projected CYE 23 Pharmacy (form type C) category of service.

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

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

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

AHCCCS Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base encounter data received and used as the primary data source to set the CYE 23 capitation rate therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2017 through January 2022, adjudicated and approved through the second February 2022 encounter cycle.

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

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

The encounter data was summarized by month and category of service, and by utilization per 1000, unit cost, and PMPM values. The encounter data was adjusted for supplemental data and completion factors as described above in Sections I.2.B.ii.(b)(i) and I.2.B.iii.(b). The data was also adjusted to account for any COVID-19 time period which had impacts on categories of service which are not anticipated to be continued into the rating period. Additionally, the encounter data was adjusted to normalize for previous program and reimbursement changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 21 (April 1, 2021) to the midpoint of the rating period for CYE 23 (April 1, 2023). 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

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with 12-month, 36-month, and 48-month linear regression results. The 24-month linear regression results were reviewed and discarded as inappropriate for comparison as FFY20 data contained the bulk of the COVID-19 disruptions in service. Each category of service was analyzed in the same manner.

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

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

As noted above in I.1.A.iii.(c)(i)(B), the actuaries aligned the aggregation of data into consistent detailed categories of services for all programs which do not cover LTSS, and then each program includes further aggregation to rate setting categories of service and trend categories of service. The CYE 23 PMPM trend assumptions were aggregated and compared to similar aggregations of the PMPM trend assumptions for CYE 22 trend categories of service and judged reasonable to assume for projection to CYE 23, considering the change in the base data time period, the rating period, the intervening COVID-19 pandemic, as well as changes to category of service groupings.

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

The 2023 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 no outlier or negative trends in the CYE 23 CMDP capitation rate development.

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

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

The trend assumptions were developed by unit cost and utilization. Appendix 5 contains the components of the projected benefit cost trend by COS for the capitation rate.

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

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

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

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

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

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

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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 12, 2022, no additional services have been identified as necessary services to comply with MHPAEA.

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

There are no in lieu of services as defined at 42 CFR § 438.3(e)(2) included in the projected benefit costs.

I.3.B.vi. Retrospective Eligibility Periods

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

AHCCCS provides prior period coverage (PPC) for the period of time prior to the member's enrollment during which the member is eligible for covered services. PPC refers to the time frame from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the CHP Contractor. The CHP Contractor receives notification from AHCCCS of the member's enrollment. The CHP Contractor is responsible for payment of all claims for medically necessary services covered by the CHP Program and provided to members during prior period coverage.

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

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

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

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

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

No specific adjustments are made to the CYE 23 capitation rate for the CHP Program, 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.

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

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

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

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

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

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

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

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

There were no material changes made related to litigation.

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

All material and non-material changes have been included in the capitation rate development process and all requirements in this section of the 2023 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements – Not Applicable

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

I.4.B. Withhold Arrangements – Not Applicable

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

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2023 Guide provides information on the requirements for risk-sharing mechanisms. For information on the COVID-19 costs covered on a non-risk basis, see Section I.1.B.x.(c).

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

I.4.C.ii. Appropriate Documentation

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

The CYE 23 contract for the CHP Program will include a risk corridor.

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

AHCCCS has a long-standing program policy of including risk corridors within many of the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 23 contract will continue AHCCCS' long-standing program policy and will include a risk corridor. This rate certification will use the term risk corridor to be consistent with the 2023 Guide. The CHP Contract refers to the risk corridor as a reconciliation.

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

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

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.

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

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

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

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

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

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

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

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

If medical experience in the rating period aligns with pricing assumptions used in capitation rate development, there will be no remittance/payment between AHCCCS and the CHP Contractor associated with the risk corridor.

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

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

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

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

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

AHCCCS provides a reinsurance program to AHCCCS Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what one would see in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the Regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under a catastrophic case type, including reinsurance for biologic drugs. Additionally, rather than the CHP Contractor paying a premium, the capitation rate is instead adjusted by subtracting the reinsurance offset from the gross medical expense. One could view the reinsurance offset as a premium.

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The AHCCCS reinsurance program has been in place since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the CHP Contractor for covered services incurred above the deductible. The deductible is the responsibility of the CHP Contractor. The deductible for CYE 23 Regular reinsurance cases is \$75,000, an increase from the CYE 22 Regular reinsurance deductible. The limit on High Dollar Catastrophic reinsurance is \$1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

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

I.4.C.ii.(c)(ii) Effect on Development of Capitation Rates

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical expense PMPM calculated for the rate setting period. It is a separate calculation and does not affect the methodologies for development of the gross medical expense component of the capitation rate.

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

Projected reinsurance offsets are developed in accordance with generally accepted actuarial principles and practices.

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

The data used to develop the reinsurance offset amount are historical encounters incurred during CYE 21, including services provided by the previous behavioral health Contractors. The historical reinsurance payment data for catastrophic case types related to certain medical conditions and/or covered biologic and specialty drugs were also used as a validation check to ensure encounters for members with those reinsurance cases were captured within the development of the reinsurance offset. The CYE 21 encounters were adjusted for historical programmatic and reimbursement changes as described above in Sections I.2.B.iii.(d) and I.3.B.(ii)(a) and trended to the CYE 23 rating period using the same trend factors applied to the gross medical capitation rate by category of service as described in Section I.3.B.ii above. These trends are provided in Appendix 5. These encounters were then evaluated against the applicable reinsurance rules for the rating period to determine calculated potential reinsurance case payments by member. These calculated reinsurance case payments were adjusted for an expected contractor reporting factor, representing the rate at which the contractor does not report reinsurance cases which would otherwise merit reimbursement. The contractor reporting factor was developed from

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historical reinsurance payments as compared to aggregated encounters for individual members which would have triggered reinsurance payments in each contract year, using data under another AHCCCS program where the CHP integrated subcontractor also operates as an integrated subcontractor (the Arizona Long Term Care System Department of Economic Security/Division of Developmental Disabilities Program). The justification for using data from another program and population for this factor is due to only having six months of available experience for the integrated subcontractor under the CHP Program, and the similarities of the services provided between the two programs by the integrated subcontractor (integrated physical and behavioral health services). The adjusted calculated reinsurance case payments were then summed and divided by the CYE 23 projected member months to develop the reinsurance offset. The reinsurance offset was then adjusted to account for changes to the covered biologics list after the base data period to get to the final reinsurance offset. This adjustment was calculated by taking the projected PMPM costs for CYE 23 for the new covered drugs for the CHP program and applying a zero dollar deductible and coinsurance limit of 85%.

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

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

This section of the 2023 Guide provides information on delivery system and provider payment initiatives authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

The only state directed payments addressed in this certification are the ones related to the CHP Program. The contract requires the adoption of a minimum fee schedule for FQHC/RHC providers using State plan approved rates, as defined in 42 CFR § 438.6(a), as allowed under 42 CFR § 438.6(c)(1)(iii)(A). This state directed payment for FQHC/RHC providers does not require written approval prior to implementation per 42 CFR § 438.6(c)(2)(ii). The state directed payments which require pre-prints for prior approval are DAP, APSI, PSI, and HEALTHIII. The 2023 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Federally Qualified Health Centers and Rural Health Clinics

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

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. 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

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increase is intended to supplement, not supplant, payments to eligible providers. The potential rate increases range from 0.25% to 20.0%, 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 any of the following criteria:

- 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 25 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 70% 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 with more than 100 licensed beds. The PSI provides a uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, with more than 100 licensed beds. The PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

The FQHC/RHC minimum fee schedule and the DAP initiative are the only directed payments incorporated in the capitation rate. The 2023 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

The single rate cell for the CHP program is affected.

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

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

I.4.D.ii.(a)(ii)(C) Data, Assumptions, Methodology to Develop Directed Payment Adjustment Federally Qualified Health Centers and Rural Health Clinics

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

Differential Adjusted Payments

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.25% increase), Critical Access Hospitals (eligible for up to 10.75% increase), other hospitals and inpatient facilities (eligible for up to 5.0% increase), rehabilitation and long term acute care hospitals (eligible for a 0.25% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for up to a 1.0% increase), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 8.5% increase), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), physicians, physician assistants, and registered nurse practitioners specialty types (obstetrics and gynecology, pediatrics, cardiology and nephrology) (eligible for a 1.0% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), HCBS providers (eligible for up to 3.0% increase), therapeutic foster homes (eligible for up to 20.0% increase), specific provider types that have or plan to have a workforce development plan (eligible for a 1.0% increase), specific provider types that meet employment staff training requirements (eligible for a 2.0% increase), and crisis providers (eligible for a 3.0% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 21 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 23 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 23 (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).

CYE 23 Capitation Rate Certification – CHP Program

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

AHCCCS has submitted the DAP 42 CFR §438.6(c) pre-print to CMS but has not yet received approval. The DAP payment arrangement accounted for in the capitation rate, and described in the preceding sections, is included in the capitation rate 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 CHP Program are based on maximum fee schedules.

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

The APSI, PSI, and HEALTHII are not included in the CHP certified capitation rate and will be paid out via lump sum payments. The 2023 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately \$2.6 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Services Initiative

Anticipated payments including premium tax for PSI are approximately \$2.0 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 23 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments including premium tax for HEALTHII are approximately \$8.4 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 23 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 8b contains estimated PMPMs including premium tax by rate cell for informational purposes only; these payments are not made on a PMPM basis.

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

Access to Professional Services Initiative

AHCCCS has submitted the APSI 42 CFR § 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 42 CFR 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 42 CFR § 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

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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 rate certification, including minimum fee schedules using State plan approved rates as defined in 42 CFR § 438.6(a)

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

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

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

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

I.5 Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2023 Guide provides information on the non-benefit component of the capitation rate.

I.5.B. Appropriate Documentation

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

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

The CHP Contractor provided AHCCCS with an administrative expense request for funding that detailed projected employee compensation, care management costs, data processing costs, interest charges, occupancy (rent/utilities), and other administrative expenses for the current contract year and the upcoming contract year. In addition to the information provided by the CHP Contractor, the actuaries also were provided information for non-benefit costs projected for CYE 23 for Mercy Care based on their winning competitive bid to become CHP's integrated subcontractor. The CYE 23 projections for the CHP Contractor and the integrated subcontractor include expenses associated with care management. Care management activities performed by CHP and the integrated subcontractor help to ensure that members receive appropriate physical health services, including well-child examinations, screenings, immunizations, and follow-up care. Care management also ensures that members have access to high quality, comprehensive behavioral health services delivered in a timely manner and in the most appropriate setting. These administrative expense requests were reviewed by AHCCCS for reasonableness by reviewing FTE counts for the CHP Contractor, comparing against previous administrative expense requests, along with additional information regarding salary adjustments for state employees passed as part of the general appropriations bill in the 2022 legislative session.

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

The projected CYE 23 administrative expense components are shown in Appendix 7.

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

There were no methodology changes from the non-benefit cost development used in the CYE 22 rate.

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

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

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

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

The administrative component of the CYE 23 capitation rate for the CHP Program is described above in Section I.5.B.i.(a). The PMPM amounts assumed can be found in Appendix 7.

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

The CYE 23 capitation rate for the CHP Program includes a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 23 capitation rate for the CHP Program includes a provision for margin (i.e., underwriting (UW) gain) of 1.0%.

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

No other material or non-material non-benefit costs not already addressed in previous sections are reflected in the CYE 23 capitation rate for the CHP Program.

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

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

I.6. Risk Adjustment and Acuity Adjustments – Not Applicable

Not applicable. The CYE 23 capitation rate for the CHP Program does not utilize risk adjustments or acuity adjustments.

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

Section II of the 2023 Guide is not applicable to the CHP Program. Managed long-term services and supports, as defined at 42 CFR § 438.2, are not covered services under the CHP Program. The CHP Program does cover nursing facility services, and related home and community-based services, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates – Not Applicable

Section III of the 2023 Guide is not applicable to the CHP Program.

Appendix 1: Actuarial Certification

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

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

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

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- § 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 capitation rate for the CHP Program have been documented according to the guidelines established by CMS in the 2023 Guide. The CYE 23 capitation rate for the CHP Program is effective for the twelve-month time period from October 1, 2022 through September 30, 2023.

The actuarially sound capitation rate is based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rate, we have relied upon data and information provided by teams at AHCCCS, the CHP Contractor, CHP’s integrated subcontractor, and the previous behavioral health Contractors. We have relied upon AHCCCS and the Contractors for the accuracy of the data and we have accepted the data without audit, after checking the data for reasonableness and consistency.

SIGNATURE ON FILE

August 12, 2022

Erica Johnson

Date

Associate, Society of Actuaries

Member, American Academy of Actuaries

SIGNATURE ON FILE

August 12, 2022

Wenzhang Du

Date

Associate, Society of Actuaries

Member, American Academy of Actuaries

August 12, 2022



Appendix 2: Certified Capitation Rate

CHP Capitation Rate	
Effective October 1, 2022 through September 30, 2023	\$1,293.65

Appendix 3: Fiscal Impact Summary

Rate Cell	CYE 23 Projected MMs	CYE 22 Capitation Rate	CYE 22 Projected Expenses	CYE 23 Capitation Rate	CYE 23 Projected Expenses	Percentage Impact
CHP	157,741	\$1,322.22	\$208,567,236	\$1,293.65	\$204,061,745	(2.16%)

Appendix 4: Base Data and Base Data Adjustments

CYE23 Capitation Rate Certification – CHP Program

Appendix 4: Base Data and Base Data Adjustments

Category of Service	I.2.B.ii.(a)	I.2.B.ii.(b)	I.2.B.iii.(b)	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	Subtotal
	Unadjusted Base PMPM	Supplemental Data	Completion	COVID-19 and Integration Base Data Normalization	Completed and Normalized Base PMPM	Removal of DAP	Removal of Crisis	Removal of COVID-19 Tests	Other Base Data Adjustments	Adjusted Base PMPM
Physical Health Inpatient and LTC	\$41.56	0.9661	0.8273	0.8998	\$57.80	(7.66%)	0.00%	0.00%	0.00%	\$53.37
Behavioral Health Inpatient and LTC	\$179.22	1.0000	0.8637	0.9795	\$211.83	(0.87%)	0.00%	0.00%	0.00%	\$209.99
Outpatient Facility	\$14.02	0.6088	0.9242	1.0000	\$24.91	(3.52%)	0.00%	(1.95%)	0.00%	\$23.56
Emergency Facility	\$11.80	0.7408	0.9323	1.0000	\$17.09	0.00%	0.00%	0.00%	0.00%	\$17.09
Pharmacy	\$46.27	0.9740	1.0000	1.0000	\$47.50	0.00%	0.00%	0.00%	(0.23%)	\$47.39
Transportation	\$19.75	0.9989	0.9405	0.9199	\$22.85	0.00%	(0.29%)	0.00%	0.00%	\$22.79
Dental	\$25.19	0.9509	0.9592	1.1969	\$23.07	(0.70%)	0.00%	0.00%	0.00%	\$22.91
FQHC	\$17.00	0.9387	0.9428	1.0000	\$19.21	(0.34%)	0.00%	0.00%	0.00%	\$19.15
Laboratory and Radiology Services	\$7.02	0.8654	0.9220	0.8898	\$9.89	0.00%	0.00%	(40.58%)	0.00%	\$5.88
Other Professional Services	\$128.11	0.9916	0.9450	0.9869	\$138.53	(0.02%)	(8.27%)	(0.00%)	(0.00%)	\$127.04
Physical Health Practitioners	\$51.67	0.9799	0.9368	0.9293	\$60.57	(0.62%)	0.00%	0.00%	(0.20%)	\$60.07
Behavioral Health Practitioners	\$58.66	0.9994	0.9432	0.9599	\$64.83	(9.05%)	0.00%	0.00%	0.00%	\$58.97
Case Management	\$144.22	1.0000	0.9419	1.0000	\$153.11	0.00%	(1.38%)	0.00%	0.00%	\$151.00
Rehabilitation Services	\$121.01	1.0000	0.9477	1.0000	\$127.69	0.00%	0.00%	0.00%	0.00%	\$127.69
Residential Services	\$59.81	1.0000	0.9418	0.8804	\$72.13	0.00%	(1.24%)	0.00%	0.00%	\$71.23
Gross Medical	\$925.30				\$1,051.02					\$1,018.13

Appendix 5: Projected Benefit Cost Trends

Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
CHP	Physical Health Inpatient and LTC	1.0%	2.0%	3.0%
CHP	Behavioral Health Inpatient and LTC	2.0%	0.0%	2.0%
CHP	Outpatient and Emergency Facilities	1.0%	4.0%	5.0%
CHP	Pharmacy	1.0%	4.0%	5.0%
CHP	Transportation	4.0%	0.0%	4.0%
CHP	Dental	0.0%	0.0%	0.0%
CHP	Other Professional Services	2.0%	0.0%	2.0%
CHP	Physical Health Practitioners	3.5%	0.0%	3.5%
CHP	Behavioral Health Practitioners	2.5%	0.0%	2.5%
CHP	Rehabilitation Services	1.5%	0.0%	1.5%

Appendix 6: Development of Gross Medical Component

CYE23 Capitation Rate Certification – CHP Program

Appendix 6: Development of Gross Medical Component

	Appendix 4	I.3.B.iii.	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal
Category of Service	Adjusted Base PMPM	PMPM Trend	COVID-19 Tests	Aggregate Fee Schedule Changes	High Needs Therapeutic Foster Care Rates	Combined Misc. Changes	Gross Medical PMPM
Physical Health Inpatient and LTC	\$53.37	3.02%	0.00%	3.59%	0.00%	0.00%	\$ 58.67
Behavioral Health Inpatient and LTC	\$209.99	2.00%	0.00%	0.00%	0.00%	0.00%	\$ 218.48
Outpatient Facility	\$23.56	5.04%	0.00%	0.12%	0.00%	(4.62%)	\$ 24.83
Emergency Facility	\$17.09	5.04%	0.00%	0.13%	0.00%	0.00%	\$ 18.88
Pharmacy	\$47.39	5.04%	0.00%	0.00%	0.00%	(0.71%)	\$ 51.92
Transportation	\$22.79	4.00%	0.00%	5.51%	0.00%	0.86%	\$ 26.23
Dental	\$22.91	0.00%	0.00%	0.00%	0.00%	1.16%	\$ 23.18
FQHC	\$19.15	2.00%	0.00%	9.93%	0.00%	0.00%	\$ 21.90
Laboratory and Radiology Services	\$5.88	2.00%	74.53%	0.13%	0.00%	1.47%	\$ 10.84
Other Professional Services	\$127.04	2.00%	0.00%	0.44%	9.17%	0.01%	\$ 144.94
Physical Health Practitioners	\$60.07	3.50%	0.00%	0.02%	0.00%	1.23%	\$ 65.15
Behavioral Health Practitioners	\$58.97	2.50%	0.00%	2.92%	0.00%	0.52%	\$ 64.09
Case Management	\$151.00	2.50%	0.00%	1.93%	0.00%	0.00%	\$ 161.70
Rehabilitation Services	\$127.69	1.50%	0.00%	2.49%	0.00%	0.00%	\$ 134.83
Residential Services	\$71.23	1.50%	0.00%	2.50%	0.00%	0.00%	\$ 75.22
Gross Medical	\$1,018.13	2.42%	0.42%	1.49%	1.14%	0.02%	\$ 1,100.86

DAP PMPM	\$15.75
Gross Medical Plus DAP PMPM	\$1,116.61

Appendix 7: Capitation Rate Development

CYE23 Capitation Rate Certification – CHP Program

Appendix 7: Capitation Rate Development

Rate Cell	Appendix 6 Gross Medical Plus DAP PMPM	I.4.C.ii.(c) RI Offset PMPM	Subtotal Net Medical PMPM	I.5.B.i.(a) Admin PMPM	I.5.B.i.(a) Care Management PMPM	I.5.B.ii.(c) UW Gain Percent	I.5.B.ii.(c) UW Gain PMPM	I.5.B.ii.(b) Premium Tax PMPM	Total Certified Capitation Rate PMPM
CHP	\$1,116.61	(\$33.03)	\$1,083.58	\$72.80	\$98.73	1.00%	\$12.68	\$25.87	\$1,293.65

Appendix 8a: State Directed Payments – CMS Prescribed Tables

CYE23 Capitation Rate Certification – CHP Program

Appendix 8a: State Directed Payments - CMS Prescribed Tables

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

Control name of the state directed payment	Type of payment Section I.4.D.ii.(a)(i)(A)	Brief description Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.D.ii.(a)(iii)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	Minimum Fee Schedule	Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Medicaid State plan as a minimum fee schedule for FQHC/RHC providers.	Rate Adjustment
AZ_Fee_IP.OP.PC.SP.NF.HCBS .BHI.BHO.D_Renewal_20221001-20230930 (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_20221001-20230930 (APSI)	Uniform Percentage Increase	70% increase to otherwise contracted rates for professional services provided by qualified practitioners affiliated with designated hospitals.	Separate Payment Term
AZ_Fee_IP.OP1_Renewal_20221001-20230930 (PSI)	Uniform Percentage Increase	Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 beds. The uniform percentage increase is based on a fixed total payment amount, and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_IP.OP2_Renewal_20221001-20230930 (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's aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term

CYE23 Capitation Rate Certification – CHP Program

Appendix 8a: State Directed Payments - CMS Prescribed Tables

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

Control name of the state directed payment	Rate cell affected Section I.4.D.ii.(a)(ii)(A)	Impact Section I.4.D.ii.(a)(ii)(B)	Description of the adjustment Section I.4.D.ii.(a)(ii)(C)	Confirmation the rates are consistent with the preprint Section I.4.D.ii.(a)(ii)(D)	For maximum fee schedules, requested information Section I.4.D.ii.(a)(ii)(E)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	CHP	See Appendix 8b for total impact.	<p>The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates, described in Section I.3.B.ii.(a).</p> <p>The AHCCCS DHCM Rates & Reimbursement Team developed the impacts of bringing the base FQHC/RHC encounter data up to the projected CYE 23 FQHC/RHC PPS rates, by applying the change in PPS rates as a unit cost change to the CYE 21 base data. The AHCCCS DHCM Actuarial Team then reviewed the FQHC/RHC results and applied aggregated percentage impacts by program, risk group, and rate setting category of service as part of the overall fee schedule update.</p>	Not applicable.	Not applicable.
AZ_Fee_IP.OP.PC.SP.NF.HCBS.BHI.BHO.D_Renewal_20221001-20230930 (DAP)	CHP	See Appendix 6 for medical impact. See Appendix 8b for total impact.	<p>The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.25% increase), Critical Access Hospitals (eligible for up to 10.75 % increase), other hospitals and inpatient facilities (eligible for up to 5.0% increase), rehabilitation and long term acute care hospitals (eligible for a 0.25% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for up to a 1.0% increase), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 8.5% increase), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), physicians, physician assistants, and registered nurse practitioners specialty types (obstetrics and gynecology, pediatrics, cardiology and nephrology) (eligible for a 1.0% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), HCBS providers (eligible for up to 3.0% increase), therapeutic foster homes (eligible for up to 20.0% increase), specific provider types that have or plan to have a workforce development plan (eligible for a 1.0% increase), specific provider types that meet employment staff training requirements (eligible for a 2.0% increase), and crisis providers (eligible for a 3.0% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.</p> <p>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 21 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 23 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 23 (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).</p>	AHCCCS has submitted the DAP 42 CFR § 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.

CYE23 Capitation Rate Certification – CHP Program

Appendix 8a: State Directed Payments - CMS Prescribed Tables

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

Control name of the state directed payment	Aggregate amount included in the certification Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20221001-20230930 (APSI)	\$2,543,259	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Access to Professional Services Initiative (APSI) 42 CFR § 438.6(c) 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 cell, 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_20221001-20230930 (PSI)	\$1,974,715	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Pediatric Service Initiative (PSI) 42 CFR § 438.6(c) 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 cell, 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_20221001-20230930 (HEALTHII)	\$8,360,077	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) 42 CFR § 438.6(c) 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 cell, 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 8b: State Directed Payments – Estimated PMPMs

CYE 23 Estimated PMPM				
State Directed Payment	Medical	UW Gain	Premium Tax	Total
FQHC/RHC	\$1.98	\$0.02	\$0.04	\$2.04
DAP	\$15.75	\$0.16	\$0.32	\$16.23
APSI	\$15.80	\$0.00	\$0.32	\$16.12
PSI	\$12.27	\$0.00	\$0.25	\$12.52
HEALTHII	\$51.94	\$0.00	\$1.06	\$53.00