Contract Year Ending 2020
Regional Behavioral Health Authority
Program Capitation Rate Certification

October 1, 2019 through September 30, 2020

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

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AHCCCS
Arizona Health Care Cost Containment System

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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 at 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies used in the development of the October 1, 2019 through September 30, 2020 (Contract Year Ending 2020 or CYE 20) actuarially sound capitation rates for Arizona's Regional Behavioral Health Authority (RBHA) Program. The RBHA Program is changing effective October 1, 2019. Those changes are described in the rate certification below. This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 at 81 FR 27497 applicable to this rate certification, the 2019-2020 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2019-2020 Medicaid Managed Care Rate Development Guide (2020 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 2020 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

> “Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and

other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

As stated on page 2 of the 2020 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 2020 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The CYE 20 capitation rates for the RBHA Program are effective for the twelve month time period from October 1, 2019 through September 30, 2020.

I.1.A.ii. Required Elements

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

The actuarial certification letter for the CYE 20 capitation rates for the RBHA Program, signed by Erica Johnson ASA, MAAA and Windy J. Marks FSA, MAAA, is in Appendix 1. Ms. Johnson and Ms. Marks meet the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854 which is provided below for reference.

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

Ms. Johnson and Ms. Marks certify that the CYE 20 capitation rates for the RBHA Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 at 81 FR 27497.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the RBHA Contracts include the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856. The RBHA Contracts use the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 at 81 FR 27497 and the 2020 Guide.

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

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

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

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

The RBHA Program has three managed care organizations. The managed care organization is referred to as a RBHA. The RBHA Program has three Geographic Service Areas (GSAs) and one RBHA operating in each GSA. The three GSAs, along with the three RBHAs and their respective effective dates are listed below.

- Central GSA – Mercy Maricopa Integrated Care (MMIC), effective April 1, 2014
    - Effective October 1, 2018, MMIC is known as Mercy Care - RBHA

- North GSA – Health Choice Integrated Care (HCIC), effective October 1, 2015
    - Effective October 1, 2018, HCIC is known as Steward Health Choice Arizona - RBHA
- South GSA – Cenpatico Integrated Care (CIC), effective October 1, 2015
    - Effective October 1, 2018, CIC is known as Arizona Complete Health Complete Care Plan - RBHA (AZCH-CCP - RBHA)

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

The three RBHAs provide behavioral health services (including crisis intervention services) to two main Arizona Medicaid populations described below, and are responsible for providing crisis intervention services to Arizona Medicaid populations whose behavioral health services are provided by other programs. This is a change from prior years, where the RBHAs provided behavioral health services for most Arizona Medicaid members. In addition, the RBHAs provide integrated care, (that is, both physical and behavioral health services) for most members diagnosed with a Serious Mental Illness (SMI). For ease of reference, this certification will speak to the two main populations for which the RBHAs are responsible, and the crisis-only populations for which the RBHAs' only responsibility is crisis intervention services. All tables which do not specifically state otherwise are restricted to the two main populations and do not include any impacts to the crisis-only populations. When there are impacts to the crisis-only populations, the tables will note that the crisis-only populations are included. The Central GSA RBHA began providing integrated care for members with SMI in April 2014, and the North and South GSA RBHAs followed suit in October 2015.

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

- Treatment Services
- Rehabilitation Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Behavioral Health
- Behavioral Health Residential
- Behavioral Health Day Programs
- Prevention Services
- Pharmacy

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

- Hospital Inpatient
- Hospital Outpatient
- Physician Services
- Emergency Services

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

Additional information regarding covered services can be found in the RBHA Program contracts.

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

The RBHA Program has operated in the State of Arizona since 1992 and was administered by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS) until July 1, 2016. On July 1, 2016, the administration of the RBHA Program was moved from ADHS/DBHS to AHCCCS. Capitation rates for the RBHA Program prior to July 1, 2016 were developed and paid from AHCCCS to ADHS/DBHS. These historical capitation rates were developed by AHCCCS at the RBHA level and then grossed up to reflect additional expenses for ADHS/BHS administration, additional vendor expenses to determine whether a member has SMI, and additional expenses to cover Tribal Fee-for-Service claims. After the July 1, 2016 move of ADHS/DBHS into AHCCCS, these additional expenses were no longer required to be added to the capitation rates because the administration of the RBHA Program was under AHCCCS. As of October 1, 2018, the AHCCCS Complete Care (ACC) program integrated behavioral health and physical health services for most Arizona Medicaid members through the ACC Contractors. As of October 1, 2019, the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Program is integrating behavioral health and physical health services for their members. These two integration changes have removed the responsibility for providing behavioral health services for a large portion of members from the RBHAs. Those changes will be described further below.

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

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

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

The rate certification for the CYE 20 capitation rates for the RBHA Program is effective for the twelve month time period from October 1, 2019 through September 30, 2020.

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

The RBHA Program has four rate cells in CYE 20. Two rate cells tie directly to the same populations served in the previous rating period under the rate cells of the same name, while the other two rate cells are each a combination of two rate cells from the previous rating period. More information about the populations covered under the RBHA Program can be found in the Eligibility Categories section of the RBHA Contracts.

Table 1 below displays the rate cells and a brief description of the covered populations within each rate cell. The first two rate cells (two main populations) in the table below receive all of their behavioral health services through the RBHA Program, and cover the same populations and services as in the previous rating period; the last two rate cells (crisis-only populations) only receive crisis intervention services through the RBHA Program (ALTCS DES/DDD members are now included in these crisis-only populations).

Table 1: Covered Populations by Rate Cell

Rate Cell	Covered Populations
SMI	Title XIX eligible adults diagnosed with a Serious Mental Illness who may additionally receive physical health services under the RBHA Program
CMDP Child	Title XIX eligible children enrolled in Comprehensive Medical and Dental Program (CMDP)
Crisis-only Adult	Title XIX/Title XXI eligible adults not represented in other rate cells, crisis services only
Crisis-only Child	Title XIX/Title XXI eligible children not represented in other rate cells, crisis services only

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

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

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE 20 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Alternative Payment Model (APM) Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- Targeted Investments Program (42 CFR § 438.6(c)(1)(ii) at 81 FR 27860)
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

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

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

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

Proposed differences among the CYE 20 capitation rates for the RBHA Program are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the RBHA Program.

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

The CYE 20 capitation rates for the RBHA Program were developed at the rate cell level. There is no cross-subsidization of payments between the rate cells in the RBHA Program.

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

The effective dates of changes to the RBHA Program are consistent with the assumptions used to develop the CYE 20 capitation rates for the RBHA Program.

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

The capitation rates were developed so each RBHA would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 20.

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

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

In the actuaries' judgement, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To the actuaries' knowledge, there are no reasonable, appropriate and attainable costs which have not been included in the rate certification.

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

Adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR § 438.4. There are no adjustments to the rates performed outside the rate setting process.

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 20 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not Applicable. Capitation rates from previous rating periods are not used in the development of the CYE 20 capitation rates for the RBHA Program.

I.1.A.ix. Rate Certification Procedures

I.1.A.ix.(a) CMS Rate Certification Requirement for Rate Change

This is a new rate certification that documents that the RBHA Program capitation rates are changing effective October 1, 2019.

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

Not Applicable. This rate certification will change the RBHA Program capitation rates effective October 1, 2019.

I.1.A.ix.(c) CMS Rate Certification Circumstances

This section of the 2020 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell, in accordance with 42 CFR § 438.7(c)(3), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

I.1.A.ix.(d) CMS Contract Amendment Requirement

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

I.1.B. Appropriate Documentation

I.1.B.i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 20 capitation rates for the RBHA Program.

I.1.B.ii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2020 Guide. Sections of the 2020 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.iii. Differences in Federal Medical Assistance Percentage

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

The populations, FMAPs, and the percentage of costs for October 1, 2017 through September 30, 2018 (CYE 18) are provided below in Table 2. The FMAPs shown below are for the time period of January 1, 2019 through September 30, 2019.

Table 2: FMAP and Percentage of Costs by Population

Population	FMAP	Percentage of Costs
Adult Expansion	93.00%	2.17%
Child Expansion	100.00%	0.06%
Childless Adult Restoration	93.00%	36.20%
KidsCare (Title XXI)	100.00%	0.01%
Populations not listed above	69.81%	61.57%

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

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

The CYE 19 capitation rates included the § 438.6(c) pre-print item Access to Professional Services Initiative (APSI) in the certified capitation rates to be paid monthly to each RBHA. The CYE 20 capitation rates do not include APSI in the certified capitation rates to be paid monthly as the § 438.6(c) pre-print for APSI for CYE 20 is using a quarterly lump sum payment methodology as opposed to a PMPM payment methodology. The 2020 Guide requests a comparison to the final certified rates in the previous rate certification. Those comparisons, for the two rate cells (SMI, and CMDP Child) which did not change in terms of populations included, are available in Appendix 3a. Please note that due to the change in methodology for APSI payments, the comparisons between certified capitation rates in this rating period and the previous rating period are not “apples to apples” comparisons and should not be treated as such.

The 2020 Guide also requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. For the purposes of the CYE 20 certified capitation rates, the actuaries defined any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year was a negative change in the rate.

The negative change to the South SMI rate cell is driven primarily by the decrease in rebased encounters. The main driving factor behind the decrease is a continued decline in case management expenditures, outpatient hospital expenditures, and rehabilitation services expenditures. Those three categories of service together decreased 26% year over year per financial reporting from the South RBHA, and 23% year over year when reviewing completed encounters with normalization adjustments applied. In order to understand this large decrease year over year, the actuaries reviewed the last 42 months of encounter data (October 2015 through March 2019) to verify that the decrease in CYE 18 was not an anomalous year for these categories of service. Reviewing month by month normalized encounters for these categories of service, the actuaries observed that these categories of service have been decreasing over time, and the change from base encounters in CYE 17 to base encounters in CYE 18 is a continuation of that trend. The trend assumptions for these categories of service does not build in that negative trend continuing, but rather were developed as if there is a leveling off that will occur. Additionally, trend development for the CYE 19 capitation rates considered the more recent months’ (October 2017 through April 2018) decline to be an artifact of completion factors, and so did not give those months as much weight in judging what trend assumptions would be appropriate, therefore the

impact of trends on the rates in CYE 19 is a larger PMPM than it is in CYE 20, due to both the larger base, and the higher trend assumptions chosen in CYE 19 rate development compared to CYE 20 rate development.

The negative change to the North CMDP Child rate cell is driven by a combination of factors. A decrease in rebased encounters, smaller program change impacts, smaller trend impact, and administrative cost decreases all contributed to the year over year decrease in the CYE 20 rates as compared to the CYE 19 rates. The largest decrease in the rebased encounters was a reduction in inpatient behavioral hospital expenses, which is consistent with the general direction of inpatient behavioral hospital encounters over the past 42 months of data reviewed. The largest reduction in program changes is related to an updated estimate of expected costs for behavioral health services in school in the North GSA. The trend impacts for the North CMDP Child rate cell in the CYE 19 rates were twice as large as the impact of trend in the CYE 20 rates ($92.77 impact in CYE 19 as opposed to $45.48 impact in CYE 20). This reduction in trend impact was due to a lower base and also lower trend assumptions for CYE 20 capitation rates.

The Crisis-only rate cells have changes in terms of covered populations, as well as additional information on expenditures related to covered crisis intervention services. The large increases for the Crisis-only rate cells are a combination of multiple factors. One of the factors is moving the crisis intervention services provided to members with developmental disabilities (last year's RBHA rate cells DD Adult and DD Child) into the Crisis-only rate cells (these members' other behavioral health services are being integrated under the DES/DDD program effective October 1, 2019). Another factor is information brought to the attention of AHCCCS and the actuaries related to ancillary crisis expenditures which are not captured in the specific procedure codes originally used to develop the Crisis-only capitation rates. These ancillary crisis expenditures are services such as laboratory and transportation services provided to members in the first 24 hours of a crisis episode which the RBHAs have been paying for, rather than the AHCCCS Complete Care plans as was expected in the CYE 19 capitation rates. The CYE 20 ACC and RBHA rates have an adjustment to shift these ancillary services provided within the first 24 hours of a crisis episode from the ACC rate development to the RBHA rate development.

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

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

I.2. Data

This section provides documentation for the Data section of the 2020 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 Division of Health Care Management (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) at 81 FR 27858.

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 20 capitation rates for the RBHA Program include the following:

- Adjudicated and approved encounter data submitted by the RBHAs and provided from the AHCCCS PMMIS mainframe
  - Incurred from October 1, 2015 through March 31, 2019
  - Adjudicated and approved through April 15, 2019
- Enrollment data for the RBHA Program provided from the AHCCCS PMMIS mainframe
  - October 1, 2015 through March 31, 2019
- Annual audited financial statements submitted by the RBHAs and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
  - October 1, 2015 through September 30, 2016 (CYE 16 or FFY 16)
  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17)
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
- Quarterly financial statements submitted by the RBHAs and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
  - October 1, 2015 through September 30, 2018 (quarterly financials from CYEs 16, 17 and 18)
  - October 1, 2018 through March 31, 2018 (CYE 19 Q1 and Q2)
- AHCCCS Fee-for-Service fee schedules developed and maintained by the AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement Team related to DAP, see Section 1.4.D.

- Data from AHCCCS 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 for current and previous rate cells provided by the RBHAs
- Supplemental data regarding crisis intervention services cost projections provided by the RBHAs
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the IMD analysis, incurred in CYE 18
- Historical and projected enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
  - Projections for CYE 20
  - Historical enrollment from mid CYE 19 and earlier
- Any additional data used and not identified here will be identified in their applicable sections below

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

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

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

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

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

The RBHA Program has approximately 37.5% of expenditures in sub-capitation and block purchase payment arrangements (sub-cap/block payments) for the two main populations. A block purchase payment arrangement is defined by AHCCCS as a payment arrangement methodology where a contracted amount for a block of services is divided by 12 and paid in monthly installments to the provider. The encounter data includes encounters for sub-cap/block payment arrangements; however, they are populated with a "HP Paid Amount" (HP standing for health plan) of zero. To use the sub-cap/block payment encounters for rate development, a methodology has been developed and tested for repricing the expenditures for these encounters.

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

Table 3 below provides a distribution of the CYE 18 encounter data by sub-cap/block payments, non-sub-cap/block payments and by Category of Service (COS) for the two main populations. The Crisis-only Adult and Crisis-only Child populations were assumed to have the same distribution for Crisis Intervention Services as calculated for the two main populations below.

Table 3: CYE 18 Non-Subcap/Non-Block and Subcap/Block percentages by Category of Service

Category of Service	Non-Subcap/Non-Block Payments	Subcap/Block Payments
Behavioral Health Day Programs	0.7%	99.3%
Case Management	3.3%	96.7%
Crisis Intervention Services	5.3%	94.7%
Dental Services	98.5%	1.5%
FQHC/RHC	97.5%	2.5%
Inpatient Behavioral Health	89.2%	10.8%
Inpatient Hospital	100.0%	0.0%
Medical Services	60.3%	39.7%
Nursing Facility (Short-term)	100.0%	0.0%
Other Services	87.4%	12.6%
Outpatient Hospital	99.9%	0.1%
Pharmacy	100.0%	0.0%
Rehabilitation Services	4.5%	95.5%
Residential Services	82.0%	18.0%
Support Services	29.3%	70.7%
Transportation	77.4%	22.6%
Treatment Services	17.7%	82.3%
Total	**62.5%**	**37.5%**

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.

The AHCCCS Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a per member per month (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 Actuarial Team reports the findings to the AHCCCS Data Analysis & Research (DAR) Team, which then works with the RBHAs to identify determinants. In addition, the AHCCCS DAR Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

The RBHAs know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides the RBHAs with the “Encounter Monthly Data File” (aka the “magic” file)

which contains the previous 36 months of encounter data. Data fields contained in this file include, but are not limited to, adjudication status, AHCCCS ID, Claim Reference Number (CRN), Provider ID and various cost amounts. The adjudication status has five types: adjudicated/approved, adjudicated/plan denied, adjudicated/AHCCCS denied, pended and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters, but providing this file to the RBHAs allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions.

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

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

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

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

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

The AHCCCS DHCM Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe. The AHCCCS DHCM Actuarial Team ensured that encounter data only with valid AHCCCS member IDs was used in developing the CYE 20 capitation rates for the RBHA Program. Additionally, the AHCCCS DHCM Actuarial Team ensured that only services covered under the state plan were included.

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

The AHCCCS DHCM Actuarial Team compared the encounter data for all services provided by the RBHAs to both the populations covered by the RBHAs going forward and to the services provided by the RBHAs for populations which will be covered by the ACC Contractors and by ALTCS DES/DDD to the RBHAs annual financial statement data for CYE 18. After adjustments to the encounter data for completion, the comparisons showed that the financial statements and the encounter data were consistent.

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

As required by ASOP No. 23, the AHCCCS DHCM Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the RBHAs and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and quarterly financial statement data submitted by the RBHAs and reviewed by the AHCCCS DHCM Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data and the rate development is dependent upon this reliance. The actuaries notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP and fee schedule impacts, on data provided by the AHCCCS financial analysts with regards to some program changes, on information and data provided by Mercer consultants with regards to mental health parity and pharmacy reimbursement

savings, on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment, and on cost projections provided by the RBHAs for the crisis intervention category of service.

The AHCCCS DHCM Actuarial Team found the encounter data to be appropriate for the purposes of developing the CYE 20 capitation rates for the RBHA program.

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

The AHCCCS DHCM Actuarial Team has not identified any other concerns with the quality or availability of the data.

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

The AHCCCS DHCM Actuarial Team determined that the CYE 18 encounter data was appropriate to use as the base data for developing the CYE 20 capitation rates for the RBHA Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 20 capitation rates for the RBHA Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounter served as the primary data source for the development of the CYE 20 capitation rates for the RBHA Program.

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

Not applicable. The AHCCCS DHCM Actuarial Team did not rely on a data book to develop the CYE 20 capitation rates for the RBHA program.

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

This section describes adjustments made to the CYE 18 encounter data that was used as the base data for developing the CYE 20 capitation rates for the RBHA Program.

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

Not applicable. No credibility adjustments were made to the CYE 18 encounter data.

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

Completion Factors

The AHCCCS DHCM Actuarial Team developed completion factors to apply to the CYE 18 encounter data. Completion factors were calculated using the development method with monthly encounter data incurred from October 1, 2015 through March 31, 2019 and adjudicated and approved through April 15, 2019. The completion factors were developed by GSA, major category of service, and by month of service. The major category of service was based upon the AHCCCS form type, which indicates the type of form used to submit a claim. AHCCCS has six form types; Professional and Other Services (form type A), Prescription Drug (form type C), Dental Services (form type D), Inpatient Hospital (form type I), Nursing Facility (form type L), and Outpatient Hospital (form type O). Dental Services (0.11% of CYE 18 encounters) were combined with Professional and Other Services and Nursing Facility Services (0.52% of CYE 18 encounters) were combined with Inpatient Hospital. The monthly completion factors for CYE 18

were applied to the CYE 18 encounter data. Table 4a below displays the aggregate completion factors for CYE 18 by GSA and major category of service. Table 4b below displays the aggregate impact of completion by GSA.

Table 4a: CYE 18 Completion Factors for Encounters by GSA

GSA	Professional and Other Services (Form Types A and D)	Pharmacy (Form Type C)	Inpatient Hospital and Nursing Facility (Form Types I and L)	Outpatient Hospital (Form Type O)	Total
Central	0.9736	0.9877	0.8906	0.9406	0.9585
North	0.9714	0.9857	0.9000	0.9229	0.9603
South	0.9523	0.9839	0.8900	0.9275	0.9448
Total	**0.9676**	**0.9866**	**0.8912**	**0.9338**	**0.9551**

Table 4b: Impact of Completion Factors

GSA	Before Completion	After Completion	Impact
Central	$1,670.35	$1,742.59	4.3%
North	$1,186.91	$1,235.95	4.1%
South	$1,196.40	$1,266.30	5.8%
Total	**$1,457.76**	**$1,526.26**	**4.7%**

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, 2017 through September 30, 2018) are described below, or in section I.3.A.v. for base data adjustments required with respect to IMD in-lieu-of services. All program and fee schedule changes which occurred or are effective on or after October 1, 2018 are described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less for every individual rate cell, that adjustment was deemed non-material and has been grouped in the combined miscellaneous base data adjustment subset below, along with a brief description of each adjustment. Some of the impacts for base data adjustment changes described below (indicated by an asterisk) were developed by AHCCCS financial analysts with oversight from the DHCM Clinical Quality Management Team and the Office of the Director's Chief Medical Officer. As noted above in Section I.2.B.ii.(b)(ii), the actuaries relied upon the professional judgment of the 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 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.

Pharmacy Reimbursement Savings

Analysis of pharmacy claims for all AHCCCS managed care programs and AHCCCS Fee-for-Service (FFS) program has identified significant variability across all Contractors, and analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to the lesser of Health Plan Paid amounts or AHCCCS FFS repriced amounts would result in an annual savings of $68.2 million or 5.6% of pharmacy spend for FFY 18 across all programs. AHCCCS recognizes that the full savings amount may not be reasonably achievable in a single year, and is therefore adjusting the base pharmacy data of each program by 33% of the savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing. Based on continued analysis, further adjustments may be made to phase-in larger savings amounts in subsequent contract periods.

The amount of the base data adjustment for pharmacy reimbursement savings for the RBHA program is shown below in Table 5a by GSA. Totals may not add up due to rounding.

Table 5a: Pharmacy Reimbursement Savings

GSA	Dollars removed for change	PMPM change
Central	($4,528,487)	($12.13)
North	($350,328)	($4.04)
South	($953,667)	($4.59)
Total	**($5,832,482)**	**($8.73)**

Behavioral Health Non-emergency Transportation to Community-Based Support Programs *

Policy guidance effective July 1, 2018, clarified that covered non-emergency medical transportation (NEMT) services may be provided to transport an individual to select community-based support programs (CBSP). The policy specifies a list of select qualifying CBSP, such as Alcoholics Anonymous and National Alliance on Mental Illness Family Support. The base data adjustment reflects the fact that only one quarter of CYE 18 was impacted by the policy, and adjusts the first three quarters in a similar fashion.

Under the policy change, one RBHA was anticipated to reduce the number of services for which they reimburse, to exclude NEMT services provided to transport individuals to nonqualified CBSP and other services that are not associated with an AHCCCS-registered provider. Other RBHAs were anticipated to increase the number of services for which they reimburse, to include NEMT services provided to transport individuals to CBSP activities, as a result of the policy change.

The estimated impact uses the same percentage change assumed for each RBHA in the CYE 19 rates. The percent was not updated from the CYE 19 rates due to limited information available at the time the estimate was updated for rate development.

The overall estimated impact used to adjust the first three quarters of the base year for the Behavioral Health NEMT policy change by GSA is displayed below in Table 5b. Totals may not add up due to rounding.

Table 5b: BH NEMT to CBSP

GSA	Dollars	PMPM change
Central	($1,505,036)	($4.03)
North	$309,014	$3.56
South	$782,318	$3.76
Total	**($413,704)**	**($0.62)**

Combined Miscellaneous Base Data Adjustments

- **Removal of Differential Adjusted Payments from Base Data**
  CYE 18 capitation rates funded Differential Adjusted Payments (DAP) made from October 1, 2017 through September 30, 2018 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, 2018, AHCCCS has removed the impact of CYE 18 DAP from the base period.

  See Section I.4.D. for information on adjustments included in CYE 20 capitation rates for DAP that are effective from October 1, 2019 through September 30, 2020.
- **APR-DRG Reimbursement Rate Changes**
  AHCCCS transitioned from version 31 to version 34 of the All Patient Refined Diagnostic Related Groups (APR-DRG) payment classification system on January 1, 2018. To make the APR-DRG grouper fully ICD-10 code compliant, AHCCCS rebased the inpatient system by updating the DRG grouper version, relative weights and DRG base rates via payment simulation modeling using more recent data.
- **Out-of-Network Inpatient Behavioral Health Services ***
  As part of the 2018 Legislative session, the Arizona Legislature passed HB 2659 which limits AHCCCS reimbursement of inpatient behavioral health services provided at a facility that does not contract with the member's Contractor to 90% of AHCCCS fee schedule rates, beginning July 1, 2018. Prior to the law's implementation, AHCCCS reimbursed these non-contracted services at 100% of fee schedule rates.
- **Hepatitis C (HCV) Treatment**
  In 2017, the AHCCCS Pharmacy and Therapeutics (P&T) Committee reviewed the HCV Direct Acting Antiviral Agents (DAA) and recommended Mavyret as the sole preferred agent to treat HCV based on both clinical efficacy and cost effectiveness. AHCCCS accepted the P&T's recommendation and also removed fibrosis level requirements that were previously necessary in order to access treatment and removed a one treatment per lifetime limitation effective January 1, 2018.

The aggregate amount of the costs of the miscellaneous non-material base data adjustments are displayed by GSA below in Table 5c. Totals may not add up due to rounding.

Table 5c: Combined Misc. Base Data Adjustments

GSA	Dollars	PMPM change
Central	($1,245,529)	($3.34)
North	($146,219)	($1.69)
South	($586,755)	($2.82)
Total	**($1,978,503)**	**($2.96)**

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

The AHCCCS DHCM Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 20 capitation rates for the RBHA Program.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2020 Guide.

I.3.A. Rate Development Standards

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

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

I.3.A.ii. Variations in Assumptions

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

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

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

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

Any in-lieu-of services (and the specific utilization and unit costs associated with such) provided in the base period have been included in the rate development as is, and treated in the same manner as all other State Plan approved services, with the exception of IMD in-lieu-of services provided to enrollees age 21 to 64. For enrollees age 21 to 64, for inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.6(e), and this is described below in Section I.3.A.v.

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

The projected benefit costs include costs for members age 21 to 64 that have a stay of no more than 15 cumulative days in a month in an Institution for Mental Disease (IMD) in accordance with 42 CFR § 438.6(e) at 81 FR 27861.

Costs Associated with an Institution for Mental Disease Stay

The AHCCCS DHCM Actuarial Team adjusted the base data to remove the costs associated with stays in an IMD for enrollees age 21 to 64 in accordance with 42 CFR § 438.6(e) at 81 FR 27861. The AHCCCS DHCM Actuarial Team repriced all utilization of an IMD at the cost of the same services through providers included under the State plan, regardless of length of stay. The AHCCCS DHCM Actuarial Team then removed costs for members age 21 to 64 for stays in an IMD exceeding 15 cumulative days in a month, whether through a single stay or multiple within the month. Additionally, the AHCCCS DHCM Actuarial Team removed all associated medical costs that were provided to the member during the IMD stay(s) that exceeded 15 cumulative days in a month.

The data used to determine the base data adjustment was the CYE 18 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 18 encounter data, the AHCCCS DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The list of IMDs was updated during the CYE 20 rate development in a collaborative effort between the health plans and the AHCCCS DHCM Actuarial Team. The costs associated with an institutional stay at an IMD were repriced to the Non-IMD price-per-day. The Non-IMD price-per-day used in the analysis was $864.51 and was derived from the CYE 18 encounter data for similar IMD services that occurred within a Non-IMD setting. The encounter data was used for the repricing analysis rather than the AHCCCS Fee-for-Service fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a Non-IMD setting, which may not be fully captured within the AHCCCS Fee-for-Service fee schedule per diem rate. The costs associated with an institutional stay at an IMD that were repriced in the base data are displayed below in Table 6a. Totals may not add up due to rounding.

Table 6a: Reprice of Costs for all IMD Stays by GSA

GSA	Repriced IMD Dollars Added	Repriced IMD PMPM Added
Central	$3,724,586	$9.98
North	$39,413	$0.45
South	$553,590	$2.66
Total	**$4,317,588**	**$6.46**

The AHCCCS DHCM Actuarial Team identified all members age 21 to 64 who had IMD stays which exceeded 15 cumulative days in a month, and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed below in Table 6b. Totals may not add up due to rounding.

Table 6b: Removal of Repriced Stays More Than 15 Days in a Month by GSA

GSA	Repriced IMD Dollars Removed	Repriced IMD PMPM Removed
Central	($3,979,255)	($10.66)
North	($24,529)	($0.28)
South	($1,161,767)	($5.59)
Total	**($5,165,551)**	**($7.73)**

Once a member was identified as having an IMD stay(s) greater than 15 cumulative days in a month, all encounter data for the member was pulled for the timeframe(s) they were in the IMD in order to remove those additional medical service costs from rate development. The associated costs removed from the base data are displayed below in Table 6c. Totals may not add up due to rounding.

Table 6c: Removal of Related Costs for IMD Stays of More Than 15 Days in a Month by GSA

GSA	Related Cost Dollars Removed	Related Cost PMPM Removed
Central	($1,243,206)	($3.33)
North	($5,714)	($0.07)
South	($303,256)	($1.46)
Total	**($1,552,176)**	**($2.32)**

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

The final projected benefit costs are detailed in Appendix 6.

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

The section provides information on the projected benefit costs included in the CYE 20 capitation rates for the RBHA Program.

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

The base data described in Section I.2.B.ii was summarized by GSA and rate cell. Adjustments were made to the base data to reflect completion, and all base data changes described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in I.3.A.v. The adjusted base data PMPMs were trended forward 24 months, from the midpoint of the CYE 18 time period to the midpoint of the CYE 20 rating period. The projected PMPMs were then adjusted for prospective program changes that are described within this section of the 2020 Guide. Appendix 4 contains the base data and base data adjustments by GSA and rate cell, Appendix 5 contains the projected benefit cost trends by GSA and rate cell, and Appendix 6 contains the prospective program changes by GSA and rate cell. Additionally, Appendix 6 illustrates the capitation rate development by GSA and rate cell, which includes the DAP, reinsurance offset, administrative expense, underwriting (UW) gain, and premium tax.

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

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

Pharmacy & Therapeutics Committee Decisions*

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 19 that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 20. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

To estimate the impact of adopted changes, the financial analysts relied on projections of drug utilization prepared by Magellan Rx Management, the agency's provider of drug rebate administrative services. Magellan has a nationwide vantage point that was drawn from in projecting how recommendations would impact drug utilization by AHCCCS members. In instances where Magellan did not provide a projected impact of an adopted change, the actuaries relied upon the judgement of DHCM financial analysts to project the impact. For CYE 20 rate development, the aggregate impact of adopted changes was allocated across risk cells and GSAs using FFY 18 encounter data for the affected drug classes.

The combined impacts to the RBHA program of the adopted P&T Committee recommendations are displayed by GSA below in Table 7a. Totals may not add up due to rounding.

Table 7a: P& T Committee Decisions

GSA	Dollars	PMPM
Central	$1,663,850	$4.46
North	($140,781)	($1.62)
South	$111,701	$0.54
Total	**$1,634,770**	**$2.45**

Telehealth for Rural and Urban Access to Care*

Effective October 1, 2019, AHCCCS policy is revised to improve access to telehealth services. The revision to policy eliminates restrictions on service categories for which telehealth can be used, removes place of service requirements for the distant site provider, and clarifies that telehealth services may be used in urban and rural settings.

Distance to a provider may act as a barrier to care for remotely located individuals. As a result, elimination of restrictions on service categories for which telehealth can be used is expected to reduce differences in use across service areas. To estimate the impact, utilization rates by county were reviewed for services that were expected to be affected by the change. It was assumed that utilization rates by county would gradually increase to a level that is at least 1 standard deviation below the statewide average in the base data.

Removal of place of service requirements for distant site providers and clarification that telehealth service are permitted in urban and rural settings are expected to increase service use more broadly

across service areas. The changes were collectively estimated to gradually increase statewide use of affected services by 1% over base period use.

Greater availability of telehealth services is also expected to reduce use of non-emergency medical transportation (NEMT) services to distant providers. To estimate the reduction in NEMT services, the DHCM Actuarial Team first estimated the size of the shift from "in-office" service use to telehealth services resulting from the policy change. One study reviewed found that 88% of increases to telehealth use represent a net increase in services while 12% represent a shift from current in-office use. Using these findings, the amount of shifted services was estimated in relation to the estimated net increase to services described in the preceding paragraphs. Encounters of services affected by the policy were then analyzed and it was determined that 7.7% of in-office service use was accompanied by a NEMT trip on the same day of service. The capitation rates were therefore adjusted for a reduction in NEMT costs equal to 7.7% of the estimated shift to telehealth service use.

Due to data limitations experienced in preparing the estimate and uncertainty about provider and member responses to the change, the DHCM Actuarial Team assumed that the full impact will be phased in over the 3 years of FFY 20 to FFY 22. As a result, the CYE 20 capitation rates have been adjusted to include one-third of the phased in estimate for changes to telehealth services.

For CYE 20 rate development, the projected change was allocated across risk cells and GSAs using encounter data of medical and NEMT services expected to be affected by the change. The overall impact of the change by GSA is displayed below in Table 7b. Totals may not add up due to rounding.

Table 7b: Telehealth

GSA	Dollars	PMPM
Central	$105,586	$0.28
North	$303,040	$3.49
South	$164,473	$0.79
Total	**$573,098**	**$0.86**

AHCCCS Fee-for-Service Fee Schedule Updates

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

Additionally, the RBHA Contracts have requirements that the RBHAs reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. This contract requirement was

effective April 1, 2015. The AHCCCS Fee-for-Service Fee Schedule Updates program change includes a fee schedule adjustment to bring the encounter base data from CYE 18 FQHC PPS rates up to projected CYE 20 FQHC PPS rates.

Effective October 1, 2019, AHCCCS will be updating provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 20 capitation rates have been adjusted to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to the CYE 20 capitation rates was the CYE 18 encounter data. The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 20 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program.

AHCCCS will additionally be increasing some fee schedule rates effective January 1, 2020 to recognize the next minimum wage increase resulting from the passing of Proposition 206. The methodology used to develop the adjustment to the CYE 20 capitation rates is the same as that of other fee schedule updates.

The overall impact of the AHCCCS Fee-for-Service fee schedule updates program change by GSA is illustrated below in Table 7c. Totals may not add up due to rounding.

Table 7c: AHCCCS Fee-for-Service Fee Schedule and Minimum Wage Updates

GSA	Dollars	PMPM
Central	$4,216,454	$11.29
North	$737,443	$8.50
South	$1,894,267	$9.11
Total	**$6,848,165**	**$10.25**

Behavioral Health Services in Schools *

The Arizona Legislature passed SB 1520 during the 2018 Legislative session which includes an appropriation to fund increased behavioral health services in schools. The targeted services are in addition to any existing behavioral health services provided, including those provided to students with disabilities under the state's School Based Services program. AHCCCS adjusted CYE 19 capitation rates effective October 1, 2018 for the additional costs of services that will be provided in schools. HB 2747 passed during the 2019 Legislative session continues to fund behavioral health services in schools. For CYE 20 rate development, the overall impact was allocated using YTD FFY 19 encounter data of Medicaid behavioral health services provided in schools.

The impact of the Behavioral Health Services in Schools program change by GSA is displayed below in Table 7d.

Table 7d: Behavioral Health Services in Schools

GSA	Dollars	PMPM
Central	$921,434	$2.47
North	$38,287	$0.44
South	$83,758	$0.40
Total	**$1,043,479**	**$1.56**

Adjustments to Crisis Intervention

The CYE 20 capitation rates for the RBHA Program include additional funding for crisis services above what is in the encounter base data due to a large portion of the costs required to provide crisis intervention services being unencounterable. Examples of crisis services that are not encounterable include 24/7 availability of crisis counselors and mobile crisis teams standing by whether or not anyone needs their services. This is a continuation of the methodology from the CYE 19 capitation rate development which used a discrete adjustment to crisis intervention services, having a similar effect as that of an under-reporting factor for a single category of service. The amount of dollars added to the crisis encounter data was based on RBHA financials (reflecting actual costs for all services including non-encountered services) as well as RBHA projected expenses (informed by anticipated contract amounts). RBHAs have indicated that previously contracted amounts to provide crisis services would be insufficient to continue to secure contracts with specialized crisis providers. Therefore, RBHA projected expenses for these contracts in CYE 20 most accurately reflect anticipated actual costs.

Additionally, during CYE 20 rate development the DHCM Actuarial team was made aware of concerns by the RBHAs regarding ancillary crisis expenditures which are not reflected in the specific crisis reporting that AHCCCS had defined for evaluating crisis expenditures by the RBHAs for CYE 19. These ancillary crisis services, such as transportation and laboratory services provided within 24 hours of a crisis episode, were expected to be the responsibility of the AHCCCS Complete Care (ACC) plans in the development of CYE 19 capitation rates. This has not been the practice in effect during CYE 19. Therefore, to address this issue and align practice with payment, the DHCM Actuarial team ran additional data to analyze the amount of ancillary crisis services provided by the RBHAs within 24 hours of a crisis episode and removed those encounters from the ACC program base data (ACC base data for CYE 20 rate development is a combination of physical and behavioral health services provided by three separate programs, including the RBHA program, during the base data time frame, CYE 18) and added them to the RBHA crisis-only rate cell encounter data as a separate adjustment.

The overall impact of the additional dollars for crisis intervention services over the base encounter data, including the impact of the additional ancillary encounters, is shown below in Table 7e. Totals may not add due to rounding. Note that the aggregated dollar and PMPM impacts for the GSAs expressed in this table are calculated across all four rate cells where impacts expressed elsewhere within this section are specific to and calculated across the two main populations.

Table 7e: Adjustments to Crisis Intervention

GSA	Dollars	PMPM
Central	$25,617,978	$2.35
North	$3,651,918	$1.94
South	$13,751,997	$2.68
Total	**$43,021,893**	**$2.40**

Combined Miscellaneous Program Changes

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 for every individual rate cell across all GSAs, that program change was deemed non-material for the purpose of the actuarial rate certification. The impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership for the two main populations by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 7f. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **LISAC Mental Health Assessments***
  Effective November 1, 2018, AHCCCS included Licensed Independent Substance Abuse Counselors (LISAC) among qualifying providers that will be reimbursed for non-physician mental health assessments. The scope of practice for LISAC includes evaluation and treatment of substance abuse disorders, which can require use of mental health assessments. After unintendedly removing the permission for LISAC to bill for these services during the period from July 1, 2017 to October 31, 2018, the change restored that billing authority.
- **Naturopathic Physicians Providing EPSDT***
  In CYE 19, AHCCCS began accepting applications for Doctors of Naturopathic Medicine (ND) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children under 21 years of age. The AHCCCS Office of Administrative and Legal Services (OALS) has interpreted federal and state laws to require the State to cover "medical care, or any other type of remedial care recognized under State law" provided by an ND as EPSDT services to "correct or ameliorate" any physical or mental conditions of the member. Use of services provided by NDs to members will largely replace existing use of services provided by other registered physician provider types. State law, however, places some limitations on the medications NDs may prescribe while many of the practitioners use pharmacological interventions sparingly. As a result, a number of ND office visits will require additional follow-up visits to a prescribing provider, which will increase use of services.
- **Advanced Practice Nurse MAT***
  The Federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) permits Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists to administer Buprenorphine for medication assisted treatment (MAT). The federal law is expected to increase use of MAT and costs to the program.

- **Transportation Network Companies for NEMT ***
  Beginning May 1, 2019, AHCCCS established a Transportation Network Company (TNC) provider type that delivers non-emergency medical transportation (NEMT) services through a ride-sharing model. The TNC-specific fee schedule is lower than ordinary NEMT base rates. The expansion of providers that can deliver NEMT services to members is also expected to reduce missed medical appointments and thus increase medical utilization. The estimated cost reduction associated with lower priced NEMT services provided by TNCs exceeds the estimated cost increase of additional office visits and NEMT rides associated with additional office visits.
- **Behavioral Health Residential Facilities (BHRF) Personal Care Differential***
  Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team will establish a differentiated Fee For Service rate for Behavioral Health Residential Facilities (BHRF) that are licensed by ADHS to provide personal care services.
- **3D Mammography ***
  Effective June 1, 2019, upon recommendation of the AHCCCS Quality Management Team, AHCCCS began covering digital breast tomosynthesis (3D mammograms) for preventive screening and diagnosis of adults 21 years of age and older. The AHCCCS Quality Management Team made the recommendation in recognition of studies that find use of 3D mammograms in addition to or in place of 2D services has at times improved detection of breast cancer in some populations. Contractors are permitted to use prior authorization criteria in evaluating medical necessity of 3D services for members.
- **Applied Behavior Analysis ***
  AHCCCS policy is updated effective October 1, 2019 to include clarifying language on the requirement for the AHCCCS Complete Care and Regional Behavioral Health Authority programs to provide covered Applied Behavior Analysis (ABA) services to children not receiving these services through another program. They are covered services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children under 21 years of age. The AHCCCS DHCM Actuarial Team estimated and incorporated the impact of the ABA change in CYE 19 capitation rates. The policy effective date was delayed from October 1, 2018 after CYE 19 rate development was completed, and while the actuaries were not made aware of the delay until CYE 20 rate development had begun, the CYE 19 capitation rates are still actuarially sound and do not need to be adjusted for this delay.
- **SSI/SSDI Outreach, Access and Recovery (SOAR) ***
  Effective October 1, 2018, AHCCCS began recognizing SOAR as a distinct reimbursable case management service. Through SOAR, providers assist individuals that are homeless, or at risk of becoming homeless, and that have a serious mental illness in applying for federal SSI/SSDI benefits.
- **Substance Use Disorder Assessment ***
  Effective October 1, 2018, AHCCCS updated provider fee schedules to include a targeted increase to providers who conduct a computer-guided, structured interview utilizing American Society of Addiction Medicine (ASAM) software. The service enables providers to determine the appropriate level of treatment based upon a set of medically accepted criteria.

- **Social Determinants of Health ***
  The Targeted Investments Program has benchmarks for screening members for the presence of social determinants of health (SDOH). These benchmarks are expected to result in increased use of the covered screening services in CYE 19 and CYE 20.
- **Rx Rebates Adjustment**
  An adjustment was made to reflect the impact of Rx Rebates reported within the RBHA Program financial statements, as pharmacy encounter data does not include these adjustments. The data reviewed to develop the impact was the CYE 16, CYE 17, CYE 18, and CYE 19 Q1 & Q2 financial statement reports. From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment to the projected CYE 20 Pharmacy category of service to reflect the levels of reported Rx Rebates by GSA.

Table 7f: Combined Miscellaneous

GSA	Dollars	PMPM
Central	($1,228,271)	($3.29)
North	($162,849)	($1.88)
South	($286,495)	($1.38)
Total	**($1,677,615)**	**($2.51)**

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) Overpayments to Providers

The RBHAs are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuaries to set the CYE 20 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was 42 months of encounter data incurred from October 1, 2015 through March 31, 2019 and adjudicated and approved through April 15, 2019. The trend is developed primarily with actual experience from the Medicaid population.

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

The encounter data was summarized by GSA, rate cell, month, and major category of service, and by utilization per 1000, unit cost, and PMPM values. The encounter data was adjusted for completion and to normalize for previous program changes. Projected benefit cost trends were developed to project the

base data forward 24 months, from the midpoint of CYE 18 (April 1, 2018) to the midpoint of the rating period for CYE 20 (April 1, 2020). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. Projected benefit cost trends were based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results for the two main population rate cells.

Projected benefit cost trends were developed at the major category of service level of detail for the SMI and CMDP Child rate cells within each GSA. The actuaries did not develop a separate trend assumption for the Crisis-Only rate cells. The actuaries judged it reasonable to use the same trend assumptions developed for SMI and CMDP Child to project forward the encounters for ancillary crisis services for the Crisis-Only rate cells (that is, the trend assumption for crisis intervention services for SMI was the same trend assumption applied to the Crisis-Only Adult completed ancillary crisis encounters, and likewise for the CMDP Child and Crisis-Only Child). There was no trend applied to the crisis intervention services for the Crisis-Only rate cells due to the adjustment to align CYE 20 projections with anticipated contract amounts from the RBHAs for those services, as noted in Section I.3.B.ii.(a).

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

No comparisons were made against other AHCCCS programs due to the unique aspects of the RBHA Program. Comparisons were made against the trends used in the previous rating period, and the change in trends by categories of service was deemed reasonable considering the change in the base data time period.

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

The 2020 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%.

The only outlier is the Pharmacy category of service for Central SMI rate cell which has a PMPM trend above 7%. The Central SMI rate cell has seen continued large unit cost increases in the Pharmacy category of service for the last several years. The actuaries note that in continued conversations with the Central RBHA that this has been a sustained concern, particularly in combination with limits on prior authorization and restrictions on the ability of the RBHA to re-direct individuals to lower cost prescription drugs based on changes in policy from the AHCCCS Pharmacy & Therapeutics (P&T) Committee. The actuaries reviewed the utilization and unit cost data for this category of service for the past 54 months, and from October 1, 2014 through March 30, 2019, the average unit cost for this rate cell has nearly doubled. This sustained increase year over year, along with review of the moving averages and linear regression results across multiple time frames, lead the actuaries to judge that the assumed unit cost trend for this rate cell and category of service was the most appropriate choice to reflect expected costs in CYE 20, and the resulting PMPM trend assumption is in line with the most recent twelve months of experience.

The actuaries assumed negative utilization trends in the North GSA for the SMI rate cell for Inpatient Hospital and Residential Service categories of service. Each of these negative trend assumptions was

based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month and 36-month linear regression results. For both negative utilization trend assumptions, all regression lines for the COS utilization data are negatively sloped and the negative slopes are more extreme than the utilization trend rate assumed in capitation rate development.

The actuaries assumed negative unit cost trends in the Central GSA for the CMDP rate cell for the Rehabilitation/Treatment Services category of service, in the North GSA for the SMI rate cell for Medical Services, Rehabilitation/Treatment Services, and Support Services categories of service, and in the South GSA for the CMDP Child rate cell for the Rehabilitation/Treatment Services, Residential Services, and Support Services categories of service. Each of these negative unit cost trend assumptions was based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month and 36-month linear regression results. For all negative unit cost trend assumptions, all regression lines for the rate cell's COS unit cost data are negatively sloped and the negative slopes are more extreme than the unit cost trend rates assumed in capitation rate development.

Where the direction of linear regression results varied by time frame, the actuaries used actuarial judgement with all data available, including feedback from the RBHAs obtained before rate development began, to make individual assumptions by category of service, but in general, if all linear regression trends were positive, a positive trend assumption was chosen, and if all linear regression trends were negative, a negative trend assumption was chosen.

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

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

The projected benefit cost trends by GSA, rate cell, and major category of service for utilization per 1000, unit cost, and PMPM values are included in Appendix 5. The aggregate projected benefit cost trends by GSA for utilization per 1000, unit cost, and PMPM values are included below in Table 8.

Table 8: CYE 20 Annualized Trends

GSA	Util/1000	Unit Cost	PMPM
Central	1.01%	3.11%	4.15%
North	0.79%	1.15%	1.95%
South	1.12%	1.05%	2.18%
Total	**1.01%**	**2.38%**	**3.41%**

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

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

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

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

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

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

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

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

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

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

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

The AHCCCS DHCM Medical Management Team, the AHCCCS Office of Administrative Legal Services (OALS) Legal Counsel Team, and the AHCCCS Office of the Director, in coordination with AHCCCS managed care contractors and Mercer consultants, have completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA. Updates to program analysis will be reviewed throughout the year for continued compliance.

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

The following types of services can be provided as in-lieu-of-services: home and community based services (HCBS) covered in lieu of a nursing facility and services in alternative inpatient settings licensed by ADHS/DLS in lieu of services in an inpatient hospital (distinct and disparate from in-lieu-of services provided in an IMD). These services are then included in the RBHA Program's capitation rate development categories of service. Encounters which are in-lieu-of-services are not identified separately in the data. Thus, the actuaries cannot define the percentage of cost that in-lieu-of services represented in the capitation rate development categories of service. However, the in-lieu-of services are treated exactly the same as all other State Plan approved services in capitation rate development. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the capitation rate development has complied with the requirements of 42 CFR § 438.6(e), and this is described above in Section I.3.A.v.

I.3.B.vi. Retrospective Eligibility Periods

I.3.B.vi.(a) RBHA Responsibility

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

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

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

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

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

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

No specific adjustments are made to the CYE 20 capitation rates for the RBHA 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.

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

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

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

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

Material adjustments related to provider payment requirements under Delivery System and Provider Payment Initiatives are discussed in Section I.4.D of this rate certification. Additionally, provider payment requirements related to FQHCs are described in Section I.3.B.ii.

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

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

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

There were no material adjustments made related to litigation.

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

All material and non-material changes have been included in the rate development process and all requirements in this section of the 2020 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

The CYE 20 capitation rates for the RBHA Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2) at 81 FR 27589, called the Alternative Payment Model (APM) Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where a RBHA may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the RBHA that are aimed at quality improvement, such as reducing costs, improving health outcomes or improving access to care. The incentive arrangement will not exceed 105% of the capitation payments. For reference, the RBHA CYE 18 APM – Performance Based Payment amounts were $6.2 million.

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

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

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

All enrollees, children and adults, may be covered by this incentive arrangement. Likewise, all network providers have the opportunity to participate in the APM arrangements and all covered services are eligible for inclusion. RBHAs are mandated to utilize the APM strategies in the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 as defined at https://hcp-lan.org/workproducts/apm-whitepaper.pdf. Their provider contracts must include performance measures for quality and/or cost efficiency.

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

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

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

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

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

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 20 capitation rates for the RBHA Program. Additionally, incentive payments for the APM Initiative – Performance Based Payments incentive arrangement had no impact on the development of the CYE 20 capitation rates for the RBHA Program. The anticipated incentive payment amount will be paid by AHCCCS to the RBHAs through lump sum payments after the completion of the CYE 20 contract year.

I.4.B. Withhold Arrangements

Not applicable. There are no withhold arrangements in the CYE 20 capitation rates for the RBHA Program.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2020 Guide provides information on the requirements for risk-sharing mechanisms.

I.4.C.ii. Appropriate Documentation

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

The CYE 20 capitation rates for the RBHA Program will include a risk corridor across all rate cells and a separate risk corridor for members transitioning to Title XIX from RBHA non-Title XIX eligibility.

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

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk sharing arrangement also contributes to Contractor stability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 20 capitation rates will continue AHCCCS' long-standing program policy and will include a risk corridor. This rate certification will use the term risk corridor to be consistent with the 2020 Guide. The RBHA Contracts refer to the risk corridors as either a reconciliation, or as limiting Contractor's profits and losses.

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

There are two risk corridor type arrangements in the RBHA program. The first is a reconciliation of costs to reimbursement and the second is a reconciliation of costs associated with members transitioning to Title XIX from RBHA non-Title XIX eligibility if a Non-Title XIX enrollment segment was created before Title XIX enrollment.

The first risk corridor, which is across all rate cells, will reconcile the RBHA's medical cost expenses to the net capitation paid to each RBHA. Net capitation is equal to the capitation rates paid less the administrative component, the health insurance provider fee (if applicable), and the premium tax, plus any reinsurance payments. The RBHA's medical cost expenses are equal to the RBHA's fully adjudicated encounters and sub-cap/block payment expenses as reported by the RBHA with dates of service during

the contract year. Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically computed no sooner than 15 months after the contract year. This risk corridor will limit the RBHA's profits to 4% and losses to 2%.

The second risk corridor, related to members transitioning to Title XIX from RBHA non-Title XIX eligibility, will be a payment made to the RBHA for Title XIX behavioral health covered service medical expenses provided during the prior period coverage (PPC) timeframe to General Mental Health/Substance Abuse (GMH/SA) and non-CMDP child members who are initially eligible as Non-Title XIX and assigned to a RBHA who then transition to Title XIX eligibility. This risk corridor limits the RBHA's profits and losses to 0% for these services, and the reconciliation amounts (payments and expenses) are excluded from any other reconciliation on the RBHA's service expenses. The actuaries have calculated an estimate ($4.7 million) of the potential reconciliation by extracting encounter data for members transitioning to Title XIX from RBHA non-Title XIX eligibility. There is neither a capitation rate, nor a rate cell for members transitioning, as there is not a reasonable method to estimate how many members transition in a year, much less on a monthly basis.

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

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

The risk corridors did not have any effect on the development of the CYE 20 capitation rates for the RBHA Program.

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

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

I.4.C.ii.(b) Remittance/Payment Requirements for Specified Medical Loss Ratio

Not applicable. The RBHA Program contracts do not include an MLR remittance/payment requirement.

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

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

To better align integrated populations across programs, effective October 1, 2018, AHCCCS extended the reinsurance program it operates to the RBHA Contracts for the SMI rate cell. AHCCCS provides a reinsurance program for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what you would see in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types – with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biological drugs. Additionally, rather than the RBHAs paying a premium, the capitation rates are instead adjusted

by subtracting the reinsurance offset from the gross medical expenses. One could view the reinsurance offset as a premium.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS will reimburse the RBHA Contractors for covered services incurred above the deductible. The deductible is the responsibility of the RBHA Contractors. The deductible for regular reinsurance cases is $35,000. The limit on other catastrophic reinsurance is $1,000,000. This limit is applied on all reinsurance case types other than transplants. Once a reinsurance case hits this limit, the RBHA Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

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

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

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

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

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

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

The data used to develop the reinsurance offset was encounter data for CYE 18 (base data year). The encounter data was completed and trended forward to CYE 20, using completion and trend factors developed for the benefit costs base data. For regular reinsurance case types, the actuaries then calculated what reinsurance payments would have been made using the CYE 18 completed and trended encounter data as if the reinsurance program had been in effect at that time, using the specific deductibles and coinsurance percentages. Using those calculated reinsurance payments, the actuaries then changed the amounts to a PMPM offset by dividing through by base data year member months for the SMI rate cell. For the other reinsurance case types, the actuaries extracted encounter data using specific diagnosis codes, and/or National Drug Codes (NDCs) to see if any would have created a reinsurance case had reinsurance been in place during CYE 18. The encounter data was completed and specific coinsurance percentages were applied to arrive at the CYE 20 reinsurance amount.

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

I.4.D.i. Rate Development Standards

This section of the 2020 Guide provides information on delivery system and provider payment initiatives authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

The only pre-prints addressed in this certification are the ones related to the RBHA Program. Those pre-prints are FQHC Differential Adjusted Payments, Differential Adjusted Payments, Targeted Investments PCPs, Targeted Investments Behavioral Health, Targeted Investments Hospitals, Targeted Investments Criminal Justice, Access to Professional Services Initiative, and Pediatric Service Initiative. This certification combines the FQHC Differential Adjusted Payments under the Differential Adjusted Payments language and all Targeted Investments under Targeted Investments.

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

Differential Adjusted Payments

The Differential Adjusted Payment (DAP) initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 28.5%, depending on the provider type.

Targeted Investments Program

The Targeted Investments Program is designed to provide a uniform dollar increase to eligible AHCCCS providers to develop systems for integrated care and support ongoing efforts to improve care coordination, increase efficiencies in service delivery, and reduce fragmentation between behavioral health and physical health care.

Access to Professional Services Initiative

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

- A hospital facility with an ACGME-accredited teaching program and which is operated pursuant to the authority in Arizona Statute Title 48, Chapter 31; or,
- A hospital facility with:
    - An ACGME-accredited teaching program with a state university, and

- AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2014; or,
- A freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than one hundred (100) licensed pediatric beds, excluding nursery beds.

The APSI provides a uniform percentage increase of 85% 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 Service Initiative

The Pediatric Service Initiative (PSI) seeks to provide enhanced support to ensure financial viability of the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. In 2014, as the Arizona legislature expanded coverage for adults, it authorized AHCCCS to make uncompensated care payments to the state's freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. CMS approved an extension of the Safety Net Care Pool (SNCP) for freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds, only, "in light of their critical role in Medicaid delivery and as a transition to reforming the current payment system" (CMS demonstration approval letter, Dec. 26, 2013). Independent evaluations of the SNCP confirmed the need for enhanced funding for freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds and recommended that AHCCCS "consider additional policy changes to direct funding to Phoenix Children's Hospital (PCH) and the recipients it serves" should PCH continue to experience uncompensated costs (Evaluation of Safety Net Care Pool Payments for Phoenix Children's Hospital, Navigant, March 29, 2018). The PSI is consistent with AHCCCS' and CMS' shared goals of ensuring financial support through payment rates rather than separate funding pools.

The PSI provides a uniform percentage increase of 36% to otherwise contracted rates for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The rate increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

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

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

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

The SMI and CMDP Child rate cells are affected. See Appendix 6 for medical impact by rate cell. See Appendix 7 for total impact by rate cell.

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

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 4.0% increase), Critical Access Hospitals (eligible for up to 28.5% increase), other hospitals and inpatient facilities (eligible for up to 4.0% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral

health outpatient clinics and integrated clinics (eligible for up to 7.0% increase on all services provided), physicians, physician assistants, registered nurse practitioners, dental providers (all eligible for a 1.0% increase), home and community based services providers (eligible for a 1.0% increase on specified services at specified places of service) and Federally Qualified Health Centers (FQHCs) (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 18 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 20 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

The amount of increased medical payments for the DAP included in the CYE 20 capitation rates for the RBHA program are displayed below in Table 9. These projected medical payments do not include underwriting gain or premium tax. Totals may not add up due to rounding.

Table 9: DAP

GSA	Non-FQHC Dollar Impact	FQHC Dollar Impact	Total Dollar Impact
Central	$2,387,993	$41,006	$2,428,999
North	$470,253	$8,417	$478,669
South	$907,555	$44,073	$951,628
Total	**$3,765,801**	**$93,497**	**$3,859,297**

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

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

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

The Targeted Investments Program, Access to Professional Services Initiative, and Pediatric Service Initiative are not included in the RBHA certified capitation rates and will be paid out via lump sum payments.

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

Targeted Investments Program

Table 10 below includes the CYE 20 anticipated payments including premium tax for each of the Targeted Investment pre-prints. AHCCCS will distribute the final amounts in the form of annual lump sum payments to the Contractors after the completion of the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Table 10: Targeted Investments Dollar Impacts

GSA	TI PCPs	TI Hospitals	TI Behavioral Health	TI Criminal Justice	Total TI
Central	$0	$1,240,249	$16,491,719	$3,697,916	$21,429,884
North	$0	$66,338	$2,406,225	$1,925,766	$4,398,328
South	$0	$247,830	$5,071,705	$482,253	$5,801,787
Total	**$0**	**$1,554,417**	**$23,969,648**	**$6,105,935**	**$31,630,000**

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $5.9 million. AHCCCS will distribute the total payment via three quarterly lump sum payments to the Contractors, and a final lump sum payment after the completion of the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Pediatric Service Initiative

Anticipated payments including premium tax for PSI are approximately $250,000. AHCCCS will distribute the total payment via three quarterly lump sum payments to the Contractors, and a final lump sum payment after the completion of the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

I.4.D.ii.(a)(iii)(B) Providers Receiving Payment

Targeted Investments Program

The providers receiving the payments include primary care physicians, Integrated Clinic providers, Behavioral Health Outpatient Clinics, and hospitals which qualify for the Targeted Investments Program and who demonstrate performance improvement by meeting certain benchmarks for integrating and coordinating physical and behavioral health care.

Access to Professional Services Initiative

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

Pediatric Service Initiative

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

I.4.D.ii.(a)(iii)(C) Distribution Methodology

Targeted Investments Program

The distribution methodology for the TI program for CYE 20 will be based on the utilization of services by members with providers participating in the TI program. Adjudicated and approved encounter data will be used to allocate the TI payments by capitation rate cell. The encounter data that will be used for this distribution includes: billing provider tax IDs (TINs) that were eligible and received payments for the TI program, relevant claim health plan information, relevant rate cell information, and health plan paid (HPP) information. The encounter HPP data for these TINs and claim health plans could exceed the amount that each TIN would receive in TI payments. The encounter data is therefore only used for distribution purposes to calculate the distribution percentage at the capitation rate cell level per TIN and claim health plan. This distribution percentage will then be applied to the actual TI amounts by TIN and claim health plan to derive the amount per capitation rate cell level. Member month data is also utilized to develop the PMPMs for TI payments associated with each rate cell. The estimated amount for CYE 20 TI was developed by using CYE 18 encounter data. The same definition of eligible services was applied for the estimated amount.

Access to Professional Services Initiative

The distribution methodology for the CYE 20 APSI payments will be based on members' utilization of services from APSI qualified providers. The 85 percent uniform percentage increase will be applied to eligible services performed by APSI qualified providers. Eligible services are those submitted on Form CMS-1500s and dental encounters, excluding any subcapitated/block purchase arrangements (identified by CN1 Code 05 on the encounter), and excluding services where AHCCCS is not the primary payer. The estimated amount for CYE 20 APSI was developed by applying the 85 percent uniform increase to CYE 18 utilization of eligible services based on encounters for the CYE 18 APSI qualified providers. The same definition of eligible services was applied for the estimated amount. The APSI qualified providers were identified by Billing Provider Tax IDs in AHCCCS encounter system. The encounter data used to distribute the final payment amounts will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells. The CYE 18 utilization is used as the basis for where to distribute the first three quarterly lump sum payments. The final quarterly lump sum payment will use CYE 20 encounter data for APSI qualified providers. The CYE 20 encounter data used to distribute the final lump sum payment amount will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 18, and thus distribution used to make the three initial quarterly lump sum payments.

Pediatric Service Initiative

The distribution methodology for the CYE 20 PSI will be based on members' utilization of inpatient and outpatient services at freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The 36 percent uniform percentage increase will be applied to eligible services performed by providers eligible for the Pediatric Service Initiative. Eligible services are those submitted on UB-04 Inpatient Hospital and UB-04 Outpatient Hospital. The estimated amount for CYE 20 PSI was developed by applying the 36 percent uniform increase to CYE 18 utilization of eligible services based on encounters for the providers eligible for the Pediatric Services Initiative. The same definition of eligible services was applied for the estimated amount. The providers were identified by Servicing Provider Tax IDs in AHCCCS encounter system. The encounter data used to distribute the final payment amounts will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells. The CYE 18 utilization is used as the basis for where to distribute the first three quarterly lump sum payments. The final quarterly lump sum payments will use CYE 20 encounter data for eligible providers. The CYE 20 encounter data used to distribute the final lump sum payment amount will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 18, and thus distribution used to make the three initial quarterly lump sum payments.

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

Appendix 7 contains estimated PMPMs including premium tax by rate cell.

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

Targeted Investments Program

These payments are being made under the approved Targeted Investment Program § 438.6(c) payment arrangements in a manner consistent with the pre-prints reviewed by CMS.

Access to Professional Services Initiative

AHCCCS has submitted the APSI § 438.6(c) pre-print to CMS, but has not yet received approval. The pre-print will be amended and re-submitted to CMS to include the definition of eligible services listed above in the distribution methodology. The payment arrangement is accounted for in a manner consistent with the amended pre-print.

Pediatric Service Initiative

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

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

Targeted Investments Program

After the rating period is complete and the final TI payments are made, AHCCCS will submit documentation to CMS which incorporates the total amount of the TI payments into the rate certification's rate cells, consistent with the distribution methodology described in Section

I.4.D.ii.(a)(iii)(C), and as if the payment information had been fully known when the rates were initially developed.

Access to Professional Services Initiative

After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology described in Section I.4.D.ii.(a)(iii)(C), and as if the payment information had been fully known when the rates were initially developed.

Pediatric Service Initiative

After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology described in Section I.4.D.ii.(a)(iii)(C), and as if the payment information had been fully known when the rates were initially developed.

I.4.E. Pass-Through Payments

Not applicable. There are no pass-through payments in the CYE 20 capitation rates for the RBHA Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2020 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

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

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

The primary data sources used to develop the administrative component of the CYE 20 capitation rates for the RBHA Program were reported administrative expenses from the CYE 18 audited annual financial statements and CYE 19 Q1 & Q2 unaudited financial statements. In addition, the RBHAs were required to submit supplemental data which included administrative expenses by rate cell for CYE 18 and YTD CYE 19, administrative expense projections for the full year of CYE 19 and CYE 20, and actual and projected membership for those time frames. The supplemental data was then reviewed in conjunction with the non-benefit cost projections developed by the actuaries. Other sources of data reviewed and utilized in the development of the non-benefit cost projections were trends and forecasts for various Consumer Price Indices (CPI) and Employment Cost Indices (ECI) data from IHS Global Insight.

The actuaries developed and reviewed several methodologies for projecting administrative expenses for the RBHAs, comparing results to projections provided by the RBHAs, as well as reviewing the results as a percentage of pre-tax capitation. After reviewing all of the various results, the actuaries judged that due to similar results between the actuaries' projections and the projections from the RBHAs operating in the Central and North GSAs, the Central and North GSA RBHAs' projections for CYE 20 were reasonable, appropriate, and attainable. The CYE 20 projection from the RBHA operating in the South GSA, however, showed an unreasonable amount of growth, not in line with the various combinations of data, assumptions and methodologies reviewed by the actuaries and other members of the DHCM Actuarial Team. As such, the data, assumptions and methodology used to project the administrative expenses assumed in capitation rates for the South GSA is described below.

For the South GSA, administrative expenses related to the SMI and CMDP rate cells from the CYE 18 audited financials, and supplemental administrative expenses related to Crisis-Only rate cells as estimated for CYE 18, were reviewed to calculate a percentage of total administrative expenses, based on administrative line level detail, related to wage earners. The total administrative cost from the two sources was then multiplied by the calculated wage earner-related percentage, and that amount was inflated using the estimated change in CPI for wage earners from CYE 18 to CYE 20. The inflated amount was added back to the non-inflated portion of the total administrative cost for the final projected administrative expense for CYE 20. This methodology was judged to result in the most reasonable, appropriate, and attainable non-benefit cost projection for the South GSA.

The actuaries recognize that the administrative expenses as a percentage of pre-tax capitation rates for the South GSA RBHA are high in comparison to the other GSAs, and judge the variance to be acceptable.

The total CYE 20 administrative expense PMPMs and percentage of the pre-tax capitation rates are displayed below in Table 11. Note that the aggregated PMPM impacts and percentages of pre-tax capitation for the GSAs expressed in this table are calculated across all four rate cells.

Table 11: CYE 20 Administrative Expenses and Percentage of Pre-tax Capitation

GSA	Admin PMPM	Percentage of Pre-tax Capitation
Central	$5.39	7.12%
North	$4.84	7.08%
South	$6.22	9.20%
Total	**$5.57**	**7.67%**

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

The data, assumptions, and methodology used to develop the CYE 20 projected administrative costs are different than the previous rating period and have been documented above. The previous methodology is documented in the CYE 19 actuarial rate certification. The DHCM Actuarial Team determined that the change in methodology was reasonable given the change in the responsibilities of the RBHA Program.

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

No other material adjustments were applied to the projected non-benefit costs of the CYE 20 capitation rates for the RBHA Program.

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

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

The administrative component of the CYE 20 capitation rates for the RBHA Program is described above in Section I.5.B.i. (a).

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

The CYE 20 capitation rates for the RBHA Program include a provision of 2.0% for premium tax. The premium tax is applied to the total capitation. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. 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 20 capitation rates for the RBHA Program include a provision of 1.0% for underwriting gain.

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

There are no other material non-benefit costs added to the non-benefit component for the CYE 20 capitation rates for the RBHA Program.

I.5.B.iii. Health Insurance Providers Fee

I.5.B.iii.(a) Address if in Rates

The capitation rates for the RBHA Program reflected in this rate certification do not incorporate the Health Insurance Providers Fee (HIPF). AHCCCS will follow previous capitation rate methodologies for the HIPF in which capitation rates are amended to reflect the calculated HIPF and related tax impacts, except in years where there is a moratorium and no capitation rate adjustment happens. AHCCCS

intends to submit a new actuarial certification due to this update, except in years where there is a moratorium and no capitation rate adjustment happens.

I.5.B.iii.(b) Data Year or Fee Year

Not applicable. The HIPF is not incorporated into the CYE 20 capitation rates for the RBHA Program.

I.5.B.iii.(c) Description of how Fee was Determined

Not applicable. The HIPF is not incorporated into the CYE 20 capitation rates for the RBHA Program.

I.5.B.iii.(d) Address if not in Rates

The capitation rates in this certification do not include the fee because the rates will be adjusted to account for the fee at a later date, except in years where there is a moratorium and no capitation rate adjustment happens. If there is no moratorium, a new certification will be submitted with the rate impacts to CMS once the fees are known.

The PMPM capitation adjustments will be developed based on the HIPF liability reported to AHCCCS. The Contractors are notified of the HIPF liability for the entire corporate entity by the Treasury Department. The Contractors who receive multiple streams of revenue applicable to the HIPF calculation will be responsible for allocating an appropriate portion of their HIPF liability to AHCCCS, which will be verified by the AHCCCS DHCM Actuarial Team for reasonableness and appropriateness. To determine if the reported revenue and the HIPF liability allocations to AHCCCS from the Contractors is reasonable and appropriate, the AHCCCS DHCM Actuarial Team will review for each Contractor the HIPF liability allocated to AHCCCS as a percentage of the total HIPF liability from the IRS, and the revenue allocated to AHCCCS as a percentage of the total revenue reported to the IRS. Additionally, the AHCCCS DHCM Actuarial Team will compare the revenue allocated to each AHCCCS program from each Contractor against paid capitation data and determine if the revenue allocated by Contractor to each AHCCCS program is reasonable and appropriate.

As in previous years, the PMPM adjustments will be developed based on each corporate entity's actual member months within each applicable rate cell. The HIPF adjustment to the capitation rates is expected to be calculated late in the fee year.

I.5.B.iii.(e) Summary of Benefits Under 26 CFR § 57.2(h)(2)(ix)

The portion of the CYE 20 capitation rates for the RBHA Program attributable to nursing facility services, and related home and community based services, for 90 days of short-term convalescent care are located below in Table 12.

Table 12: Portion of the CYE 20 Capitation Rates for HCBS and NF

Rate Cell	Central	North	South
	HCBS/NF	HCBS/NF	HCBS/NF
SMI	$65.19	$11.07	$19.53
CMDP Child	$11.73	$64.98	$40.99

I.5.B.iii.(f) Historical HIPF Fees in Capitation Rates

For any HIPF that has been paid in 2014, 2015, 2016, and/or 2018, the HIPF has been included in the capitation rates as a retroactive amendment to the initially certified capitation rates.

I.6. Risk Adjustment and Acuity Adjustments

Not applicable. The CYE 20 capitation rates for the RBHA program do not include risk adjustment or acuity adjustment.

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

Section II of the 2020 Medicaid Managed Care Rate Development Guide is not applicable to the RBHA Program. Managed long-term services and supports, as defined at 42 CFR § 438.2 at 81 FR 27855, are not covered services under the RBHA Program. The RBHA 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

Section III of the 2020 Medicaid Managed Care Rate Development Guide is not applicable to the RBHA Program, as there have been no changes to the capitation rate development process in this regard.

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

Prior to January 1, 2014, the RBHA Program did not have a separate rate cell for the childless adults up to 100% FPL population. This population would have been included in the various adult rate cells which existed at the time, without any delineation between the members based on their income. After January 1, 2014, the RBHA Program rate cell structure included the new adult group in the various adult rate cells which existed at the time, without any delineation between the members based on their income. The RBHA Program has never analyzed the new adult group separate of other members, and there are no data, assumptions, or methodologies specific to the new adult group within any rate cell. The CYE 20 capitation rates for the RBHA Program have continued this approach.

Appendix 1: Actuarial Certification

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

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 20 capitation rates for the RBHA Program have been documented according to the guidelines established by CMS in the 2020 Guide. The CYE 20 capitation rates for the RBHA Program are effective for the twelve month time period from October 1, 2019 through September 30, 2020.

The actuarially sound capitation rates are based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rates, we have relied upon data, information, and the professional judgment provided by teams at AHCCCS and the RBHAs. We have relied upon AHCCCS and the RBHAs for the accuracy of the data and we have accepted the data without audit, after checking the data for reasonableness and consistency unless stated otherwise.

SIGNATURE ON FILE	August 15, 2019
Erica Johnson	Date

Associate, Society of Actuaries
Member, American Academy of Actuaries

SIGNATURE ON FILE	August 15, 2019
Windy J. Marks	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Central GSA

Rate Cell	CYE 20 Capitation Rate
SMI	$2,574.76
CMDP Child	$817.98
Crisis-only Adult	$8.79
Crisis-only Child	$1.36

North GSA

Rate Cell	CYE 20 Capitation Rate
SMI	$1,493.14
CMDP Child	$1,225.27
Crisis-only Adult	$4.80
Crisis-only Child	$1.47

South GSA

Rate Cell	CYE 20 Capitation Rate
SMI	$1,649.28
CMDP Child	$1,017.84
Crisis-only Adult	$11.58
Crisis-only Child	$2.74

Appendix 3: Comparisons and Fiscal Impact Summary

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

Central GSA

Rate Cell	CYE 20 Capitation Rate	CYE 19 Capitation Rate (includes APSI)	% Change
SMI	$2,574.76	$2,368.16	8.7%
CMDP Child	$817.98	$762.00	7.3%

North GSA

Rate Cell	CYE 20 Capitation Rate	CYE 19 Capitation Rate (includes APSI)	% Change
SMI	$1,493.14	$1,466.58	1.8%
CMDP Child	$1,225.27	$1,266.40	-3.2%

South GSA

Rate Cell	CYE 20 Capitation Rate	CYE 19 Capitation Rate (includes APSI)	% Change
SMI	$1,649.28	$1,706.25	-3.3%
CMDP Child	$1,017.84	$970.35	4.9%

Totals may not add up due to rounding.

Appendix 3b: Fiscal Impact Summary

Central GSA

Rate Cell	CYE 20 Projected MMs	CYE 20 Capitation Rate	CYE 20 Projected Expenses
SMI	275,719	$2,574.76	$709,910,005
CMDP Child	97,658	$817.98	$79,881,622
Other Adult	5,141,516	$8.79	$45,183,586
Other Child	5,380,520	$1.36	$7,343,725
Total	**10,895,412**	**$77.31**	**$842,318,939**

North GSA

Rate Cell	CYE 20 Projected MMs	CYE 20 Capitation Rate	CYE 20 Projected Expenses
SMI	71,046	$1,493.14	$106,081,017
CMDP Child	15,671	$1,225.27	$19,201,747
Other Adult	1,028,874	$4.80	$4,940,684
Other Child	769,365	$1.47	$1,128,712
Total	**1,884,956**	**$69.68**	**$131,352,160**

South GSA

Rate Cell	CYE 20 Projected MMs	CYE 20 Capitation Rate	CYE 20 Projected Expenses
SMI	166,402	$1,649.28	$274,442,720
CMDP Child	41,458	$1,017.84	$42,198,142
Other Adult	2,676,236	$11.58	$30,986,631
Other Child	2,244,084	$2.74	$6,149,652
Total	**5,128,180**	**$68.99**	**$353,777,145**

Totals may not add up due to rounding.

Appendix 4: Base Data and Base Data Adjustments

GSA: Central
Rate Cell: SMI
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 268,548
Projection Period Member Months: 275,719

	Non-Subcapitated/Block Payment Base Data			Subcapitated/Block Payment Base Data										
Category of Service	PMPM	Completion	Adjusted PMPM	PMPM	Completion	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Pharmacy Reimb. Savings	BH NEMT	Comb. Misc. Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.00	0.9736	$0.00	$11.73	0.9736	$12.05	$12.05	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$12.05
Case Management	$2.63	0.9736	$2.70	$216.00	0.9736	$221.84	$224.55	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$224.55
Crisis Intervention Services	$0.50	0.9736	$0.51	$60.56	0.9736	$62.20	$62.71	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$62.71
Dental Services	$1.39	0.9736	$1.43	$0.02	0.9736	$0.02	$1.45	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.45
FQHC/RHC	$16.39	0.9736	$16.83	$0.01	0.9736	$0.01	$16.85	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$16.85
Inpatient Behavioral Health	$162.08	0.9045	$179.20	$8.24	0.9461	$8.71	$187.91	7.19%	-7.17%	0.00%	0.00%	0.00%	-0.92%	$185.27
Inpatient Hospital	$222.33	0.8906	$249.65	$0.00	0.8906	$0.00	$249.65	0.00%	0.00%	0.00%	0.00%	0.00%	-0.25%	$249.03
Medical Services	$106.45	0.9736	$109.33	$80.94	0.9736	$83.13	$192.46	0.00%	0.00%	-2.34%	0.00%	0.00%	0.00%	$187.94
Nursing Facility (Short-term)	$9.02	0.8906	$10.13	$0.00	0.8906	$0.00	$10.13	0.00%	0.00%	0.00%	0.00%	0.00%	-1.31%	$9.99
Other Services	$14.24	0.9736	$14.62	$0.90	0.9736	$0.93	$15.55	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$15.55
Outpatient Hospital	$93.67	0.9406	$99.59	$0.00	0.9406	$0.00	$99.59	0.00%	0.00%	0.00%	0.00%	0.00%	-0.42%	$99.17
Pharmacy	$410.09	0.9877	$415.19	$0.00	0.9877	$0.00	$415.19	0.00%	0.00%	0.00%	-3.84%	0.00%	-0.40%	$397.66
Rehabilitation Services	$0.63	0.9736	$0.64	$172.56	0.9736	$177.23	$177.88	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$177.88
Residential Services	$133.32	0.9736	$136.92	$7.21	0.9736	$7.41	$144.33	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$144.33
Support Services	$2.92	0.9736	$3.00	$89.45	0.9736	$91.87	$94.87	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$94.87
Transportation	$133.53	0.9736	$137.15	$19.84	0.9736	$20.37	$157.52	0.00%	0.00%	0.00%	0.00%	-3.30%	0.00%	$152.33
Treatment Services	$23.38	0.9736	$24.02	$82.11	0.9736	$84.33	$108.34	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$108.34
Gross Medical	**$1,332.57**		**$1,400.92**	**$749.57**		**$770.11**	**$2,171.03**							**$2,139.97**

GSA: Central
Rate Cell: CMDP Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 105,096
Projection Period Member Months: 97,658

	Non-Subcapitated/Block Payment Base Data			Subcapitated/Block Payment Base Data										
Category of Service	PMPM	Completion	Adjusted PMPM	PMPM	Completion	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Pharmacy Reimb. Savings	BH NEMT	Comb. Misc. Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.00	0.9736	$0.00	$0.22	0.9736	$0.22	$0.22	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.22
Case Management	$0.85	0.9736	$0.88	$137.07	0.9736	$140.78	$141.66	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$141.66
Crisis Intervention Services	$0.07	0.9736	$0.07	$18.53	0.9736	$19.04	$19.11	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$19.11
Dental Services	$0.00	0.9736	$0.00	$0.00	0.9736	$0.00	$0.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.01
FQHC/RHC	$0.08	0.9736	$0.08	$0.00	0.9736	$0.00	$0.08	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.08
Inpatient Behavioral Health	$131.13	0.8937	$146.72	$0.32	0.9736	$0.33	$147.05	0.00%	0.00%	0.00%	0.00%	0.00%	-0.07%	$146.96
Inpatient Hospital	$13.01	0.8906	$14.60	$0.00	0.8906	$0.00	$14.60	0.00%	0.00%	0.00%	0.00%	0.00%	0.07%	$14.61
Medical Services	$0.59	0.9736	$0.60	$7.28	0.9736	$7.48	$8.08	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$8.08
Nursing Facility (Short-term)	$0.00	0.8906	$0.00	$0.00	0.8906	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.00	0.9736	$0.00	$0.00	0.9736	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Outpatient Hospital	$0.02	0.9406	$0.02	$0.37	0.9406	$0.40	$0.41	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.41
Pharmacy	$23.48	0.9877	$23.77	$0.00	0.9877	$0.00	$23.77	0.00%	0.00%	0.00%	-5.66%	0.00%	0.00%	$22.43
Rehabilitation Services	$2.91	0.9736	$2.99	$84.53	0.9736	$86.82	$89.81	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$89.81
Residential Services	$29.48	0.9736	$30.28	$0.97	0.9736	$1.00	$31.27	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$31.27
Support Services	$33.92	0.9736	$34.84	$22.75	0.9736	$23.36	$58.21	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$58.21
Transportation	$15.61	0.9736	$16.03	$5.42	0.9736	$5.57	$21.60	0.00%	0.00%	0.00%	0.00%	-3.43%	0.00%	$20.86
Treatment Services	$2.40	0.9736	$2.47	$87.11	0.9736	$89.47	$91.94	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$91.94
Gross Medical	**$253.54**		**$273.35**	**$364.59**		**$374.47**	**$647.82**							**$645.65**

GSA: North
Rate Cell: SMI
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 72,463
Projection Period Member Months: 71,046

	Non-Subcapitated/Block Payment Base Data			Subcapitated/Block Payment Base Data										
Category of Service	PMPM	Completion	Adjusted PMPM	PMPM	Completion	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Pharmacy Reimb. Savings	BH NEMT	Comb. Misc. Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.00	0.9714	$0.00	$0.01	0.9714	$0.01	$0.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.01
Case Management	$0.46	0.9714	$0.48	$106.47	0.9714	$109.60	$110.08	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$110.08
Crisis Intervention Services	$1.41	0.9714	$1.45	$18.22	0.9714	$18.75	$20.21	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$20.21
Dental Services	$1.23	0.9714	$1.27	$0.03	0.9714	$0.03	$1.30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.30
FQHC/RHC	$12.79	0.9714	$13.16	$0.03	0.9714	$0.03	$13.19	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.19
Inpatient Behavioral Health	$32.85	0.9148	$35.91	$70.61	0.9048	$78.03	$113.94	0.49%	-0.30%	0.00%	0.00%	0.00%	-0.75%	$113.29
Inpatient Hospital	$65.20	0.9000	$72.44	$0.00	0.9000	$0.00	$72.44	0.00%	0.00%	0.00%	0.00%	0.00%	-0.28%	$72.24
Medical Services	$70.44	0.9714	$72.52	$23.94	0.9714	$24.65	$97.17	0.00%	0.00%	-0.08%	0.00%	0.00%	0.00%	$97.09
Nursing Facility (Short-term)	$4.49	0.9000	$4.99	$0.00	0.9000	$0.00	$4.99	0.00%	0.00%	0.00%	0.00%	0.00%	-1.27%	$4.93
Other Services	$3.52	0.9714	$3.63	$9.10	0.9714	$9.37	$12.99	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$12.99
Outpatient Hospital	$97.84	0.9229	$106.01	$0.00	0.9229	$0.00	$106.02	0.00%	0.00%	0.00%	0.00%	0.00%	-0.26%	$105.74
Pharmacy	$250.89	0.9857	$254.52	$0.00	0.9857	$0.00	$254.52	0.00%	0.00%	0.00%	-1.85%	0.00%	-0.25%	$249.19
Rehabilitation Services	$2.67	0.9714	$2.75	$82.85	0.9714	$85.29	$88.04	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$88.04
Residential Services	$97.99	0.9714	$100.88	$54.80	0.9714	$56.42	$157.30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$157.30
Support Services	$1.19	0.9714	$1.22	$53.19	0.9714	$54.75	$55.97	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$55.97
Transportation	$42.88	0.9714	$44.14	$54.54	0.9714	$56.15	$100.29	0.00%	0.00%	0.00%	0.00%	3.83%	0.00%	$104.13
Treatment Services	$3.81	0.9714	$3.93	$63.58	0.9714	$65.45	$69.38	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$69.38
Gross Medical	**$689.66**		**$719.30**	**$537.36**		**$558.54**	**$1,277.84**							**$1,275.07**

GSA: North
Rate Cell: CMDP Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 14,984
Projection Period Member Months: 15,671

	Non-Subcapitated/Block Payment Base Data			Subcapitated/Block Payment Base Data										
Category of Service	PMPM	Completion	Adjusted PMPM	PMPM	Completion	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Pharmacy Reimb. Savings	BH NEMT	Comb. Misc. Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.00	0.9714	$0.00	$0.00	0.9714	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Case Management	$10.10	0.9714	$10.40	$179.82	0.9714	$185.12	$195.52	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$195.52
Crisis Intervention Services	$1.14	0.9714	$1.17	$6.49	0.9714	$6.68	$7.85	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$7.85
Dental Services	$0.00	0.9714	$0.00	$0.02	0.9714	$0.02	$0.02	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.02
FQHC/RHC	$0.02	0.9714	$0.02	$0.00	0.9714	$0.00	$0.02	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.02
Inpatient Behavioral Health	$138.53	0.9006	$153.82	$0.79	0.9714	$0.81	$154.63	0.00%	0.00%	0.00%	0.00%	0.00%	-0.07%	$154.51
Inpatient Hospital	$3.38	0.9000	$3.75	$0.00	0.9000	$0.00	$3.75	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3.75
Medical Services	$0.65	0.9714	$0.67	$6.89	0.9714	$7.09	$7.76	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$7.76
Nursing Facility (Short-term)	$0.00	0.9000	$0.00	$0.00	0.9000	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.00	0.9714	$0.00	$0.00	0.9714	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Outpatient Hospital	$0.00	0.9229	$0.00	$0.00	0.9229	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Pharmacy	$22.25	0.9857	$22.57	$0.00	0.9857	$0.00	$22.57	0.00%	0.00%	0.00%	-4.50%	0.00%	0.00%	$21.55
Rehabilitation Services	$1.53	0.9714	$1.58	$108.60	0.9714	$111.81	$113.38	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$113.38
Residential Services	$72.50	0.9714	$74.64	$8.05	0.9714	$8.28	$82.92	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$82.92
Support Services	$197.90	0.9714	$203.74	$81.53	0.9714	$83.93	$287.67	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$287.67
Transportation	$13.04	0.9714	$13.43	$25.19	0.9714	$25.93	$39.35	0.00%	0.00%	0.00%	0.00%	5.82%	0.00%	$41.65
Treatment Services	$22.76	0.9714	$23.43	$91.78	0.9714	$94.48	$117.92	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$117.92
Gross Medical	**$483.80**		**$509.21**	**$509.15**		**$524.16**	**$1,033.37**							**$1,034.53**

GSA: South
Rate Cell: SMI
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 167,071
Projection Period Member Months: 166,402

	Non-Subcapitated/Block Payment Base Data			Subcapitated/Block Payment Base Data										
Category of Service	PMPM	Completion	Adjusted PMPM	PMPM	Completion	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Pharmacy Reimb. Savings	BH NEMT	Comb. Misc. Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.14	0.9523	$0.15	$1.90	0.9523	$2.00	$2.15	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.15
Case Management	$9.46	0.9523	$9.93	$76.77	0.9523	$80.62	$90.55	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$90.55
Crisis Intervention Services	$7.90	0.9523	$8.30	$73.31	0.9523	$76.98	$85.28	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$85.28
Dental Services	$0.59	0.9523	$0.62	$0.01	0.9523	$0.01	$0.63	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.63
FQHC/RHC	$28.66	0.9523	$30.09	$1.47	0.9523	$1.54	$31.64	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$31.64
Inpatient Behavioral Health	$118.25	0.9000	$131.38	$18.39	0.9523	$19.31	$150.69	2.21%	-4.53%	0.00%	0.00%	0.00%	-0.61%	$146.14
Inpatient Hospital	$116.86	0.8900	$131.31	$0.00	0.8900	$0.00	$131.31	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%	$131.55
Medical Services	$95.32	0.9523	$100.09	$47.17	0.9523	$49.53	$149.63	0.00%	0.00%	-1.22%	0.00%	0.00%	-0.31%	$147.34
Nursing Facility (Short-term)	$12.22	0.8900	$13.73	$0.00	0.8900	$0.00	$13.73	0.00%	0.00%	0.00%	0.00%	0.00%	-1.17%	$13.57
Other Services	$13.11	0.9523	$13.77	$0.03	0.9523	$0.03	$13.80	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.80
Outpatient Hospital	$83.97	0.9275	$90.54	$0.03	0.9275	$0.03	$90.57	0.00%	0.00%	0.00%	0.00%	0.00%	-0.22%	$90.37
Pharmacy	$237.11	0.9839	$241.00	$0.00	0.9839	$0.00	$241.00	0.00%	0.00%	0.00%	-2.34%	0.00%	-0.85%	$233.34
Rehabilitation Services	$13.40	0.9523	$14.08	$39.03	0.9523	$40.99	$55.07	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$55.07
Residential Services	$53.63	0.9523	$56.32	$42.24	0.9523	$44.35	$100.67	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$100.67
Support Services	$18.01	0.9523	$18.91	$18.39	0.9523	$19.31	$38.22	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$38.22
Transportation	$61.42	0.9523	$64.49	$20.91	0.9523	$21.96	$86.45	0.00%	0.00%	0.00%	0.00%	4.83%	0.00%	$90.63
Treatment Services	$21.71	0.9523	$22.80	$80.05	0.9523	$84.06	$106.87	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$106.87
Gross Medical	**$891.76**		**$947.50**	**$419.70**		**$440.73**	**$1,388.22**							**$1,377.80**

GSA: South
Rate Cell: CMDP Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 46,224
Projection Period Member Months: 41,458

	Non-Subcapitated/Block Payment Base Data			Subcapitated/Block Payment Base Data										
Category of Service	PMPM	Completion	Adjusted PMPM	PMPM	Completion	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Pharmacy Reimb. Savings	BH NEMT	Comb. Misc. Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.02	0.9523	$0.02	$2.39	0.9523	$2.51	$2.53	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.53
Case Management	$17.42	0.9523	$18.30	$106.51	0.9523	$111.85	$130.14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$130.14
Crisis Intervention Services	$5.01	0.9523	$5.26	$17.25	0.9523	$18.11	$23.38	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$23.38
Dental Services	$0.00	0.9523	$0.00	$0.01	0.9523	$0.01	$0.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.01
FQHC/RHC	$3.05	0.9523	$3.20	$0.12	0.9523	$0.12	$3.32	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3.32
Inpatient Behavioral Health	$93.76	0.8936	$104.93	$6.55	0.9523	$6.88	$111.81	0.00%	0.00%	0.00%	0.00%	0.00%	-0.08%	$111.72
Inpatient Hospital	$2.64	0.8900	$2.97	$0.00	0.8900	$0.00	$2.97	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.97
Medical Services	$0.90	0.9523	$0.94	$12.77	0.9523	$13.41	$14.35	0.00%	0.00%	0.00%	0.00%	0.00%	-0.58%	$14.27
Nursing Facility (Short-term)	$0.00	0.8900	$0.00	$0.00	0.8900	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.00	0.9523	$0.00	$0.00	0.9523	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Outpatient Hospital	$0.36	0.9275	$0.39	$0.00	0.9275	$0.00	$0.39	0.00%	0.00%	0.00%	0.00%	0.00%	-0.14%	$0.39
Pharmacy	$20.57	0.9839	$20.90	$0.00	0.9839	$0.00	$20.90	0.00%	0.00%	0.00%	-1.66%	0.00%	0.00%	$20.56
Rehabilitation Services	$7.26	0.9523	$7.63	$33.25	0.9523	$34.92	$42.54	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$42.54
Residential Services	$123.40	0.9523	$129.58	$6.61	0.9523	$6.94	$136.52	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$136.52
Support Services	$92.95	0.9523	$97.61	$25.15	0.9523	$26.41	$124.02	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$124.02
Transportation	$6.43	0.9523	$6.76	$27.39	0.9523	$28.76	$35.52	0.00%	0.00%	0.00%	0.00%	5.91%	0.00%	$37.62
Treatment Services	$30.68	0.9523	$32.22	$138.09	0.9523	$145.01	$177.22	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$177.22
Gross Medical	**$404.46**		**$430.71**	**$376.08**		**$394.93**	**$825.64**							**$827.21**

Appendix 5: Projected Benefit Cost Trends

Central				
Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	1.5%	3.0%	4.5%
SMI	Inpatient Hospital	0.0%	3.0%	3.0%
SMI	Medical Services	2.0%	0.0%	2.0%
SMI	Other Services	0.0%	1.5%	1.5%
SMI	Pharmacy	1.0%	14.0%	15.1%
SMI	Rehabilitation/Treatment Services	1.5%	1.0%	2.5%
SMI	Residential Services	0.0%	0.0%	0.0%
SMI	Support Services	0.0%	1.0%	1.0%
CMDP Child	Inpatient Behavioral Health	4.5%	0.5%	5.0%
CMDP Child	Inpatient Hospital	0.0%	0.0%	0.0%
CMDP Child	Medical Services	3.0%	1.5%	4.5%
CMDP Child	Other Services	0.5%	0.5%	1.0%
CMDP Child	Pharmacy	2.0%	3.5%	5.6%
CMDP Child	Rehabilitation/Treatment Services	6.5%	0.0%	6.5%
CMDP Child	Residential Services	3.0%	1.0%	4.0%
CMDP Child	Support Services	2.0%	2.0%	4.0%

North				
Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	0.0%	1.5%	1.5%
SMI	Inpatient Hospital	-0.5%	2.0%	1.5%
SMI	Medical Services	1.0%	-0.5%	0.5%
SMI	Other Services	1.0%	4.5%	5.5%
SMI	Pharmacy	0.0%	5.5%	5.5%
SMI	Rehabilitation/Treatment Services	0.5%	-0.5%	0.0%
SMI	Residential Services	-0.5%	0.5%	0.0%
SMI	Support Services	0.5%	-0.5%	0.0%
CMDP Child	Inpatient Behavioral Health	1.0%	3.0%	4.0%
CMDP Child	Inpatient Hospital	0.0%	0.0%	0.0%
CMDP Child	Medical Services	1.5%	1.5%	3.0%
CMDP Child	Other Services	1.5%	0.5%	2.0%
CMDP Child	Pharmacy	3.0%	2.0%	5.1%
CMDP Child	Rehabilitation/Treatment Services	2.0%	0.0%	2.0%
CMDP Child	Residential Services	1.5%	1.0%	2.5%
CMDP Child	Support Services	1.5%	0.0%	1.5%

South				
Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	1.5%	1.5%	3.0%
SMI	Inpatient Hospital	0.5%	0.5%	1.0%
SMI	Medical Services	0.5%	1.0%	1.5%
SMI	Other Services	1.0%	1.0%	2.0%
SMI	Pharmacy	1.0%	4.5%	5.5%
SMI	Rehabilitation/Treatment Services	0.0%	0.0%	0.0%
SMI	Residential Services	3.0%	0.0%	3.0%
SMI	Support Services	1.0%	0.0%	1.0%
CMDP Child	Inpatient Behavioral Health	2.5%	2.0%	4.6%
CMDP Child	Inpatient Hospital	0.0%	0.0%	0.0%
CMDP Child	Medical Services	1.5%	1.5%	3.0%
CMDP Child	Other Services	0.0%	4.0%	4.0%
CMDP Child	Pharmacy	3.5%	2.0%	5.6%
CMDP Child	Rehabilitation/Treatment Services	2.5%	-0.5%	2.0%
CMDP Child	Residential Services	2.5%	-1.0%	1.5%
CMDP Child	Support Services	2.5%	-0.5%	2.0%

Appendix 6: CYE 20 Capitation Rate Development

GSA: Central
Rate Cell: SMI
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 268,548
Projection Period Member Months: 275,719

Category of Service	Adjusted Base PMPM	Trend	P&T Decisions	Telehealth	Fee Schedule Changes/Min Wage	Behavioral Health In Schools	Crisis Adjustments	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$12.05	1.50%	0.00%	0.00%	0.73%	0.00%	0.00%	0.00%	$12.50
Case Management	$224.55	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.17%	$229.45
Crisis Intervention Services	$62.71	1.50%	0.00%	0.00%	0.73%	0.00%	33.20%	0.00%	$86.69
Dental Services	$1.45	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.49
FQHC/RHC	$16.85	1.50%	0.00%	0.00%	1.00%	0.00%	0.00%	0.00%	$17.53
Inpatient Behavioral Health	$185.27	4.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$202.49
Inpatient Hospital	$249.03	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$264.19
Medical Services	$187.94	2.00%	0.00%	0.04%	0.40%	0.00%	0.00%	0.06%	$196.51
Nursing Facility (Short-term)	$9.99	1.50%	0.00%	0.00%	7.60%	0.00%	0.00%	0.00%	$11.08
Other Services	$15.55	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$16.02
Outpatient Hospital	$99.17	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$102.16
Pharmacy	$397.66	15.14%	1.12%	0.00%	0.00%	0.00%	0.00%	-0.75%	$529.12
Rehabilitation Services	$177.88	2.51%	0.00%	0.00%	0.73%	0.00%	0.00%	0.00%	$188.30
Residential Services	$144.33	0.00%	0.00%	0.00%	0.73%	0.00%	0.00%	1.01%	$146.86
Support Services	$94.87	1.00%	0.00%	0.15%	6.95%	0.00%	0.00%	0.00%	$103.67
Transportation	$152.33	1.00%	0.00%	0.00%	1.20%	0.00%	0.00%	-1.68%	$154.61
Treatment Services	$108.34	2.51%	0.00%	0.07%	0.73%	0.00%	0.00%	0.00%	$114.77
Gross Medical	**$2,139.97**	**4.57%**	**0.25%**	**0.01%**	**0.60%**	**0.00%**	**0.91%**	**-0.20%**	**$2,377.46**

Total DAP	**$8.07**
Total Gross Medical PMPM	**$2,385.53**
Reinsurance Offset	**($67.15)**
Total Net Medical PMPM	**$2,318.39**

Differential Adjusted Payments (DAP)	
Non-FQHC	$7.92
FQHC	$0.15
Total DAP	**$8.07**

Non-benefit Expenses	PMPM
Admin	$179.65
Total Medical with Admin	$2,498.03
UW Gain	$25.23
Pre-tax Capitation PMPM	$2,523.27
Premium Tax	$51.50
Capitation PMPM	**$2,574.76**

GSA: Central
Rate Cell: CMDP Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 105,096
Projection Period Member Months: 97,658

Category of Service	Adjusted Base PMPM	Trend	P&T Decisions	Telehealth	Fee Schedule Changes/Min Wage	Behavioral Health In Schools	Crisis Adjustments	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$0.22	1.00%	0.00%	0.00%	0.55%	0.00%	0.00%	0.00%	$0.23
Case Management	$141.66	4.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.22%	$153.67
Crisis Intervention Services	$19.11	1.00%	0.00%	0.00%	0.55%	0.00%	48.74%	0.00%	$29.15
Dental Services	$0.01	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.01
FQHC/RHC	$0.08	1.00%	0.00%	0.00%	1.59%	0.00%	0.00%	0.00%	$0.08
Inpatient Behavioral Health	$146.96	5.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$162.09
Inpatient Hospital	$14.61	5.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$16.12
Medical Services	$8.08	4.54%	0.00%	0.27%	2.24%	0.00%	0.00%	0.15%	$9.06
Nursing Facility (Short-term)	$0.00	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.00	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Outpatient Hospital	$0.41	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.42
Pharmacy	$22.43	5.57%	1.32%	0.00%	0.00%	0.00%	0.00%	-0.75%	$25.13
Rehabilitation Services	$89.81	6.50%	0.00%	0.00%	0.55%	0.00%	0.00%	0.71%	$103.16
Residential Services	$31.27	4.03%	0.00%	0.00%	0.55%	0.00%	0.00%	0.00%	$34.03
Support Services	$58.21	4.04%	0.00%	0.08%	2.37%	0.00%	0.00%	0.00%	$64.54
Transportation	$20.86	4.04%	0.00%	0.00%	0.62%	0.00%	0.00%	-1.86%	$22.30
Treatment Services	$91.94	6.50%	0.00%	0.16%	0.55%	8.98%	0.00%	0.00%	$114.46
Gross Medical	**$645.65**	**4.95%**	**0.05%**	**0.03%**	**0.46%**	**1.32%**	**1.31%**	**0.06%**	**$734.45**

Total DAP	**$2.08**
Total Gross Medical PMPM	**$736.53**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$736.53**

Differential Adjusted Payments (DAP)	
Non-FQHC	$2.08
FQHC	$0.00
Total DAP	**$2.08**

Non-benefit Expenses	PMPM
Admin	$57.07
Total Medical with Admin	$793.60
UW Gain	$8.02
Pre-tax Capitation PMPM	$801.62
Premium Tax	$16.36
Capitation PMPM	**$817.98**

GSA: Central
Rate Cell: Crisis Adult
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 5,078,049
Projection Period Member Months: 5,141,516

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$4.82	0.9537	$5.05	N/A	$1.99	$7.05
Ancillary Crisis Services	$0.80	0.9537	$0.84	1.5%	$0.00	$0.87
Gross Medical	**$5.62**		**$5.89**			**$7.91**

Total Gross Medical PMPM	**$7.91**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$7.91**

Non-benefit Expenses	PMPM
Admin	$0.61
Total Medical with Admin	$8.53
UW Gain	$0.09
Pre-tax Capitation PMPM	$8.61
Premium Tax	$0.18
Capitation PMPM	**$8.79**

GSA: Central
Rate Cell: Crisis Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 5,409,190
Projection Period Member Months: 5,380,520

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$0.67	0.9553	$0.70	N/A	$0.29	$0.99
Ancillary Crisis Services	$0.22	0.9537	$0.23	1.0%	$0.00	$0.24
Gross Medical	**$0.89**		**$0.93**			**$1.23**

Total Gross Medical PMPM	**$1.23**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$1.23**

Non-benefit Expenses	PMPM
Admin	$0.10
Total Medical with Admin	$1.32
UW Gain	$0.01
Pre-tax Capitation PMPM	$1.34
Premium Tax	$0.03
Capitation PMPM	**$1.36**

GSA: North
Rate Cell: SMI
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 72,463
Projection Period Member Months: 71,046

Category of Service	Adjusted Base PMPM	Trend	P&T Decisions	Telehealth	Fee Schedule Changes/Min Wage	Behavioral Health In Schools	Crisis Adjustments	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$0.01	5.55%	0.00%	0.00%	1.11%	0.00%	0.00%	0.00%	$0.01
Case Management	$110.08	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.17%	$110.26
Crisis Intervention Services	$20.21	5.55%	0.00%	0.00%	1.11%	0.00%	51.76%	0.00%	$34.54
Dental Services	$1.30	5.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.44
FQHC/RHC	$13.19	5.55%	0.00%	0.00%	0.43%	0.00%	0.00%	0.00%	$14.76
Inpatient Behavioral Health	$113.29	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$116.71
Inpatient Hospital	$72.24	1.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$74.41
Medical Services	$97.09	0.50%	0.00%	0.92%	0.16%	0.00%	0.00%	0.16%	$99.27
Nursing Facility (Short-term)	$4.93	5.55%	0.00%	0.00%	6.84%	0.00%	0.00%	0.00%	$5.86
Other Services	$12.99	5.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.48
Outpatient Hospital	$105.74	5.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$117.79
Pharmacy	$249.19	5.50%	-0.62%	0.00%	0.00%	0.00%	0.00%	-0.94%	$273.03
Rehabilitation Services	$88.04	0.00%	0.00%	0.00%	1.11%	0.00%	0.00%	0.00%	$89.01
Residential Services	$157.30	0.00%	0.00%	0.00%	1.11%	0.00%	0.00%	0.45%	$159.75
Support Services	$55.97	0.00%	0.00%	3.24%	2.02%	0.00%	0.00%	0.00%	$58.95
Transportation	$104.13	0.00%	0.00%	0.00%	1.92%	0.00%	0.00%	-0.81%	$105.28
Treatment Services	$69.38	0.00%	0.00%	1.31%	1.11%	0.00%	0.00%	0.00%	$71.06
Gross Medical	**$1,275.07**	**2.05%**	**-0.13%**	**0.27%**	**0.56%**	**0.00%**	**0.88%**	**-0.18%**	**$1,346.61**

Total DAP	**$6.36**
Total Gross Medical PMPM	**$1,352.97**
Reinsurance Offset	**($7.99)**
Total Net Medical PMPM	**$1,344.98**

Differential Adjusted Payments (DAP)	
Non-FQHC	$6.24
FQHC	$0.12
Total DAP	**$6.36**

Non-benefit Expenses	PMPM
Admin	$103.66
Total Medical with Admin	$1,448.64
UW Gain	$14.63
Pre-tax Capitation PMPM	$1,463.28
Premium Tax	$29.86
Capitation PMPM	**$1,493.14**

GSA: North
Rate Cell: CMDP Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 14,984
Projection Period Member Months: 15,671

Category of Service	Adjusted Base PMPM	Trend	P&T Decisions	Telehealth	Fee Schedule Changes/Min Wage	Behavioral Health In Schools	Crisis Adjustments	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$0.00	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Case Management	$195.52	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.12%	$201.67
Crisis Intervention Services	$7.85	2.01%	0.00%	0.00%	0.75%	0.00%	52.46%	0.00%	$12.55
Dental Services	$0.02	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.02
FQHC/RHC	$0.02	2.01%	0.00%	0.00%	0.43%	0.00%	0.00%	0.00%	$0.02
Inpatient Behavioral Health	$154.51	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$167.22
Inpatient Hospital	$3.75	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$4.06
Medical Services	$7.76	3.02%	0.00%	3.54%	3.42%	0.00%	0.00%	0.20%	$8.84
Nursing Facility (Short-term)	$0.00	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.00	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Outpatient Hospital	$0.00	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Pharmacy	$21.55	5.06%	-4.97%	0.00%	0.00%	0.00%	0.00%	-0.95%	$22.39
Rehabilitation Services	$113.38	2.00%	0.00%	0.00%	0.75%	0.00%	0.00%	0.61%	$119.57
Residential Services	$82.92	2.51%	0.00%	0.00%	0.75%	0.00%	0.00%	0.17%	$87.95
Support Services	$287.67	1.50%	0.00%	0.20%	3.35%	0.00%	0.00%	0.00%	$306.89
Transportation	$41.65	1.50%	0.00%	0.00%	0.63%	0.00%	0.00%	-1.09%	$42.71
Treatment Services	$117.92	2.00%	0.00%	1.67%	0.75%	1.94%	0.00%	0.00%	$128.10
Gross Medical	**$1,034.53**	**2.17%**	**-0.11%**	**0.27%**	**1.21%**	**0.22%**	**0.39%**	**0.04%**	**$1,101.99**

Total DAP	**$1.70**
Total Gross Medical PMPM	**$1,103.69**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$1,103.69**

Differential Adjusted Payments (DAP)	
Non-FQHC	$1.70
FQHC	$0.00
Total DAP	**$1.70**

Non-benefit Expenses	PMPM
Admin	$85.06
Total Medical with Admin	$1,188.75
UW Gain	$12.01
Pre-tax Capitation PMPM	$1,200.76
Premium Tax	$24.51
Capitation PMPM	**$1,225.27**

GSA: North
Rate Cell: Crisis Adult
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 1,030,691
Projection Period Member Months: 1,028,874

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$2.21	0.9585	$2.31	N/A	$1.54	$3.85
Ancillary Crisis Services	$0.41	0.9590	$0.43	5.5%	$0.00	$0.48
Gross Medical	**$2.63**		**$2.74**			**$4.33**

Total Gross Medical PMPM	**$4.33**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$4.33**

Non-benefit Expenses	PMPM
Admin	$0.33
Total Medical with Admin	$4.66
UW Gain	$0.05
Pre-tax Capitation PMPM	$4.71
Premium Tax	$0.10
Capitation PMPM	**$4.80**

GSA: North
Rate Cell: Crisis Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 754,318
Projection Period Member Months: 769,365

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$0.62	0.9592	$0.64	N/A	$0.40	$1.05
Ancillary Crisis Services	$0.25	0.9590	$0.27	2.0%	$0.00	$0.28
Gross Medical	**$0.87**		**$0.91**			**$1.32**

Total Gross Medical PMPM	**$1.32**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$1.32**

Non-benefit Expenses	PMPM
Admin	$0.10
Total Medical with Admin	$1.42
UW Gain	$0.01
Pre-tax Capitation PMPM	$1.44
Premium Tax	$0.03
Capitation PMPM	**$1.47**

GSA: South
Rate Cell: SMI
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 167,071
Projection Period Member Months: 166,402

Category of Service	Adjusted Base PMPM	Trend	P&T Decisions	Telehealth	Fee Schedule Changes/Min Wage	Behavioral Health In Schools	Crisis Adjustments	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$2.15	2.01%	0.00%	0.00%	0.93%	0.00%	0.00%	0.00%	$2.26
Case Management	$90.55	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.29%	$92.63
Crisis Intervention Services	$85.28	2.01%	0.00%	0.00%	0.93%	0.00%	22.49%	0.00%	$109.70
Dental Services	$0.63	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.65
FQHC/RHC	$31.64	2.01%	0.00%	0.00%	0.42%	0.00%	0.00%	0.00%	$33.06
Inpatient Behavioral Health	$146.14	3.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$155.11
Inpatient Hospital	$131.55	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$134.20
Medical Services	$147.34	1.50%	0.00%	0.11%	0.38%	0.00%	0.00%	0.13%	$152.76
Nursing Facility (Short-term)	$13.57	2.01%	0.00%	0.00%	8.03%	0.00%	0.00%	0.00%	$15.25
Other Services	$13.80	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.36
Outpatient Hospital	$90.37	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$94.04
Pharmacy	$233.34	5.54%	0.07%	0.00%	0.00%	0.00%	0.00%	-0.74%	$258.18
Rehabilitation Services	$55.07	0.00%	0.00%	0.00%	0.93%	0.00%	0.00%	0.00%	$55.58
Residential Services	$100.67	3.00%	0.00%	0.00%	0.93%	0.00%	0.00%	0.45%	$108.28
Support Services	$38.22	1.00%	0.00%	0.88%	2.29%	0.00%	0.00%	0.00%	$40.23
Transportation	$90.63	1.00%	0.00%	0.00%	2.29%	0.00%	0.00%	-0.96%	$93.66
Treatment Services	$106.87	0.00%	0.00%	0.16%	0.93%	0.00%	0.00%	0.00%	$108.03
Gross Medical	**$1,377.80**	**2.26%**	**0.01%**	**0.05%**	**0.57%**	**0.00%**	**1.39%**	**-0.13%**	**$1,467.99**

Total DAP	**$5.44**
Total Gross Medical PMPM	**$1,473.43**
Reinsurance Offset	**($22.04)**
Total Net Medical PMPM	**$1,451.39**

Differential Adjusted Payments (DAP)	
Non-FQHC	$5.19
FQHC	$0.26
Total DAP	**$5.44**

Non-benefit Expenses	PMPM
Admin	$148.74
Total Medical with Admin	$1,600.13
UW Gain	$16.16
Pre-tax Capitation PMPM	$1,616.29
Premium Tax	$32.99
Capitation PMPM	**$1,649.28**

GSA: South
Rate Cell: CMDP Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 46,224
Projection Period Member Months: 41,458

Category of Service	Adjusted Base PMPM	Trend	P&T Decisions	Telehealth	Fee Schedule Changes/Min Wage	Behavioral Health In Schools	Crisis Adjustments	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$2.53	4.00%	0.00%	0.00%	1.45%	0.00%	0.00%	0.00%	$2.78
Case Management	$130.14	1.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.20%	$135.64
Crisis Intervention Services	$23.38	4.00%	0.00%	0.00%	1.45%	0.00%	30.71%	0.00%	$33.53
Dental Services	$0.01	4.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.01
FQHC/RHC	$3.32	4.00%	0.00%	0.00%	0.50%	0.00%	0.00%	0.00%	$3.61
Inpatient Behavioral Health	$111.72	4.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$122.12
Inpatient Hospital	$2.97	4.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3.25
Medical Services	$14.27	3.02%	0.00%	0.80%	4.38%	0.00%	0.00%	0.46%	$16.00
Nursing Facility (Short-term)	$0.00	4.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.00	4.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Outpatient Hospital	$0.39	4.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.42
Pharmacy	$20.56	5.57%	8.69%	0.00%	0.00%	0.00%	0.00%	-0.75%	$24.71
Rehabilitation Services	$42.54	1.99%	0.00%	0.00%	1.45%	0.00%	0.00%	1.61%	$45.62
Residential Services	$136.52	1.48%	0.00%	0.00%	1.45%	0.00%	0.00%	0.16%	$142.86
Support Services	$124.02	1.99%	0.00%	0.19%	4.66%	0.00%	0.00%	0.00%	$135.26
Transportation	$37.62	1.99%	0.00%	0.00%	0.71%	0.00%	0.00%	-1.25%	$38.91
Treatment Services	$177.22	1.99%	0.00%	0.46%	1.45%	1.08%	0.00%	0.00%	$189.90
Gross Medical	**$827.21**	**2.44%**	**0.23%**	**0.14%**	**1.47%**	**0.23%**	**0.89%**	**0.07%**	**$894.62**

Total DAP	**$1.10**
Total Gross Medical PMPM	**$895.72**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$895.72**

Differential Adjusted Payments (DAP)	
Non-FQHC	$1.07
FQHC	$0.03
Total DAP	**$1.10**

Non-benefit Expenses	PMPM
Admin	$91.79
Total Medical with Admin	$987.51
UW Gain	$9.97
Pre-tax Capitation PMPM	$997.49
Premium Tax	$20.36
Capitation PMPM	**$1,017.84**

GSA: South
Rate Cell: Crisis Adult
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 2,733,467
Projection Period Member Months: 2,676,236

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$6.84	0.9638	$7.10	N/A	$2.12	$9.22
Ancillary Crisis Services	$0.90	0.9636	$0.93	2.0%	$0.00	$0.97
Gross Medical	**$7.74**		**$8.03**			**$10.19**

Total Gross Medical PMPM	**$10.19**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$10.19**

Non-benefit Expenses	PMPM
Admin	$1.04
Total Medical with Admin	$11.23
UW Gain	$0.11
Pre-tax Capitation PMPM	$11.35
Premium Tax	$0.23
Capitation PMPM	**$11.58**

GSA: South
Rate Cell: Crisis Child
Base Period: October 1, 2017 through September 30, 2018
Projection Period: October 1, 2019 through September 30, 2020
Base Period Member Months: 2,295,138
Projection Period Member Months: 2,244,084

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$1.55	0.9629	$1.61	N/A	$0.48	$2.09
Ancillary Crisis Services	$0.29	0.9636	$0.30	4.0%	$0.00	$0.32
Gross Medical	**$1.83**		**$1.90**			**$2.41**

Total Gross Medical PMPM	**$2.41**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$2.41**

Non-benefit Expenses	PMPM
Admin	$0.25
Total Medical with Admin	$2.66
UW Gain	$0.03
Pre-tax Capitation PMPM	$2.69
Premium Tax	$0.05
Capitation PMPM	**$2.74**

Appendix 7: Delivery System and Provider Payment Initiatives

GSA	Rate Cell	CYE 20 DAP PMPMs		
		Non-FQHC DAP PMPM	FQHC DAP PMPM	Total DAP PMPM
Central	SMI	$8.17	$0.15	$8.32
Central	CMDP Child	$2.14	$0.00	$2.14
Central	Crisis-only Adult	$0.00	$0.00	$0.00
Central	Crisis-only Child	$0.00	$0.00	$0.00
North	SMI	$6.44	$0.12	$6.56
North	CMDP Child	$1.75	$0.00	$1.75
North	Crisis-only Adult	$0.00	$0.00	$0.00
North	Crisis-only Child	$0.00	$0.00	$0.00
South	SMI	$5.35	$0.27	$5.61
South	CMDP Child	$1.10	$0.03	$1.14
South	Crisis-only Adult	$0.00	$0.00	$0.00
South	Crisis-only Child	$0.00	$0.00	$0.00

GSA	Rate Cell	CYE 20 Estimated TI PMPMs				
		TI PCP PMPM	TI Hospital PMPM	TI BH PMPM	TI Justice PMPM	Total TI PMPM
Central	SMI	$0.00	$4.63	$49.26	$13.55	$67.44
Central	CMDP Child	$0.00	$0.21	$33.13	$1.29	$34.63
Central	Crisis-only Adult	$0.00	$0.00	$0.00	$0.00	$0.00
Central	Crisis-only Child	$0.00	$0.00	$0.00	$0.00	$0.00
North	SMI	$0.00	$0.82	$30.57	$25.43	$56.82
North	CMDP Child	$0.00	$0.59	$17.23	$9.35	$27.17
North	Crisis-only Adult	$0.00	$0.00	$0.00	$0.00	$0.00
North	Crisis-only Child	$0.00	$0.00	$0.00	$0.00	$0.00
South	SMI	$0.00	$1.50	$25.35	$2.43	$29.28
South	CMDP Child	$0.00	$0.05	$19.53	$1.79	$21.37
South	Crisis-only Adult	$0.00	$0.00	$0.00	$0.00	$0.00
South	Crisis-only Child	$0.00	$0.00	$0.00	$0.00	$0.00

	CYE 20 Estimated APSI PMPM		
Rate Cell	Central	North	South
SMI	$10.23	$1.23	$18.72
CMDP Child	$0.51	$0.20	$0.62
Crisis Adult	$0.00	$0.00	$0.00
Crisis Child	$0.00	$0.00	$0.00

	CYE 20 Estimated PSI PMPM		
Rate Cell	Central	North	South
SMI	$0.10	$0.01	$0.00
CMDP Child	$1.99	$0.36	$0.00
Crisis Adult	$0.00	$0.00	$0.00
Crisis Child	$0.00	$0.00	$0.00