


AHCCCS
Arizona Health Care Cost Containment System

Contract Year Ending 2023
Capitation Rate Certification Amendment
AHCCCS Complete Care and
AHCCCS Complete Care – Regional Behavioral Health Agreement
Program

October 1, 2022 through September 30, 2023

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Business and Finance

March 23, 2023




Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This rate certification amendment documents the revision of capitation rates from those previously certified for the Arizona Health Cost Containment System (AHCCCS) Complete Care (ACC) and AHCCCS Complete Care – Regional Behavioral Health Agreement (ACC-RBHA) Program in the actuarial rate certification signed August 12, 2022. On December 29, 2022, the Consolidated Appropriations Act, 2023 (CAA, 2023) was enacted which contained an important change to the continuous enrollment condition of the Families First Coronavirus Response Act (FFCRA). CAA, 2023 decoupled the end of the continuous enrollment requirement for Medicaid from the end of the Public Health Emergency (PHE) declaration, and instead the condition will end on March 31, 2023. Beginning April 1, 2023, states may terminate Medicaid enrollment for individuals who are no longer eligible. The ACC and ACC-RBHA Program capitation rates in the actuarial rate certification, signed August 12, 2022, included acuity factors based on a model with the assumption of a PHE end date and end of the continuous enrollment condition in January 2023. This capitation rate amendment is necessary to correct the acuity model and the resultant acuity factors included in the capitation rates to reflect the new known date for the start of disenrollments for ACC and ACC-RBHA members. Given the necessary amendment to the capitation rates, in addition to the change in the acuity factors, for administrative ease, the actuaries are including the costs of three non-material program and reimbursement changes that were not known or approved when the original capitation rates and actuarial rate certification was submitted to the Centers for Medicare & Medicaid Services (CMS) in this capitation rate certification amendment. There are no other changes to data, assumptions, or methodologies from the original actuarial rate certification besides the ones listed in this amendment.

This rate certification was prepared for CMS, or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

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

The 2023 Guide describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2023 Guide to help facilitate the review of this rate certification by CMS. This amendment only addresses changes from the original certification; it does not purport to address all subsections of the 2023 Guide as most subsections are unchanged.

Section I Medicaid Managed Care Rates

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

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

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

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

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

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

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

As stated on pages 2 and 3 of the 2023 Guide, CMS will also use these three principles in applying the regulation standards:

- the capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
- the rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- the documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR Part 438 and generally accepted actuarial principles and practices.

I.1. General Information

The certified CYE 23 capitation rates for the ACC and ACC-RBHA Program are effective for the 12-month time period from October 1, 2022, through September 30, 2023, and have changed from the original CYE 23 capitation rate certification. The changes documented in this rate certification amendment are acuity factor, program, and reimbursement changes. Please see the original rate certification for additional information about the ACC and ACC-RBHA Program.

The actuarial certification letter for the amended CYE 23 capitation rates for the ACC and ACC-RBHA Program, signed by Windy J. Marks, FSA, MAAA and Erica Johnson, ASA, MAAA, is in Appendix 1. Ms. Marks and Ms. Johnson meet the requirements for the definition of an Actuary described at 42 CFR § 438.2.

Ms. Marks and Ms. Johnson certify that the amended CYE 23 capitation rates for the ACC and ACC-RBHA Program contained in this rate certification amendment are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ACC and ACC-RBHA Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ACC and ACC-RBHA Program contract uses the term risk group instead of rate cell. This rate certification amendment will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438, the 2023 Guide, and the original rate certification. Appendix 3 compares the CYE 23 amended certified capitation rates to the CYE 23 original certified capitation rates, applying the same weight (projected membership) as was applied in the CYE 23 original certified capitation rates.

This rate certification amendment retroactively adjusts capitation rates to the beginning of the rating period. The acuity factors incorporated into the capitation rates reflect the expected aggregate change in acuity by population across the full contract year, so a retroactive adjustment to the beginning of the rating period is necessary to reflect the change in the expected aggregate acuity of the population for CYE 23 based on the change in the assumed start date for member disenrollments. For administrative ease, the amended capitation rates also incorporate the projected costs for three non-material program and reimbursement changes that were not known or approved when the original capitation rates and actuarial rate certification was submitted to the Centers for Medicare & Medicaid Services (CMS).

The data, assumptions, and methodologies used to develop the magnitude of the capitation rate adjustments are included below in I.3. Projected Benefit Costs and Trends and I.6. Risk Adjustment and Acuity Adjustments. The state has not made any previous adjustment to rates in the rating period by a *de minimis* amount or otherwise. This rate certification amendment will address and account for all differences from the most recently certified rates.

Proposed differences among the CYE 23 capitation rates for the ACC and ACC-RBHA Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered

under the ACC and ACC-RBHA Program. The CYE 23 capitation rates were developed at the rate cell level. Payments from rate cells do not cross-subsidize payments from other rate cells. The effective dates of changes to the ACC and ACC-RBHA Program are consistent with the assumptions used to develop the CYE 23 capitation rates for the ACC and ACC-RBHA Program. The capitation rates were developed so each Contractor would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 23.

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 amendment. There have been no adjustments to the rates performed outside of the rate setting process described in the rate certification. The amended CYE 23 capitation rates certified in this report represent the contracted rates by rate cell. The state will submit a contract amendment to CMS.

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

Table 1: Future Rate Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
State Directed Payments (Targeted Investments, ARPA HCBS, Pediatric SNF)	Fall 2023	AHCCCS has not finalized the required pre-print for these directed payments.

I.2. Data

Please see the original certification for all data sources used or reviewed in the development of the medical portion of the CYE 23 capitation rates for the ACC and ACC-RBHA Program, along with information on completeness, accuracy, and consistency of the data.

I.3. Projected Benefit Costs and Trends

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

The information provided here is specific to the three program and reimbursement changes being incorporated into the revised capitation rates that were not known or approved when the original certification was submitted to CMS. Each of the three changes have a non-material impact (defined as changes less than 0.2% on the gross medical component of the rate for every individual risk group at the GSA level) on the capitation rates and are summarized together below.

The impacts for these three changes were developed by AHCCCS Division of Business and Finance (DBF) financial analysts (formerly under the AHCCCS Division of Health Care Management (DHCM)) with oversight from the AHCCCS Division of Health Care Services (DHCS, formerly DHCM) Clinical Quality

Management (CQM) Team and the Office of the Director's Chief Medical Officer. The actuaries relied upon the professional judgment of the AHCCCS DBF 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 DBF 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.

Combined Miscellaneous Program Changes

The impacts for the three non-material changes were aggregated for this amended certification by summing the dollar impacts for each non-material adjustment across risk groups within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 2. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Esketamine Evaluation and Management codes**
  Effective January 1, 2023, AHCCCS adopted billing and coding guidance from CMS to fund two hours of patient observation after the administration of esketamine nasal spray. This product is indicated for use in conjunction with an oral antidepressant for treatment-resistant depression in adults. The product is administered under the direct supervision of a healthcare provider in a certified healthcare setting because of the risks of serious adverse outcomes.
- **Long-Acting Reversible Contraception (LARC)**
  Effective February 1, 2023, AHCCCS revised reimbursement rates for LARCs to equal the Wholesale Acquisition Cost (WAC) which reflects the costs providers pay for these medications.
- **Community Health Workers/Community Health Representatives**
  Effective April 1, 2023, AHCCCS implemented a new Community Health Worker (CHW)/Community Health Representative (CHR) benefit. A CHW/CHR is a frontline public health worker who is a trusted member of the community with a close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Table 2: Combined Miscellaneous

GSA	Dollar Impact	PMPM Impact
North	$124,228	$0.05
Central	$1,060,838	$0.07
South	$218,131	$0.04
Total	**$1,403,196**	**$0.06**

The actuaries have made no other changes to the projected benefit costs and trend assumptions for the CYE 23 capitation rates for the ACC and ACC-RBHA Program. All projected benefit cost changes have been included in the rate development process and are documented above or in the original rate certification.

I.4. Special Contract Provisions Related to Payment

There have been no changes to incentive arrangements, withhold arrangements, state directed payments, or risk-sharing mechanisms from the original rate certification.

I.5. Projected Non-Benefit Costs

There have been no changes to administrative costs or the percentages for premium tax and underwriting gain from the original capitation rate certification.

I.6. Risk Adjustment and Acuity Adjustments

There have been no changes to risk adjustment from the original capitation rate certification. There has been a change in the acuity adjustment factors incorporated into the capitation rates to reflect the change in the start dates for redeterminations and disenrollments under the decoupling of the continuous enrollment condition of the FFCRA from the end of the PHE declaration in the CAA, 2023. The development of the acuity adjustment factors follows the same process as described in the original capitation rate certification. The only adjustments are to incorporate a revised date for the start of member disenrollments after redetermination and updating the inputs with a more recent "COVID-19 override" list. The impact of the change in aggregate acuity factors from the original certification by GSA is illustrated below in Table 3. Totals may not add up due to rounding.

Table 3: Impact of Change in Acuity Factors from Original Capitation Rate Certification

GSA	Dollar Impact	PMPM Impact
North	($2,934,987)	($1.28)
Central	($28,241,940)	($1.83)
South	($10,539,221)	($1.82)
Total	**($41,716,148)**	**($1.78)**

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

Section II of the 2023 Medicaid Managed Care Rate Development Guide is not applicable to the ACC and ACC-RBHA Program. Managed long-term services and supports, as defined at 42 CFR § 438.2, are not covered services under the ACC and ACC-RBHA Program. The ACC and ACC-RBHA Program does cover nursing facility services, and related HCBS, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates

Please see the original rate certification for additional information. The data, assumptions, and methodologies used for the revision of the projected gross medical expenses for the amended CYE 23 capitation rates are described above in Sections I.3. and I.6. There are no other changes from the original rate certification.

Appendix 1: Actuarial Certification

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

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

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

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

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

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

The data, assumptions, and methodologies used to revise the CYE 23 capitation rates for the ACC and ACC-RBHA Program have been documented according to the guidelines established by CMS in the 2023 Guide. The amended CYE 23 capitation rates for the ACC and ACC-RBHA Program are effective for the 12-month time period from October 1, 2022, through September 30, 2023.

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 and information provided by teams at AHCCCS and the Contractors. We have relied upon AHCCCS and the Contractors for the accuracy of the data and we have accepted the data without audit, after checking the data for reasonableness and consistency unless stated otherwise.

SIGNATURE ON FILE	March 23, 2023
Windy J. Marks	Date
Fellow, Society of Actuaries	
Member, American Academy of Actuaries	

SIGNATURE ON FILE	March 23, 2023
Erica Johnson	Date
Associate, Society of Actuaries	
Member, American Academy of Actuaries	

Appendix 2: Certified Capitation Rates

GSA	Contractor	AGE < 1	AGE 1-20	AGE 21+	Duals	SSIWO	Prop 204 Childless Adults	Expansion Adults	Delivery Supplemental Payments	SMI	Crisis 24 Hour Group
North	Care1st Health Plan Arizona, Inc.	$646.22	$212.19	$398.76	$153.50	$1,234.37	$656.67	$479.36	$7,376.47	$1,659.79	$6.30
North	Health Choice Arizona, Inc.	$681.48	$198.99	$390.52	$145.13	$1,278.10	$635.26	$478.31	$7,376.47	NA	NA
Central	Arizona Complete Health - Complete Care Plan	$702.17	$186.71	$416.06	$174.54	$1,160.42	$671.98	$447.93	$7,229.97	NA	NA
Central	Banner - University Family Care	$662.48	$193.01	$406.00	$175.57	$1,207.27	$653.09	$461.44	$7,229.97	NA	NA
Central	Molina Healthcare of Arizona, Inc.	$741.32	$222.59	$418.79	$199.27	$1,326.09	$697.91	$492.56	$7,229.97	NA	NA
Central	Mercy Care	$675.28	$197.11	$464.61	$169.33	$1,413.53	$757.48	$487.70	$7,229.97	$2,482.31	$8.40
Central	Health Choice Arizona, Inc.	$649.10	$199.20	$437.26	$177.03	$1,253.30	$686.37	$454.94	$7,229.97	NA	NA
Central	UnitedHealthcare Community Plan	$651.67	$195.55	$444.70	$169.99	$1,331.48	$701.71	$474.83	$7,229.97	NA	NA
South	Arizona Complete Health - Complete Care Plan	$672.63	$205.21	$411.66	$149.38	$1,329.60	$622.75	$435.39	$7,418.52	$1,615.68	$7.87
South	Banner - University Family Care	$699.75	$209.23	$415.67	$150.95	$1,299.48	$626.05	$447.53	$7,418.52	NA	NA
South	UnitedHealthcare Community Plan (Pima Only)	$743.13	$217.74	$448.55	$144.73	$1,371.11	$648.98	$461.66	$7,418.52	NA	NA

Appendix 3: Fiscal Impact Summary

GSA	Risk Group	CYE 23 Projected MMs	Weighted CYE 23 Original Cap Rate	CYE 23 Original Projected Expenditures	Weighted CYE 23 Adjusted Cap Rate	CYE 23 Adjusted Projected Expenditures	Percentage Impact
North	AGE < 1	42,186	$666.90	$28,133,894	$666.90	$28,133,894	0.00%
North	AGE 1-20	818,889	$205.67	$168,417,311	$204.94	$167,820,283	(0.35%)
North	AGE 21+	385,108	$396.25	$152,598,678	$394.08	$151,761,939	(0.55%)
North	Duals	194,671	$149.12	$29,029,910	$149.32	$29,068,546	0.13%
North	SSIWO	71,464	$1,260.27	$90,063,416	$1,257.99	$89,900,262	(0.18%)
North	Prop 204 Childless Adults	568,366	$645.26	$366,745,336	$644.71	$366,430,549	(0.09%)
North	Expansion Adults	144,155	$485.43	$69,977,505	$478.77	$69,017,793	(1.37%)
North	Delivery Supplemental Payments	2,364	$7,376.47	$17,437,971	$7,376.47	$17,437,971	0.00%
North	SMI	72,634	$1,663.96	$120,859,992.38	$1,659.79	$120,557,290	(0.25%)
North	Crisis 24 Hour Group	3,162,017	$6.30	$19,928,766	$6.30	$19,928,766	0.00%
North	**Total** [1,2]	2,297,473		$1,063,192,780		$1,060,057,292	(0.29%)
Central	AGE < 1	360,750	$672.74	$242,690,729	$672.75	$242,693,664	0.00%
Central	AGE 1-20	6,499,644	$196.12	$1,274,687,446	$195.56	$1,271,082,886	(0.28%)
Central	AGE 21+	2,576,272	$444.28	$1,144,598,500	$441.18	$1,136,588,545	(0.70%)
Central	Duals	883,674	$172.53	$152,459,349	$172.56	$152,488,644	0.02%
Central	SSIWO	420,224	$1,308.53	$549,876,813	$1,306.24	$548,915,122	(0.17%)
Central	Prop 204 Childless Adults	3,419,225	$707.46	$2,418,964,683	$705.56	$2,412,464,482	(0.27%)
Central	Expansion Adults	891,638	$477.28	$425,565,038	$471.49	$420,395,689	(1.21%)
Central	Delivery Supplemental Payments	17,834	$7,229.97	$128,939,283	$7,229.97	$128,939,283	0.00%
Central	SMI	346,627	$2,499.44	$866,372,352	$2,482.31	$860,437,042	(0.69%)
Central	Crisis 24 Hour Group	15,377,847	$8.40	129,158,639	$8.40	$129,158,639	0.00%
Central	**Total** [1,2]	15,398,054		$7,333,312,831		$7,303,163,996	(0.41%)
South	AGE < 1	114,634	$701.28	$80,390,616	$701.28	$80,390,616	0.00%
South	AGE 1-20	2,095,449	$211.15	$442,453,719	$210.16	$440,379,700	(0.47%)
South	AGE 21+	1,005,350	$425.97	$428,244,053	$422.96	$425,219,683	(0.71%)
South	Duals	506,223	$148.68	$75,267,551	$148.66	$75,253,120	(0.02%)
South	SSIWO	179,728	$1,331.65	$239,335,593	$1,328.85	$238,832,584	(0.21%)
South	Prop 204 Childless Adults	1,342,980	$632.94	$850,022,428	$631.41	$847,965,406	(0.24%)
South	Expansion Adults	372,948	$454.09	$169,350,907	$447.47	$166,881,568	(1.46%)
South	Delivery Supplemental Payments	6,202	$7,418.52	$46,009,681	$7,418.52	$46,009,681	0.00%
South	SMI	159,760	$1,624.42	$259,518,502	$1,615.68	$258,121,335	(0.54%)
South	Crisis 24 Hour Group	5,905,409	$7.87	$46,486,303	$7.87	$46,486,303	0.00%
South	**Total** [1,2]	5,777,072		$2,637,079,353		$2,625,539,997	(0.44%)
Total	AGE < 1	517,571	$678.58	$351,215,239	$678.59	$351,218,174	0.00%
Total	AGE 1-20	9,413,982	$200.29	$1,885,558,476	$199.63	$1,879,282,869	(0.33%)
Total	AGE 21+	3,966,730	$434.98	$1,725,441,232	$431.99	$1,713,570,166	(0.69%)
Total	Duals	1,584,568	$162.04	$256,756,809	$162.07	$256,810,311	0.02%
Total	SSIWO	671,416	$1,309.58	$879,275,822	$1,307.16	$877,647,968	(0.19%)
Total	Prop 204 Childless Adults	5,330,571	$682.05	$3,635,732,447	$680.39	$3,626,860,437	(0.24%)
Total	Expansion Adults	1,408,741	$471.98	$664,893,450	$465.87	$656,295,051	(1.29%)
Total	Delivery Supplemental Payments	26,400	$7,287.38	$192,386,935	$7,287.38	$192,386,935	0.00%
Total	SMI	579,022	$2,153.20	$1,246,750,846	$2,140.02	$1,239,115,667	(0.61%)
Total	Crisis 24 Hour Group	24,445,273	$8.00	$195,573,708	$8.00	$195,573,708	0.00%
Total	**Total** [1,2]	23,472,600		$11,033,584,964		$10,988,761,284	(0.41%)

1) Total Projected MMs doesn't include Delivery Supplemental Payment members or Crisis 24 Hour Group member months
2) Totals may not add up due to rounding