AHCCCS
Arizona Health Care Cost Containment System

Contract Year Ending 2021
Regional Behavioral Health Authority
Program Capitation Rate Certification

October 1, 2020 through September 30, 2021

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

November 13, 2020

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, 2020 through September 30, 2021 (Contract Year Ending 2021 (CYE 21), or alternatively, Federal Fiscal Year 2021 (FFY 21)) actuarially sound capitation rates for Arizona's Regional Behavioral Health Authority (RBHA) Program. The RBHA Program is changing effective October 1, 2020 and April 1, 2021. 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.

At the time of this rate certification, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on setting capitation rates, including whether the pandemic will increase or decrease costs in CYE 21. Given the lack of reliable and historical information for this unprecedented public health emergency, the Arizona Health Care Cost Containment System (AHCCCS) made the decision to not predict rates of foregone care, deferred care, and pent-up demand. However, it is known that the COVID-19 pandemic could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this rate certification. AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. In times such as these, the risk-sharing arrangements are even more important to the stability of the system.

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 at 81 FR 27497 applicable to this rate certification, the 2020-2021 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2020-2021 Medicaid Managed Care Rate Development Guide (2021 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 2021 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 2021 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 2021 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The CYE 21 capitation rates for the RBHA Program are effective for the 12-month time period from October 1, 2020 through September 30, 2021, with the exception of the Comprehensive Medical and Dental Program (CMDP) Child rate cell, which has a capitation rate effective for the 6-month time period from October 1, 2020 through March 31, 2021. The services provided under the CMDP Child rate cell in the RBHA Program are moving to another program effective April 1, 2021.

I.1.A.ii. Required Elements

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

The actuarial certification letter for the CYE 21 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 21 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 2021 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 became known as Steward Health Choice Arizona - RBHA
  - Effective December 31, 2019, Steward Health Choice Arizona - RBHA is known as Health Choice Arizona - RBHA
- South GSA – Cenpatico Integrated Care (CIC), effective October 1, 2015
  - Effective October 1, 2018, CIC is known as Arizona Complete Health Complete Care Plan - RBHA (AZCH-CCP - RBHA)

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

The three RBHAs provide integrated care (that is, both physical and behavioral health services) for most Arizona Medicaid members diagnosed with a Serious Mental Illness (SMI), behavioral health services to Arizona children living in foster care (CMDP Child), and the first 24 hours of crisis intervention services to all Arizona Medicaid populations (including those whose behavioral health services are provided by other programs) through two Crisis rate cells (Crisis Adult, Crisis Child). This is a change from the previous year, when the Crisis-only rate cells included the first 24 hours of crisis intervention services only for those populations whose behavioral health services were provided by other programs and the SMI and CMDP Child rate cells included crisis intervention services within those capitation rates. For ease of reference, this certification will speak to the two main populations (SMI and CMDP Child), and the two Crisis rate cells. All tables which do not specifically state otherwise are restricted to the two main populations and do not include any impacts to the Crisis rate cells. When there are impacts to the Crisis rate cells, the tables will note that the Crisis rate cells 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
- Inpatient Behavioral Health
- Behavioral Health Residential
- Behavioral Health Day Programs
- Prevention Services
- Pharmacy
- Crisis Intervention Services (Crisis rate cells)

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/DBHS administration, additional vendor expenses to determine whether a member has SMI, and additional expenses to cover Tribal Fee-for-Service (FFS) claims. After the July 1, 2016 move of ADHS/DBHS into AHCCCS, these additional expenses were no longer required to be added to the capitation rates because the administration of the RBHA Program was under AHCCCS. As of October 1, 2018, the AHCCCS Complete Care (ACC) Program integrated behavioral health and physical health services for most Arizona Medicaid members through the ACC Contractors. As of October 1, 2019, the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Program integrated behavioral health and physical health services for their members. Effective April 1, 2020, the Arizona Department of Child Safety (DCS) CMDP will be integrating behavioral health with the physical health services that CMDP already provides for their members (Arizona children living in foster care) under the DCS Comprehensive Health Plan (DCS CHP), ending the RBHAs' responsibility for behavioral health services for the CMDP Child rate cell. 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 21 capitation rates for the RBHA Program is effective for the 12-month time period from October 1, 2020 through September 30, 2021, with the exception of the CMDP Child rate cell, which has a capitation rate effective for the 6-month time period from October 1, 2020 through March 31, 2021.

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

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 behavioral health services through the RBHA Program, and cover the same populations as in the previous rating period; however, the services covered under the rate cells have changed as crisis intervention services for all populations are now in the Crisis rate cells. The two Crisis rate cells cover crisis intervention services for all Arizona Medicaid populations, including the populations in the two main populations. More information about the populations covered under the RBHA Program can be found in the Eligibility Categories section of the RBHA Contracts.

Table 1: Covered Populations by Rate Cell

Rate Cell	Covered Populations
SMI	Title XIX eligible adults diagnosed with a Serious Mental Illness who may additionally receive physical health services under the RBHA Program
CMDP Child	Title XIX eligible children enrolled in the CMDP
Crisis Adult	Title XIX/Title XXI eligible adults
Crisis Child	Title XIX/Title XXI eligible children

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.

Due to the public health emergency, and the maintenance of effort requirements included in Families First Coronavirus Response Act, with a few exceptions as noted in the law, members who were eligible at the beginning of the public health emergency, or who become eligible during the public health emergency, will remain treated as eligible for such benefits through the end of the month in which the public health emergency ends. Given the lack of reliable and historical information for this unprecedented public health emergency, the AHCCCS Division of Health Care Management (DHCM)

Actuarial Team made the decision not to predict rates of foregone care, deferred care, and pent-up demand.

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 21 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)
- 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)
- Hospital Enhanced Access Leading To Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Targeted Investments (TI) program (42 CFR § 438.6(c)(1)(ii) 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

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 (FFP)

Proposed differences among the CYE 21 capitation rates for the RBHA Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the RBHA Program.

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

The CYE 21 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 21 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 21.

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 21 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not Applicable. Capitation rates from previous rating periods are not used in the development of the CYE 21 capitation rates for the RBHA Program.

I.1.A.ix. Rate Certification Procedures

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

This section of the 2021 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

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

This is a new rate certification that documents that the RBHA Program capitation rates are changing effective October 1, 2020.

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

Not applicable. This rate certification will change the RBHA Program capitation rates effective October 1, 2020. This rate certification also addresses the contract amendment which will remove responsibility for CMDP Child behavioral health from the RBHA contract effective April 1, 2021. Additionally, AHCCCS will be including contract amendments with the submission of this rate certification which remove language which imposed an upper limit on administrative expenses for Pharmacy Benefit Manager (PBM) subcontractors, the capitation rates certified herein were developed without the specified upper limit.

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

This section of the 2021 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.(e) CMS Contract Amendment Requirement

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

I.1.A.ix.(f) CMS Rate Amendment Requirement for Changes in Law

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

I.1.B. Appropriate Documentation

I.1.B.i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 21 capitation rates for the RBHA Program.

I.1.B.ii. Rate Assumptions

This section of the 2021 Guide notes that it is not permissible to certify rate ranges, and the actuary must be responsible for all assumptions and adjustments underlying the certified capitation rates, and the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for the variation.

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

I.1.B.iii. 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 2021 Guide. Sections of the 2021 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.iv. Differences in Federal Medical Assistance Percentage

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

The percentages of costs by the various populations for October 1, 2018 through September 30, 2019 (CYE 19) for the RBHA Program are provided below in Table 2, along with the associated FMAP for the time period of January 1, 2020 through September 30, 2020. The FMAPs shown do not incorporate the increased FMAP associated with the public health emergency.

Table 2: Percentage of Costs by Population and Associated FMAP

Population	Percentage of Costs	FMAP
Adult Expansion	2.20%	90.00%
Child Expansion	0.08%	90.51%
Childless Adult Restoration	32.24%	90.00%
KidsCare (Title XXI)	0.00%	90.51%
Breast and Cervical Cancer	0.01%	79.01%
Populations not listed above	65.47%	70.02%

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

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

The CYE 20 capitation rates for the SMI and CMDP Child rate cells included crisis intervention services as a category of service, while the CYE 20 Crisis-only Adult and Crisis-only Child rate cells did not include the SMI and CMDP Child populations. The CYE 21 capitation rates have removed the crisis intervention services from the SMI and CMDP Child rate cells as a category of service, and incorporated those expenses associated with the first 24 hours of crisis intervention services and the population membership projections into the CYE 21 Crisis Adult and Crisis Child rate cells. The 2021 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 served, are available in Appendix 3a. Please note that due to the change in services (for SMI and CMDP Child) and populations (Crisis Adult, Crisis Child), 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 evaluated as such.

The 2021 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 21 certified capitation rates, the actuaries defined any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year as a negative change in the rate.

The negative change to the South SMI rate cell is driven by the removal of the crisis intervention category of service, as it accounted for 6.1% of the CYE 18 base encounter data. The percentage of encounters attributable to the crisis intervention category of services for South SMI in CYE 20 was higher than that for CYE 20 Central and North SMI, 2.9% and 1.6% respectively, which is part of the reason for not seeing a corresponding decrease in those rate cells due to the removal.

The large positive change to the South CMDP Child rate cell is driven primarily by the rebase from CYE 18 encounters to CYE 19 encounters. There were four categories of service (by order of magnitude, Inpatient Behavioral Health, Case Management, Residential Services, and Support Services) which had per member per month (PMPM) increases of greater than 15% year over year, for a total change across the four categories of $171.40 PMPM. The removal of the crisis intervention services category of service from the South CMDP Child rate cell, in contrast, reduced the rebased encounters by $23.38 PMPM, accounting for 2.8% of the gross medical expense for the rate cell in CYE 20.

The Crisis rate cells have changes in terms of covered populations by adding the SMI and CMDP Child populations into the rate cells, moving the expenses which were previously included as part of the SMI and CMDP Child rate cells into the Crisis Adult and Child rate cells, as well as shifts based on aligning the capitation rates for the Crisis Adult and Child cells with the projected expenses for the contract year as provided by the RBHAs, rather than allocating projections based on historical encounter expenditures. Aligning the capitation rates with how the RBHAs have set up their contracted block payments is a more accurate predictor of costs by rate cell for the upcoming contract year, since the population mix that will use crisis intervention services in any given year fluctuates more than that of other services. Every Crisis rate cell thus either has a resultant negative change, or a large positive change when comparing to last year's capitation rate. The actuaries have included in Appendix 3b a restatement of the projected CYE 20 dollars, using the same CYE 20 projected membership included in the CYE 20 certification, in alignment with the changes to the services and populations and projections for this year.

Another change to the Crisis rate cells is with respect to the ancillary crisis expenditures (those expenditures which are not captured in the specific procedure codes originally used to define the "crisis intervention services" category of service, as addressed in the CYE 20 rate certification), as effective October 1, 2020, there is a change associated with the responsibility for transportation costs which affects ancillary crisis costs. The RBHAs' (for the Crisis rate cells) responsibility for transportation expenses will be restricted to non-emergency transportation (NEMT) to a crisis stabilization unit. Transportation from a crisis stabilization unit, as well as all emergency transportation, will be the responsibility of the plan that is responsible for physical and behavioral health services for the member (with the exception of the CMDP rate cell in the first six months of the year, as the CMDP plan will only be responsible for physical health until April 1, 2021, including associated transportation services). This policy change should decrease confusion by transportation providers regarding the appropriate entity to bill.

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

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

I.1.B.vi. Future Rate Amendments

There are no known amendments anticipated to be provided to CMS in the future which would impact capitation rates. The contract amendment which will end the RBHA Program's responsibility for behavioral health services for the CMDP Child rate cell effective April 1, 2021 has been addressed in this rate certification.

I.2. Data

This section provides documentation for the Data section of the 2021 Guide.

I.2.A. Rate Development Standards

I.2.A.i. Compliance with 42 CFR § 438.5(c)

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

Since AHCCCS employs their own actuaries, a formal data request was not needed between the AHCCCS DHCM Actuarial Team and the State. The AHCCCS DHCM Actuarial Team worked with the appropriate teams at AHCCCS to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) 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 21 capitation rates for the RBHA Program include the following:

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

  - October 1, 2019 through March 31, 2020 (CYE 20 Q1 and Q2)
- AHCCCS FFS fee schedules developed and maintained by the AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement Team related to DAP and TI, see Section 1.4.D.
- Data from AHCCCS DHCM financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)
- Data regarding contracted block payments for crisis intervention services provided by the RBHAs

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership for current and previous rate cells provided by the RBHAs
- Supplemental data regarding crisis intervention services cost projections and historical costs provided by the RBHAs
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CYE 19
- Historical and projected enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
  - Projections for CYE 21
  - Historical enrollment from mid CYE 20 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 26.4% 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 reimbursed on a FFS basis by the RBHA. This allowed amount field is used in the repricing methodology instead of the paid amount field to estimate the expenditures for the sub-cap/block payment encounters.

Table 3 below provides a distribution of the CYE 19 encounter data by sub-cap/block payments, non-sub-cap/block payments and by category of service for the two main populations. The Crisis rate cells are approximately 91.7% sub-cap/block payments for crisis intervention services.

Table 3: CYE 19 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	39.2%	60.8%
Case Management	26.1%	73.9%
Dental Services	98.2%	1.8%
FQHC/RHC	99.9%	0.1%
Inpatient Behavioral Health	92.1%	7.9%
Inpatient Hospital	99.9%	0.1%
Medical Services	69.4%	30.6%
Nursing Facility (Short-term)	100.0%	0.0%
Other Services	91.6%	8.4%
Outpatient Hospital	99.8%	0.2%
Pharmacy	100.0%	0.0%
Rehabilitation Services	9.0%	91.0%
Residential Services	92.9%	7.1%
Support Services	41.8%	58.2%
Transportation	84.6%	15.4%
Treatment Services	47.6%	52.4%
Total	**73.6%**	**26.4%**

I.2.B.ii.(b) Availability and Quality of the Data

I.2.B.ii.(b)(i) Data Validation Steps

Guidelines and formats for submitting individual encounters generally follow health insurance industry standards used by commercial insurance companies and Medicare; however, some requirements are specific to the AHCCCS program. All encounter submissions are subject to translation and validation using standards and custom business rules (guidelines). Once translation has occurred and the encounters pass validation, they are passed to the AHCCCS PMMIS mainframe and are subject to approximately 500 claims type edits resulting in the approval, denial, or pend of each encounter. This process occurs for both regular and sub-capitated encounters.

The AHCCCS Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a PMPM basis looking for anomalous patterns in encounter, unit, or cost totals,

such as incurred months where totals are unusually low or high. If any anomalies are found, the AHCCCS Actuarial Team reports the findings to the AHCCCS Office of Data Analytics (ODA) Team, which then works with the RBHAs to identify causes. In addition, the AHCCCS ODA Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

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

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

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

The AHCCCS 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 only encounter data with valid AHCCCS member IDs was used in developing the CYE 21 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 CYE 19 encounter data for the SMI and CMDP Child rate cells, excluding crisis intervention services, to the RBHAs annual financial statement data, excluding crisis intervention services, for CYE 19. After adjustments to the encounter data for completion and encounter issues, the comparisons showed that the financial statements and the encounter data were consistent. The reason for excluding crisis intervention services from the comparison of encounter data to financial data for the SMI and CMDP Child cells is that crisis intervention services are paid for

primarily, as noted above in Section I.2.B.ii.(a)(iv), via sub-cap/block purchasing arrangements, and the allocation of these costs in financial statements are based on how those payment arrangements are set up, rather than based on the utilization of the services by each risk group. The actuaries instead reviewed contracted block payment amounts as reported by the RBHAs for crisis intervention services and encounters for ancillary crisis services across all rate cells in the base period in comparison to the financial statements.

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

As required by ASOP No. 23, the AHCCCS DHCM Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the RBHAs and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the RBHAs and reviewed by the AHCCCS DHCM Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data and the rate development is dependent upon this reliance. The actuaries notes additional reliance on data provided by the AHCCCS DHCM Rates & Reimbursement Team with regard to DAP and fee schedule impacts, on data provided by the AHCCCS DHCM financial analysts with regard to some program changes, on information and data provided by Mercer consultants with regard to pharmacy reimbursement savings, on information and data provided by Milliman consultants with regard to the HEALTHII program, on data provided by the AHCCCS DBF Budget Team with regard to projected enrollment, on data provided by the RBHAs with regard to administrative costs, and on contracted block payment amounts and cost projections provided by the RBHAs for the crisis intervention category of service.

The AHCCCS DHCM Actuarial Team found the encounter data, with adjustments for encounter issues, in conjunction with the additional data on contracted block payments for crisis intervention services to be appropriate for the purposes of developing the CYE 21 capitation rates for the RBHA Program. The development of the encounter issue adjustments are described below in Section I.2.B.iii.(c).

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

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

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

The actuaries determined that the CYE 19 encounter data was appropriate to use as the base data for developing the CYE 21 capitation rates for the two main populations of the RBHA Program with the encounter issue adjustment previously noted. The actuaries determined that the CYE 19 encounter data, contracted block payment information for CYE 19, CYE 20, and CYE 21 were appropriate to use as the data for developing the CYE 21 capitation rates for the two Crisis cells covering all Arizona Medicaid populations for the RBHA Program.

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

As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 21 capitation rates for the two main populations for the RBHA Program.

For the two Crisis cells, both encounter data and contracted block payment amounts are used for the development of the CYE 21 capitation rates. The inclusion of data other than encounters for developing the CYE 21 capitation rates is due to the nature of the crisis intervention service model. Crisis intervention services are based on a "firehouse" model, in which costs are incurred for staffing 24/7 crisis telephone lines, 24/7 crisis mobile teams, and 24/7 crisis stabilization units, whether or not there are services provided. The RBHAs therefore contract and pay for these staffing costs through block payment arrangements, which keeps the system running smoothly, since the numbers of people seeking crisis in any given year can be very different, and trying to price fee schedules to account for those differences could under or over fund the services in any given year if the projections turn out different than reality.

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

Not applicable. As described above in Section I.2.B.ii.(c)(i), managed care encounters are used in the rate development for all rate cells in the CYE 21 capitation rates for the RBHA Program.

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

Not applicable. The AHCCCS DHCM Actuarial Team did not rely on a data book to develop the CYE 21 capitation rates for the RBHA Program.

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

This section describes adjustments made to the CYE 19 encounter data that was used as the base data for developing the CYE 21 capitation rates for the RBHA Program.

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

Not applicable. No credibility adjustments were made to the CYE 19 encounter data.

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

Completion Factors

The AHCCCS DHCM Actuarial Team developed completion factors to apply to the CYE 19 encounter data. Completion factors were calculated using the development method with monthly encounter data incurred from October 2016 through early March 2020 and adjudicated and approved through early March 2020. The completion factors were developed by GSA, major category of service, and by month of service. The major categories of service are based upon the AHCCCS form type, which indicates the type of form used to submit a claim. AHCCCS has six form types: Professional and Other Services (form type A), Prescription Drug (form type C), Dental Services (form type D), Inpatient Hospital (form type I), Nursing Facility (form type L), and Outpatient Hospital (form type O). Dental Services (0.06% of CYE 19 encounters) were combined with Professional and Other Services and Nursing Facility Services (0.43% of CYE 19 encounters) were combined with Inpatient Hospital. The monthly completion factors for CYE 19 were applied to the CYE 19 encounter data. Table 4a below displays the aggregate completion factors

for CYE 19 by GSA and major category of service. Table 4b below displays the aggregate impact of completion by GSA.

Table 4a: CYE 19 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	0.9663	0.9880	0.9184	0.9609	0.9614
North	0.9774	0.9912	0.9128	0.9761	0.9703
South	0.9302	0.9904	0.8861	0.9154	0.9306
Total	**0.9582**	**0.9889**	**0.9097**	**0.9487**	**0.9545**

Table 4b: Impact of Completion Factors by GSA

GSA	Before Completion	After Completion	Impact
Central	$1,632.77	$1,698.44	4.0%
North	$1,223.74	$1,261.31	3.1%
South	$1,135.39	$1,220.15	7.5%
Total	**$1,424.35**	**$1,492.27**	**4.8%**

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

Encounter Issue Adjustment Factors

During the rate development process, the Central RBHA was determined to have missing encounters due to a delay in encounter submission for the last two months of CYE 19. To correct for the missing encounters, the actuaries calculated factors (by form type) which averaged the first ten months of completed encounter data for the year divided by the average of the last two months, and applied those factors to the last two months of the contract year to bring them up to a reasonable level. The actuaries then compared the revised amounts against supplemental data from the RBHA regarding paid claims by month to confirm the reasonability of the approach and magnitude of correction. The other encounter issue corrected for had to do with delayed processing of claim payments by the South RBHA due to claims payment system issues related to the ACC integration. The completion factors for the South RBHA corrected for some of this delay; however, after review of completed encounters by month across the past three years, the actuaries could see that the completion factors were not fully correcting for this issue in the first half of CYE 19, and as a result, the actuaries used a similar methodology as that described above, by calculating factors by form type which increased the first six months of CYE 19 encounters. The reasonability of the adjustments were assessed by comparing the revised totals to the financials, and viewing the adjusted months in line with the monthly data used in the trend model. The actuaries were confident in the suitability of the data in aggregate after these adjustments. Table 5 below displays the aggregate impact of the encounter issue factors for CYE 19 by GSA.

Table 5: Impact of Encounter Issue Factors by GSA

GSA	Before Adjustment	After Adjustment	Impact
Central	$1,698.44	$1,743.35	2.6%
North	$1,261.31	$1,261.31	0.0%
South	$1,220.15	$1,276.09	4.6%
Total	**$1,492.27**	**$1,534.71**	**2.8%**

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

As noted above, the services covered under each rate cell are changing effective October 1, 2020. The actuaries restricted the base encounter data for each rate cell to only the services which will be provided effective October 1, 2020 for purposes of moving forward from the base data year to the rating period.

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2018 through September 30, 2019) 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, 2019 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 DHCM financial analysts with oversight from the AHCCCS 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 AHCCCS DHCM financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuaries met with the AHCCCS DHCM financial analysts to understand at a high level how the estimated amounts were derived and the data used for the amounts. The actuaries were unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

Removal of Differential Adjusted Payments from Base Data

CYE 19 capitation rates funded DAP made from October 1, 2018 through September 30, 2019 to distinguish providers which committed to supporting designated actions that improve the patient care experience, improve member health and reduce cost of care growth. As these payments expired September 30, 2019, AHCCCS has removed the impact of CYE 19 DAP from the base period. To remove the impact, the AHCCCS DHCM Actuarial Team requested provider IDs for the qualifying providers for the CYE 19 DAP by specific measure from the AHCCCS Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 19 were then adjusted downward by the

appropriate percentage bump specific to the DAP measure. The associated costs removed from the base data are displayed below in Table 6a. Totals may not add up due to rounding.

See Section I.4.D. for information on adjustments included in CYE 21 capitation rates for DAP that are effective from October 1, 2020 through September 30, 2021.

Table 6a: Removal of DAP from Base Data

GSA	Dollar Impact	PMPM Impact
Central	($3,042,718)	($7.51)
North	($439,761)	($4.58)
South	($1,407,512)	($6.20)
Total	**($4,889,991)**	**($6.71)**

Removal of Access to Professional Services Initiative

CYE 19 capitation rates funded APSI fee schedule increases for claim payments made from October 1, 2018 through September 30, 2019. The enhanced fee schedule was used to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. As these enhanced fee schedule payments expired September 30, 2019, AHCCCS has removed the impact of CYE 19 APSI from the base period. To remove the impact, the AHCCCS DHCM Actuarial Team extracted adjudicated and approved encounter data (submitted on form CMS-1500s and dental encounters) for the qualifying providers, identified by Billing Provider Tax ID, excluded any sub-capitated/block purchasing arrangements (identified by CN1 Code 05 on the encounters) and any encounters for which AHCCCCS was not the primary payer, and calculated the increase due to the enhanced fee scheduled to remove from the base data. The encounter data included relevant rate cell and program information to be able to distribute into the individual rate cells. The associated costs removed from the base data are displayed below in Table 6b. Totals may not add up due to rounding.

Table 6b: Removal of APSI from Base Data

GSA	Dollar Impact	PMPM Impact
Central	($1,545,521)	($3.81)
North	($60,134)	($0.63)
South	($1,927,936)	($8.49)
Total	**($3,533,591)**	**($4.85)**

Pharmacy Reimbursement Savings

Analysis of pharmacy claims for all AHCCCS managed care programs and AHCCCS FFS program identified significant variability across all Contractors, and analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to 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 Contractors should reasonably be able to achieve pharmacy pricing that is at or

near that achieved by the AHCCCS FFS program. However, AHCCCS recognized that the full savings amount may not be reasonably achievable in a single year, and for CYE 20 therefore adjusted 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, for CYE 21, AHCCCS is adjusting the base pharmacy data of each program by 66% of the savings identified in the analysis of CYE 18 pharmacy data. This is consistent with subsequent analysis of the CYE 19 pharmacy data.

The amount of the base data adjustment for pharmacy reimbursement savings for the RBHA Program is displayed below in Table 6c. Totals may not add up due to rounding.

Table 6c: Pharmacy Reimbursement Savings

GSA	Dollar Impact	PMPM Impact
Central	($9,795,187)	($24.16)
North	($788,066)	($8.21)
South	($2,125,567)	($9.36)
Total	**($12,708,820)**	**($17.44)**

Pharmacy Benefit Manager Administrative Spread Removal

In July 2019, AHCCCS provided additional guidance on several contract requirements that aim to increase transparency and cost-effectiveness. One requirement provided guidance on how the PBM pass-through pricing model was to be implemented and administrative expenses reported. In accordance with contract requirements, the AHCCCS DHCM Actuarial Team has incorporated savings to medical expense costs associated with the removal of spread pricing from CYE 19 base period encounters. The percentages used to adjust pharmacy encounters for the removal of PBM admin spread from the base data encounters were developed based on additional data provided by the RBHAs through surveys, data requests, and additional clarifying communications between AHCCCS and the RBHAs. The non-benefit costs reflected in the CYE 21 capitation rates reflect the requirements for transparency in reporting PBM administrative expenses.

The amount of the base data adjustment for PBM admin spread removal for the RBHA Program is shown below in Table 6d by GSA. Totals may not add up due to rounding.

Table 6d: PBM Administrative Spread Removal

GSA	Dollars removed for change	PMPM change
Central	($2,176,426)	($5.37)
North	$0	$0.00
South	($1,106,247)	($4.87)
Total	**($3,282,674)**	**($4.51)**

Combined Miscellaneous Base Data Adjustments

- **Pharmacy and Therapeutics Committee Recommendations – Base Year ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 19 that impacted utilization and unit costs of Contractors' pharmacy costs in CYE 19. 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.
- **Prenatal Syphilis Screens ***
  In September 2018, the ADHS declared a syphilis outbreak for women and babies in Arizona. In response to the outbreak, AHCCCS issued a joint position statement with ADHS on February 28, 2019 to clarify that AHCCCS covers 3 prenatal syphilis screens during a member's pregnancy. The statement aligns with screening recommendations from the Centers for Disease Control and Prevention (CDC) that all pregnant women receive a screen during their first prenatal visit, and again early in the third trimester and at the time of delivery if they are at high risk of syphilis.
- **Transportation Network Companies ***
  Beginning May 1, 2019, AHCCCS established a Transportation Network Company (TNC) provider type that delivers NEMT services through a ride-sharing model. The TNC-specific fee schedule is lower than ordinary NEMT base rates.
- **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.

The aggregate amount of the costs of the miscellaneous non-material base data adjustments are displayed by GSA below in Table 6e. Totals may not add up due to rounding.

Table 6e: Combined Misc. Base Data Adjustments

GSA	Dollars	PMPM change
Central	($268,849)	($0.66)
North	($137,990)	($1.44)
South	$11,409	$0.05
Total	**($395,430)**	**($0.54)**

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 21 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 2021 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 FFP 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 aged 21-64. For enrollees aged 21-64, for inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.6(e), and this is described below in Section I.3.A.v.

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

The projected benefit costs include costs for members aged 21-64 that have a stay of no more than 15 cumulative days in a month in an IMD in accordance with 42 CFR § 438.6(e) 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 aged 21-64 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 aged 21-64 for stays in an IMD exceeding 15 cumulative days in a month, whether through a single stay or multiple within the month. Additionally, the AHCCCS DHCM Actuarial Team removed all associated medical costs that were provided to the member during the IMD stay(s) that exceeded 15 cumulative days in a month.

The data used to determine the base data adjustment was the CYE 19 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 19 encounter data, the AHCCCS DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the Non-IMD price-per-day. The Non-IMD price-per-day used in the analysis was $874.95 and was derived from the CYE 19 encounter data for similar IMD services that occurred within a Non-IMD setting. The encounter data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a Non-IMD setting, which may not be fully captured within the AHCCCS FFS fee schedule per diem rate. The costs associated with an institutional stay at an IMD that were repriced in the base data are displayed below in Table 7a. Totals may not add up due to rounding.

Table 7a: Reprice of Costs for all IMD Stays by GSA

GSA	Repriced IMD Dollars Added	Repriced IMD PMPM Added
Central	$2,542,992	$6.27
North	$96,961	$1.01
South	$829,281	$3.65
Total	$3,469,234	$4.76

The AHCCCS DHCM Actuarial Team identified all members aged 21-64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed below in Table 7b. Totals may not add up due to rounding.

Table 7b: Removal of Repriced Stays More Than 15 Days in a Month by GSA

GSA	Repriced IMD Dollars Removed	Repriced IMD PMPM Removed
Central	($4,336,510)	($10.70)
North	($298,069)	($3.10)
South	($1,354,940)	($5.97)
Total	($5,989,519)	($8.22)

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 7c. Totals may not add up due to rounding.

Table 7c: 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	($1,126,289)	($2.78)
North	($31,929)	($0.33)
South	($241,599)	($1.06)
Total	($1,399,817)	($1.92)

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

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

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

The section provides information on the projected benefit costs included in the CYE 21 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 SMI rate cells' adjusted base data PMPMs were trended forward 24 months, from the midpoint of the CYE 19 time period to the midpoint of the CYE 21 rating period. The CMDP Child rate cells' adjusted base data PMPMs were trended forward 21 months, from the midpoint of the CYE 19 time period to the midpoint of the 6-month period for CYE 21 capitation rates under the RBHA Program. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below. Appendix 4 contains the base data and base data adjustments by GSA and rate cell, Appendix 5 contains the projected benefit cost trends by GSA and rate cell, and Appendix 6 contains the prospective program changes by GSA and rate cell. Additionally, Appendix 6 illustrates the capitation rate development by GSA and rate cell, which includes the DAP, reinsurance offset, administrative expense, underwriting (UW) gain, and premium tax.

The capitation rates were adjusted for all program and reimbursement changes. If a program or reimbursement change had an impact of 0.2% or less for every individual rate cell, that program or reimbursement change was deemed non-material and has been grouped in the combined miscellaneous subset below. The aggregate dollars in each of the tables below for the CMDP Child rate cell are the projected 6-month impacts, for all other rate cells, the aggregate dollars are the projected annual impacts.

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

Medical Officer. The actuaries relied upon the professional judgment of the AHCCCS DHCM financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuaries met with the AHCCCS DHCM financial analysts to understand at a high level how the estimated amounts were derived and the data used for the amounts. The actuaries were unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

Following national and state emergency declarations in March 2020, AHCCCS has sought authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. As of this writing, Appendix K authorities are approved from March 13, 2020 to March 31, 2021 while other select 1115 waiver changes are approved from March 1, 2020 until 60 days after the end of the federal emergency declaration. For CYE 21 rate development, the actuaries have incorporated projected impacts of these authorities and other AHCCCS responses to the COVID-19 outbreak for portions of the contract period, these are indicated by a ǂ symbol.

Pharmacy & Therapeutics Committee Decisions – CYE 20 and forward*

On the recommendations of the P&T Committee, AHCCCS adopted policy changes during CYE 20 that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 21. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

To estimate the impact of adopted P&T Committee changes, the AHCCCS DHCM financial analysts largely relied on projections of drug utilization prepared by Magellan Rx Management, the agency's provider of drug rebate administrative services. Magellan has a nationwide vantage point that was drawn from in projecting how recommendations would impact drug utilization by AHCCCS members. In instances where Magellan did not provide a projected impact of an adopted change, the actuaries relied upon the judgement of AHCCCS DHCM financial analysts to project the impact. For CYE 21 rate development, the aggregate impact of adopted changes was allocated across risk cells and GSAs using FFY 19 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 8a. Totals may not add up due to rounding.

Table 8a: P&T Committee Decisions

GSA	SMI PMPM	SMI Dollars	CMDP Child PMPM	CMDP Child Dollars
Central	$5.78	$1,759,992	($0.24)	($12,278)
North	$1.17	$92,503	($0.13)	($1,125)
South	$2.62	$480,554	($0.18)	($3,923)
Total	**$4.12**	**$2,333,049**	**($0.21)**	**($17,326)**

Expanded Telehealth Use *‡

To ensure access to care during the public health emergency, AHCCCS has temporarily expanded coverage of telephonic codes and mandated that services delivered telephonically or through telehealth (TPTH) are reimbursed at the same rates as for in-person services, for both physical and behavioral health services. April and May 2020 data provided by Contractors indicates use of TPTH services has been essential for continued provision of services and represented annualized growth of 1,308% above base period use. Most growth in the use of these services during the public health emergency is expected to represent a cost-neutral shift from use of in-person services. Increased use of TPTH services are, however, expected to reduce the rate of missed appointments and lower use NEMT and emergency department (ED) visits.

AHCCCS DHCM financial analysts reviewed Contractor-provided utilization of physical and behavioral health TPTH services for April and May 2020. It was projected that monthly use of TPTH for October 1, 2020 to March 31, 2021 of the contract period would equal the monthly use reported for April and May 2020. For purposes of projecting TPTH use for April 1, 2021 to September 30, 2021 of the contract period, AHCCCS DHCM financial analysts relied on a national projection developed by McKinsey & Co. of potential TPTH use following the public health emergency. The AHCCCS percent share of McKinsey's national projection was estimated to equal AHCCCS' percent share of 2017 National Health Expenditures. It was further assumed that use would be phased in at 33% of AHCCCS projected TPTH services during the first year following the public health emergency.

As more services shift from being provided in person to through TPTH, the rate of missed appointments is expected to decrease, resulting in additional program service use. Based on a literature review, it was assumed that the missed appointment rate for TPTH-eligible services was 25% during the base period. Based on findings from additional studies, it was assumed that TPTH-provided services could result in a 50% reduction in missed appointments compared to in-person appointments. Combining these assumptions, the AHCCCS DHCM financial analysts estimated that 14.3% of growth in TPTH during CYE 21 would represent new services.

Use of TPTH is expected to reduce the need for NEMT services. AHCCCS DHCM financial analysts determined that 11.0% of claims for in-person services of the most heavily used TPTH codes were accompanied by same day use of NEMT during the CYE 2019 base period. It was therefore, estimated that 11.0% of the increase to TPTH services in CYE 21 would result in a reduction in NEMT rides. Cost savings was calculated using the average trip and mileage costs of NEMT rides multiplied by the estimated reduction in rides.

Use of TPTH is additionally expected to reduce the use of low-to-moderate severity ED visits. The McKinsey & Co. national projection noted above assumed that 20% of all ED visits could transition to TPTH following the public health emergency. Consistent with the 33% first year phase-in assumption above for projected TPTH services following the public health emergency, AHCCCS DHCM financial analysts projected a 6.6% reduction (33% phase-in of a 20% reduction) in ED visits in CYE 2021 resulting

from TPTH use. Cost savings from the change was calculated using the cost reduction of TPTH services relative to the cost of low-to-moderate severity ED visits, multiplied by the estimated reduction in ED visits.

For CYE 21 rate development, the projected impact of growth in TPTH services was allocated across rate cells and GSAs using base period encounters of TPTH-eligible services, NEMT, and ED visits. The overall impact of the change by GSA is displayed below in Table 8b. Totals may not add up due to rounding.

Table 8b: Net Impacts of Expanded Telehealth Use

GSA	SMI PMPM	SMI Dollars	CMDP Child PMPM	CMDP Child Dollars
Central	$15.31	$4,660,750	$12.21	$617,167
North	$8.88	$703,004	$13.99	$118,045
South	$13.59	$2,490,679	$17.41	$381,685
Total	**$13.86**	**$7,854,433**	**$13.80**	**$1,116,897**

AHCCCS FFS Fee Schedule Updates

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS FFS programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts except where authorized under applicable law, regulation or waiver, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding health plan fee schedules.

Additionally, the RBHA Contracts have requirements that the RBHAs reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates program change includes a fee schedule adjustment to bring the encounter base data from CYE 19 FQHC PPS rates up to projected CYE 21 FQHC PPS rates.

Effective October 1, 2020, AHCCCS will be updating provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 21 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 21 capitation rates was the CYE 19 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 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program.

In March 2020, the Arizona Legislature passed and Governor Ducey signed into law HB 2668 (Laws 2020, Chapter 46) which establishes a new hospital assessment effective October 1, 2020. Monies from this assessment are to be deposited into the Health Care Investment Fund (HCIF) and used to make directed payments to hospitals, as well as increase base reimbursement rates for services reimbursed under the dental fee schedule and physician fee schedule, not including the physician drug fee schedule, to the extent necessary as determined by AHCCCS to restore provider rates to those in existence prior to reductions implemented in state fiscal year 2009. In order to implement this legislation, AHCCCS has included a provision in the CYE 21 contracts requiring the percentage increases associated with HCIF provider rate increases be implemented by the Contractors. The AHCCCS DHCM Rates & Reimbursement Team used the CYE 19 encounter data to develop the adjustment to the CYE 21 capitation rates. 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 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program.

CMS expanded the range of Medicare codes that may be billed for services provided by a resident without the direct supervision of a primary care physician, using the GE modifier. AHCCCS has aligned with CMS by expanding the set of codes for which resident-provided services can be billed using the GE modifier. The AHCCCS DHCM financial analysts applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program as part of the fee schedule changes as the change is non-material for the RBHA Program when considered alone.

A technical issue was identified in the setting of CYE 19 FFS rates for various durable medical equipment (DME) codes. The CYE 21 capitation rates include a correction to these DME FFS rates. This correction is non-material for the RBHA Program when considered alone.

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

AHCCCS will additionally be increasing some fee schedule rates effective January 1, 2021 to recognize the next minimum wage increase resulting from the passing of Proposition 206. The increased costs for this change have been included with the fee schedule changes already discussed as the minimum wage change is non-material to the RBHA Program when considered alone.

The overall impact of the AHCCCS FFS fee schedule updates by GSA is illustrated below in Table 8c. Totals may not add up due to rounding.

Table 8c: Impact of Aggregate AHCCCS FFS Fee Schedule Updates

GSA	SMI PMPM	SMI Dollars	CMDP Child PMPM	CMDP Child Dollars
Central	$42.89	$13,054,494	$7.83	$395,755
North	$24.10	$1,907,436	$17.65	$148,902
South	$27.14	$4,975,046	$12.83	$281,386
Total	**$35.17**	**$19,936,976**	**$10.21**	**$826,043**

Increase to Annual Respite Hour Limit * ‡

CMS approved AHCCCS' requested 1115 Waiver authority to increase the annual limit in covered respite care services that a member may receive from 600 hours to 720 hours a year. The authority is effective retroactively from March 1, 2020 until 60 days after the end of the federal emergency declaration. The estimates assume that the authority will extend for the 12 months of CYE 21. To estimate the impact of this change, the AHCCCS DHCM financial analysts first reviewed base period encounters of respite care services. In projecting the impact of this change, analysts made the assumption that members currently receiving the full 600 hours of services permitted during the base period would begin receiving the full 720 hours of respite services permitted under the expanded 1115 waiver authority during the contract period. Analysts further assumed that use of respite care services by all other members using respite care services during the base period would increase by 20%, which equals the percentage increase in the annual cap.

For CYE 21 rate development, the projected impact of additional respite services was allocated across rate cells and GSAs using base period encounters. The overall impact of the change by GSA is displayed below in Table 8d. Totals may not add up due to rounding.

Table 8d: Impact of Increase to Annual Respite Hour Limit

GSA	SMI PMPM	SMI Dollars	CMDP Child PMPM	CMDP Child Dollars
Central	$0.47	$143,075	$1.61	$81,522
North	$0.12	$9,364	$10.70	$90,291
South	$0.28	$50,770	$5.56	$121,948
Total	**$0.36**	**$203,209**	**$3.63**	**$293,761**

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 8e. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Additional Allowed Providers for MAT and Mental Health Assessments ***
  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. Additionally, AHCCCS revised billing authority to correct an inadvertent exclusion of 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.
- **Behavioral Health Residential Facilities (BHRF) Personal Care Differential ***
  Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team established a differentiated FFS rate for Behavioral Health Residential Facilities (BHRF) that are licensed by ADHS to provide personal care services.
- **Increased Frequency of Dental Fluoride Visits ***
  Beginning February 1, 2020, AHCCCS increased the maximum number of dental fluoride varnish applications that members may receive, from 2 to 4 applications a year.
- **Inpatient Dental Hygienist Teeth Cleanings ***
  As part of the 2019 Legislative session, the Arizona Legislature passed HB 2058 which permits dental hygienists to provide services in an inpatient hospital setting under supervision of a physician. The legislation is expected to increase provision of inpatient teeth cleanings for prevention of ventilator associated pneumonia (VAP).
- **Applied Behavior Analysis ***
  AHCCCS policy was updated effective November 1, 2019 to include clarifying language on the requirement for the ACC and RBHA Programs to provide covered Applied Behavior Analysis (ABA) services to children not receiving these services through another program. The policy clarification is consistent with CMS guidance dated July 7, 2014, which directs states to cover medically necessary services for treatment of autism spectrum disorder as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children under 21 years of age. The policy guidance is expected to gradually raise awareness and increase utilization of these covered ABA services in CYE 20 and CYE 21.
- **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. Due to a slower-than-anticipated adoption of the ASAM software, impacts of the change in the base period

encounters are limited. For CYE 21 rate development, additional impacts for the change are included above any base period encounters.

- **Pay and Chase Guidance ***

  Federal regulation 42 CRF 433.139, *Payment of Claims*, requires agencies and their Contractors to pay and chase claims for preventive pediatric care services, including EPSDT services, regardless of the existence of third party liability at the time the claim is filed. Preventive pediatric care refers to screening and diagnostic services to identify congenital, physical, mental health routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infectious and communicable diseases from occurring in children under 21 years of age. As a result of questions to AHCCCS regarding coordination of benefits for members with Autism Spectrum Disorder, the agency provided additional clarification to Contractors in FFY 20 on preventive services that must be reimbursed on a pay and chase basis. This clarification is anticipated to increase costs of Contractors in situations in which they are unable to successfully recover funding from liable third parties.

- **Cystic Fibrosis Drug Approval ***

  On October 21, 2019, the Food and Drug Administration (FDA) approved the cystic fibrosis transmembrane conductance regulator (CFTR) modulator drug Trikafta for treatment of cystic fibrosis in individuals aged 12 years and older. The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Trikafta on October 21, 2019. Effective October 1, 2020, all CFTR drugs (Trikafta, Symdeko, and Orkambi) are eligible for reinsurance.

- **Sickle Cell Anemia Drugs Approval ***

  In November 2019, the FDA approved the drugs Oxbryta and Adakveo for treatment of sickle cell disease. Collectively, the drugs are approved for treatment of individuals 12 years and older. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Oxbryta and Adakveo on November 25, 2019 and November 20, 2019, respectively.

- **Duchenne Muscular Dystrophy Drug Approval ***

  On December 12, 2019, the FDA approved Vyondys 53 for treatment of Duchenne muscular dystrophy in individuals with a mutation that is amenable to exon 53 skipping. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Vyondys 53 on December 12, 2019.

- **Peanut Allergy Drug Approval ***

  On January 31, 2020, the FDA approved the immunotherapy drug Palforzia for treatment of peanut allergy in children 4 to 17 years of age. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers.

In accordance with requirements of participation in MDRP, AHCCCS began coverage of Palforzia on January 31, 2020.

- **Mantle Cell Lymphoma Drug Approval ***
  On July 24, 2020, the FDA approved Tecartus for the treatment of adult patients with relapsed or refractory mantle cell lymphoma . The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebates agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Tecartus on July 24, 2020. Beginning October 1, 2020, Tecartus will be eligible for reinsurance.
- **Spinal Muscular Atrophy Drug Approval ***
  On August 7, 2020, the FDA approved Evrysdi for the treatment of Spinal Muscular Atrophy in patients 2 months and older. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Evrysdi on August 7, 2020. Effective October 1, 2020, Evrysdi is eligible for reinsurance.
- **Adult Hepatitis C Screening Recommendation ***
  On March 2, 2020, the U.S. Preventive Services Task Force (USPSTF) published a final recommendation that all adults 19 to 79 years of age be screened for hepatitis C. This represents an expansion of recommended screening from the previous guidance that adults born between 1945 and 1965 be screened. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the USPSTF final recommendation on hepatitis screenings for adults.
- **Adult Human Papillomavirus Immunization Guidance ***
  On August 16, 2019, the CDC Advisory Committee on Immunizations (ACIP) released a recommendation that adults 27 to 45 years of age at risk of contracting human papillomavirus immunization (HPV) are vaccinated. This represents an expansion to previous guidance, which recommended HPV immunizations for adults 19 to 26 years of age. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the ACIP recommendation on HPV immunizations for adults.
- **Depression and Anxiety Screening Codes ***
  Effective August 1, 2020, AHCCCS began coverage of procedure code 96127 for brief emotional or behavioral assessments.
- **Off Campus Hospital Outpatient Department Reimbursement ***
  Effective October 1, 2020, AHCCCS is reimbursing services billed at off campus hospital outpatient departments on a UB-04 form with PO or PN modifiers according to the physician or ambulatory surgical center fee schedules. The change will represent a decrease in reimbursement relative to outpatient hospital fee schedule rates that providers billed before the change.
- **Outpatient Psychiatric Hospital Reimbursement ***
  Beginning October 1, 2020, AHCCCS is implementing an outpatient hospital fee schedule reimbursement methodology for outpatient services provided by psychiatric hospitals. Prior to this change, AHCCCS manually approved Contractor payments to psychiatric hospitals for

outpatient services, which were not subject to a specific reimbursement methodology. To estimate the impact, the AHCCCS DHCM financial analysts repriced base period encounters at outpatient hospital fee schedule rates.

- **Supports During School Hours * ǂ**
  Member students receive medically necessary services that are specified in an Individualized Education Program (IEP) from school-based providers participating in the School Based Claiming (SBC) FFS program. Due to virtual learning environments necessitated by the public health emergency, it may not be feasible for schools to provide in-person attendant care and nursing services through SBC. It is therefore, anticipated that these services will transition to Contractor provider networks.
- **Flu Vaccine Initiative *ǂ**
  AHCCCS is implementing initiatives in the contract year to support use of influenza vaccinations during the COVID-19 outbreak. Effective September 1, 2020, the agency increased FFS rates on influenza vaccination and administration codes and on administration codes for all Vaccine For Children (VFC) program vaccines by 10%. Effective September 1, 2020, AHCCCS also modified policy guidance to permit pharmacists to administer influenza vaccinations to children ages 3 - 18 years old and to permit qualified emergency medical service providers to administer influenza vaccinations to members of all ages. Prior to the change, policy limited pharmacist-administered influenza vaccines to adults 19 years and older. Lastly, Contractors are providing a $10 gift card to members that receive an influenza vaccination in the contract period. AHCCCS anticipates this gift card incentive will increase member use of these services. Contractor costs to purchase and administer the gift cards are funded separately in the non-benefit portion of the CYE 21 capitation rates.
- **Rx Rebates Adjustment**
  An adjustment was made to reflect the impact of Rx Rebates reported within the RBHA Program financial statements, as pharmacy encounter data does not include these adjustments. The data reviewed to develop the impact was the CYE 17, CYE 18, CYE 19, and CYE 20 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 21 Pharmacy category of service to reflect the levels of reported Rx Rebates by GSA.

Table 8e: Combined Miscellaneous Program Changes

GSA	SMI PMPM	SMI Dollars	CMDP Child PMPM	CMDP Child Dollars
Central	($1.18)	($359,682)	$1.54	$77,812
North	($2.02)	($160,248)	$1.32	$11,161
South	($2.24)	($411,190)	$1.69	$36,959
Total	**($1.64)**	**($931,120)**	**$1.56**	**$125,932**

Adjustments to Crisis Intervention

As noted above in Section I.2.B.ii.(c)(i), for the two Crisis cells, both encounter data and contracted block payment amounts are used for the development of the CYE 21 capitation rates. The inclusion of data other than encounters for developing the CYE 21 capitation rates is due to the nature of the crisis intervention service model. Crisis intervention services are based on a "firehouse" model, in which costs are incurred for staffing 24/7 crisis telephone lines, 24/7 crisis mobile teams, and 24/7 crisis stabilization units, whether there are services provided or not. The RBHAs therefore contract and pay for these staffing costs through block payment arrangements, which keeps the system running smoothly, since the numbers of people seeking crisis in any given year can be very different, and trying to price fee schedules to account for those differences could under or over fund the services in any given year if the projections turn out different than reality. This "always on" model of care is the most efficient way to ensure that members in crisis have access to crisis intervention services at all times without needing to go to the ED, reducing costs, increasing access, and providing care to members in their most vulnerable states.

Due to the "firehouse" model, the actuaries have included additional costs for crisis intervention services above what is in the encounter base data. This is a continuation of the methodology from the CYE 20 capitation rate development which used a discrete adjustment to crisis intervention services, having a similar effect as that of an under-reporting factor for a single category of service. The amount of dollars added to the crisis encounter data are based on the difference between the completed base year encounters, and the CYE 21 contracted block payment arrangements for each of the three types of crisis intervention services (crisis telephone lines, crisis mobile teams, and crisis stabilization units) between the RBHAs and the service providers. The RBHA CYE 21 contracted block payments for crisis intervention services plus ancillary crisis base encounter data completed and trended forward most accurately reflect anticipated actual costs.

Ancillary crisis services, such as NEMT to a crisis stabilization unit and laboratory services provided in the first 24 hours of a crisis episode, continue to be the responsibility of the RBHAs for CYE 21. The AHCCCS DHCM Actuarial team pulled encounter data related to ancillary crisis services provided by the RBHAs within 24 hours of a crisis episode, added completion, adjusted for a policy change effective October 1, 2020 which clarifies that emergency transportation as well as NEMT (unless such NEMT is to a crisis stabilization unit) is the responsibility of the plan of enrollment for physical health services, added 24 months of trend (midpoint to midpoint), and added those amounts to the RBHA Crisis rate cell capitation rate development.

The overall impact of the additional dollars for crisis intervention services over the base encounter data, including the impact of the additional ancillary encounters, is shown below in Table 8f. Totals may not add due to rounding. Note that the aggregated PMPM and dollar impacts for the GSAs expressed in this table are calculated on each of the Crisis rate cells where impacts expressed elsewhere within this section are specific to and calculated across the two main populations.

Table 8f: Adjustments to Crisis Rate Cells

GSA	Crisis Adult PMPM	Crisis Adult Dollars	Crisis Child PMPM	Crisis Child Dollars
Central	$7.42	$46,347,612	$0.32	$1,881,527
North	$3.53	$6,553,956	$0.44	$509,511
South	$7.17	$25,633,797	$2.93	$7,451,811
Total	**$3.71**	**$78,535,366**	**$0.47**	**$9,842,849**

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 21 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 the encounter data incurred from October 2016 through early March 2020 and adjudicated and approved through the first encounter cycle in March 2020. The trend was developed primarily with actual experience from the Medicaid population.

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

The encounter data was summarized by GSA, rate cell, month, and major category of service, and by utilization per 1000, unit cost, and PMPM values. The encounter data was adjusted for completion, the encounter issues described in Section I.2.B.iii.(C), and to normalize for previous program changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 19 (April 1, 2019) to the midpoint of the rating period for CYE 21 (April 1, 2021), with the exception of the CMDP Child rate cells (midpoint of 6-month rating period is January 1, 2020, 21 months from the midpoint of CYE 19). 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. There was no trend applied to the crisis intervention services

encounters (specified procedure codes which define crisis) for the Crisis rate cells due to the adjustment to align CYE 21 projections with anticipated crisis spend (block payment contract amounts and non-block cost projections) from the RBHAs for those services, as noted in Section I.3.B.ii.(a). The trend applied to the ancillary crisis encounters was based on the trend which would have been applied to crisis intervention services, absent the adjustment listed above.

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. Trends were also compared between GSAs and variances were determined to be reasonable and appropriate.

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

The 2021 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuaries defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%.

There are three PMPM trends which crossed the outlier threshold, all related to the Inpatient Behavioral Health category of service. For Central SMI, Central CMDP Child, and South CMDP Child rate cells, the outlier trend is driven by large sustained utilization increases in this category of service. This is true for each of the main populations across the state; however these three specific PMPM trends are those that crossed the 7% threshold for outlier status. AHCCCS conducted a study reviewing access to and utilization of behavioral health providers across the state, and found low utilization and lack of access to Inpatient Behavioral Health services. Two of the main drivers were the level of reimbursement to providers and a lack of beds. Since that study, AHCCCS has increased FFS reimbursement levels, and more bed capacity has been built. These changes have been catalysts for sustained utilization increases (across all rate cells and GSAs, but even more acutely in the Central GSA) in the Inpatient Behavioral Health category of service. The significant increase in Inpatient Behavioral Health bed utilization over the last 3 years has shown how much demand was previously not being met, and the continued increased utilization in the most recent contract year shows that there is still unmet demand, and facilities are still building out more space for beds due to the demand for these services. The RBHAs have done much work to increase engagement with members before and after inpatient stays, along with utilization management review, and value based contracting to align outcomes and incentives, funding discharge coordinators, and other measures aimed at dampening the growth.

The actuaries assumed negative utilization trends in the North GSA for the CMDP Child rate cell for the Residential Services category of service, in the Central GSA for the SMI rate cell for the Rehabilitation/Treatment and Support Services categories of service, and in the South GSA for the SMI rate cell for the Rehabilitation/Treatment category of service. Each of these negative utilization 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 utilization trend assumptions, all regression lines for the rate cell's category of service utilization data are negatively sloped and the negative slopes are more extreme than the trend rate assumed in capitation rate development.

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

Where the direction of linear regression results varied by time frame, the actuaries used actuarial judgement with all data available, including feedback from the RBHAs obtained before rate development began, to make individual assumptions by category of service, 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 annualized projected benefit cost trends by GSA for utilization per 1000, unit cost, and PMPM values are included below in Table 9.

Table 9: CYE 21 Annualized Trends

GSA	Util/1000	Unit Cost	PMPM
Central	0.26%	3.65%	3.91%
North	1.25%	1.93%	3.21%
South	0.52%	1.70%	2.22%
Total	**0.43%**	**2.96%**	**3.40%**

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

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

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

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

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

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

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

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

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

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

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS DHCM Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA.

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 21 capitation rates for the RBHA Program for the prior period time frame, given that the encounter and enrollment data are already included within the base data used for capitation rate development.

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

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

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

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

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

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

"The Contractor 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 2021 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 21 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 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 Program CYE 19 APM – Performance Based Payment amounts are anticipated to be $2.0 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 21 capitation rates and had no effect on the development of the capitation rates for the RBHA Program. The incentive payments will be paid by AHCCCS to the RBHAs through lump sum payments after the completion of the CYE 21 contract year.

I.4.B. Withhold Arrangements – Not Applicable

Not applicable. There are no withhold arrangements in the CYE 21 capitation rates for the RBHA Program.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2021 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 21 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 21 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 2021 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 and premium tax, plus any reinsurance payments. The RBHA's medical cost expenses are equal to the RBHA's fully adjudicated encounters and sub-cap/block payment expenses as reported by the RBHA with dates of service during the contract year. Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are

typically computed no sooner than 15 months after the contract year. This risk corridor will limit the RBHA's profits to 4% and losses to 2%.

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

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 21 capitation rates for the RBHA Program.

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

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

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

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

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

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

To better align integrated populations across programs, effective October 1, 2018, AHCCCS extended the reinsurance program it operates to the RBHA 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. Once a reinsurance case hits this limit, the RBHA Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

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

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

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

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

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

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

The methodology for setting the reinsurance offset has changed from the CYE 20 RBHA capitation rates. CYE 21 is the first year the actuaries had historical reinsurance payments for the base year (CYE 19). The data used to develop the reinsurance offset for CYE 21 are historical reinsurance payments to the RBHAs for services incurred during CYE 19. These reinsurance payments were divided by the CYE 19 SMI member months to develop a PMPM offset, before completion. This was done at the GSA and major reinsurance case type level (Regular, Biological and Catastrophic). The reinsurance PMPMs were then completed and adjusted for any adjustments that impacted CYE 19 base encounter data as described above in Section I.2.B.iii.(d). The adjusted reinsurance PMPMs were trended forward to CYE 21 using medical trend rates for the appropriate categories. Regular reinsurance case type used the Inpatient Hospital category of service trend, Biological reinsurance case type used the Pharmacy category of

service trend, and Catastrophic reinsurance case type used aggregated trend rates for the SMI rate cells by GSA across all categories of service.

The adjusted and trended reinsurance PMPMs were then further modified to account for changes to the reinsurance program from CYE 19 to CYE 21, to account for similar adjustments as those described above in Section I.3.B.(ii)(a), and for deductible leveraging to arrive at the CYE 21 reinsurance PMPMs. Changes to the reinsurance program from CYE 19 to CYE 21 included adding several drugs (Trikafta, Symdeko, Orkambi, Tecartus, and Evrysdi) to the list of drugs covered by the AHCCCS reinsurance program.

The projected costs of the additional drugs covered by the reinsurance program, noted above in Section I.3.B.ii.(a), was calculated by taking the projected costs for CYE 21 for those drugs and applying a zero dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset. The combined dollar impact to the reinsurance offsets for the RBHA Program is $235,000.

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

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

I.4.D.i. Rate Development Standards

This section of the 2021 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, Access to Professional Services Initiative, Pediatric Services Initiative, Hospital Enhanced Access Leading to Health Improvements Initiative, Targeted Investments PCPs, Targeted Investments Behavioral Health, Targeted Investments Hospitals, and Targeted Investments Criminal Justice. 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 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 20.0%, depending on the provider type.

Access to Professional Services Initiative

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

- A hospital facility with an ACGME-accredited teaching program and which is operated pursuant to the authority in Arizona Statute Title 48, Chapter 31; or,
- A hospital facility with:
    - An ACGME-accredited teaching program with a state university, and
    - AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2014; or,
- A freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than one hundred (100) licensed pediatric beds, excluding nursery beds.

The APSI provides a uniform percentage increase of 62% to otherwise contracted rates for qualified practitioners for all claims for which AHCCCS is the primary payer. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Pediatric Services Initiative

The PSI seeks to provide enhanced support to ensure financial viability of the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The PSI provides a uniform dollar increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Targeted Investments Program

The TI 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.

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

DAP 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.

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

See Appendix 6 for medical impact by rate cell. See Appendix 7 for total impact by rate cell.

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

Differential Adjusted Payments

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.5% increase; up to 13.5% for select services), Critical Access Hospitals (eligible for up to 10.0% increase; up to 20.0% for select services), other hospitals and inpatient facilities (eligible for up to 4.5% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 7.0% increase on all services provided), physicians, physician assistants, registered nurse practitioners, dental providers (all eligible for up to 2.0% increase), HCBS providers (eligible for up to 1.0% increase on specified services at specified places of service) and 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 19 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 21 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 21 capitation rates for the RBHA Program are displayed below in Table 10. The table includes the full year projections for SMI and the 6-month projections for CMDP Child. These projected medical payments do not include underwriting gain or premium tax. Totals may not add up due to rounding.

Table 10: Differential Adjusted Payments

GSA	Non-FQHC Dollar Impact	FQHC Dollar Impact	Total Dollar Impact
Central	$4,675,396	$31,387	$4,706,783
North	$1,009,320	$10,561	$1,019,881
South	$2,080,202	$47,567	$2,127,769
Total	**$7,764,918**	**$89,514**	**$7,854,432**

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

The DAP which are accounted for in the capitation rates, and described in the preceding sections, are being made under an approved § 438.6(c) pre-print in a manner consistent with the pre-print reviewed by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

I.4.D.ii.(a)(ii)(E) Maximum Fee Schedule – Not Applicable

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

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

The APSI, PSI, HEALTHII, and TI program 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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $6.0 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year (RBHA encounter data used for CMDP Child rate cells will be from the first six months of the contract year). The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Pediatric Services Initiative

Anticipated payments including premium tax for PSI are approximately $74,000. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 21 utilization will be used to redistribute the payments (RBHA encounter data used for CMDP Child rate cells will be from the first six months of the contract year). The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments including premium tax for HEALTHII are approximately $73.4 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 21 utilization will be used to redistribute the payments (RBHA encounter data used for CMDP Child rate cells will be from the first six months of the contract year). The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Targeted Investments Program

Table 11 below includes the CYE 21 anticipated payments including premium tax for each of the Targeted Investment pre-prints. The table includes the full year projections for SMI and the 6-month projections for CMDP Child. AHCCCS will distribute the final amounts in the form of annual lump sum payments to the Contractors after the completion of the contract year (RBHA encounter data used for

CMDP Child rate cells will be from the first six months of the contract year). The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Table 11: Targeted Investments Program

GSA	TI PCPs	TI Hospitals	TI Behavioral Health	TI Criminal Justice	Total TI
Central	$0	$864,648	$9,555,003	$2,377	$10,422,028
North	$0	$60,769	$1,359,205	$2,076	$1,422,050
South	$0	$104,337	$3,031,181	$404	$3,135,922
Total	**$0**	**$1,029,754**	**$13,945,389**	**$4,857**	**$14,980,000**

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Targeted Investments Program

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

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

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 Services Initiative

The qualifying providers receiving the uniform dollar 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.

Hospital Enhanced Access Leading to Health Improvements Initiative

The qualifying providers receiving the payments include hospitals providing contracted Medicaid Managed Care acute inpatient and ambulatory outpatient services.

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 TI program and who demonstrate performance improvement by meeting certain benchmarks for integrating and coordinating physical and behavioral health care.

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

Access to Professional Services Initiative

The distribution methodology for the CYE 21 APSI payments will be based on members' utilization of services from APSI qualified providers. The 62 percent uniform percentage increase will be applied to eligible services performed by APSI qualified providers as defined in the pre-print. The estimated amount for CYE 21 APSI was developed by applying the 62 percent uniform increase to CYE 19 utilization of eligible services based on encounters for the CYE 19 APSI qualified providers. The same definition of eligible services was used to develop the estimated amount. The APSI qualified providers were identified by Billing Provider Tax IDs in AHCCCS encounter system. The CYE 19 utilization is used as the basis for where to distribute the quarterly lump sum payments. The final lump sum payment will use CYE 21 encounter data for APSI qualified providers. The CYE 21 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 19, as well as the distribution used to make the quarterly lump sum payments.

Pediatric Services Initiative

The distribution methodology for PSI for CYE 21 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 uniform dollar increase will be applied to eligible services performed by providers eligible for the PSI (identified in the encounters by Servicing Provider Tax IDs). Eligible services are those submitted on UB-04 Inpatient Hospital and UB-04 Outpatient Hospital. Adjudicated and approved encounter data have been used to allocate the interim

PSI payments by capitation rate cell. CYE 19 utilization is the basis for the initial distribution of interim quarterly lump sum payments. After the end of the contract year, with sufficient run out, PSI interim quarterly payments will be reconciled using CYE 21 encounter utilization data to re-distribute the interim lump sum payments in the appropriate amounts. The CYE 21 encounter data 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 19.

Hospital Enhanced Access Leading to Health Improvements Initiative

The distribution methodology for HEALTHII for CYE 21 will be based on the utilization of services by members with providers participating in the HEALTHII program. Adjudicated and approved encounter data have been used to allocate the interim HEALTHII payments by capitation rate cell. CYE 19 utilization is the basis for the initial distribution of the interim quarterly lump sum payments. After the end of the contract year, with sufficient run out, HEALTHII interim quarterly payments will be reconciled using CYE 21 encounter utilization data to re-distribute the interim lump sum payments in the appropriate amounts. The CYE 21 encounter data 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 19.

Targeted Investments Program

The distribution methodology for the TI program for CYE 21 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 ID numbers (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 each CYE 21 TI was developed using CYE 19 encounter data and projected percentages of costs in the different TI programs as provided by the AHCCCS DHCM Rates & Reimbursement Team. The same definition of eligible services was applied for the estimated amount.

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

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

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

Access to Professional Services Initiative

These payments are being made under the approved APSI § 438.6(c) payment arrangement in a manner consistent with the pre-print reviewed by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

Pediatric Services Initiative

These payments are being made under the approved PSI § 438.6(c) payment arrangement in a manner consistent with the pre-print reviewed by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

Hospital Enhanced Access Leading to Health Improvements Initiative

These payments are being made under the approved HEALTHII § 438.6(c) payment arrangement in a manner consistent with the pre-print reviewed by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

Targeted Investments Program

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

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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)(D), and as if the payment information had been fully known when the rates were initially developed.

I.4.D.ii.(b) Confirmation of No Other Directed Payments

There are not any additional directed payments in the program that are not addressed in the certification.

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

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

AHCCCS will be including contract amendments with the submission of this rate certification which clarify the regulatory authority for any minimum fee schedule requirements which exist in contract language.

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

Not applicable. There are no pass-through payments in the CYE 21 capitation rates for the RBHA Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2021 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

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

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

The actuaries reviewed reported administrative expenses from the CYE 19 audited annual financial statements and CYE 20 Q1 & Q2 unaudited financial statements. In addition, the RBHAs were required to submit supplemental data which included administrative expenses by rate cell for CYE 19 and year-to-date CYE 20, administrative expense projections for the full year for CYE 20 and CYE 21, and actual and projected membership for those time frames. The supplemental data was then reviewed in conjunction with the non-benefit cost projections developed by the actuaries. Other sources of data reviewed and utilized in the development of the non-benefit cost projections were trends and forecasts for various Consumer Price Indices (CPI) and Employment Cost Indices (ECI) data from IHS Markit.

The actuaries developed and reviewed several methodologies for projecting administrative expenses for the RBHAs, comparing results to projections provided by the RBHAs, as well as reviewing the results as a percentage of pre-tax capitation. After reviewing all of the various results, the actuaries judged that due to similar results between the actuaries' projections across the various methodologies and the projections from the RBHAs, the RBHAs' projections for CYE 21 were reasonable, appropriate, and attainable. The RBHAs' projections for CYE 21 include non-benefit expenses associated with their PBM administrative subcontractors as required by PBM transparency. Additional expenses were included in the projected administrative costs for requirements identified by AHCCCS for the upcoming year, inclusive of the administrative costs required to administer the flu vaccine gift card initiative, which would not have been reflected in the RBHAs' supplemental administrative data nor their financials.

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 21 administrative expense PMPMs and percentage of the pre-tax capitation rates are displayed below in Table 12. 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 12: CYE 21 Administrative Expenses and Percentage of Pre-tax Capitation

GSA	Admin PMPM	Percentage of Pre-tax Capitation
Central	$6.14	8.05%
North	$4.41	8.74%
South	$6.13	9.76%
Total	**$5.89**	**8.57%**

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

The data, assumptions, and methodology used to develop the CYE 21 projected administrative costs are different than the previous rating period and have been documented above. The previous methodology is documented in the CYE 20 actuarial rate certification.

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

No other material adjustments were applied to the projected non-benefit costs of the CYE 21 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 21 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 21 capitation rates for the RBHA Program include a provision of 2.0% for premium tax. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 21 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

No other material or non-material non-benefit costs not already addressed in the previous sections are reflected in the CYE 21 capitation rates for the RBHA Program.

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

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

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

I.5.B.iv.(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). The HIPF for Fee Year 2020 has been incorporated as a retroactive amendment to the initially certified capitation rates for CYE 20. Fee Year 2020 is the final HIPF, as the Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502 repealed the annual fee for calendar years beginning after December 31, 2020.

I.5.B.iv.(b) Data Year or Fee Year – Not Applicable

Not applicable. The HIPF is not incorporated into the CYE 21 capitation rates for the RBHA Program.

I.5.B.iv.(c) Description of how Fee was Determined – Not Applicable

Not applicable. The HIPF is not incorporated into the CYE 21 capitation rates for the RBHA Program.

I.5.B.iv.(d) Address if not in Rates – Not Applicable

The capitation rates in this certification will not be adjusted to account for the fee at a later date.

I.5.B.iv.(e) Summary of Benefits Under 26 CFR § 57.2(h)(2)(ix) – Not Applicable

The portion of the CYE 21 capitation rates for the RBHA Program attributable to nursing facility services, and related HCBS, for 90 days of short-term convalescent care are located below in Table 13. This information is provided for information purposes only, as the HIPF is repealed, as noted above.

Table 13: Portion of the CYE 21 Capitation Rates for HCBS and NF

Rate Cell	Central	North	South
	HCBS/NF	HCBS/NF	HCBS/NF
SMI	$58.91	$11.74	$19.33
CMDP Child	$12.47	$63.66	$40.65

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

For HIPF that have been paid in 2014, 2015, 2016, 2018, and 2020, 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

Not applicable. The CYE 21 capitation rates for the RBHA Program do not include risk adjustment or acuity adjustment.

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

Section II of the 2021 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 HCBS, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates – Not Applicable

Section III of the 2021 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 21 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 21 capitation rates for the RBHA Program have been documented according to the guidelines established by CMS in the 2021 Guide. The CYE 21 capitation rates for the RBHA Program are effective for the 12-month time period from October 1, 2020 through September 30, 2021, with the exception of the CMDP Child rate cell capitation rates which are effective for the 6-month time period from October 1, 2020 through March 31, 2021.

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	November 13, 2020
Erica Johnson	Date

Associate, Society of Actuaries
Member, American Academy of Actuaries

SIGNATURE ON FILE	November 13, 2020
Windy J. Marks	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Central GSA

Rate Cell	CYE 21 Capitation Rate
SMI	$2,592.33
CMDP Child	$881.38
Crisis Adult	$13.60
Crisis Child	$0.83

North GSA

Rate Cell	CYE 21 Capitation Rate
SMI	$1,606.24
CMDP Child	$1,284.11
Crisis Adult	$5.68
Crisis Child	$0.71

South GSA

Rate Cell	CYE 21 Capitation Rate
SMI	$1,641.07
CMDP Child	$1,223.88
Crisis Adult	$11.59
Crisis Child	$4.18

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 21 Capitation Rate	CYE 20 Capitation Rate	% Change
SMI[1]	$2,592.33	$2,574.76	0.7%
CMDP Child[2,3]	$881.38	$817.98	7.8%
Crisis Adult[4]	$13.60	Population served by this rate cell has changed	
Crisis Child[4]	$0.83	Population served by this rate cell has changed	

1) CYE 20 rate included crisis intervention services, CYE 21 rate shifted crisis intervention services to Crisis Adult
2) CYE 20 rate included crisis intervention services, CYE 21 rate shifted crisis intervention services to Crisis Child
3) CYE 21 CMDP rate cell is effective for six months (October 1, 2020 through March 31, 2021)
4) Crisis Adult and Crisis Child rate cells cover crisis intervention services for all Arizona Medicaid populations, including SMI and CMDP Child

North GSA

Rate Cell	CYE 21 Capitation Rate	CYE 20 Capitation Rate	% Change
SMI[1]	$1,606.24	$1,493.14	7.6%
CMDP Child[2,3]	$1,284.11	$1,225.27	4.8%
Crisis Adult[4]	$5.68	Population served by this rate cell has changed	
Crisis Child[4]	$0.71	Population served by this rate cell has changed	

1) CYE 20 rate included crisis intervention services, CYE 21 rate shifted crisis intervention services to Crisis Adult
2) CYE 20 rate included crisis intervention services, CYE 21 rate shifted crisis intervention services to Crisis Child
3) CYE 21 CMDP rate cell is effective for six months (October 1, 2020 through March 31, 2021)
4) Crisis Adult and Crisis Child rate cells cover crisis intervention services for all Arizona Medicaid populations, including SMI and CMDP Child

South GSA

Rate Cell	CYE 21 Capitation Rate	CYE 20 Capitation Rate	% Change
SMI[1]	$1,641.07	$1,649.28	-0.5%
CMDP Child[2,3]	$1,223.88	$1,017.84	20.2%
Crisis Adult[4]	$11.59	Population served by this rate cell has changed	
Crisis Child[4]	$4.18	Population served by this rate cell has changed	

1) CYE 20 rate included crisis intervention services, CYE 21 rate shifted crisis intervention services to Crisis Adult
2) CYE 20 rate included crisis intervention services, CYE 21 rate shifted crisis intervention services to Crisis Child
3) CYE 21 CMDP rate cell is effective for six months (October 1, 2020 through March 31, 2021)
4) Crisis Adult and Crisis Child rate cells cover crisis intervention services for all Arizona Medicaid populations, including SMI and CMDP Child

Appendix 3b: Fiscal Impact Summary

Central GSA

Rate Cell	CYE 21 Projected MMs	CYE 21 Capitation Rate	CYE 21 Projected Expenses	CYE 20 Projected Dollars Restated[1]
SMI	304,360	$2,592.33	$789,001,974	$683,364,027
CMDP Child	101,057	$881.38	$89,069,105	$76,720,019
Crisis Adult	6,242,635	$13.60	$84,885,537	$78,472,725
Crisis Child	5,790,206	$0.83	$4,822,187	$3,762,169

1) The CYE 20 rates included crisis intervention services in the SMI and CMDP Child Rate Cells, CYE 21 rates shift crisis intervention services to Crisis Adult/Child respectively. The CYE 20 dollars shown here are not adjusted for membership growth. The CYE 20 crisis dollars have also been restated in alignment with the methodology for this year, using RBHA projections that have not been reallocated based on encounters in the base data period.

North GSA

Rate Cell	CYE 21 Projected MMs	CYE 21 Capitation Rate	CYE 21 Projected Expenses	CYE 20 Projected Dollars Restated[1]
SMI	79,149	$1,606.24	$127,132,674	$103,356,673
CMDP Child	16,868	$1,284.11	$21,659,766	$18,983,428
Crisis Adult	1,856,756	$5.68	$10,555,405	$8,063,694
Crisis Child	1,161,369	$0.71	$826,738	$901,755

1) The CYE 20 rates included crisis intervention services in the SMI and CMDP Child Rate Cells, CYE 21 rates shift crisis intervention services to Crisis Adult/Child respectively. The CYE 20 dollars shown here are not adjusted for membership growth. The CYE 20 crisis dollars have also been restated in alignment with the methodology for this year, using RBHA projections that have not been reallocated based on encounters in the base data period.

South GSA

Rate Cell	CYE 21 Projected MMs	CYE 21 Capitation Rate	CYE 21 Projected Expenses	CYE 20 Projected Dollars Restated[1]
SMI	183,292	$1,641.07	$300,795,933	$253,698,811
CMDP Child	43,823	$1,223.88	$53,634,145	$40,618,640
Crisis Adult	3,575,199	$11.59	$41,447,927	$48,302,568
Crisis Child	2,539,028	$4.18	$10,605,977	$9,698,937

1) The CYE 20 rates included crisis intervention services in the SMI and CMDP Child Rate Cells, CYE 21 rates shift crisis intervention services to Crisis Adult/Child respectively. The CYE 20 dollars shown here are not adjusted for membership growth. The CYE 20 crisis dollars have also been restated in alignment with the methodology for this year, using RBHA projections that have not been reallocated based on encounters in the base data period.

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, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 274,282
Projection Period Member Months: 304,360

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP Removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Spread Admin Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.01	0.9663	0.9663	$0.01	$10.59	0.9663	0.9663	$11.34	$11.35	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$11.35
Case Management	$3.97	0.9663	0.9663	$4.25	$199.71	0.9663	0.9663	$213.87	$218.13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$218.13
Dental Services	$1.11	0.9663	0.8638	$1.33	$0.03	0.9663	0.8635	$0.04	$1.37	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.37
FQHC/RHC	$12.39	0.9663	0.9646	$13.29	$0.01	0.9663	0.9359	$0.01	$13.30	0.00%	0.00%	0.00%	-0.79%	0.00%	0.00%	0.00%	0.00%	$13.19
Inpatient Behavioral Health	$172.48	0.9259	0.9562	$194.82	$14.10	0.9524	0.9628	$15.38	$210.20	3.97%	-6.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$204.31
Inpatient Hospital	$194.05	0.9184	0.9544	$221.39	$0.14	0.9184	0.9544	$0.16	$221.55	0.00%	0.00%	0.00%	-3.14%	0.00%	0.00%	0.00%	0.00%	$214.59
Medical Services	$95.67	0.9663	0.9663	$102.46	$77.31	0.9663	0.9663	$82.80	$185.26	0.00%	0.00%	-2.00%	-0.01%	0.00%	0.00%	0.00%	0.04%	$181.61
Nursing Facility (Short-term)	$5.72	0.9184	0.9876	$6.31	$0.01	0.9184	0.9876	$0.01	$6.32	0.00%	0.00%	0.00%	-0.57%	0.00%	0.00%	0.00%	0.00%	$6.28
Other Services	$13.63	0.9663	0.9663	$14.60	$0.13	0.9663	0.9663	$0.14	$14.74	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.74
Outpatient Hospital	$86.58	0.9609	0.9821	$91.75	$0.06	0.9609	0.9822	$0.06	$91.81	0.00%	0.00%	0.00%	-2.97%	0.00%	0.00%	0.00%	0.00%	$89.08
Pharmacy	$472.32	0.9880	1.0000	$478.03	$0.00	0.9880	1.0000	$0.00	$478.03	0.00%	0.00%	0.00%	0.00%	0.00%	-6.53%	-1.57%	-0.32%	$438.39
Rehabilitation Services	$0.86	0.9663	0.9663	$0.93	$156.92	0.9663	0.9663	$168.06	$168.98	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$168.98
Residential Services	$125.30	0.9663	0.9663	$134.19	$5.24	0.9663	0.9663	$5.61	$139.80	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$139.80
Support Services	$3.55	0.9663	0.9663	$3.80	$81.86	0.9663	0.9663	$87.67	$91.47	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$91.47
Transportation	$124.15	0.9663	0.9663	$132.95	$18.19	0.9663	0.9663	$19.48	$152.44	0.00%	0.00%	0.00%	0.00%	-3.22%	0.00%	0.00%	0.00%	$147.52
Treatment Services	$25.85	0.9663	0.9663	$27.68	$77.74	0.9663	0.9663	$83.25	$110.93	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$110.93
Gross Medical	**$1,337.64**			**$1,427.79**	**$642.04**			**$687.88**	**$2,115.67**									**$2,051.75**

GSA: Central
Rate Cell: CMDP Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through March 31, 2021
Base Period Member Months: 98,421
Projection Period Member Months: 50,558

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP Removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Spread Admin Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.34	0.9663	0.9847	$0.36	$0.06	0.9663	0.9847	$0.06	$0.42	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.42
Case Management	$1.70	0.9663	0.9847	$1.78	$139.28	0.9663	0.9847	$146.38	$148.16	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$148.16
Dental Services	$0.00	0.9663	0.9048	$0.00	$0.00	0.9663	0.9048	$0.00	$0.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.01
FQHC/RHC	$0.05	0.9663	0.9847	$0.05	$0.00	0.9663	0.9048	$0.00	$0.05	0.00%	0.00%	0.00%	-0.75%	0.00%	0.00%	0.00%	0.00%	$0.05
Inpatient Behavioral Health	$173.62	0.9203	0.9994	$188.77	$0.20	0.9663	0.9847	$0.22	$188.98	0.00%	0.00%	0.00%	-0.23%	0.00%	0.00%	0.00%	0.00%	$188.54
Inpatient Hospital	$16.38	0.9184	1.0000	$17.83	$0.00	0.9184	1.0000	$0.00	$17.83	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$17.83
Medical Services	$0.67	0.9663	0.9847	$0.70	$8.40	0.9663	0.9847	$8.83	$9.53	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	0.00%	$9.53
Nursing Facility (Short-term)	$0.00	0.9184	1.0000	$0.00	$0.00	0.9184	1.0000	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.03	0.9663	0.9847	$0.03	$0.10	0.9663	0.9847	$0.11	$0.14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.14
Outpatient Hospital	$0.08	0.9609	1.0000	$0.08	$0.09	0.9609	1.0000	$0.10	$0.18	0.00%	0.00%	0.00%	-0.41%	0.00%	0.00%	0.00%	0.00%	$0.18
Pharmacy	$28.04	0.9880	1.0000	$28.38	$0.00	0.9880	1.0000	$0.00	$28.38	0.00%	0.00%	0.00%	0.00%	0.00%	-10.13%	-1.57%	5.23%	$26.42
Rehabilitation Services	$3.31	0.9663	0.9847	$3.48	$89.32	0.9663	0.9847	$93.88	$97.35	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$97.35
Residential Services	$32.32	0.9663	0.9847	$33.97	$1.54	0.9663	0.9847	$1.62	$35.59	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$35.59
Support Services	$37.29	0.9663	0.9847	$39.19	$23.38	0.9663	0.9847	$24.57	$63.76	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$63.76
Transportation	$12.18	0.9663	0.9847	$12.80	$5.05	0.9663	0.9847	$5.30	$18.10	0.00%	0.00%	0.00%	0.00%	-2.73%	0.00%	0.00%	0.00%	$17.61
Treatment Services	$3.84	0.9663	0.9847	$4.03	$88.71	0.9663	0.9847	$93.24	$97.27	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$97.27
Gross Medical	**$309.84**			**$331.46**	**$356.14**			**$374.29**	**$705.75**									**$702.85**

GSA: North
Rate Cell: SMI
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 71,342
Projection Period Member Months: 79,149

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP Removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Spread Admin Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.00	0.9774	1.0000	$0.00	$0.00	0.9774	1.0000	$0.00	$0.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.01
Case Management	$1.48	0.9774	1.0000	$1.51	$93.74	0.9774	1.0000	$95.91	$97.43	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$97.43
Dental Services	$1.92	0.9774	1.0000	$1.96	$0.00	0.9774	1.0000	$0.00	$1.96	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.96
FQHC/RHC	$15.77	0.9774	1.0000	$16.13	$0.01	0.9774	1.0000	$0.01	$16.14	0.00%	0.00%	0.00%	-0.41%	0.00%	0.00%	0.00%	0.00%	$16.08
Inpatient Behavioral Health	$39.78	0.9257	1.0000	$42.97	$66.60	0.9182	1.0000	$72.53	$115.51	1.06%	-3.23%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$112.97
Inpatient Hospital	$72.95	0.9128	1.0000	$79.92	$0.00	0.9128	1.0000	$0.00	$79.92	0.00%	0.00%	0.00%	-2.71%	0.00%	0.00%	0.00%	0.00%	$77.75
Medical Services	$77.94	0.9774	1.0000	$79.74	$29.84	0.9774	1.0000	$30.53	$110.27	0.00%	0.00%	-0.37%	0.00%	0.00%	0.00%	0.00%	0.09%	$109.96
Nursing Facility (Short-term)	$5.28	0.9128	1.0000	$5.78	$0.00	0.9128	1.0000	$0.00	$5.78	0.00%	0.00%	0.00%	-0.63%	0.00%	0.00%	0.00%	0.00%	$5.75
Other Services	$5.49	0.9774	1.0000	$5.61	$7.78	0.9774	1.0000	$7.96	$13.57	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.57
Outpatient Hospital	$107.37	0.9761	1.0000	$110.00	$0.66	0.9761	1.0000	$0.68	$110.68	0.00%	0.00%	0.00%	-2.97%	0.00%	0.00%	0.00%	0.00%	$107.39
Pharmacy	$274.14	0.9912	1.0000	$276.58	$0.00	0.9912	1.0000	$0.00	$276.58	0.00%	0.00%	0.00%	0.00%	0.00%	-3.46%	0.00%	-0.82%	$264.83
Rehabilitation Services	$2.15	0.9774	1.0000	$2.20	$82.54	0.9774	1.0000	$84.45	$86.66	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$86.66
Residential Services	$105.22	0.9774	1.0000	$107.65	$55.11	0.9774	1.0000	$56.38	$164.04	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$164.04
Support Services	$0.24	0.9774	1.0000	$0.25	$46.74	0.9774	1.0000	$47.82	$48.07	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$48.07
Transportation	$50.00	0.9774	1.0000	$51.16	$59.39	0.9774	1.0000	$60.77	$111.93	0.00%	0.00%	0.00%	0.00%	-0.66%	0.00%	0.00%	0.00%	$111.19
Treatment Services	$5.63	0.9774	1.0000	$5.76	$69.08	0.9774	1.0000	$70.68	$76.44	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$76.44
Gross Medical	**$765.36**			**$787.24**	**$511.49**			**$527.73**	**$1,314.97**									**$1,294.08**

GSA: North
Rate Cell: CMDP Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through March 31, 2021
Base Period Member Months: 16,428
Projection Period Member Months: 8,439

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP Removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Spread Admin Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$0.03	0.9774	1.0000	$0.03	$0.00	0.9774	1.0000	$0.00	$0.03	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.03
Case Management	$25.08	0.9774	1.0000	$25.66	$149.26	0.9774	1.0000	$152.72	$178.38	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$178.38
Dental Services	$0.28	0.9774	1.0000	$0.29	$0.00	0.9774	1.0000	$0.00	$0.29	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.29
FQHC/RHC	$0.68	0.9774	1.0000	$0.70	$0.00	0.9774	1.0000	$0.00	$0.70	0.00%	0.00%	0.00%	-0.45%	0.00%	0.00%	0.00%	0.00%	$0.69
Inpatient Behavioral Health	$172.56	0.9136	1.0000	$188.88	$0.28	0.9774	1.0000	$0.29	$189.17	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$189.17
Inpatient Hospital	$2.03	0.9128	1.0000	$2.22	$0.00	0.9128	1.0000	$0.00	$2.22	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.22
Medical Services	$3.36	0.9774	1.0000	$3.44	$5.51	0.9774	1.0000	$5.63	$9.07	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$9.07
Nursing Facility (Short-term)	$0.00	0.9128	1.0000	$0.00	$0.00	0.9128	1.0000	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.02	0.9774	1.0000	$0.02	$0.09	0.9774	1.0000	$0.09	$0.11	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.11
Outpatient Hospital	$0.39	0.9761	1.0000	$0.40	$0.00	0.9761	1.0000	$0.00	$0.40	0.00%	0.00%	0.00%	-3.38%	0.00%	0.00%	0.00%	0.00%	$0.39
Pharmacy	$20.91	0.9912	1.0000	$21.10	$0.00	0.9912	1.0000	$0.00	$21.10	0.00%	0.00%	0.00%	0.00%	0.00%	-8.79%	0.00%	8.50%	$20.88
Rehabilitation Services	$9.78	0.9774	1.0000	$10.00	$88.25	0.9774	1.0000	$90.29	$100.30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$100.30
Residential Services	$39.91	0.9774	1.0000	$40.83	$6.04	0.9774	1.0000	$6.18	$47.02	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$47.02
Support Services	$212.80	0.9774	1.0000	$217.73	$81.40	0.9774	1.0000	$83.29	$301.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$301.01
Transportation	$18.35	0.9774	1.0000	$18.78	$20.61	0.9774	1.0000	$21.09	$39.87	0.00%	0.00%	0.00%	0.00%	-0.26%	0.00%	0.00%	0.00%	$39.76
Treatment Services	$34.87	0.9774	1.0000	$35.67	$100.63	0.9774	1.0000	$102.96	$138.63	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$138.63
Gross Medical	**$541.05**			**$565.75**	**$452.08**			**$462.55**	**$1,028.29**									**$1,027.95**

GSA: South
Rate Cell: SMI
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 165,204
Projection Period Member Months: 183,292

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP Removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Spread Admin Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$9.93	0.9302	0.9324	$11.45	$0.00	0.9302	0.9324	$0.00	$11.45	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$11.45
Case Management	$102.68	0.9302	0.9324	$118.39	$0.50	0.9302	0.9324	$0.57	$118.97	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$118.97
Dental Services	$0.80	0.9302	0.9997	$0.86	$0.00	0.9302	1.0000	$0.00	$0.86	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.86
FQHC/RHC	$31.50	0.9302	0.9362	$36.18	$0.05	0.9302	0.9420	$0.06	$36.23	0.00%	0.00%	0.00%	-0.66%	0.00%	0.00%	0.00%	0.00%	$36.00
Inpatient Behavioral Health	$133.31	0.8939	0.9873	$151.06	$0.19	0.8998	0.9780	$0.21	$151.27	2.99%	-4.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$148.40
Inpatient Hospital	$105.00	0.8861	1.0000	$118.50	$0.31	0.8861	1.0000	$0.35	$118.85	0.00%	0.00%	0.00%	-3.19%	0.00%	0.00%	0.00%	0.00%	$115.06
Medical Services	$127.63	0.9302	0.9324	$147.17	$0.20	0.9302	0.9324	$0.23	$147.40	0.00%	0.00%	-0.89%	-0.37%	0.00%	0.00%	0.00%	0.07%	$145.65
Nursing Facility (Short-term)	$12.07	0.8861	1.0000	$13.62	$0.00	0.8861	1.0000	$0.00	$13.62	0.00%	0.00%	0.00%	-1.18%	0.00%	0.00%	0.00%	0.00%	$13.46
Other Services	$12.64	0.9302	0.9324	$14.57	$0.04	0.9302	0.9324	$0.04	$14.62	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.62
Outpatient Hospital	$85.29	0.9154	1.0000	$93.17	$0.00	0.9154	1.0000	$0.00	$93.17	0.00%	0.00%	0.00%	-3.12%	0.00%	0.00%	0.00%	0.00%	$90.27
Pharmacy	$245.27	0.9904	1.0000	$247.64	$0.00	0.9904	1.0000	$0.00	$247.64	0.00%	0.00%	0.00%	0.00%	0.00%	-4.61%	-2.50%	-0.21%	$229.82
Rehabilitation Services	$19.31	0.9302	0.9324	$22.27	$0.03	0.9302	0.9324	$0.03	$22.30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$22.30
Residential Services	$108.81	0.9302	0.9324	$125.47	$0.04	0.9302	0.9324	$0.05	$125.51	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$125.51
Support Services	$40.93	0.9302	0.9324	$47.19	$0.03	0.9302	0.9324	$0.03	$47.22	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$47.22
Transportation	$79.75	0.9302	0.9324	$91.96	$0.11	0.9302	0.9324	$0.13	$92.09	0.00%	0.00%	0.00%	0.00%	-11.32%	0.00%	0.00%	0.00%	$81.66
Treatment Services	$97.72	0.9302	0.9324	$112.69	$0.39	0.9302	0.9324	$0.46	$113.14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$113.14
Gross Medical	**$1,212.64**			**$1,352.20**	**$1.89**			**$2.17**	**$1,354.36**									**$1,314.40**

GSA: South
Rate Cell: CMDP Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through March 31, 2021
Base Period Member Months: 42,680
Projection Period Member Months: 21,924

	Non-Subcapitated/Block Payment Base Data				Subcapitated/Block Payment Base Data													
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	PMPM	Completion	Encounter Issue	Adjusted PMPM	Combined Base PMPM	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Base DAP Removal	Base APSI Removal	Pharmacy Reimb. Savings	PBM Spread Admin Removal	Combined Base Data Adjustments	Adjusted Base PMPM
Behavioral Health Day Programs	$1.54	0.9302	0.9032	$1.83	$0.00	0.9302	1.0000	$0.00	$1.83	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.83
Case Management	$151.43	0.9302	0.9032	$180.26	$1.03	0.9302	0.9032	$1.22	$181.48	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$181.48
Dental Services	$0.01	0.9302	1.0000	$0.01	$0.00	0.9302	1.0000	$0.00	$0.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.01
FQHC/RHC	$3.16	0.9302	0.9033	$3.76	$0.00	0.9302	1.0000	$0.00	$3.76	0.00%	0.00%	0.00%	-0.61%	0.00%	0.00%	0.00%	0.00%	$3.74
Inpatient Behavioral Health	$162.02	0.8887	0.9936	$183.48	$0.11	0.8896	0.9915	$0.13	$183.61	0.00%	0.00%	0.00%	-0.03%	0.00%	0.00%	0.00%	0.00%	$183.56
Inpatient Hospital	$6.38	0.8861	1.0000	$7.20	$0.00	0.8861	1.0000	$0.00	$7.20	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$7.20
Medical Services	$7.94	0.9302	0.9032	$9.45	$0.03	0.9302	0.9032	$0.04	$9.49	0.00%	0.00%	0.00%	-0.81%	0.00%	0.00%	0.00%	0.00%	$9.41
Nursing Facility (Short-term)	$0.00	0.8861	1.0000	$0.00	$0.00	0.8861	1.0000	$0.00	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.09	0.9302	0.9032	$0.11	$0.03	0.9302	0.9032	$0.03	$0.14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.14
Outpatient Hospital	$1.00	0.9154	1.0000	$1.09	$0.05	0.9154	1.0000	$0.05	$1.14	0.00%	0.00%	0.00%	-2.81%	0.00%	0.00%	0.00%	0.00%	$1.11
Pharmacy	$21.40	0.9904	1.0000	$21.61	$0.00	0.9904	1.0000	$0.00	$21.61	0.00%	0.00%	0.00%	0.00%	0.00%	-3.49%	-2.50%	9.20%	$22.20
Rehabilitation Services	$31.90	0.9302	0.9032	$37.97	$0.62	0.9302	0.9032	$0.74	$38.71	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$38.71
Residential Services	$137.39	0.9302	0.9032	$163.54	$0.00	0.9302	1.0000	$0.00	$163.54	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$163.54
Support Services	$121.57	0.9302	0.9032	$144.71	$0.48	0.9302	0.9032	$0.57	$145.29	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$145.29
Transportation	$28.61	0.9302	0.9032	$34.06	$0.21	0.9302	0.9032	$0.25	$34.31	0.00%	0.00%	0.00%	0.00%	-1.15%	0.00%	0.00%	0.00%	$33.91
Treatment Services	$151.40	0.9302	0.9032	$180.21	$0.65	0.9302	0.9032	$0.78	$180.99	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$180.99
Gross Medical	**$825.83**			**$969.29**	**$3.22**			**$3.82**	**$973.11**									**$973.12**

Appendix 5: Projected Benefit Cost Trends

Central				
Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	10.0%	4.0%	14.4%
SMI	Inpatient Hospital	2.0%	4.0%	6.1%
SMI	Medical Services	1.0%	2.5%	3.5%
SMI	Other Services	1.0%	2.0%	3.0%
SMI	Pharmacy	1.5%	5.0%	6.6%
SMI	Rehabilitation/Treatment Services	-0.5%	2.0%	1.5%
SMI	Residential Services	4.0%	0.0%	4.0%
SMI	Support Services	-0.5%	3.0%	2.5%
CMDP Child	Inpatient Behavioral Health	10.0%	1.0%	11.1%
CMDP Child	Inpatient Hospital	0.0%	0.0%	0.0%
CMDP Child	Medical Services	0.0%	0.0%	0.0%
CMDP Child	Other Services	0.0%	5.0%	5.0%
CMDP Child	Pharmacy	2.4%	1.0%	3.4%
CMDP Child	Rehabilitation/Treatment Services	0.0%	0.0%	0.0%
CMDP Child	Residential Services	2.0%	1.0%	3.0%
CMDP Child	Support Services	0.0%	2.0%	2.0%

North				
Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	5.5%	1.0%	6.6%
SMI	Inpatient Hospital	3.0%	2.5%	5.6%
SMI	Medical Services	1.0%	2.0%	3.0%
SMI	Other Services	3.0%	0.0%	3.0%
SMI	Pharmacy	2.0%	4.5%	6.6%
SMI	Rehabilitation/Treatment Services	1.0%	0.0%	1.0%
SMI	Residential Services	3.0%	0.0%	3.0%
SMI	Support Services	1.0%	1.0%	2.0%
CMDP Child	Inpatient Behavioral Health	5.5%	1.0%	6.6%
CMDP Child	Inpatient Hospital	0.0%	0.0%	0.0%
CMDP Child	Medical Services	5.0%	0.0%	5.0%
CMDP Child	Other Services	0.0%	5.0%	5.0%
CMDP Child	Pharmacy	0.0%	2.2%	2.2%
CMDP Child	Rehabilitation/Treatment Services	2.0%	1.0%	3.0%
CMDP Child	Residential Services	-0.5%	-0.5%	-1.0%
CMDP Child	Support Services	0.5%	2.0%	2.5%

South				
Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
SMI	Inpatient Behavioral Health	4.0%	2.5%	6.6%
SMI	Inpatient Hospital	3.0%	0.0%	3.0%
SMI	Medical Services	1.0%	0.0%	1.0%
SMI	Other Services	3.0%	0.0%	3.0%
SMI	Pharmacy	0.0%	4.5%	4.5%
SMI	Rehabilitation/Treatment Services	-0.5%	1.0%	0.5%
SMI	Residential Services	3.0%	0.0%	3.0%
SMI	Support Services	0.0%	3.0%	3.0%
CMDP Child	Inpatient Behavioral Health	6.0%	3.0%	9.2%
CMDP Child	Inpatient Hospital	0.0%	0.0%	0.0%
CMDP Child	Medical Services	2.6%	-0.2%	2.4%
CMDP Child	Other Services	0.0%	5.0%	5.0%
CMDP Child	Pharmacy	1.0%	1.0%	2.0%
CMDP Child	Rehabilitation/Treatment Services	0.0%	-0.5%	-0.5%
CMDP Child	Residential Services	2.0%	-0.5%	1.5%
CMDP Child	Support Services	0.0%	3.0%	3.0%

Appendix 6: CYE 21 Capitation Rate Development

GSA: Central
Rate Cell: SMI
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 274,282
Projection Period Member Months: 304,360

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions FFY20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$11.35	3.02%	0.00%	0.00%	1.05%	0.00%	$12.18
Case Management	$218.13	2.49%	0.00%	0.00%	0.00%	0.02%	$229.16
Dental Services	$1.37	3.02%	0.00%	0.00%	11.03%	0.00%	$1.61
FQHC/RHC	$13.19	3.02%	0.00%	0.00%	1.21%	0.00%	$14.17
Inpatient Behavioral Health	$204.31	14.40%	0.00%	0.00%	0.00%	0.00%	$267.38
Inpatient Hospital	$214.59	6.08%	0.00%	0.00%	0.00%	0.00%	$241.48
Medical Services	$181.61	3.52%	0.00%	3.89%	13.76%	0.07%	$230.19
Nursing Facility (Short-term)	$6.28	3.02%	0.00%	0.00%	5.07%	0.00%	$7.00
Other Services	$14.74	3.02%	0.00%	0.00%	0.00%	0.00%	$15.64
Outpatient Hospital	$89.08	3.02%	0.00%	-0.33%	0.00%	0.00%	$94.23
Pharmacy	$438.39	6.58%	1.16%	0.00%	0.00%	-0.51%	$501.15
Rehabilitation Services	$168.98	1.49%	0.00%	1.95%	1.05%	0.00%	$179.32
Residential Services	$139.80	4.00%	0.00%	0.00%	1.05%	0.78%	$154.00
Support Services	$91.47	2.49%	0.00%	1.63%	7.07%	0.45%	$105.01
Transportation	$147.52	2.49%	0.00%	-6.78%	1.76%	0.00%	$146.97
Treatment Services	$110.93	1.49%	0.00%	11.89%	1.05%	0.00%	$129.20
Gross Medical	**$2,051.75**	**5.08%**	**0.26%**	**0.67%**	**1.88%**	**-0.03%**	**$2,328.71**

Total DAP	**$15.54**
Total Gross Medical PMPM	**$2,344.25**
Reinsurance Offset	**($33.61)**
Total Net Medical PMPM	**$2,310.64**

AHCCCS Differential Adjusted Payments (DAP)	
Non-FQHC	$15.42
FQHC	$0.12
Total AHCCCS DAP	**$15.54**

Non-benefit Expenses	PMPM
Admin	$204.44
Total Medical with Admin	$2,515.08
UW Gain	$25.40
Pre-tax Capitation PMPM	$2,540.48
Premium Tax	$51.85
Capitation PMPM	**$2,592.33**

GSA: Central
Rate Cell: CMDP Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through March 31, 2021
Base Period Member Months: 98,421
Projection Period Member Months: 50,558

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions FFY20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$0.42	5.00%	0.00%	0.00%	1.11%	0.00%	$0.46
Case Management	$148.16	2.00%	0.00%	0.00%	0.00%	0.03%	$153.43
Dental Services	$0.01	5.00%	0.00%	0.00%	7.91%	0.00%	$0.01
FQHC/RHC	$0.05	5.00%	0.00%	0.00%	0.32%	0.00%	$0.05
Inpatient Behavioral Health	$188.54	11.10%	0.00%	0.00%	0.00%	0.00%	$226.68
Inpatient Hospital	$17.83	11.10%	0.00%	0.00%	0.00%	0.00%	$21.44
Medical Services	$9.53	0.00%	0.00%	62.15%	23.85%	0.00%	$19.14
Nursing Facility (Short-term)	$0.00	5.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.14	5.00%	0.00%	0.00%	0.00%	0.00%	$0.15
Outpatient Hospital	$0.18	5.00%	0.00%	-1.25%	0.00%	0.62%	$0.19
Pharmacy	$26.42	3.42%	-0.87%	0.00%	0.00%	-0.60%	$27.61
Rehabilitation Services	$97.35	0.00%	0.00%	2.73%	1.11%	0.00%	$101.12
Residential Services	$35.59	3.02%	0.00%	0.00%	1.11%	0.00%	$37.91
Support Services	$63.76	2.00%	0.00%	1.86%	1.62%	2.52%	$70.04
Transportation	$17.61	2.00%	0.00%	-45.06%	3.04%	0.00%	$10.32
Treatment Services	$97.27	0.00%	0.00%	10.92%	1.11%	1.43%	$110.64
Gross Medical	**$702.85**	**4.27%**	**-0.03%**	**1.61%**	**1.02%**	**0.41%**	**$779.20**

Total DAP	**$6.40**
Total Gross Medical PMPM	**$785.60**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$785.60**

AHCCCS Differential Adjusted Payments (DAP)	
Non-FQHC	$6.40
FQHC	$0.00
Total AHCCCS DAP	**$6.40**

Non-benefit Expenses	PMPM
Admin	$69.51
Total Medical with Admin	$855.11
UW Gain	$8.64
Pre-tax Capitation PMPM	$863.75
Premium Tax	$17.63
Capitation PMPM	**$881.38**

GSA: Central
Rate Cell: Crisis Adult
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 6,103,827
Projection Period Member Months: 6,242,635

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$4.54	0.9663	$4.70	N/A	$6.44	$11.13
Ancillary Crisis Services	$0.90	0.9663	$0.93	3.0%	$0.00	$0.99
Gross Medical	**$5.44**		**$5.63**			**$12.12**

Total Gross Medical PMPM	**$12.12**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$12.12**

Non-benefit Expenses	PMPM
Admin	$1.07
Total Medical with Admin	$13.19
UW Gain	$0.13
Pre-tax Capitation PMPM	$13.33
Premium Tax	$0.27
Capitation PMPM	**$13.60**

GSA: Central
Rate Cell: Crisis Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 5,465,748
Projection Period Member Months: 5,790,206

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$0.40	0.9663	$0.42	N/A	$0.11	$0.53
Ancillary Crisis Services	$0.19	0.9663	$0.20	5.0%	$0.00	$0.22
Gross Medical	**$0.59**		**$0.61**			**$0.74**

Total Gross Medical PMPM	**$0.74**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$0.74**

Non-benefit Expenses	PMPM
Admin	$0.07
Total Medical with Admin	$0.81
UW Gain	$0.01
Pre-tax Capitation PMPM	$0.82
Premium Tax	$0.02
Capitation PMPM	**$0.83**

GSA: North
Rate Cell: SMI
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 71,342
Projection Period Member Months: 79,149

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions FFY20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$0.01	3.00%	0.00%	0.00%	0.61%	0.00%	$0.01
Case Management	$97.43	2.01%	0.00%	0.00%	0.00%	0.03%	$101.42
Dental Services	$1.96	3.00%	0.00%	0.00%	13.33%	0.00%	$2.36
FQHC/RHC	$16.08	3.00%	0.00%	0.00%	1.30%	0.00%	$17.28
Inpatient Behavioral Health	$112.97	6.55%	0.00%	0.00%	0.00%	0.00%	$128.26
Inpatient Hospital	$77.75	5.58%	0.00%	0.00%	0.89%	0.01%	$87.44
Medical Services	$109.96	3.02%	0.00%	3.91%	12.98%	0.15%	$137.20
Nursing Facility (Short-term)	$5.75	3.00%	0.00%	0.00%	5.03%	0.00%	$6.41
Other Services	$13.57	3.00%	0.00%	0.00%	0.00%	0.00%	$14.40
Outpatient Hospital	$107.39	3.00%	0.00%	-0.45%	0.00%	0.00%	$113.42
Pharmacy	$264.83	6.59%	0.39%	0.00%	0.00%	-0.93%	$299.25
Rehabilitation Services	$86.66	1.00%	0.00%	2.31%	0.61%	0.00%	$91.00
Residential Services	$164.04	3.00%	0.00%	0.00%	0.61%	0.32%	$175.65
Support Services	$48.07	2.01%	0.00%	1.89%	1.90%	0.23%	$52.05
Transportation	$111.19	2.01%	0.00%	-5.46%	3.33%	0.00%	$113.02
Treatment Services	$76.44	1.00%	0.00%	10.48%	0.61%	0.00%	$86.68
Gross Medical	**$1,294.08**	**3.77%**	**0.08%**	**0.64%**	**1.72%**	**-0.13%**	**$1,425.84**

Total DAP	**$13.03**
Total Gross Medical PMPM	**$1,438.87**
Reinsurance Offset	**($18.10)**
Total Net Medical PMPM	**$1,420.76**

AHCCCS Differential Adjusted Payments (DAP)	
Non-FQHC	$12.89
FQHC	$0.14
Total AHCCCS DAP	**$13.03**

Non-benefit Expenses	PMPM
Admin	$137.61
Total Medical with Admin	$1,558.37
UW Gain	$15.74
Pre-tax Capitation PMPM	$1,574.11
Premium Tax	$32.12
Capitation PMPM	**$1,606.24**

GSA: North
Rate Cell: CMDP Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through March 31, 2021
Base Period Member Months: 16,428
Projection Period Member Months: 8,439

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions FFY20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$0.03	5.00%	0.00%	0.00%	1.87%	0.00%	$0.03
Case Management	$178.38	2.51%	0.00%	0.00%	0.00%	0.03%	$186.35
Dental Services	$0.29	5.00%	0.00%	0.00%	13.06%	0.00%	$0.36
FQHC/RHC	$0.69	5.00%	0.00%	0.00%	1.35%	0.00%	$0.76
Inpatient Behavioral Health	$189.17	6.55%	0.00%	0.00%	0.00%	0.00%	$211.40
Inpatient Hospital	$2.22	6.55%	0.00%	0.00%	0.00%	0.00%	$2.49
Medical Services	$9.07	5.00%	0.00%	68.67%	20.97%	0.00%	$20.17
Nursing Facility (Short-term)	$0.00	5.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.11	5.00%	0.00%	0.00%	0.00%	0.00%	$0.12
Outpatient Hospital	$0.39	5.00%	0.00%	0.00%	0.00%	0.00%	$0.42
Pharmacy	$20.88	2.20%	-0.61%	0.00%	0.00%	-0.90%	$21.36
Rehabilitation Services	$100.30	3.02%	0.00%	2.88%	1.87%	0.00%	$110.74
Residential Services	$47.02	-1.00%	0.00%	0.00%	1.87%	0.00%	$47.06
Support Services	$301.01	2.51%	0.00%	0.45%	2.43%	3.32%	$334.17
Transportation	$39.76	2.51%	0.00%	-22.67%	1.67%	0.00%	$32.65
Treatment Services	$138.63	3.02%	0.00%	8.33%	1.87%	0.89%	$162.62
Gross Medical	**$1,027.95**	**3.25%**	**-0.01%**	**1.29%**	**1.60%**	**1.08%**	**$1,130.69**

Total DAP	**$5.14**
Total Gross Medical PMPM	**$1,135.83**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$1,135.83**

AHCCCS Differential Adjusted Payments (DAP)	
Non-FQHC	$5.13
FQHC	$0.01
Total AHCCCS DAP	**$5.14**

Non-benefit Expenses	PMPM
Admin	$110.01
Total Medical with Admin	$1,245.85
UW Gain	$12.58
Pre-tax Capitation PMPM	$1,258.43
Premium Tax	$25.68
Capitation PMPM	**$1,284.11**

GSA: North
Rate Cell: Crisis Adult
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 1,789,373
Projection Period Member Months: 1,856,756

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$1.46	0.9774	$1.50	N/A	$3.08	$4.58
Ancillary Crisis Services	$0.41	0.9774	$0.42	3.0%	$0.00	$0.45
Gross Medical	**$1.88**		**$1.92**			**$5.03**

Total Gross Medical PMPM	**$5.03**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$5.03**

Non-benefit Expenses	PMPM
Admin	$0.49
Total Medical with Admin	$5.52
UW Gain	$0.06
Pre-tax Capitation PMPM	$5.57
Premium Tax	$0.11
Capitation PMPM	**$5.68**

GSA: North
Rate Cell: Crisis Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 1,096,133
Projection Period Member Months: 1,161,369

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$0.19	0.9774	$0.19	N/A	$0.36	$0.55
Ancillary Crisis Services	$0.07	0.9774	$0.07	5.0%	$0.00	$0.08
Gross Medical	**$0.26**		**$0.26**			**$0.63**

Total Gross Medical PMPM	**$0.63**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$0.63**

Non-benefit Expenses	PMPM
Admin	$0.06
Total Medical with Admin	$0.69
UW Gain	$0.01
Pre-tax Capitation PMPM	$0.70
Premium Tax	$0.01
Capitation PMPM	**$0.71**

GSA: South
Rate Cell: SMI
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 165,204
Projection Period Member Months: 183,292

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions FFY20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$11.45	3.00%	0.00%	0.00%	0.71%	0.00%	$12.23
Case Management	$118.97	3.00%	0.00%	0.00%	0.00%	0.04%	$126.27
Dental Services	$0.86	3.00%	0.00%	0.00%	12.36%	0.00%	$1.03
FQHC/RHC	$36.00	3.00%	0.00%	0.00%	1.09%	0.00%	$38.60
Inpatient Behavioral Health	$148.40	6.60%	0.00%	0.00%	0.00%	0.00%	$168.64
Inpatient Hospital	$115.06	3.00%	0.00%	0.00%	1.02%	0.00%	$123.31
Medical Services	$145.65	1.00%	0.00%	4.59%	11.95%	0.10%	$174.15
Nursing Facility (Short-term)	$13.46	3.00%	0.00%	0.00%	4.64%	0.00%	$14.95
Other Services	$14.62	3.00%	0.00%	0.00%	0.00%	0.00%	$15.51
Outpatient Hospital	$90.27	3.00%	0.00%	-0.49%	0.00%	-0.28%	$95.03
Pharmacy	$229.82	4.50%	1.04%	0.00%	0.00%	-1.03%	$251.00
Rehabilitation Services	$22.30	0.50%	0.00%	13.57%	0.71%	0.00%	$25.76
Residential Services	$125.51	3.00%	0.00%	0.00%	0.71%	0.30%	$134.50
Support Services	$47.22	3.00%	0.00%	2.82%	1.65%	0.53%	$52.64
Transportation	$81.66	3.00%	0.00%	-10.92%	4.10%	0.00%	$80.34
Treatment Services	$113.14	0.50%	0.00%	10.70%	0.71%	0.01%	$127.40
Gross Medical	**$1,314.40**	**3.20%**	**0.19%**	**0.97%**	**1.92%**	**-0.14%**	**$1,441.34**

Total DAP	**$11.66**
Total Gross Medical PMPM	**$1,453.01**
Reinsurance Offset	**($17.74)**
Total Net Medical PMPM	**$1,435.26**

AHCCCS Differential Adjusted Payments (DAP)	
Non-FQHC	$11.38
FQHC	$0.28
Total AHCCCS DAP	**$11.66**

Non-benefit Expenses	PMPM
Admin	$156.91
Total Medical with Admin	$1,592.17
UW Gain	$16.08
Pre-tax Capitation PMPM	$1,608.25
Premium Tax	$32.82
Capitation PMPM	**$1,641.07**

GSA: South
Rate Cell: CMDP Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through March 31, 2021
Base Period Member Months: 42,680
Projection Period Member Months: 21,924

Category of Service	Adjusted Base PMPM	TREND	P&T Committee Decisions FFY20 Forward	Telehealth	Fee Schedule Changes/Min Wage	Combined Misc. Changes	Gross Medical
Behavioral Health Day Programs	$1.83	5.00%	0.00%	0.00%	1.38%	0.00%	$2.02
Case Management	$181.48	3.00%	0.00%	0.00%	0.00%	0.03%	$191.16
Dental Services	$0.01	5.00%	0.00%	0.00%	8.58%	0.00%	$0.02
FQHC/RHC	$3.74	5.00%	0.00%	0.00%	0.98%	0.00%	$4.11
Inpatient Behavioral Health	$183.56	9.18%	0.00%	0.00%	0.00%	0.00%	$214.05
Inpatient Hospital	$7.20	9.18%	0.00%	0.00%	0.00%	0.00%	$8.39
Medical Services	$9.41	2.39%	0.00%	86.24%	18.18%	0.02%	$21.59
Nursing Facility (Short-term)	$0.00	5.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Other Services	$0.14	5.00%	0.00%	0.00%	0.00%	0.00%	$0.15
Outpatient Hospital	$1.11	5.00%	0.00%	-2.20%	0.00%	-1.21%	$1.17
Pharmacy	$22.20	2.01%	-0.78%	0.00%	0.00%	-0.50%	$22.70
Rehabilitation Services	$38.71	-0.50%	0.00%	9.88%	1.38%	0.00%	$42.75
Residential Services	$163.54	1.49%	0.00%	0.00%	1.38%	0.00%	$170.15
Support Services	$145.29	3.00%	0.00%	1.14%	1.97%	3.60%	$163.47
Transportation	$33.91	3.00%	0.00%	-32.85%	3.29%	0.00%	$24.77
Treatment Services	$180.99	-0.50%	0.00%	8.45%	1.38%	0.84%	$198.93
Gross Medical	**$973.12**	**3.19%**	**-0.02%**	**1.69%**	**1.22%**	**0.69%**	**$1,065.44**

Total DAP	**$4.95**
Total Gross Medical PMPM	**$1,070.39**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$1,070.39**

AHCCCS Differential Adjusted Payments (DAP)	
Non-FQHC	$4.93
FQHC	$0.02
Total AHCCCS DAP	**$4.95**

Non-benefit Expenses	PMPM
Admin	$117.02
Total Medical with Admin	$1,187.41
UW Gain	$11.99
Pre-tax Capitation PMPM	$1,199.41
Premium Tax	$24.48
Capitation PMPM	**$1,223.88**

GSA: South
Rate Cell: Crisis Adult
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 3,467,456
Projection Period Member Months: 3,575,199

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$2.76	0.9302	$2.97	N/A	$6.53	$9.49
Ancillary Crisis Services	$0.57	0.9302	$0.61	3.0%	$0.00	$0.64
Gross Medical	**$3.33**		**$3.58**			**$10.14**

Total Gross Medical PMPM	**$10.14**
Reinsurance Offset	**$0.00**
Total Net Medical PMPM	**$10.14**

Non-benefit Expenses	PMPM
Admin	$1.11
Total Medical with Admin	$11.25
UW Gain	$0.11
Pre-tax Capitation PMPM	$11.36
Premium Tax	$0.23
Capitation PMPM	**$11.59**

GSA: South
Rate Cell: Crisis Child
Base Period: October 1, 2018 through September 30, 2019
Projection Period: October 1, 2020 through September 30, 2021
Base Period Member Months: 2,398,240
Projection Period Member Months: 2,539,028

Category of Service	PMPM	Base Completion	Adjusted Base PMPM	Trend	Crisis Adjustments	Gross Medical
Crisis Intervention Services	$0.67	0.9302	$0.72	N/A	$2.78	$3.50
Ancillary Crisis Services	$0.13	0.9302	$0.14	5.0%	$0.00	$0.15
Gross Medical	**$0.80**		**$0.86**			**$3.65**

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

Non-benefit Expenses	PMPM
Admin	$0.40
Total Medical with Admin	$4.05
UW Gain	$0.04
Pre-tax Capitation PMPM	$4.09
Premium Tax	$0.08
Capitation PMPM	**$4.18**

Appendix 7: Delivery System and Provider Payment Initiatives

GSA	Rate Cell	CYE 21 DAP PMPMs[1]		
		Non-FQHC DAP PMPM	FQHC DAP PMPM	Total DAP PMPM
Central	SMI	$15.90	$0.12	$16.02
Central	CMDP Child	$6.60	$0.00	$6.60
Central	Crisis Adult	$0.00	$0.00	$0.00
Central	Crisis Child	$0.00	$0.00	$0.00
North	SMI	$13.28	$0.15	$13.43
North	CMDP Child	$5.29	$0.01	$5.30
North	Crisis Adult	$0.00	$0.00	$0.00
North	Crisis Child	$0.00	$0.00	$0.00
South	SMI	$11.73	$0.29	$12.02
South	CMDP Child	$5.09	$0.02	$5.11
South	Crisis Adult	$0.00	$0.00	$0.00
South	Crisis Child	$0.00	$0.00	$0.00

1) The PMPMs here are inclusive of premium tax, underwriting gain and risk adjustment.

	CYE 21 Estimated APSI PMPM		
Rate Cell	Central	North	South
SMI	$7.99	$1.33	$18.64
CMDP Child	$0.76	$0.18	$0.61
Crisis Adult	$0.00	$0.00	$0.00
Crisis Child	$0.00	$0.00	$0.00

	CYE 21 Estimated PSI PMPM		
Rate Cell	Central	North	South
SMI	$0.04	$0.00	$0.00
CMDP Child	$1.22	$0.00	$0.00
Crisis Adult	$0.00	$0.00	$0.00
Crisis Child	$0.00	$0.00	$0.00

	CYE 21 Estimated HEALTHII PMPM		
Rate Cell	Central	North	South
SMI	$132.25	$118.84	$123.71
CMDP Child	$14.15	$7.06	$14.42
Crisis Adult	$0.00	$0.00	$0.00
Crisis Child	$0.00	$0.00	$0.00

GSA	Rate Cell	CYE 21 Estimated TI PMPMs				
		TI PCP PMPM	TI Hospital PMPM	TI BH PMPM	TI Justice PMPM	Total TI PMPM
Central	SMI	$0.00	$2.67	$26.05	$0.01	$28.73
Central	CMDP Child	$0.00	$1.04	$32.15	$0.00	$33.20
Central	Crisis Adult	$0.00	$0.00	$0.00	$0.00	$0.00
Central	Crisis Child	$0.00	$0.00	$0.00	$0.00	$0.00
North	SMI	$0.00	$0.70	$15.65	$0.03	$16.38
North	CMDP Child	$0.00	$0.61	$14.28	$0.01	$14.90
North	Crisis Adult	$0.00	$0.00	$0.00	$0.00	$0.00
North	Crisis Child	$0.00	$0.00	$0.00	$0.00	$0.00
South	SMI	$0.00	$0.54	$14.01	$0.00	$14.55
South	CMDP Child	$0.00	$0.26	$21.14	$0.00	$21.40
South	Crisis Adult	$0.00	$0.00	$0.00	$0.00	$0.00
South	Crisis Child	$0.00	$0.00	$0.00	$0.00	$0.00