Contract Year Ending 2020 Comprehensive Medical and Dental Program Capitation Rate Certification

October 1, 2019 through September 30, 2020

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

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AHCCCS
Arizona Health Care Cost Containment System

Table of Contents

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 to develop the actuarially sound capitation rates effective October 1, 2019 for Arizona's Comprehensive Medical and Dental Program (CMDP). Hereafter, the term "CYE 20" will refer to the 12-month rating period ending September 30, 2020. Comparisons to prior rates in this certification refer to the previously submitted actuarial memorandum for capitation rates as signed by Matthew C. Varitek on February 14, 2019. This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

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

The 2020 Medicaid Managed Care Rate Development Guide (2020 Guide) describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2020 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

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

expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

As stated on page 2 of the 2020 Guide, CMS will also use these three principles in applying the regulation standards:

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

I.1. General Information

This section provides documentation for the General Information section of the 2020 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

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

I.1.A.ii. Required Elements

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

The actuarial certification letter for the CYE 20 capitation rates for the CMDP, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854 and 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.

Mr. Varitek certifies that the CYE 20 capitation rates for the CMDP contained in this rate certification is 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 are located in Appendix 2. Additionally, the CMDP contract includes the final and certified capitation rates in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856.

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

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

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

The CMDP is the health plan within the Arizona Department of Child Safety (DCS) that is responsible for managing the health care needs for children in foster care. The CMDP does not contract with any external managed care plans to deliver covered services.

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

Services covered by the CMDP include physical health services, limited behavioral health services (i.e. treatment for ADHD, anxiety and depression when provided by the member's primary care physician) and CRS specialty care. Prior to October 1, 2018, CRS specialty care was provided through the Children's Rehabilitative Services (CRS) program to CMDP members who were diagnosed with a CRS-qualifying health condition. Since October 1, 2018, those CRS specialty services have been provided through the CMDP. Capitation rates reflect this program change.

Additional information regarding covered services can be found in the CMDP contract.

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

CMDP was formed in July 1970 by state law under Arizona Revised Statute (A.R.S.) § 8-512. CMDP operates on a statewide basis.

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

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

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

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

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

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

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

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

There are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the populations to be covered under the CMDP during CYE 20.

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

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

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

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

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

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

The CYE 20 capitation rates for the CMDP are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the CMDP.

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

The capitation rates were developed as one statewide rate cell.

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

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

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

The certified capitation rates allow the CMDP to reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 20.

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

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

In the actuary's judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To the actuary's 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 capitation 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 capitation rates performed outside the rate setting process.

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

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

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 20 capitation rates for the CMDP.

I.1.A.ix. Rate Certification Procedures

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

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

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

Not applicable. This rate certification will change the CMDP capitation rates effective October 1, 2019.

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

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

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

CMS requires a contract amendment be submitted whenever capitation rates change for any reason other than application of an approved payment term (e.g. risk adjustment methodology) which was included in the initial managed are contract. The state will submit a contract amendment to CMS to reflect the CMDP capitation rates changing effective October 1, 2019.

I.1.B. Appropriate Documentation

I.1.B.i. Elements

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

I.1.B.ii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes relevant section numbers from the 2020 Guide. Sections that do not apply will be marked as “Not Applicable”; any section wherein all subsections are not applicable will be collapsed to the section heading.

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

Variations in the assumptions used to develop the projected benefit costs for the covered populations were based on valid rate development standards and not based on the rate of Federal Medical Assistance Percentage (FMAP). The covered populations under the CMDP receive the regular FMAP. The enhanced FMAP amounts for the Children’s Health Insurance Program (CHIP) do not apply because the CHIP is not a covered population under the CMDP. AHCCCS administers the CHIP through the AHCCCS KidsCare program.

I.1.B.iv. Comparison of Rates

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

The comparisons between the most recent certified CYE 19 CMDP capitation rates and the CYE 20 capitation rates being certified in this actuarial rate certification are available in Appendix 3.

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

same rate cell in the prior year was a negative change in the rate. For the CMDP, there were no large or negative changes in rates from the previous rating period.

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

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

I.2. Data

This section provides documentation for the Data section of the 2020 Guide.

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

Since AHCCCS employs their own actuaries, a formal data request was not needed between the AHCCCS Division of Health Care Management (DHCM) Actuarial Team and the State. The AHCCCS DHCM Actuarial Team worked with the appropriate teams at AHCCCS to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) at 81 FR 27858.

I.2.B.ii. Data Used for Rate Development

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

I.2.B.ii.(a)(i) Types of Data Used

The types of data that AHCCCS relied upon for developing the CYE 20 capitation rates for the CMDP were:

- Adjudicated and approved encounter data submitted by the CMDP and the CRS Contractor;
- Pended encounter data submitted by the CMDP;
- Enrollment data tied to capitation paid to the CMDP and the CRS Contractor;
- Projected enrollment data;
- Quarterly and annual financial statements submitted by the CMDP and the CRS Contractor;
- Detailed administrative expense data and projections from the CMDP; and
- Supplemental encounter data files for services provided by the CMDP that had not been submitted for processing by the AHCCCS data warehouse.

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

All data used during the rate development process was for the federal fiscal years (FFY) 2016, 2017, and 2018 (October 1, 2015 through September 30, 2018).

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

The enrollment and encounter data were provided from the AHCCCS PMMIS mainframe. The financial statement data were provided by the AHCCCS DHCM Finance & Reimbursement Team. The projected enrollment data for CYE 20 was provided by the AHCCCS Division of Business and Finance (DBF) Budget Team. The supplemental encounter data files and detailed administrative expense data were provided by the CMDP.

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

While the CMDP does not have sub-capitated contracts with providers, the encounter data for CRS specialty services provided to children with CRS-eligible health conditions does contain sub-capitated payment amounts. The CRS Contractor used a sub-capitated/block purchasing arrangement for some professional services. The sub-capitated/block purchasing arrangements between the CRS Contractor and its providers still required that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05, and health plan paid of zero (i.e. sub-capitated)) encounters to estimate a health plan valued amount for these encounters. The units of service data from the encounters and the estimated health plan valued amounts were used for the basis of calculating utilization and unit cost. The CRS contractor responsible for providing CRS specialty care services to CMDP members with a CRS qualifying condition, had sub-capitated/block purchasing arrangements which account for approximately 0.2% of gross medical expenses in the base year, inclusive of the non-CRS and CRS services.

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

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

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

The AHCCCS DHCM Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a PMPM basis looking for anomalous patterns in encounter, unit, or cost totals, such as incurred months where totals are unusually low or high. If any anomalies are found, the AHCCCS DHCM Actuarial Team reports the findings to the AHCCCS Data Analysis & Research (DAR) Team, which then works with the CMDP to determine causal factors. In addition, the AHCCCS DAR Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

The CMDP and the CRS Contractor 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 CMDP and the CRS Contractor 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 CMDP and the CRS Contractor allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions.

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

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

- The encounter data used in the adjustment contained AHCCCS member IDs, service dates, servicing provider IDs, procedure codes, and paid amounts, so that duplicated amounts could be excluded from the adjustments;
- Because those informational fields were available, AHCCCS was comfortable making adjustments supported by medical expense data rather than an under-reporting factor calculated from high-level financial statements;
- The adjustment was applied to the encounter counts and health plan valued amounts for each incurred month in the base period as determined by the service dates on the encounters. This method of adjustment was more accurate for rate and trend development than estimating future runout by calculating completion factors.

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

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

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

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

Through review of the encounter data provided from the AHCCCS PMMIS mainframe, the AHCCCS DHCM Actuarial Team ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 20 capitation rates for the CMDP. 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 reviewed the encounter data for consistency by viewing month over month, year over year as well as encounter data versus financial statements.

The monthly encounter cycle of the AHCCCS data warehouse ensures that no duplicated encounters exist among the adjudicated and approved encounters. AHCCCS further compared the pended and non-submitted encounters from the supplemental data files using the member ID, date of service, servicing provider ID, and paid amount to remove duplicated encounters from those sources so that the adjustment to base data would be accurate.

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

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

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon encounter data submitted by the CMDP and the CRS Contractor and provided from the AHCCCS PMMIS mainframe as well as the supplemental encounter files provided by the CMDP. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the CMDP and the CRS Contractor and reviewed by the AHCCCS DHCM Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS DHCM Rates & Reimbursement Team with regards to DAP and fee schedule impacts, on information and data provided by Mercer consultants with regards to mental health parity and pharmacy reimbursement savings, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

The AHCCCS DHCM Actuarial Team found the encounter data, with adjustments for encounter issues as described in Section I.2.B.ii.(b)(i), to be appropriate for the purposes of developing the CYE 20 capitation rates for the CMDP.

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

The AHCCCS DHCM Actuarial Team did not identify any material concerns with the availability or quality of the data, with the exception of the encounter issue noted in the previous section.

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

The AHCCCS DHCM Actuarial Team determined that the FFY 18 encounter data was appropriate to use as the base data for developing the CYE 20 capitation rates for the CMDP with the encounter issue adjustment previously noted.

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

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

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

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

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

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

I.2.B.iii Adjustments to the Data

The CMDP encounter data was adjusted as described in Section I.2.B.ii.(b)(i) for pended and non-submitted encounters. The CRS encounter data was adjusted for completion. Historical program and fee schedule changes were applied as described in Section I.2.B.iii.(d) to bring the historical data to current program and reimbursement levels.

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

No credibility adjustment was necessary.

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

Completion factors were not applied to the encounter data from the CMDP due to the inclusion of pended and non-submitted encounters from the supplemental data, as noted in Section I.2.B.ii.(b)(i), for which the service unit counts and Health Plan Valued amounts would have ordinarily been estimated by completion factors calculated using historical runout patterns. The aggregated FFY 18 supplemental encounter files adjustment applied to each category of service are shown in Appendix 4.

Completion factors were applied to the encounter data for CRS specialty services from the CRS Contractor active in FFY 18. The aggregated FFY 18 completion factors applied to each category of service are shown in Appendix 4.

Each of the aggregated factors shown in the appendix is a calculated figure to denote the impact if the factor had applied to both CMDP and CRS data.

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

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

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2017 through September 30, 2018) are described below. Additional adjustments for program and fee schedule changes which occurred before April 1, 2019 are also included below. All program and fee schedule changes which occurred or are effective on or after April 1, 2019 are described in Section I.3.B.ii.(a).

Some of the impacts for base data adjustment changes described below (indicated by an asterisk) were developed by AHCCCS financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the DHCM Clinical Quality Management Team and the Office of the Director's Chief Medical Officer. The actuary relied upon the professional judgment of the financial analysts with regard to the reasonableness and appropriateness of the data, assumptions and methodologies that were used to develop the estimated amounts. The actuary met with the AHCCCS financial analysts to understand at a high level how the estimated amounts were derived and the data used for the amounts. The actuary

was unable to judge the reasonableness of the data, assumptions and methodologies without performing a substantial amount of additional work.

Table 1 summarizes the impacts for historical program and reimbursement changes described below. Totals may not add up due to rounding.

Table 1: Impacts of Historical Program/Reimbursement Changes

Change	Dollar Impact	PMPM Impact
DRG Reimbursement Rate Changes	$77,555	$0.50
Provider Fee Schedule Changes	$67,575	$0.44
Program Changes (Genetic Testing , SDOH)	$182,087	$1.18
Total Historical Program and Reimbursement Changes	**$327,218**	**$2.11**

Program and Reimbursement Changes

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service 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. Arizona Revised Statute 8-512(E) requires of the CMDP that, "The department shall reimburse a provider according to the rates established by the Arizona health care cost containment system administration pursuant to title 36, chapter 39, article 1". Effective October 1, 2018, AHCCCS updated provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The base data has been adjusted to reflect these fee schedule changes.

DRG Reimbursement Rate Changes

AHCCCS transitioned from version 31 to version 34 of the All Patient Refined Diagnostic Related Groups (APR-DRG) payment classification system on January 1, 2018. To make the APR-DRG grouper fully ICD-10 code compliant, AHCCCS rebased the inpatient system by updating the DRG grouper version, relative weights and DRG base rates via payment simulation modeling using more recent data.

The AHCCCS DHCM Actuarial Team estimated and incorporated the impact of the DRG rebase in CYE 18 capitation rates. The method used to develop the CYE 18 capitation rates was deemed appropriate for continued use in adjusting the first quarter of CYE 18 data to reflect the APR-DRG change prior to implementation in order to develop CYE 20 capitation rates. This method was described in the CYE 18 certification and the language has been copied here for convenience of review.

> "Navigant Consulting did the rebase of the AHCCCS DRG system. Their modeling approach: "Rebasing calculations included updated base rates (both standardized amounts and wage indices), relative weights, and addition and change of policy adjusters. Outlier identification and payment methodology has not changed nor has any other underlying claim pricing calculation

(notwithstanding the above noted changes to factors, indices, and statewide standardized base rate).

To affect a budget neutral payment system change, Navigant first repriced the FFY 2016 claims under current APR-DRG v31 FFS rates, including changes to the payment system which have occurred since the FFY 2016 claims period (such as the removal of the transition factor, coding improvement factor, and the increase of the high acuity pediatric adjuster to 1.945). Navigant then repriced the same claims set using the APR-DRG v34 grouper and weights and calculated a statewide standardized amount (adjusted to each facility's labor cost using CMS's published FFY 2017 Final Rule Wage Indices). The statewide standardized amount was calculated to result in total simulated rebased payments equal to current system payments.

The next modeling step was to increase select policy adjusters to meet program funding goals, as determined by AHCCCS. These adjustments included an increase of the high acuity pediatric policy adjuster to 2.30, the addition of a service policy adjuster for burn cases (as identified by APR-DRG groups 841-844) of 2.70, the increase of the policy adjuster for other adult services to 1.025, and the increase of the existing High Volume Hold Harmless adjuster to 1.11."

The PMPM adjustments to apply to each rate cell were then developed as the total simulated APR-DRG rebased payments with the new policy adjuster factors applied to each inpatient hospital admission during FFY 16 by members in each rate cell, minus the total actual payments associated with those admissions, divided by the FFY 16 member months for each rate cell.

The AHCCCS Division of Health Care Management (DHCM) Actuarial Team relied upon Navigant and AHCCCS DHCM Rates & Reimbursement Team for the reasonableness of these assumptions."

Genetic Testing*

AHCCCS policy guidance changed to clarify that covered genetic testing services include specific chromosomal tests for diagnosing developmental delays in infants and children. The policy guidance was expected to lead to increased use of these covered services beginning in FFY 19. The estimated impact was determined by analyzing prior year encounters and projecting increase in use of genetic testing services.

Social Determinants of Health*

The Targeted Investments Program has benchmarks for screening members for the presence of social determinants of health (SDOH). These benchmarks were expected to result in increased use of the covered screening services in FFY 19. This change had less than 0.2% impact on the capitation rate.

Removal of DAP from Base Period

CYE 18 capitation rates for the CMDP and CRS program funded Differential Adjusted Payments (DAP) made from October 1, 2017 through September 30, 2018 to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health and reduce cost of care growth. As these payments expired September 30, 2018, AHCCCS has removed the impact of CYE 18 DAP from the base period. To remove the impact, the AHCCCS DHCM Actuarial Team

requested provider IDs for the qualifying providers for the CYE 18 DAP by specific measure from the AHCCCS Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 18 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 Appendix 4. Totals may not add up due to rounding.

See Section I.4.D. below for information on adjustments included in CYE 20 capitation rates for DAP that are effective from October 1, 2019 through September 30, 2020.

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

The AHCCCS DHCM Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 20 capitation rates. Additionally, the service costs incurred by one high-cost member who was enrolled in the CMDP for only a portion of CYE 18 were excluded from the base data. The member in question is disenrolled as of this writing, and to include the costs in the base data would have inflated the projected CYE 20 medical expenses and reinsurance offset above the levels that can be expected given the current membership.

I.3. Projected Benefit Costs and Trends

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

I.3.A Rate Development Standards

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

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

I.3.A.ii. Variations in Assumptions

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

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

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

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

The projected benefit costs may include costs for in-lieu-of services defined at 42 CFR § 438.3(e)(2), as the CMDP allows the following types of services 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. These services are then included in the CMDP's capitation rate development categories of service. Encounters which are in-lieu-of services are not identified separately in the data, and are not repriced to the cost of the State plan service or setting, and are treated the same as all other data for rate development.

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

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

I.3.B. Appropriate Documentation

I.3.B.i Projected Benefit Costs

Appendix 6 contains the projected CYE 20 gross medical expenses PMPM on a statewide basis for use in the capitation rates.

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

This section provides information on the projected benefit costs included in the CYE 20 capitation rates for the CMDP.

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

The data described in Section I.2.B.ii.(a) was adjusted to reflect historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The adjusted base data per-member-per-month (PMPM) expenditures for each category of service (COS) were trended forward 24 months, from the midpoint of the FFY 18 time period to the midpoint of the CYE 20 rating period by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a)(ii). The projected PMPMs were then adjusted for prospective program changes that are described in this section. Appendix 4 contains the base data and base data adjustments, Appendix 5 contains the projected benefit cost trends, and Appendix 6 contains the prospective program changes. Additionally, Appendix 6 illustrates the capitation rate development, which includes the CYE 20 DAP, reinsurance offset, third party liability offset, administrative expense, case management expense, underwriting (UW) gain, and premium tax.

The capitation rates were adjusted for all program changes. If a program change had an impact of 0.2% of less on the statewide capitation rate, that program change was deemed non-material and has been grouped in the combined miscellaneous program changes subset below, along with a brief description of the non-material items.

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

Table 2 summarizes the impacts for prospective program and reimbursement changes effective at any point during the CYE 20 rating period.

Table 2: Impacts of Prospective Program/Reimbursement Changes

Change	Dollar Impact	PMPM Impact
Provider Fee Schedule Changes	$24,448	$0.16
Pharmacy Reimbursement Savings	-$162,606	-$1.05
Combined Miscellaneous Program Changes	-$10,177	-$0.07
Total Prospective Program and Reimbursement Changes	**-$148,335**	**-$0.96**

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service 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. Arizona Revised Statute 8-512(E) requires of the CMDP that, "The department shall reimburse a provider according to the rates established by the Arizona health care cost containment system administration pursuant to title 36, chapter 39, article 1".

Effective October 1, 2019, AHCCCS is updating provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 20 capitation rates have been adjusted to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to CYE 20 capitation rates was the CYE 18 encounter data across all programs. The AHCCCS DHCSM Rates & Reimbursement Team applied the AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 20 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. The projected CYE 20 PMPM impact, as provided in Table 2, was incorporated into expense projections for the rating period.

Pharmacy Reimbursement Savings

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

The change for the CMDP is estimated to decrease medical expenses by approximately $163,000, or $1.05 PMPM as displayed above in Table 2.

Combined Miscellaneous Program Changes

- ***Prenatal Syphilis Screening****
  In September 2018, the Arizona Department of Health Services (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.
- ***Bilateral Cochlear Implants****

Effective March 1, 2019, AHCCCS revised policy to specify coverage of bilateral cochlear impacts for children 20 years of age or younger. The change recognizes the latest standard of care and a CMS decision memo regarding the appropriateness of bilateral cochlear implants. Prior to the change, policy specified coverage of unilateral cochlear implants for children.

- ***Naturopathic Physicians Providing EPSDT ****
  In CYE 2019, AHCCCS began accepting applications for Doctors of Naturopathic Medicine (ND) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children under 21 years of age. The AHCCCS Office of Administrative and Legal Services (OALS) has interpreted federal and state laws to require the State to cover "medical care, or any other type of remedial care recognized under State law" provided by an ND as EPSDT services to "correct or ameliorate" any physical or mental conditions of the member. Use of services provided by NDs to members will largely replace existing use of services provided by other registered physician provider types. State law, however, places some limitations on the medications NDs may prescribe while many of the practitioners use pharmacological interventions sparingly. As a result, a number of ND office visits will require additional follow-up visits to a prescribing provider, which will increase use of services.
- ***Transportation Network Companies for NEMT ****
  Beginning May 1, 2019, AHCCCS established a Transportation Network Company (TNC) provider type that delivers non-emergency medical transportation (NEMT) services through a ride-sharing model. The TNC-specific fee schedule is lower than ordinary NEMT base rates. The expansion of providers that can deliver NEMT services to members is also expected to reduce missed medical appointments and thus increase medical utilization. The estimated cost reduction associated with lower priced NEMT services provided by TNCs exceeds the estimated cost increase of additional office visits and NEMT rides associated with additional office visits.
- ***Pharmacy and Therapeutics Committee Recommendations ****
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 2019 that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 2020. 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.
- ***Telehealth for Rural and Urban Access to Care ****
  Effective October 1, 2019, AHCCCS policy is revised to improve access to telehealth services. The revision to policy eliminates restrictions on service categories for which telehealth can be used, removes place of service requirements for the distant site provider, and clarifies that telehealth services may be used in urban and rural settings.

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

There were no material changes to the components of the capitation rates or the process of their development, other than those changes described elsewhere in the certification.

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

The CMDP is 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 actuary to set the CYE 20 capitation rates therefore includes those adjustments.

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

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

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

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

Please see Section I.2.B.ii.(a) for the types of data that AHCCCS relied upon for developing the projected benefit cost trends for the CMDP and the CRS specialty services added to the CMDP.

All data used was specific to the CMDP population and the CRS specialty services provided to CMDP members with a CRS qualifying condition.

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

Historical utilization, unit cost and PMPM data for the non-CRS services and the CRS specialty services provided to CMDP members from FFY 16, FFY 17, and FFY 18 were combined, organized by incurred year and month and COS. The three years of data were normalized for historical program and fee schedule changes. For the combined non-CRS services and CRS specialty services provided to CMDP members, the trend rates were developed to adjust the base data (midpoint of April 1, 2018) forward 24 months to the midpoint of the rating period (April 1, 2020).

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. No simple formulaic solution exists to determine future trend; actuarial judgment is required. Each category of service was analyzed in the same manner.

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

The PMPM trends by COS were compared to the CYE 19 rate development PMPM trends for the CMDP. The actuary judged the changes in PMPM trends to be reasonable for all categories of service.

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

The 2020 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuary defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. There are no outlier or negative trends in the CYE 20 CMDP capitation rate development.

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

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

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

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

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

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

No other components were used in the development of the annualized trend assumptions summarized in Appendix 5.

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

Projected benefit cost trends vary by category of service.

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

No other material adjustments were made to the trend assumptions.

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

No other adjustments were made to the trend assumptions.

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

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

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

The following types of services can be provided as in-lieu-of-services: home and community based services (HCBS) covered in lieu of a nursing facility and services in alternative inpatient settings licensed by ADHS/DLS in lieu of services in an inpatient hospital. These services are then included in CMDP's capitation rate development categories of service. Encounters which are in-lieu-of-services are not identified separately in the data. Thus, the actuary 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.

I.3.B.vi. Retrospective Eligibility Periods

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

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

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

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

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

No specific adjustments are made to the CYE 20 capitation rates for the CMDP, given that the encounter and enrollment data are already included within the base data used for rate development.

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

This section of the 2020 Guide provides information on what must be documented for all material changes to covered benefits or services since the last rate certification.

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

Documentation of impacts for all material changes to covered benefits or services since the last rate certification has been provided above in Section I.3.B.ii.

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

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

"The Contractor 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

Adjustments related to provider reimbursement changes are discussed in Section I.3.B.ii.(a). Adjustments related to provider payment requirements are discussed in Section I.4.D of this rate certification.

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

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

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

There were no material changes since the last rate certification related to litigation.

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

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

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

Not Applicable. No incentive arrangements exist with the CMDP.

I.4.B. Withhold Arrangements

Not Applicable. No withhold arrangement exists with the CMDP.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

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

I.4.C.ii. Appropriate Documentation

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

The CYE 20 capitation rates for the CMDP will include a risk corridor.

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

AHCCCS has a long-standing program policy of including risk corridors within many of the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 20 capitation rates are consistent with AHCCCS' long-standing program policy and will include a risk corridor for all services under the CMDP. This rate certification will use the term risk corridor to be consistent with the 2020 Guide. The CMDP Contract refers to the risk corridor as a reconciliation.

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

The risk corridor will reconcile the CMDP's medical cost expenses to the net capitation paid to the CMDP. Net capitation is equal to the capitation rates paid, less the premium tax and the administrative component, plus the reinsurance payments. The CMDP's medical cost expenses are equal to the fully adjudicated encounters 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. The risk corridor will limit the CMDP profits to 6% and losses to 2%.

Additional information regarding the risk corridor can be found in the CMDP contract.

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

The risk corridor did not have any effect on the development of the capitation rates for the CMDP.

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

The threshold amounts for the risk corridor were set using actuarial judgement with consideration of conversations and input between the AHCCCS DHCM Actuarial Team, the AHCCCS DHCM Finance & Reinsurance Team, the AHCCCS Office of the Director, and the CMDP leadership.

I.4.C.ii.(b) Description of Medical Loss Ratio

Not applicable. The CMDP contract does not include a remittance/payment requirement.

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

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

AHCCCS provides a reinsurance program to the CMDP for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what one would see in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than the CMDP paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical expense. 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 reimburses the CMDP for covered services incurred above the deductible. The deductible is the responsibility of the CMDP. There has been no change to the deductible or coinsurance factors applicable to the regular CMDP reinsurance program since the last rate setting period. Effective October 1, 2018, the threshold at which a reinsurance case becomes eligible for high-dollar catastrophic coverage was increased from $650,000 to $1 million. Once a reinsurance case hits this limit, the MCO is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

Effective October 1, 2018, CRS services for CMDP members, which previously accumulated toward a $75,000 deductible associated with the CRS program, are combined with non-CRS services to accumulate towards the $20,000 deductible associated with the CMDP.

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

For additional information, including all deductibles and coinsurance amounts, on the reinsurance program refer to the Reinsurance section of the CMDP contract.

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

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical expense PMPM calculated for the rate setting period. It is a separate

calculation and does not affect the methodologies for development of the gross medical expense component of the capitation rate.

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

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

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

The data used to develop the reinsurance offset are calculated reinsurance payments to the CMDP for services provided to CMDP members and incurred during FFY 18, including CRS specialty services provided through the CRS Contractor at that time. The calculated reinsurance payments were developed from CYE 18 encounters that were adjusted for historical programmatic and reimbursement changes and trended to the CYE 20 rating period using the same trend factors applied to the gross medical capitation rate by category of service (provided in Appendix 5). Calculated reinsurance payments were used to develop the CYE 20 reinsurance offset in order to align expected payments with the timing of incurred services, to reflect that CRS and non-CRS services would accumulate toward a single deductible for each reinsurance case, and to reflect deductible leveraging through applying expense trends to the CYE 18 encounters. The calculated payments are expressed as PMPMs in Appendix 6.

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

I.4.D.i. Rate Development Standards

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

I.4.D.ii. Appropriate Documentation

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

The only pre-prints addressed in this certification are the ones related to the CMDP. Those pre-prints are FQHC Differential Adjusted Payments and Differential Adjusted Payments. This certification combines both under the Differential Adjusted Payments language.

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

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

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

Differential Adjustment Payments are the only directed payments incorporated in the capitation rates. See Appendix 6 for medical impact PMPM. See Appendix 7 for total impact PMPM.

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

The statewide rate cell is affected.

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

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 4.0% increase), Critical Access Hospitals (eligible for up to 28.5% increase), other hospitals and inpatient facilities (eligible for up to 4.0% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral health outpatient clinics and integrated clinics (eligible for up to 7.0% increase on all services provided), physicians, physician assistants, registered nurse practitioners, dental providers (all eligible for a 1.0% increase), home and community based services providers (eligible for a 1.0% increase on specified services at specified places of service) and Federally Qualified Health Centers (FQHCs) (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 18 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 20 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

The amount of increased total payments for the DAP included in the CYE 20 capitation rates for the CMDP program is approximately $695,000 inclusive of underwriting gain and premium tax, with approximately $689,000 for Non-FQHC DAP and approximately $6,000 for FQHC DAP.

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

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

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

Not applicable. There are no directed payments under separate payment arrangement for the CMDP.

I.4.E. Pass-Through Payments

Not applicable. Pass-through payments, as defined in 42 CFR § 438.6(a) at 81 FR 27497, were not developed for the CYE 20 capitation rates for the CMDP.

I.5 Projected Non-Benefit Costs

I.5.A. Rate Development Standards

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

I.5.B. Appropriate Documentation

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

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

The CMDP provided AHCCCS with an administrative expense request for funding that detailed projected employee compensation, data processing costs, management fees, interest charges, occupancy (rent/utilities), and other administrative expenses for the current contract year and the upcoming contract year. These administrative expense requests were reviewed by AHCCCS for reasonableness by comparing against previous administrative expense requests. Once the reports were determined to be reasonable by AHCCCS, an administrative expense PMPM was calculated using the appropriate projected member months for the contract year.

The projection for CYE 20 includes expected costs associated with issuing a Request for Proposal (RFP) for a contractor to provide administrative services for the CMDP.

The administrative expense PMPM including the expected costs associated with the RFP was evaluated along with the projected gross medical expense, reinsurance offset, and care management expense PMPM amount to ensure compliance with the minimum 85 percent MLR requirement, as calculated under 42 CFR § 438.8. The projected administrative expense PMPM built into the CYE 20 capitation rate was therefore adjusted on that basis.

The projected CYE 20 administrative expense component is shown in Appendix 6.

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

The expenses related to the RFP are a new addition to data reviewed for the CMDP for CYE 20. There were no expenses related to the RFP in the CYE 19 capitation rates.

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

There were no other adjustments (material or non-material) to the projected non-benefit expenses included in the capitation rates.

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

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

The administrative component of the CYE 20 capitation rates for the CMDP is described above in Section I.5.B.i.(a). The PMPM amounts assumed can be found in Appendix 6.

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

The CYE 20 capitation rates for the CMDP include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 20 capitation rates for the CMDP include a provision of 1% for margin (i.e. underwriting gain).

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

No other material or non-material non-benefit costs are reflected in the CYE 20 capitation rates for the CMDP.

I.5.B.iii. Health Insurance Provider's Fee

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

Not applicable. The CMDP is a governmental entity and thus is excluded from the Health Insurance Providers Fee (HIPF).

I.6. Risk Adjustment and Acuity Adjustments

This section of the 2020 Guide is not applicable to the CMDP. The CMDP does not utilize risk adjustments or acuity adjustments. This is not anticipated to change.

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

Section II of the 2020 Guide is not applicable to the CMDP. Managed long-term services and supports, as defined at 42 CFR § 438.2 at 81 FR 27855, are not covered services under the CMDP. The CMDP does cover nursing facility services, and related home and community based services, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates

Section III of the 2020 Guide is not applicable to the CMDP.

Appendix 1: Actuarial Certification

I, Matthew C. Varitek, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I 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 is considered actuarially sound according to the following criteria from 42 CFR § 438.4 at 81 FR 27858:

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

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

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

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

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

The actuarially sound capitation rates are based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rates, I have relied upon data and information provided by AHCCCS and the CMDP. I have relied upon AHCCCS and the CMDP for the accuracy of the data and I have accepted the data without audit, after checking the data for reasonableness and consistency.

SIGNATURE ON FILE	August 14, 2019
Matthew C. Varitek	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Actuarial Certified Capitation Rates

CMDP Capitation Rates	
Effective October 1, 2019 through September 30, 2020	$325.55

Appendix 3: Fiscal Impact Summary Compared to CYE 19

CMDP	Projected CYE 20 Member Months	CYE 19 Capitation Rate Effective 4/1/19 - 9/30/19	CYE 20 Capitation Rate Effective 10/01/19 - 09/30/20	CYE 20 Projected Expenditures (based on 4/1/19 rate)	CYE 20 Projected Expenditures (based on 10/1/19 rate)	Dollar Impact	Percent-age Impact
Statewide	154,787	$304.71	$325.55	$47,165,276	$50,391,046	$3,225,770	6.8%

Appendix 4: Unadjusted and Adjusted Base Data

Gross Medical Expenses						
Service Category	Unadjusted Base Data PMPMs	Supplemental Encounter Files	Completion Factors	Pgm/Reimb Changes	DAP PMPM Removed	Adjusted Base Data
Professional	$88.27	1.1616	0.9968	1.0146	$0.00	$104.35
Pharmacy	$25.55	1.0001	0.9997	1.0000	$0.00	$25.56
Dental	$25.84	1.2488	0.9994	1.0000	$0.00	$32.29
Inpatient & NF	$36.49	1.1144	0.9686	1.0119	-$0.28	$42.20
Outpatient	$22.36	1.4874	0.9772	1.0035	-$0.10	$34.05
Total	**$198.50**				**-$0.38**	**$238.45**

Appendix 5: Projected Benefit Cost Trends

Service Category (Non-CRS and CRS Expenses)	Annualized Trend Rates		
	Utilization	Unit Cost	PMPM
Professional	2.0%	3.3%	5.4%
Pharmacy	0.3%	0.1%	0.4%
Dental	2.5%	0.2%	2.7%
Inpatient & NF	0.1%	4.0%	4.1%
Outpatient	1.5%	0.5%	2.0%

Appendix 6: Projected CYE 20 Capitation Rate Development

Projected Combined Gross Medical Expense						
Service Category	Adj Base Data PMPM	Trend	Prgm Chg 10/1/19	Reimb Chg 10/1/19 [1]	10/1/19 DAP	Proj GME PMPM (10/1/19 - 9/30/20)
Professional	$104.35	5.4%	$0.22	$0.13	$0.33	$116.52
Pharmacy	$25.56	0.4%	-$0.28	-$1.05	$0.00	$24.43
Dental	$32.29	2.7%	$0.00	$0.00	$0.16	$34.22
Inpatient & NF	$42.20	4.1%	$0.00	$0.03	$2.96	$48.73
Outpatient	$34.05	2.0%	$0.00	$0.00	$0.91	$36.34
Total	$238.45		-$0.07	-$0.89	$4.36	$260.24

1. The Reimb Chg column includes Pharmacy Reimbursement Savings

Service Category	Capitation build from Proj GME PMPM (10/1/19 - 9/30/20)
Total Gross Medical Expense PMPM	$260.24
Less Reinsurance PMPM	-$13.48
Less TPL PMPM	$0.00
Net Claim Cost PMPM	$246.76
Care Management PMPM	$22.40
Administrative Expenses PMPM	$46.59
Underwriting Gain PMPM	$3.29
Premium Tax Rate	2.0%
Projected CYE 20 Capitation Rate	**$325.55**

Appendix 7: Projected Delivery System and Provider Payment Initiatives, PMPM

Rate Cell	DAP Non-FQHC	DAP FQHC	DAP Total
Statewide	$4.45	$0.04	$4.49

Note: All amounts shown include underwriting gain and premium tax.