Contract Year Ending 2024
Capitation Rate Certification Amendment
AHCCCS Complete Care and
AHCCCS Complete Care – Regional Behavioral Health Agreement
Program

October 1, 2023 through March 31, 2024 and
April 1, 2024 through September 30, 2024

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Business and Finance

March 25, 2024

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Introduction and Limitations

The purpose of this rate certification amendment is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This rate certification amendment provides documentation for revisions to the capitation rates for the Arizona Health Cost Containment System (AHCCCS) Complete Care (ACC) and AHCCCS Complete Care – Regional Behavioral Health Agreement (ACC-RBHA) Program for the six-month period covering April 1, 2024, through September 30, 2024. The original rate certification signed August 11, 2023, provides further documentation on the development of the original capitation rates, and an amended actuarial rate certification signed January 31, 2024, was submitted to document a new state directed payment paid through a separate payment arrangement which did not impact the certified capitation rates. The acuity adjustment factors included in the development of the previously certified capitation rates were dependent on assumptions regarding the volume and acuity of disenrolling members due to the end of the maintenance of effort (MOE) requirements associated with the COVID-19 Public Health Emergency (PHE) and the actuaries stated in the documentation of those rates that an update might be incorporated for the latter half of the rating period to address material differences from assumptions to actual disenrollments. The AHCCCS Division of Business and Finance (DBF) Actuarial Team updated the acuity factor modeling to incorporate actual member disenrollment and the actuaries determined there was enough variability between the original factors and the updated factors at a risk group level that it was necessary to adjust the capitation rates prospectively (April 1, 2024, through September 30, 2024) to incorporate those differences. The actuaries are also adjusting the risk adjustment factors for the time frame April 1, 2024, through September 30, 2024, consistent with the information provided in the original capitation rate certification, updating the Marker Study Period and Member Snapshot Period to time frames that incorporate more of the unwinding of the PHE. There have been no other changes to data, assumptions, or methodologies used and provided in the previous actuarial rate certifications besides the ones listed in this amendment.

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 AHCCCS website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2023-2024 Medicaid Managed Care Rate Development Guide (2024 Guide), Actuarial Standards of Practice and generally accepted actuarial principles and practices.

The 2024 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 2024 Guide to help facilitate the review of this rate certification amendment by CMS. This amendment only addresses changes from the original certification; it does not purport to address all subsections of the 2024 Guide as most subsections are unchanged.

Section I Medicaid Managed Care Rates

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

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

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

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

- Actuarial Standards of Practice (ASOPs) applicable to Medicaid managed care rate setting which were effective before the start date of the rating period:
  - ASOP No. 1 - Introductory Actuarial Standard of Practice,
  - ASOP No. 5 - Incurred Health and Disability Claims,
  - ASOP No. 12 - Risk Classification (for All Practice Areas),
  - ASOP No. 23 - Data Quality,
  - ASOP No. 25 - Credibility Procedures,
  - ASOP No. 41 - Actuarial Communications,
  - ASOP No. 45 - The Use of Health Status Based Risk Adjustment Methodologies,
  - ASOP No. 49 - Medicaid Managed Care Capitation Rate Development and Certification, and
  - ASOP No. 56 - Modeling.
- The 2016 and 2020 Medicaid and CHIP Managed Care Final Rules (CMS-2390-F and CMS-2408-F)
- FAQs related to payments to MCOs and PIHPs for IMD stays
- The 2023-2024 Medicaid Managed Care Rate Development Guide (2024 Guide) published by CMS

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

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

As stated on pages 2 and 3 of the 2024 Guide, CMS will also use these three principles in applying the regulation standards:

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

I.1. General Information

The certified capitation rates for the ACC and ACC-RBHA Program are effective for the 12-month time period from October 1, 2023, through September 30, 2024 (CYE 24), with one set of capitation rates being effective for the 6-month time period from October 1, 2023, through March 31, 2024, and the second set of capitation rates being effective for the 6-month time period from April 1, 2024, through September 30, 2024. The CYE 24 capitation rates effective for the first half of the year are unchanged from the original CYE 24 capitation rate certification signed August 11, 2023, and the certification amendment signed January 31, 2024. This rate certification amendment addresses and accounts for all differences from the previously certified rates, i.e., changes to the risk adjustment and acuity adjustment factors for the second half of the year. Documentation of these changes can be found in Sections I.6. Risk Adjustment and I.7. Acuity Adjustment, respectively. The capitation rates effective for the second half of the year were developed in the same way as the original capitation rates except for the two listed changes. Please see the original rate certification for additional information about the ACC and ACC-RBHA Program. The state has not made any previous adjustment to rates in the rating period by a *de minimis* amount or otherwise.

The actuarial certification letter for the revised CYE 24 capitation rates for the ACC and ACC-RBHA Program, signed by Matthew C. Varitek, FSA, MAAA and Erica Johnson, ASA, MAAA, is in Appendix 1. Mr. Varitek and Ms. Johnson meet the requirements for the definition of an Actuary described at 42 CFR § 438.2.

Mr. Varitek and Ms. Johnson certify that the CYE 24 capitation rates for the ACC and ACC-RBHA Program contained in this rate certification amendment are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ACC and ACC-RBHA Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ACC and ACC-RBHA Program contract uses the term risk group instead of rate cell. This rate certification amendment will use the term rate cell when identifying a population at the certified capitation rate level to be consistent with the applicable provisions of 42 CFR Part 438, the 2024 Guide, and the prior rate certifications, and will use the term risk group when identifying a population not at the certified capitation rate level, e.g., the AGE < 1 risk group represents children under age 1 in the ACC and ACC-RBHA Program. Appendix 3 compares the CYE 24 revised certified capitation rates for the period April 1, 2024, through September 30, 2024, to the CYE 24 original certified capitation rates which are for the period October 1, 2023, through March 31, 2024.

Proposed differences among the CYE 24 capitation rates for the ACC and ACC-RBHA Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the ACC and ACC-RBHA Program. The CYE 24 capitation rates were developed at the rate cell level. Payments from rate cells do not cross-subsidize payments from other rate cells. The effective dates of changes to the ACC and ACC-RBHA Program are consistent with the assumptions used to develop the CYE 24 capitation rates for the ACC and ACC-RBHA Program. The capitation rates were

developed so each Contractor would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 24.

In the actuaries' judgement, all adjustments to the capitation rates or to any portion of the capitation rates reflect reasonable, appropriate, and attainable costs. To the actuaries' knowledge, there are no reasonable, appropriate, and attainable costs which have not been included in the rate certification amendment. There have been no adjustments to the rates performed outside of the rate setting process described in the rate certification. The amended CYE 24 capitation rates certified in this report represent the contracted rates by rate cell. The state will submit a contract amendment to CMS.

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

Table 1: Future Rate Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
Targeted Investments 2.0	Summer/Fall 2024	AHCCCS has not finalized the required pre-print for this directed payment.

I.2. Data

Please see the original capitation rate certification for all data sources used or reviewed in the development of the CYE 24 capitation rates for the ACC and ACC-RBHA Program, along with information on completeness, accuracy, and consistency of the data.

I.3. Projected Benefit Costs and Trends

Please see the original capitation rate certification for all projected benefit costs and trends used in the development of the CYE 24 capitation rates for the ACC and ACC-RBHA Program.

I.4. Special Contract Provisions Related to Payment

There have been no changes to incentive arrangements, withhold arrangements, or risk-sharing mechanisms from the original rate certification. The amended certification dated January 31, 2024, certified the new Safety Net Services Initiative (SNSI) directed payment added to the CYE 24 contract.

I.5. Projected Non-Benefit Costs

There have been no changes to administrative costs or the percentages for premium tax and underwriting gain from the original capitation rate certification. Please see the original capitation rate certification for all projected non-benefit costs used in the development of the CYE 24 capitation rates for the ACC and ACC-RBHA Program.

I.6. Risk Adjustment

Please see the original capitation rate certification for relevant definitions of terms, a description of the model used, and the methodology for developing and applying risk adjustment factors, all of which are unchanged. The changes in the risk adjustment factors follow from updating the Marker Study Periods and Member Snapshot Periods mid-year to incorporate more of the unwinding of the PHE as shown below in Table 2.

Table 2: Marker Study Period and Member Snapshot Period by Risk Group and Effective Dates

Effective Dates	October 1, 2023 – March 31, 2024		April 1, 2024 – September 30, 2024	
Risk Adjusted Risk Groups	Marker Study Period	Member Snapshot Period	Marker Study Period	Member Snapshot Period
Newborns (i.e., AGE < 1)	August 2021 – July 2022	August 2021 – July 2022	September 2022 – August 2023	September 2022 – August 2023
Non-Newborns	August 2021 – July 2022	June 2023	September 2022 – August 2023	January 2024

I.7. Acuity Adjustments

I.7.A. Rate Development Standards

This section of the 2024 Guide provides information on acuity adjustments which account for significant uncertainty about the health status or risk of a population, which are permissible adjustments to the capitation rates under 42 CFR § 438.5(f).

I.7.B. Appropriate Documentation

I.7.B.i. Acuity Adjustment Description

The CYE 24 capitation rates include acuity adjustments developed and applied to the base data medical expenses to prospectively account for changes in the health status of the ACC and ACC-RBHA populations during and after the unwinding period for the COVID-19 PHE. The acuity adjustment factors developed and used for the first half of the year were developed using assumptions about the COVID-19 override members expected to be disenrolled across populations during the unwinding. The acuity adjustment factors being used for the second half of the year have been developed based on calculations using the actual disenrollments of COVID-19 override members by risk group through the end of January 2024.

I.7.B.i.(a) Reason for Acuity Adjustment

Please see the original capitation rate certification for documentation of the rationale for the acuity adjustments. The acuity adjustment factors in the original capitation rates projected an increase in the health needs of the population in a return towards pre-pandemic acuity levels due to less costly members on the COVID-19 override list being disenrolled. The revised acuity factors vary from the previous acuity factors both positively and negatively dependent on the actual disenrollment by risk group, and in aggregate, the total fiscal impact of the changes is a slight decrease from the previous projections. There are three risk groups (SSIWO, Expansion Adults, and members with SMI) in which the change in the acuity adjustment factors for the second half of the year causes the capitation rates in one or more GSAs to change by more than the +/-1.5% de minimis amounts allowable without an updated certification. The acuity factor update calculations were all performed in the same way using the same data sources, and differences in the results are due to actual experience during the base data period used for the capitation rate development of the disenrolled COVID-19 override members rather than the hypothetical average experience of expected disenrolled override members.

I.7.B.i.(b) Acuity Adjustment Model

Please see the original capitation rate certification for documentation of the development process for the acuity adjustments used in the original CYE 24 capitation rates.

The model developed to estimate acuity adjustment factors by risk group and geographical service area (GSA) in the original CYE 24 capitation rates included several assumptions that impacted the resulting acuity factors, most of which were developed in conjunction with input from subject matter experts from AHCCCS Division of Member and Provider Services (DMPS) and available historical data. The revised capitation rates include acuity adjustment factors developed using actual disenrollment data of COVID-19 override members, rather than estimated disenrollments using assumed percentages of

members in the eligibility failure (EF) or verification failure (VF) groups within the override list. The members on the override list who have been categorized as disenrolled for the updated acuity adjustment factors fall into two categories: members disenrolled on or after April 1, 2023 (the first day AHCCCS began disenrolling members due to the end of the PHE), that stayed disenrolled, or members disenrolled on or after April 1, 2023, who did not re-enroll until at least six months after the initial disenrollment, with enrollment data observed through the end of January 2024. The 6-month threshold was decided on for categorization as it is longer than the 90-day prior period coverage (PPC) period where members may receive retroactive coverage 90 days prior to the date they applied for care under AHCCCS; additional analysis was done to check the relative acuity in the base data experience of the members who re-enrolled within six months and that analysis showed those members re-enrolling within the 6-month threshold was similar to the total ACC and ACC-RBHA populations by risk group. The AHCCCS DBF Actuarial Team extracted adjudicated and approved encounter data for all members on the COVID-19 override list as well as membership information for the base year (CYE 22: October 1, 2021, through September 30, 2022) and isolated the experience and enrollment of those override members who were categorized as disenrolled. The disenrolled members' experience was then subtracted from the total ACC and ACC-RBHA population's experience (base experience), and the per member per month (PMPM) of the remaining population (total less disenrolled) by risk group was divided by the PMPM of the total population by risk group to update the acuity adjustment factors for the second half of the year based on actual disenrollments at the risk group level through the end of January 2024.

I.7.B.i.(c) Data and Source of Data

Please see the original CYE 24 rate certification for the data and sources of data used for the acuity factors applied for the first half of the year. The primary data sources used or reviewed for the amended acuity factors applied in the second half of the year were:

- Adjudicated and approved encounter data for the ACC and ACC-RBHA populations submitted by the Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
    - Incurred from October 2021 through September 2022
    - Adjudicated and approved through the first February 2024 encounter processing cycle
- Enrollment data for the ACC and ACC-RBHA populations from the AHCCCS PMMIS mainframe
    - October 2022 through January 2024
- List of COVID-19 override members provided by the AHCCCS DMPS team (same list used in original CYE 24 acuity factor development)

I.7.B.i.(d) Relationship

The acuity adjustment factors are calculated independently of the capitation rate setting process and are incorporated in such a way that the only potential interaction that could change the result is the order of their inclusion within the rate development process.

I.7.B.i.(e) Frequency

The AHCCCS DBF Actuarial Team does not intend to make further changes to the acuity adjustment factors for CYE 24, so the frequency for calculation of acuity adjustment for CYE 24 is semi-annual.

I.7.B.i.(f) Description of Use of Acuity Adjustment Scores in Capitation Rates

The acuity adjustment factors are applied to the base data after all other base data adjustments and before trend as shown in Appendix 4 of the original rate certification. The differences in the certified capitation rates for the first half of the year and the second half of the year (apart from the change in risk adjustment factors which are budget neutral in aggregate) are due to changing the acuity factors applied for each time period. The acuity factors applied for each period are displayed in Table 3 below. The acuity adjustment factors differ by risk group and GSA but are applied equally at the detailed category of service level.

Table 3: Acuity Factor Applied to Base Data After Other Base Data Adjustments and Before Trend

GSA	Risk Group	Capitation Rates Effective	
		October 1, 2023 – March 31, 2024	April 1, 2024 – September 30, 2024
North	AGE < 1	1.000	1.000
North	AGE 1-20	1.038	1.039
North	AGE 21+	1.057	1.057
North	Duals	1.017	1.014
North	SSIWO	1.012	0.994
North	Prop 204 Childless Adults	1.041	1.039
North	Expansion Adults	1.117	1.162
North	Delivery Supplemental Payments	1.000	1.000
North	SMI	1.043	1.023
Central	AGE < 1	1.000	1.000
Central	AGE 1-20	1.041	1.041
Central	AGE 21+	1.063	1.057
Central	Duals	1.021	1.022
Central	SSIWO	1.023	1.017
Central	Prop 204 Childless Adults	1.048	1.048
Central	Expansion Adults	1.108	1.188
Central	Delivery Supplemental Payments	1.000	1.000
Central	SMI	1.044	1.015
South	AGE < 1	1.000	1.000
South	AGE 1-20	1.042	1.039
South	AGE 21+	1.060	1.052
South	Duals	1.016	1.015
South	SSIWO	1.021	1.015
South	Prop 204 Childless Adults	1.048	1.049
South	Expansion Adults	1.095	1.167
South	Delivery Supplemental Payments	1.000	1.000
South	SMI	1.036	1.021

I.7.B.i.(g) Development in Accordance with Generally Accepted Actuarial Principles and Practices

The acuity adjustment factors have been developed in accordance with generally accepted actuarial principles and practices. There does not exist an actuarial standard of practice which specifically governs the development of acuity adjustment factors, but ASOP 49 Section 3.2.8. addresses Other Base Data Adjustments which the actuary should consider, and subsection c. addresses population adjustments which modify the base data to reflect differences between the population underlying the base period and the population expected to be covered during the rating period. The actuaries developed the original acuity model using their professional judgement in determining what was appropriate for modeling the nature of the impact of the unwinding of the MOE on the populations covered by the capitation rates. The data used in the originally certified rates was specific to the Medicaid population, consistent with the timing of the base period and incorporated information gathered since the start of disenrollments in April 2023, and was reviewed for accuracy, completeness, quality, and consistency with the data used as the basis of the capitation rates and the model incorporated all known flexibilities that Arizona had opted into as part of its renewal plan as submitted to CMS through June 2023. The actuaries updated the acuity adjustment factor modeling for the second half of the year to incorporate calculation revisions reflecting the base data experience for COVID-19 override members categorized as disenrolled between the start of April 2023 and the end of January 2024 as a replacement for the modeled factors in the first half of the year. The data used in the updated certified rates is similarly consistent with the data used as the basis of the capitation rates, is specific to the Medicaid population, consistent with the timing of the base period, and has been reviewed for accuracy, completeness, and quality. The actuaries also requested and received technical assistance for a reasonability assessment from CMS with regard to the model development during the development cycle for the CYE 23 rating period.

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

Section II of the 2024 Medicaid Managed Care Rate Development Guide is not applicable to the ACC and ACC-RBHA Program. Managed long-term services and supports, as defined at 42 CFR § 438.2, are not covered services under the ACC and ACC-RBHA Program. The ACC and ACC-RBHA Program does cover nursing facility services, and related HCBS, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates

Section III of the 2024 Medicaid Managed Care Rate Development Guide is applicable to the ACC and ACC-RBHA Program. There have been no changes to data, assumptions, or methodologies that affect the new adult group capitation rates other than those described in Sections I.6 and I.7.

Appendix 1: Actuarial Certification

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

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

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 24 capitation rates for the ACC and ACC-RBHA Program have been documented according to the guidelines established by CMS in the 2024 Guide. The CYE 24 capitation rates for the ACC and ACC-RBHA Program are effective for the 12-month time period from October 1, 2023, through September 30, 2024 (CYE 24), with one set of capitation rates being effective for the 6-month time period from October 1, 2023, through March 31, 2024, and the second set of capitation rates being effective for the 6-month time period from April 1, 2024, through September 30, 2024.

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

SIGNATURE ON FILE — March 25, 2024

Matthew C. Varitek — Date
Fellow, Society of Actuaries
Member, American Academy of Actuaries

SIGNATURE ON FILE — March 25, 2024

Erica Johnson — Date
Associate, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Appendix 2: Certified Capitation Rates

Original Capitation Rates Effective October 1, 2023 through March 31, 2024

GSA	Contractor	AGE < 1	AGE 1-20	AGE 21+	Duals	SSIWO	Prop 204 Childless Adults	Expansion Adults	Delivery Supplemental Payments	SMI	Crisis 24 Hour Group
North	Care 1st Health Plan Arizona, Inc.	$714.67	$228.06	$390.42	$141.63	$1,187.94	$606.89	$452.09	$7,157.44	$1,711.41	$6.62
North	Health Choice Arizona, Inc.	$744.59	$216.57	$386.05	$135.22	$1,231.25	$600.09	$451.66	$7,157.44	NA	NA
Central	Arizona Complete Health - Complete Care Plan	$735.61	$203.57	$413.97	$184.79	$1,196.82	$641.10	$425.32	$7,258.84	NA	NA
Central	Banner - University Family Care	$746.72	$207.81	$406.72	$184.41	$1,223.09	$640.10	$444.49	$7,258.84	NA	NA
Central	Molina Healthcare of Arizona, Inc.	$733.01	$231.94	$431.44	$214.80	$1,307.18	$649.09	$456.02	$7,258.84	NA	NA
Central	Mercy Care	$740.28	$207.66	$452.44	$178.32	$1,385.38	$690.36	$458.22	$7,258.84	$2,722.96	$9.40
Central	Health Choice Arizona, Inc.	$758.78	$214.55	$430.65	$188.97	$1,250.68	$640.99	$428.29	$7,258.84	NA	NA
Central	UnitedHealthcare Community Plan	$741.96	$212.95	$435.44	$183.66	$1,316.38	$668.75	$455.12	$7,258.84	NA	NA
South	Arizona Complete Health - Complete Care Plan	$811.72	$214.66	$416.97	$158.25	$1,351.96	$592.79	$426.63	$7,346.66	$1,758.18	$8.68
South	Banner - University Family Care	$846.79	$221.01	$424.00	$158.32	$1,336.96	$596.85	$428.36	$7,346.66	NA	NA
South	UnitedHealthcare Community Plan (Pima Only)	$860.57	$232.93	$448.84	$157.37	$1,373.99	$612.31	$445.78	$7,346.66	NA	NA

Revised Capitation Rates Effective April 1, 2024 through September 30, 2024

GSA	Contractor	AGE < 1	AGE 1-20	AGE 21+	Duals	SSIWO	Prop 204 Childless Adults	Expansion Adults	Delivery Supplemental Payments	SMI	Crisis 24 Hour Group
North	Care 1st Health Plan Arizona, Inc.	$733.56	$229.00	$394.49	$141.31	$1,174.78	$605.78	$473.34	$7,157.44	$1,682.60	$6.62
North	Health Choice Arizona, Inc.	$731.75	$216.20	$382.80	$134.90	$1,206.89	$598.37	$464.48	$7,157.44	NA	NA
Central	Arizona Complete Health - Complete Care Plan	$725.09	$205.21	$413.25	$185.06	$1,205.26	$645.89	$469.40	$7,258.84	NA	NA
Central	Banner - University Family Care	$763.03	$207.80	$407.09	$184.68	$1,215.04	$646.34	$464.28	$7,258.84	NA	NA
Central	Molina Healthcare of Arizona, Inc.	$696.75	$229.33	$420.96	$215.06	$1,299.89	$653.10	$480.65	$7,258.84	NA	NA
Central	Mercy Care	$753.77	$208.15	$450.59	$178.58	$1,358.85	$688.59	$484.63	$7,258.84	$2,652.80	$9.40
Central	Health Choice Arizona, Inc.	$761.95	$213.24	$424.36	$189.24	$1,211.56	$645.43	$447.99	$7,258.84	NA	NA
Central	UnitedHealthcare Community Plan	$730.70	$211.58	$433.43	$183.92	$1,332.75	$663.89	$482.86	$7,258.84	NA	NA
South	Arizona Complete Health - Complete Care Plan	$800.72	$215.27	$414.09	$158.00	$1,359.25	$595.65	$459.92	$7,346.66	$1,733.29	$8.68
South	Banner - University Family Care	$873.17	$219.13	$420.94	$158.07	$1,313.93	$599.98	$454.02	$7,346.66	NA	NA
South	UnitedHealthcare Community Plan (Pima Only)	$835.60	$233.18	$445.88	$157.13	$1,372.72	$607.42	$461.42	$7,346.66	NA	NA

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

Appendix 3: Fiscal Impact Summary

GSA	Risk Group	Projected MMs (4/1/24 - 9/30/24)	Original Cap Rate (10/1/23 - 3/31/24)	Projected Expenditures Original Cap Rate	Revised Cap Rate (4/1/24 - 9/30/24)	Projected Expenditures Revised Cap Rate	Percentage Impact
North	AGE < 1	21,945	$732.48	$16,073,950	$732.48	$16,073,950	(0.00%)
North	AGE 1-20	403,717	$221.74	$89,520,866	$221.96	$89,610,537	0.10%
North	AGE 21+	175,022	$387.94	$67,897,379	$387.85	$67,882,366	(0.02%)
North	Duals	93,044	$138.37	$12,874,728	$138.05	$12,845,161	(0.23%)
North	SSIWO	34,876	$1,211.43	$42,249,615	$1,192.19	$41,578,858	(1.59%)
North	Prop 204 Childless Adults	247,369	$603.09	$149,184,760	$601.64	$148,825,898	(0.24%)
North	Expansion Adults	61,358	$451.85	$27,724,571	$468.32	$28,735,347	3.65%
North	Delivery Supplemental Payments	1,405	$7,157.44	$10,056,209	$7,157.44	$10,056,209	0.00%
North	SMI	34,759	$1,711.41	$59,486,275	$1,682.60	$58,485,027	(1.68%)
North	Crisis 24 Hour Group	1,452,256	$6.62	$9,615,907	$6.62	$9,615,907	0.00%
North	**Total** [1,2]	1,072,089		$484,684,260		$483,709,260	(0.20%)
Central	AGE < 1	188,179	$742.04	$139,636,792	$742.04	$139,636,792	(0.00%)
Central	AGE 1-20	3,183,063	$209.83	$667,886,268	$209.71	$667,516,479	(0.06%)
Central	AGE 21+	1,178,262	$433.86	$511,197,141	$431.60	$508,540,981	(0.52%)
Central	Duals	419,311	$183.89	$77,107,108	$184.16	$77,218,713	0.14%
Central	SSIWO	205,143	$1,299.71	$266,626,535	$1,292.42	$265,131,491	(0.56%)
Central	Prop 204 Childless Adults	1,529,976	$662.97	$1,014,324,817	$663.44	$1,015,050,721	0.07%
Central	Expansion Adults	368,748	$446.92	$164,801,978	$475.60	$175,376,420	6.42%
Central	Delivery Supplemental Payments	10,787	$7,258.84	$78,301,114	$7,258.84	$78,301,114	0.00%
Central	SMI	177,877	$2,722.96	$484,353,563	$2,652.80	$471,873,502	(2.58%)
Central	Crisis 24 Hour Group	7,315,886	$9.40	$68,780,214	$9.40	$68,780,214	0.00%
Central	**Total** [1,2]	7,250,559		$3,473,015,530		$3,467,426,429	(0.16%)
South	AGE < 1	60,291	$837.74	$50,508,275	$837.74	$50,508,275	(0.00%)
South	AGE 1-20	1,033,692	$221.95	$229,424,848	$221.48	$228,938,205	(0.21%)
South	AGE 21+	459,919	$427.92	$196,808,227	$424.95	$195,442,709	(0.69%)
South	Duals	243,736	$158.02	$38,516,274	$157.78	$38,457,294	(0.15%)
South	SSIWO	89,358	$1,351.97	$120,809,130	$1,345.01	$120,187,582	(0.51%)
South	Prop 204 Childless Adults	591,315	$599.72	$354,621,309	$600.53	$355,103,693	0.14%
South	Expansion Adults	160,477	$432.46	$69,400,330	$458.09	$73,513,159	5.93%
South	Delivery Supplemental Payments	3,872	$7,346.66	$28,446,264	$7,346.66	$28,446,264	0.00%
South	SMI	77,184	$1,758.18	$135,702,599	$1,733.29	$133,781,276	(1.42%)
South	Crisis 24 Hour Group	2,764,839	$8.68	$23,995,944	$8.68	$23,995,944	0.00%
South	**Total** [1,2]	2,715,972		$1,248,233,199		$1,248,374,400	0.01%
Total	AGE < 1	270,414	$762.60	$206,219,017	$762.60	$206,219,017	(0.00%)
Total	AGE 1-20	4,620,472	$213.58	$986,831,982	$213.41	$986,065,220	(0.08%)
Total	AGE 21+	1,813,203	$427.92	$775,902,747	$425.69	$771,866,056	(0.52%)
Total	Duals	756,092	$169.95	$128,498,110	$169.98	$128,521,168	0.02%
Total	SSIWO	329,377	$1,304.54	$429,685,280	$1,296.08	$426,897,931	(0.65%)
Total	Prop 204 Childless Adults	2,368,660	$640.92	$1,518,130,887	$641.28	$1,518,980,313	0.06%
Total	Expansion Adults	590,583	$443.51	$261,926,879	$470.09	$277,624,926	5.99%
Total	Delivery Supplemental Payments	16,064	$7,271.14	$116,803,521	$7,271.14	$116,803,587	0.00%
Total	SMI	289,820	$2,344.71	$679,542,303	$2,291.56	$664,139,805	(2.27%)
Total	Crisis 24 Hour Group	11,532,981	$8.88	$102,392,065	$8.88	$102,392,065	0.00%
Total	**Total** [1,2]	11,038,620		$5,205,932,790		$5,199,510,089	(0.12%)

1) Total Projected MMs doesn't include Delivery Supplemental Payment members or Crisis 24 Hour Group member months

2) Totals may not add up due to rounding