Contract Year Ending 2022
AHCCCS Complete Care Program
Capitation Rate Certification

October 1, 2021 through September 30, 2022

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 1

Section I Medicaid Managed Care Rates 2

I.1. General Information 4

I.1.A. Rate Development Standards 4

I.1.A.i. Standards and Documentation for Rate Ranges 4

I.1.A.ii. Rating Period 4

I.1.A.iii. Required Elements 4

I.1.A.iii.(a) Letter from Certifying Actuary 4

I.1.A.iii.(b) Final and Certified Capitation Rates 4

I.1.A.iii.(c) Program Information 4

I.1.A.iii.(c)(i) Summary of Program 4

I.1.A.iii.(c)(i)(A) Type and Number of Managed Care Plans 4

I.1.A.iii.(c)(i)(B) General Description of Benefits 5

I.1.A.iii.(c)(i)(C) Areas of State Covered and Length of Time Program in Operation 5

I.1.A.iii.(c)(ii) Rating Period Covered 6

I.1.A.iii.(c)(iii) Covered Populations 6

I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria Impacts 6

I.1.A.iii.(c)(v) Summary of Special Contract Provisions Related to Payment 7

I.1.A.iii.(c)(vi) Retroactive Capitation Rate Adjustments – Not Applicable 7

I.1.A.iv. Rate Development Standards and Federal Financial Participation (FFP) 7

I.1.A.v. Rate Cell Cross-Subsidization 7

I.1.A.vi. Effective Dates of Changes 7

I.1.A.vii. Minimum Medical Loss Ratio 8

I.1.A.viii. Conditions for Certifying Capitation Rate Range – Not Applicable 8

I.1.A.ix. Certifying Actuarially Sound Capitation Rate Range – Not Applicable 8

I.1.A.x. Generally Accepted Actuarial Principles and Practices 8

I.1.A.x.(a) Reasonable, Appropriate, and Attainable Costs 8

I.1.A.x.(b) Rate Setting Process 8

I.1.A.x.(c) Contracted Rates 8

I.1.A.xi. Rates from Previous Rating Periods – Not Applicable 8

I.1.A.xii. COVID-19 PHE Risk Mitigation 8
I.1.A.xiii. Rate Certification Procedures 8
I.1.A.xiii.(a) Timely Filing for Claiming Federal Financial Participation 8
I.1.A.xiii.(b) CMS Rate Certification Requirement for Rate Change 9
I.1.A.xiii.(c) CMS Rate Certification Requirement for No Rate Change – Not Applicable 9
I.1.A.xiii.(d) CMS Rate Certification Circumstances 9
I.1.A.xiii.(e) CMS Contract Amendment Requirement 9
I.1.A.xiii.(f) CMS Contract and Rate Amendment Requirement for Changes in Law 9
I.1.B. Appropriate Documentation 9
I.1.B.i. Capitation Rates or Rate Ranges 9
I.1.B.ii. Elements 9
I.1.B.iii. Capitation Rate Cell Assumptions 9
I.1.B.iv. Capitation Rate Range Assumptions – Not Applicable 10
I.1.B.v. Rate Certification Index 10
I.1.B.vi. Assurance Rate Assumptions Do Not Differ by Federal Financial Participation 10
I.1.B.vii. Differences in Federal Medical Assistance Percentage 10
I.1.B.viii. Comparison to Prior Rates 11
I.1.B.viii.(a) Comparison to Previous Rate Certification 11
I.1.B.viii.(b) Material Changes to Capitation Rate Development 12
I.1.B.viii.(c) *De Minimis* Changes to Previous Period Capitation Rates 12
I.1.B.ix. Future Rate Amendments 12
I.1.B.x. COVID-19 PHE Impacts 12
I.1.B.x.(a) Available Applicable Data to Address COVID-19 PHE in Capitation Rate Setting 12
I.1.B.x.(b) How Capitation Rates Account for COVID-19 PHE Impacts 13
I.1.B.x.(c) Risk Mitigation Strategies Utilized for COVID-19 PHE 13
I.2. Data 14
I.2.A. Rate Development Standards 14
I.2.A.i. Compliance with 42 CFR § 438.5(c) 14
I.2.B. Appropriate Documentation 14
I.2.B.i. Data Request 14
I.2.B.ii. Data Used for Rate Development 14

I.2.B.ii.(a) Description of Data 14
I.2.B.ii.(a)(i) Types of Data Used 14
I.2.B.ii.(a)(ii) Age of Data 15
I.2.B.ii.(a)(iii) Sources of Data 15
I.2.B.ii.(a)(iv) Sub-capitated Arrangements 15
I.2.B.ii.(b) Availability and Quality of the Data 16
I.2.B.ii.(b)(i) Data Validation Steps 16
I.2.B.ii.(b)(i)(A) Completeness of the Data 16
I.2.B.ii.(b)(i)(B) Accuracy of the Data 16
I.2.B.ii.(b)(i)(C) Consistency of the Data 17
I.2.B.ii.(b)(ii) Actuary's Assessment of the Data 17
I.2.B.ii.(b)(iii) Data Concerns 17
I.2.B.ii.(c) Appropriate Data for Rate Development 17
I.2.B.ii.(c)(i) Not Using Encounter or Fee-for-Service Data – Not Applicable 18
I.2.B.ii.(c)(ii) Not Using Managed Care Encounter Data – Not Applicable 18
I.2.B.ii.(d) Use of a Data Book 18
I.2.B.iii. Adjustments to the Data 18
I.2.B.iii.(a) Credibility of the Data – Not Applicable 18
I.2.B.iii.(b) Completion Factors 18
I.2.B.iii.(c) Errors Found in the Data 19
I.2.B.iii.(d) Changes in the Program 19
I.2.B.iii.(e) Exclusions of Payments or Services 25
I.3. Projected Benefit Costs and Trends 26
I.3.A. Rate Development Standards 26
I.3.A.i. Compliance with 42 CFR § 438.3(c)(1)(ii) and § 438.3(e) 26
I.3.A.ii. Projected Benefit Cost Trend Assumptions 26
I.3.A.iii. In-Lieu-Of Services 26
I.3.A.iv. Institution for Mental Disease 26
I.3.B. Appropriate Documentation 27
I.3.B.i. Projected Benefit Costs 27
I.3.B.ii. Projected Benefit Cost Development 28

I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies 28
I.3.B.ii.(b) Material Changes to the Data, Assumptions, and Methodologies 39
I.3.B.ii.(c) Recoveries of Overpayments to Providers 39
I.3.B.iii. Projected Benefit Cost Trends 39
I.3.B.iii.(a) Requirements 39
I.3.B.iii.(a)(i) Projected Benefit Cost Trends Data 39
I.3.B.iii.(a)(ii) Projected Benefit Cost Trends Methodologies 40
I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons 40
I.3.B.iii.(a)(iv) Supporting Documentation for Trends 40
I.3.B.iii.(b) Projected Benefit Cost Trends by Component 41
I.3.B.iii.(b)(i) Changes in Price and Utilization 41
I.3.B.iii.(b)(ii) Alternative Methods – Not Applicable 41
I.3.B.iii.(b)(iii) Other Components 41
I.3.B.iii.(c) Variation in Trend 41
I.3.B.iii.(d) Any Other Material Adjustments 41
I.3.B.iii.(e) Any Other Adjustments 41
I.3.B.iv. Mental Health Parity and Addiction Equity Act Compliance 41
I.3.B.v. In-Lieu-Of Services 42
I.3.B.vi. Retrospective Eligibility Periods 42
I.3.B.vi.(a) Managed Care Plan Responsibility 42
I.3.B.vi.(b) Claims Data Included in Base Data 42
I.3.B.vi.(c) Enrollment Data Included in Base Data 42
I.3.B.vi.(d) Adjustments, Assumptions and Methodology 42
I.3.B.vii. Impact of All Material Changes to Covered Benefits or Services 42
I.3.B.vii.(a) Covered Benefits 42
I.3.B.vii.(b) Recoveries of Overpayments 43
I.3.B.vii.(c) Provider Payment Requirements 43
I.3.B.vii.(d) Applicable Waivers 43
I.3.B.vii.(e) Applicable Litigation 43
I.3.B.viii. Impact of All Material and Non-Material Changes 43
I.4. Special Contract Provisions Related to Payment 44

I.4.A. Incentive Arrangements 44
I.4.A.i. Rate Development Standards 44
I.4.A.ii. Appropriate Documentation 44
I.4.A.ii.(a) Description of Any Incentive Arrangements 44
I.4.A.ii.(a)(i) Time Period 44
I.4.A.ii.(a)(ii) Enrollees, Services, and Providers Covered 44
I.4.A.ii.(a)(iii) Purpose 45
I.4.A.ii.(a)(iv) Attestation to Limit on Incentive Payments 45
I.4.A.ii.(a)(v) Effect on Capitation Rate Development 45
I.4.B. Withhold Arrangements 46
I.4.B.i. Rate Development Standards 46
I.4.B.ii. Appropriate Documentation 46
I.4.B.ii.(a) Description of Any Withhold Arrangements 46
I.4.B.ii.(a)(i) Time Period 46
I.4.B.ii.(a)(ii) Enrollees, Services, and Providers Covered 46
I.4.B.ii.(a)(iii) Purpose of the Withhold 46
I.4.B.ii.(a)(iv) Description of Percentage of Capitation Rates Withheld 46
I.4.B.ii.(a)(v) Percentage of the Withheld Amount Not Reasonably Achievable 46
I.4.B.ii.(a)(vi) Description of Reasonableness of Withhold Arrangement 47
I.4.B.ii.(a)(vii) Effect on Capitation Rate Development 47
I.4.B.ii.(b) Certifying Rates less Expected Unachieved Withhold as Actuarially Sound 47
I.4.C. Risk-Sharing Mechanisms 47
I.4.C.i. Rate Development Standards 47
I.4.C.ii. Appropriate Documentation 47
I.4.C.ii.(a) Description of Risk-Sharing Mechanisms 47
I.4.C.ii.(a)(i) Rationale for Risk-Sharing Mechanisms 47
I.4.C.ii.(a)(ii) Description of Risk-Sharing Mechanism Implementation 48
I.4.C.ii.(a)(iii) Effect of Risk-Sharing Mechanisms on Capitation Rates 48
I.4.C.ii.(a)(iv) Risk-Sharing Mechanisms Documentation 49
I.4.C.ii.(b) Remittance/Payment Requirements for Specified Medical Loss Ratio – Not Applicable 49
I.4.C.ii.(c) Reinsurance Requirements 49

I.4.C.ii.(c)(i) Description of Reinsurance Requirements 49
I.4.C.ii.(c)(ii) Effect on Development of Capitation Rates 50
I.4.C.ii.(c)(iii) Development in Accordance with Generally Accepted Actuarial Principles and Practices 50
I.4.C.ii.(c)(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset 50
I.4.D. State Directed Payments 51
I.4.D.i. Rate Development Standards 51
I.4.D.ii. Appropriate Documentation 51
I.4.D.ii.(a) Description of State Directed Payments 51
I.4.D.ii.(a)(i) Type and Description of Directed Payment Arrangements 51
I.4.D.ii.(a)(ii) Directed Payments Incorporated in Capitation Rates 52
I.4.D.ii.(a)(ii)(A) Rate Cells Affected 52
I.4.D.ii.(a)(ii)(B) Impact on the Rate Cells 52
I.4.D.ii.(a)(ii)(C) Data, Assumptions, Methodology to Develop Directed Payment Adjustment 52
I.4.D.ii.(a)(ii)(D) Pre-Print Acknowledgement 53
I.4.D.ii.(a)(ii)(E) Maximum Fee Schedule – Not Applicable 53
I.4.D.ii.(a)(iii) Directed Payments Under Separate Payment Arrangement 53
I.4.D.ii.(a)(iii)(A) Aggregate Amount 53
I.4.D.ii.(a)(iii)(B) Actuarial Certification of the Amount of the Separate Payment Term 54
I.4.D.ii.(a)(iii)(C) Estimated Impact by Rate Cell 54
I.4.D.ii.(a)(iii)(D) Pre-Print Acknowledgement 54
I.4.D.ii.(a)(iii)(E) Future Documentation Requirements 55
I.4.D.ii.(b) Confirmation of No Other Directed Payments 55
I.4.D.ii.(c) Confirmation Regarding Required Reimbursement Rates 55
I.4.E. Pass-Through Payments 56
I.4.E.i. Rate Development Standards 56
I.4.E.ii. Appropriate Documentation 56
I.4.E.ii.(a) Existing Pass-Through Payments 56
I.4.E.ii.(a)(i) Description of Pass-Through Payments 56
I.4.E.ii.(a)(ii) Description of How the Pass-Through Payments Will Be Made 56
I.4.E.ii.(a)(iii) Amount of Pass-Through Payments 56
I.4.E.ii.(a)(iv) Programs that Include the Pass-Through Payments 56

I.4.E.ii.(a)(v) Providers Receiving Pass-Through Payments 56
I.4.E.ii.(a)(vi) Financing Mechanism Pass-Through Payments 57
I.4.E.ii.(a)(vi)(A) Description of Non-Federal Share 57
I.4.E.ii.(a)(vi)(B) Payments Funded by Intergovernmental Transfers – Not Applicable 57
I.4.E.ii.(a)(vi)(C) Identification of any §438.6(c) Directed Payments that Target Same Providers 57
I.4.E.ii.(b) Description of the Aggregate Pass-Through Payments 57
I.4.E.ii.(b)(i) Amount of the Aggregate Pass-Through Payments 57
I.4.E.ii.(b)(ii) Documentation of Historical Pass-Through Amounts 57
I.4.E.ii.(b)(iv) States Transitioning from FFS to Managed Care – Not Applicable 57
I.4.E.ii.(c) Base Amount Information 57
I.4.E.ii.(c)(i) Data, Assumptions, Methodology to Develop Base Amount 57
I.4.E.ii.(c)(ii) Aggregate Amounts 58
I.4.E.ii.(c)(iii) Trend Adjustments – Not Applicable 58
I.4.E.ii.(c)(iv) Calculated Base Amount Applicable Percentage 58
I.4.E.ii.(c)(v) Amount of any §438.6(c) Directed Payments 59
I.4.E.ii.(d) States Transitioning from FFS to Managed Care – Not Applicable 59
I.5. Projected Non-Benefit Costs 60
I.5.A. Rate Development Standards 60
I.5.B. Appropriate Documentation 60
I.5.B.i. Description of the Development of Projected Non-Benefit Costs 60
I.5.B.i.(a) Data, Assumptions, and Methodology 60
I.5.B.i.(b) Changes Since the Previous Rate Certification 61
I.5.B.i.(c) Any Other Material Adjustments 61
I.5.B.ii. Projected Non-Benefit Costs by Category 61
I.5.B.ii.(a) Administrative Costs 61
I.5.B.ii.(b) Taxes and Other Fees 61
I.5.B.ii.(c) Contribution to Reserves, Risk Margin, and Cost of Capital 61
I.5.B.ii.(d) Other Material Non-Benefit Costs 61
I.5.B.iii. Historical Non-Benefit Costs 61
I.6. Risk Adjustment and Acuity Adjustments 62
I.6.A. Rate Development Standards 62

I.6.A.i. Risk Adjustment 62
I.6.A.ii. Budget Neutrality 62
I.6.A.iii. Acuity Adjustment – Not Applicable 62
I.6.B. Appropriate Documentation 62
I.6.B.i. Prospective Risk Adjustment 62
I.6.B.i.(a) Data and Data Adjustments 62
I.6.B.i.(b) Model and Model Adjustments 63
I.6.B.i.(c) Relative Risk Factor Methodology 64
I.6.B.i.(d) Magnitude of Adjustment by MCO 64
I.6.B.i.(e) Predictive Value Assessment 65
I.6.B.i.(f) Actuarial Concerns 66
I.6.B.ii. Retrospective Risk Adjustment 66
I.6.B.ii.(a) The Party Calculating 66
I.6.B.ii.(b) Data and Data Adjustments 66
I.6.B.ii.(c) Model and Model Adjustments 66
I.6.B.ii.(d) Timing and Frequency 67
I.6.B.ii.(e) Actuarial Concerns 67
I.6.B.iii. Additional Items on Risk Adjustment 67
I.6.B.iii.(a) Model Changes Since Last Rating Period 67
I.6.B.iii.(b) Budget Neutrality 67
I.6.B.iv. Acuity Adjustment Description – Not Applicable 67
Section II Medicaid Managed Care Rates with Long-Term Services and Supports – Not Applicable 68
Section III New Adult Group Capitation Rates 69
III.1. Data 70
III.1.A. Description of Data for Rate Development 70
III.1.B. Documentation 70
III.1.B.i. New Data 70
III.1.B.ii. Monitoring of Costs and Experience 70
III.1.B.iii. Actual Experience vs. Projected Experience 70
III.1.B.iv. Adjustments Based Upon Actual Experience vs. Projected Experience 70
III.2. Projected Benefit Costs 72

III.2.A. Description of Projected Benefit Costs 72
III.2.A.i. Documentation if State Previously Covered the New Adult Group 72
III.2.A.i.(a) Previous Data and Experience Used 72
III.2.A.i.(b) Changes in Data Sources, Assumptions, and Methodologies 72
III.2.A.i.(c) Change in Key Assumptions 72
III.2.A.ii. Documentation if State Did Not Previously Cover the New Adult Group – Not Applicable 72
III.2.A.iii. Key Assumptions 72
III.2.B. Any Other Material Changes 73
III.3. Projected Non-Benefit Costs 74
III.3.A. Description of Issues 74
III.3.A.i. Changes in Data Sources, Assumptions, Methodologies 74
III.3.A.ii. Changes in Assumptions from Previous Rating Period 74
III.3.B. Differences between Populations – Not Applicable 74
III.4. Final Certified Rates 75
III.4.A. Documentation 75
III.4.A.i. Comparison of Rates 75
III.4.A.ii. Description of Material Changes 75
III.5. Risk Mitigation Strategies 76
III.5.A. New Adult Rates Risk Mitigation 76
III.5.B. Documentation 76
Appendix 1: Actuarial Certification 77
Appendix 2: Certified Capitation Rates 80
Appendix 3: Fiscal Impact Summary 82
Appendix 4: Base Data and Base Data Adjustments 84
Appendix 5: Projected Benefit Cost Trends 109
Appendix 6: Gross Medical Capitation Rate Development 113
Appendix 7: Capitation Rate Development 138
Appendix 8a: State Directed Payments – CMS Prescribed Tables 147
Appendix 8b: State Directed Payments – Estimated PMPMs 151

Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the October 1, 2021 through September 30, 2022 (Contract Year Ending 2022 (CYE 22), or alternatively, Federal Fiscal Year 2022 (FFY 22)) actuarially sound capitation rates for the Arizona Health Care Cost Containment System (AHCCCS) Complete Care (ACC) Program.

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 2021-2022 Medicaid Managed Care Rate Development Guide (2022 Guide), Actuarial Standards of Practice and generally accepted actuarial principles and practices.

The 2022 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 2022 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

The capitation rates included with this rate certification are considered actuarially sound according to 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."

As stated on pages 2 and 3 of the 2022 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 2022 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Standards and Documentation for Rate Ranges

This section of the 2022 Guide notes that standards and documentation expectations are not different for capitation rates and capitation rate ranges, except where otherwise stated.

I.1.A.ii. Rating Period

The CYE 22 capitation rates for the ACC Program are effective for the 12-month time period from October 1, 2021 through September 30, 2022.

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 22 capitation rates for the ACC Program, signed by Windy J. Marks, FSA, MAAA and Erica Johnson, ASA, MAAA, is in Appendix 1. Ms. Marks and Ms. Johnson meet the requirements for the definition of an Actuary described at 42 CFR § 438.2 which is provided below for reference.

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

Ms. Marks and Ms. Johnson certify that the CYE 22 capitation rates for the ACC Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ACC Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ACC contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 and the 2022 Guide.

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

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

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

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

The ACC Program contracts with seven managed care plans. The number of managed care plans contracted with the Program varies by Geographical Service Area (GSA).

A change in plans by GSA is occurring for CYE 22, due to a merger. Two AHCCCS contracted health plans, Arizona Complete Health - Complete Care Plan and Care1st Health Plan of Arizona, Inc., are affected by this merger. Effective October 1, 2021, Care1st Health Plan of Arizona, Inc. will no longer serve the Central Geographic Service Area; Care1st HealthPlan of Arizona, Inc. members impacted by this change will be transitioned to Arizona Complete Health - Complete Care Plan and provided choice as specified in the ACC contract Section D, Paragraph 3, Enrollment and Disenrollment.

The GSAs, along with the Contractors within the GSAs and the counties, for CYE 22 are listed in Table 1 below.

Table 1: Contractors by GSA and Counties

GSA	Counties	Contractors
North	Apache, Coconino, Mohave, Navajo, and Yavapai	Care1st Health Plan Arizona, Inc. Health Choice Arizona, Inc.
Central	Gila, Maricopa, and Pinal (excluding zip codes 85542, 85192, and 85550)	Arizona Complete Health – Complete Care Plan Banner – University Family Care Molina Healthcare of Arizona, Inc. Mercy Care Health Choice Arizona, Inc. UnitedHealthcare Community Plan
South	Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma (including zip codes 85542, 85192, and 85550)	Arizona Complete Health – Complete Care Plan Banner – University Family Care UnitedHealthcare Community Plan (Pima County Only)

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

This certification covers the ACC Program which offers physical and behavioral services to AHCCCS members who are Title XIX or Title XXI eligible and who do not qualify for another AHCCCS program. Services excluded are the first 24 hours of crisis intervention services and behavioral health services prior period coverage (BH PPC) for non-Title XIX (state only) eligibility members who shift to TXIX members. Both services are offered to the ACC members through the Regional Behavioral Health Authority (RBHA) Program. Additional information regarding covered services can be found in the ACC contract.

For the CYE 22 rating period, the projected expenses associated with the administration of COVID-19 vaccines are not included in the capitation rates. The Contractors are responsible for these expenses and will be reimbursed for these expenses via periodic cost-settlement payments based upon adjudicated/approved encounter data subject to the two-year claiming rule.

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

The ACC Program began providing integrated services to a majority of Arizona Medicaid members on October 1, 2018. When the ACC Program was implemented, it expanded on the Acute Care Program, which had operated on a statewide basis in the State of Arizona since 1982, bringing behavioral health

services that were a part of the RBHA Program and Children's Rehabilitative Services (CRS) that were part of the CRS Program under an integrated services umbrella.

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

The rate certification for the CYE 22 capitation rates for the ACC Program is effective for the 12-month time period from October 1, 2021 through September 30, 2022.

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

The ACC Program has eight rate cells to cover Title XIX and Title XXI members. The Delivery Supplemental Payment rate cell covers the cost of delivery, prenatal, and postpartum care and is only paid when a prospective member gives birth and the Contractors report that birth to AHCCCS. This rate cell will not receive an administrative rate and any reinsurance that might be needed for the mom or baby would fall under the individual's rate cell and not the Delivery Supplemental Payment rate cell. The member months in this rate cell represent the number of members whose Contractor received a delivery supplemental payment. Instead of being a per member per month (PMPM) amount, the Delivery Supplement Payment capitation rate is, in practice, a per member per delivery (PMPD) amount. The certification may at times refer to the delivery supplemental members as member months (MMs) and the PMPD as PMPM. More information about the populations covered under the ACC Program can be found in the Eligibility Categories section of the ACC contracts.

Table 2 below displays the rate cells and a brief description of the covered populations within each rate cell.

Table 2: Covered Populations by Rate Cell

Rate Cells	Covered Populations
AGE < 1	Title XIX and Title XXI eligible children, under the age of 1
AGE 1-20	Title XIX and Title XXI eligible children, aged 1-20
AGE 21+	Title XIX eligible adults, aged 21+
Duals	Title XIX eligible members with Medicare
SSIWO	Title XIX eligible SSI members without Medicare
Prop 204 Childless Adults	Title XIX eligible adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level
Expansion Adults	Title XIX eligible adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level
Delivery Supplemental Payments	One-time capitation payment to cover the cost of a delivery, prenatal and postpartum care for TXIX/TXXI eligible members

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

AHCCCS operates as a mandatory managed care program. Information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the ACC Program contract.

Due to the COVID-19 public health emergency (PHE), and the maintenance of effort requirements included in Families First Coronavirus Response Act (FFCRA), with a few exceptions as noted in the law, members who were eligible at the beginning of the PHE, or who become eligible during the PHE, will remain treated as eligible for such benefits through the end of the month in which the PHE ends.

I.1.A.iii.(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. The special contract provisions related to payment included in the CYE 22 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1)
- Reinsurance Arrangement (42 CFR § 438.6(b)(1))
- Alternative Payment Model (APM) Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Withhold Arrangement) (42 CFR § 438.6(b)(3))
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B))
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(B))
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(B))
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(B))
- Rural Hospital Payments (42 CFR § 438.6(d))

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

I.1.A.iii.(c)(vi) Retroactive Capitation Rate Adjustments – Not Applicable

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

I.1.A.iv. Rate Development Standards and Federal Financial Participation (FFP)

Proposed differences among the CYE 22 capitation rates for the ACC Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the ACC Program.

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

The CYE 22 capitation rates were developed at the rate cell level. Payments from rate cells do not cross-subsidize payments from other rate cells.

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

The effective dates of changes to the ACC Program are consistent with the assumptions used to develop the CYE 22 capitation rates for the ACC Program.

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

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 22.

I.1.A.viii. Conditions for Certifying Capitation Rate Range – Not Applicable

Not applicable. The actuaries are not certifying capitation rate ranges.

I.1.A.ix. Certifying Actuarially Sound Capitation Rate Range – Not Applicable

Not applicable. The actuaries are not certifying capitation rate ranges.

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

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

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

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

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

I.1.A.x.(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 22 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 22 capitation rates for the ACC Program.

I.1.A.xii. COVID-19 PHE Risk Mitigation

This section of the 2022 Guide includes CMS recommendations for risk mitigation strategies for rating periods impacted by the PHE and reminds states of specific requirements related to risk mitigation strategies. All risk mitigation strategies are addressed in the contract and below in Section I.4.C. and will be submitted to CMS prior to the start of the rating period.

I.1.A.xiii. Rate Certification Procedures

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

This section of the 2022 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

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

This is a new rate certification that documents that the ACC Program capitation rates are changing effective October 1, 2021.

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

Not applicable. This rate certification will change the ACC Program capitation rates effective October 1, 2021.

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

This section of the 2022 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 for certified rates per rate cell, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.7(c)(2), 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.xiii.(e) CMS Contract Amendment Requirement

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

I.1.A.xiii.(f) CMS Contract and Rate Amendment Requirement for Changes in Law

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

I.1.B. Appropriate Documentation

I.1.B.i. Capitation Rates or Rate Ranges

The actuaries are certifying capitation rates for each rate cell.

I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 22 capitation rates for the ACC Program.

I.1.B.iii. Capitation Rate Cell Assumptions

This section of the 2022 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for the variation.

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

I.1.B.iv. Capitation Rate Range Assumptions – Not Applicable

Not applicable. The actuaries did not develop capitation rate ranges.

I.1.B.v. 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 2022 Guide. Sections of the 2022 Guide that do not apply will be marked as "Not Applicable;" any section wherein all subsections are not applicable will be collapsed to the section heading.

I.1.B.vi. Assurance Rate Assumptions Do Not Differ by Federal Financial Participation

All proposed differences in the assumptions, methodologies, or factors used to develop the certified CYE 22 capitation rates for the ACC Program's covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

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

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

The percentages of costs by the various populations for January 1, 2019 through December 31, 2019 (CalYr19) for the ACC Program are provided below in Table 3a, along with the associated FMAP for the time period of January 1, 2021 through September 30, 2021. The FMAPs shown below do not incorporate any increased FMAP associated with the PHE.

Table 3a: FMAP Percentage of Costs by Population and Associated FMAP

Population	CalYr19 Percentage of Costs	FMAP
Adult Expansion	5.96%	90.00%
Child Expansion	2.07%	79.01%
Childless Adult Restoration	32.61%	90.00%
KidsCare (Title XXI)	1.18%	79.01%
Breast and Cervical Cancer	0.12%	79.01%
Populations not listed above	58.06%	70.01%

In addition, the ACC Program includes family planning services that are embedded within various capitation rate cells. The rate cells, FMAPs, and the projected portion of the CYE 22 capitation rates that are family planning services are provided below in Table 3b. The FMAPs shown below are for the time

period of January 1, 2021 through September 30, 2021. The FMAPs shown below do not incorporate any increased FMAP associated with the PHE.

Table 3b: Portion of Family Planning Services in Capitation Rates

Rate Cell	Portion of Family Planning Services in Capitation Rates	FMAP
AGE < 1	0.00%	90.00%
AGE 1-20	0.39%	90.00%
AGE 21+	3.49%	90.00%
Duals	0.12%	90.00%
SSIWO	0.14%	90.00%
Prop 204 Childless Adults	0.33%	90.00%
Expansion Adults	1.21%	90.00%
Delivery Supplemental Payments	0.00%	90.00%

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

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

The 2022 Guide requests a comparison to the final certified rates in the previous rate certification. Those comparisons are included in Appendix 3.

The 2022 Guide also requires descriptions of what is leading to large or negative changes in rates from the previous rating period. Since capitation rates are set at a rate cell and GSA level, and any changes to Contractor specific capitation rates are due primarily to an updated risk adjustment time frame, for the purposes of the CYE 22 certification, the actuaries compared the weighted CYE 21 GSA rate cell capitation rates to the weighted CYE 22 GSA rate cell capitation rates rather than rate cells at the Contractor specific level. Thus, for the purposes of the CYE 22 certification, the actuaries defined a large change as any weighted GSA rate cell capitation rate which is 10% greater than the previous rating period's weighted GSA rate cell capitation rate, and defined a negative change as any weighted GSA rate cell capitation rate that is less than the previous rating period's weighted GSA rate cell capitation rate. The actuaries compared the CYE 22 certified capitation rates to the CYE 21 certified capitation rates, applying the same weights applicable to CYE 22, as specified above and included in Appendix 3, as the measurement of change.

For the North GSA, the Duals rate cell capitation rate reflects a large increase driven primarily by an 8% increase in the CalYr19 base data encounters after completion over the CYE 19 base data encounters after completion.

For the South GSA, the Delivery Supplemental Payments rate cell reflects a negative change from the CYE 21 capitation rates. This negative is driven primarily by a 4.6% decrease in the CalYr19 base data encounters after completion over the CYE 19 base data encounters after completion.

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

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

I.1.B.viii.(c) *De Minimis* Changes to Previous Period Capitation Rates

The state did not adjust the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 CFR § 438.7(c)(3).

I.1.B.ix. Future Rate Amendments

The list of possible amendments which would impact capitation rates in the future are shown in Table 4 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 4: Future Rate Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
Risk Adjustment	February 2022	Updating snapshot period after choice period from merger ends, see Section I.6.
Targeted Investments (TI)	February 2022	AHCCCS has requested an extension of the TI program with submission of its Section 1115 Demonstration Waiver Renewal Request; continuation of the TI program is subject to CMS approval.
American Rescue Plan Act (ARPA) proposals	February 2022	AHCCCS has submitted ARPA proposals to CMS for review and approval. AHCCCS also needs approval from the Arizona State Legislature for implementation of any approved ARPA items.

I.1.B.x. COVID-19 PHE Impacts

I.1.B.x.(a) Available Applicable Data to Address COVID-19 PHE in Capitation Rate Setting

The AHCCCS Division of Health Care Management (DHCM) Actuarial Team has read and discussed numerous articles (Health Affairs, Health Watch, KFF, Harvard, Science Alert, CMS FAQs, JAMA, etc.), attended several webinars discussing various aspects of the impacts of COVID-19 (enrollment mix changes, deferred versus foregone care, pandemic progression timelines, hospital utilization patterns, etc.), and monitored national trends and information such as unemployment reports published by the Bureau of Labor Statistics, emerging COVID-19 case rates, and projections of vaccine utilization. The AHCCCS DHCM Actuarial Team continues to monitor national legislation and federal guidance on the PHE end date and plans to analyze changes in acuity of members due to maintenance of effort eligibility requirements in the FFCRA.

The AHCCCS DHCM Actuarial Team has found the following data to be applicable for determining how to address the COVID-19 PHE in rate setting:

- Arizona Medicaid data (before and during the PHE)
- Arizona school closure data
- Arizona, regional, and national COVID-19 vaccination data
- Arizona Medicaid telehealth data along with national projections

I.1.B.x.(b) How Capitation Rates Account for COVID-19 PHE Impacts

The CYE 22 capitation rates account for the direct and indirect impacts of the COVID-19 PHE by including projected costs associated with expanding service and telehealth coverage, reimbursement for COVID-19 testing, and approved flexibilities under Appendix K authority and select 1115 waiver changes. The CYE 22 capitation rates do not include costs for administration of COVID-19 vaccines, as there is a new cost-settlement arrangement in place for CYE 22 for those expenses. AHCCCS will continue to monitor encounters and has plans to view member acuity.

I.1.B.x.(c) Risk Mitigation Strategies Utilized for COVID-19 PHE

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 22 capitation rates will continue AHCCCS' long-standing program policy and will include risk corridors. For the CYE 22 rating period, AHCCCS is adding a cost-settlement for administration of COVID-19 vaccines and carving these costs outside of the capitation rates. This is the only risk mitigation strategy utilized specifically for COVID-19 and is the only change from the prior rating period in terms of risk strategies being utilized.

I.2. Data

This section provides documentation for the Data section of the 2022 Guide.

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

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

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

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

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

The primary data sources used or reviewed for the development of the CYE 22 capitation rates for the ACC Program were:

- Adjudicated and approved encounter data submitted by the ACC, Acute Care, RBHA, and CRS Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2017 through early March 2021
  - Adjudicated and approved through the first encounter cycle in March 2021
- Reinsurance payments made to the ACC, Acute Care, and CRS Contractors for services
  - Incurred from October 2017 through September 2020 paid through April 2021
- Enrollment data for ACC, Acute Care, and CRS Programs from the AHCCCS PMMIS mainframe
  - October 2017 through March 2021
- Annual and quarterly financial statements submitted by the ACC, Acute Care, RBHA, and CRS Contractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
  - October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19)
  - October 1, 2019 through September 30, 2020 (CYE 20 or FFY 20)
  - October 1, 2020 through December 31, 2020 (CYE 21 or FFY 21)
- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement Team related to DAP, see Section I.4.D

- Data from AHCCCS DHCM Financial Analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership provided by the Contractors
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CalYr19
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in risk adjustment, incurred from January 2019 through December 2019
- Contractors' membership as of December 2020 through January 2021 for use in risk adjustment
- Projected CYE 22 enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
- Any additional data used and not identified here will be identified in their applicable sections below

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

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

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

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

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

The ACC Contractors use sub-capitated/block purchasing arrangements for some services. During CalYr19, the encounter data showed that approximately 6.3% of total medical expenditures for the ACC Program were paid through sub-capitated arrangements. The sub-capitated arrangements between the Contractors and their providers still require 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 repricing methodology uses the minimum of AHCCCS fee schedule, the health plan billed amount, and the health plan allowed amount, less any third party insurance amounts. 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.

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 Office of Data Analytics (ODA) Team, which then works with the Contractors to identify causes. In addition, the AHCCCS ODA Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

AHCCCS Contractors 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 Contractors 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 costs 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 our Contractors allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions.

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

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

The AHCCCS ODA 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 enrolled on the date that the service was provided. The process also checks to ensure that each adjudicated and approved encounter is for a covered service under the state plan and contains the codes necessary to map it into one of the categories of service used in the rate development process.

The AHCCCS DHCM Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe. The AHCCCS DHCM Actuarial Team ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 22 capitation rates for the ACC Program. Additionally, the AHCCCS DHCM Actuarial Team ensured that only services covered under the state plan were included.

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

The AHCCCS DHCM Actuarial Team compared the CalYr19 encounter data for all services provided by the ACC Contractors to the financial statement data for the same entities for CalYr19. The actuaries also compared the CalYr19 encounter data to the yearly supplemental data request from the ACC Contractors. After adjustments to the encounter data for completion and encounter issues, the comparisons showed that the financial statements, the AHCCCS encounter data, and the ACC Contractors' encounter data were consistent.

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

As required by ASOP No. 23, the AHCCCS DHCM Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the Contractors and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the Contractors 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 actuaries note additional reliance on data provided by the AHCCCS DHCM Rates & Reimbursement Team with regard to DAP and fee schedule impacts, on data provided by the AHCCCS DHCM financial analysts with regard to some program changes, on information and data provided by Mercer consultants with regard to pharmacy reimbursement savings, on information and data provided by Milliman consultants with regard to the HEALTHII program, on information and data provided by Wakely Consulting Group with regard to risk adjustment, data provided by ACC Contractors in the yearly supplemental data request with regards to administrative component, and on data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

The AHCCCS DHCM Actuarial Team has found the encounter data, with adjustments for encounter issues, to be appropriate for the purposes of developing the CYE 22 capitation rates for the ACC Program. The development of the encounter issue adjustments are described below in Section I.2.B.iii.(c).

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

The AHCCCS DHCM Actuarial Team 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 CalYr19 encounter data was appropriate to use as the base data for developing the CYE 22 capitation rates for the ACC Program with the encounter issue adjustment previously noted.

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

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 22 capitation rates for the ACC Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 22 capitation rates for the ACC Program.

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

The rate development process of the capitation rates relied primarily on data extracted from the AHCCCS PMMIS mainframe and provided to the AHCCCS DHCM Actuarial Team via a data book. The data book contained, but was not limited to, summarized monthly enrollment data by rate cell, county, GSA, and FFY, and monthly encounter data by rate cell, county, GSA, FFY, and COS. Programming to remove certain services (Crisis and BH PPC/State Only) that are not the ACC Contractors' responsibilities is still ongoing for the data book and thus outside programming had to be used to remove those costs from the base data time frame, addressed below in Section I.2.B.iii.(d).

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

This section describes adjustments made to the CalYr19 encounter data that was used as the base data for developing the CYE 22 capitation rates for the ACC Program.

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

Not applicable. No credibility adjustments were made to the CalYr19 encounter data.

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

Completion Factors

The AHCCCS DHCM Actuarial Team developed completion factors to apply to the CalYr19 encounter data. Completion factors were calculated using the development method with monthly encounter data incurred from October 2016 through early March 2021 and adjudicated and approved through the first encounter cycle in March 2021. The completion factors were developed by GSA, major category of service and by month of service. The major categories of service are based upon the AHCCCS form type, which indicates the type of form used to submit a claim. AHCCCS has six form types: Professional and Other Services (form type A), Prescription Drug (form type C), Dental Services (form type D), Inpatient Hospital (form type I), Nursing Facility (form type L), and Outpatient Hospital (form type O). Dental Services (2.42% of CalYr19 payments) were combined with Professional and Other Services. Nursing Facility Services (0.79% of CalYr19 payments) were combined with Inpatient Hospital. The monthly completion factors for CalYr19 were applied to the CalYr19 encounter data. Aggregate completion factors by rate cell and category of service can be found in Appendix 4. Table 5 below displays the aggregate impact of completion by GSA.

Table 5: Impact of CalYr19 Completion Factors

GSA	Before Completion	After Completion	Impact
North	$321.49	$325.66	1.3%
Central	$340.75	$347.67	2.0%
South	$321.20	$328.63	2.3%
Total	$334.03	$340.82	2.0%

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

Encounter Issues

During the rate development process, it was determined that during the base data year (CalYr19) some Contractors incorrectly submitted the CN1 Code for the sub-capitated encounters for their ADA – Dental Services (form type D). To correct for the dental issue, the encounters were repriced using the sub-capitated repricing methodology described in Section I.2.B.ii.(a)(iv). The actuaries were confident in the suitability of the re-priced data and viewed the re-priced data in comparisons to financials and also compared unit cost across all Contractors. After adjustments, the actuaries were confident that the base data was reflective of actual costs and validated this by comparing to Contractor financials and completed claims data. Table 6 below displays the aggregate impact of the encounter issue by GSA.

Table 6: CalYr19 Encounter Issues

GSA	Before Adjustment	After Adjustment	Impact
North	$325.66	$325.66	0.0%
Central	$347.67	$349.26	0.5%
South	$328.63	$329.50	0.3%
Total	$340.82	$342.07	0.4%

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 (January 1, 2019 through December 31, 2019), with the exception of the October 1, 2019 fee schedule changes, are described below, or in Section I.3.A.iv. for base data adjustments required with respect to IMD in-lieu-of services. All program changes which occurred or are effective on or after January 1, 2020 are described in Section I.3.B.ii.(a). All fee schedule changes which occurred on or after October 1, 2019 are also described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less for every individual rate cell, that adjustment was deemed non-material and has been grouped in the other base data adjustment subset below.

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

Removal of Crisis Services from Base Data

While the ACC Program covers most behavioral health services of members, the RBHA Program will continue to cover crisis intervention services provided to all members during the first 24 hours following a crisis event. This includes coverage of crisis hotlines, mobile crisis teams, and stabilization services along with some ancillary services that are provided in relation to the crisis episode. The actuaries removed the cost of these services for ACC members from the base data. The associated costs removed from the base data are displayed below in Table 7a. Totals may not add up due to rounding.

Table 7a: Removal of Crisis Services from Base Data

GSA	Dollar Impact	PMPM Impact
North	($1,916,900)	($0.93)
Central	($20,200,898)	($1.46)
South	($9,217,767)	($1.77)
Total	**($31,335,565)**	**($1.48)**

Removal of Differential Adjusted Payments from Base Data

CYE 19 and CYE 20 capitation rates funded DAP made from October 1, 2018 through September 30, 2019 and from October 1, 2019 through September 30, 2020 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, 2019 and September 30, 2020, AHCCCS has removed the impact of DAP from the base period CalYr19. To remove the impact, the AHCCCS DHCM Actuarial Team requested provider IDs for the qualifying providers for the CYE 19 and CYE 20 DAP by specific measure from the AHCCCS DHCM Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 19 and CYE 20 were then adjusted downward by the appropriate percentage bump specific to the DAP measure for each respective contract year. The associated costs removed from the base data are displayed below in Table 7b. Totals may not add up due to rounding.

See Section I.4.D. for information on adjustments included in CYE 22 capitation rates for DAP that are effective from October 1, 2021 through September 30, 2022.

Table 7b: Removal of DAP from Base Data

GSA	Dollar Impact	PMPM Impact
North	($7,366,553)	($3.57)
Central	($58,863,124)	($4.26)
South	($21,074,567)	($4.04)
Total	**($87,304,243)**	**($4.14)**

Removal of Access to Professional Services Initiative

CYE 19 capitation rates funded APSI fee schedule increases for claim payments made from October 1, 2018 through September 30, 2019. The enhanced fee schedule was used to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. As these enhanced fee schedule payments expired September 30, 2019, AHCCCS has removed the impact of CYE 19 APSI from the base period CalYr19. To remove the impact, the AHCCCS DHCM Actuarial Team extracted adjudicated and approved encounter data (submitted on form CMS-1500s and dental encounters) for the qualifying providers, identified by Billing Provider Tax ID, excluded any sub-capitated/block purchasing arrangements (identified by CN1 Code 05 on the encounters) and any encounters for which AHCCCCS was not the primary payer, and calculated the increase due to the enhanced fee schedule to remove from the base data. The encounter data included relevant rate cell and program information to be able to distribute into the individual rate cells. The associated costs removed from the base data are displayed below in Table 7c. Totals may not add up due to rounding.

Table 7c: Removal of APSI from Base Data

GSA	Dollar Impact	PMPM Impact
North	($1,704,641)	($0.83)
Central	($35,341,374)	($2.56)
South	($21,428,204)	($4.11)
Total	**($58,474,219)**	**($2.77)**

Pharmacy Reimbursement Savings

Analysis of pharmacy claims for all AHCCCS managed care programs and AHCCCS FFS program identified significant variability across all Contractors, and analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to AHCCCS FFS repriced amounts would result in an annual savings of $71.5 million or 4.8% of pharmacy spend for CalYr19 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. In past years, AHCCCS recognized that the full savings amount identified in similar analyses may not be reasonably achievable in a single year. As a result, the base pharmacy data of each program was adjusted by 33% in CYE 20 and 66% in CYE 21 of the amount identified in the original CYE 18 analysis as savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing. Based on the updated analysis of CalYr19 which only considers savings based

on AHCCCS FFS pricing and does not include savings base on a lesser of calculation, for CYE 22, AHCCCS is adjusting the base pharmacy data of each program by 90% of the savings identified in the analysis of CalYr19 pharmacy data for valuing claims data to AHCCCS FFS prices.

The amount of the base data adjustment for pharmacy reimbursement savings for the ACC Program is displayed below in Table 7d. Totals may not add up due to rounding.

Table 7d: Pharmacy Reimbursement Savings

GSA	Dollar Impact	PMPM Impact
North	($3,350,433)	($1.62)
Central	($34,447,542)	($2.49)
South	($10,699,091)	($2.05)
Total	**($48,497,066)**	**($2.30)**

Pharmacy Benefit Manager (PBM) Administrative Spread Removal

In July 2019, AHCCCS provided additional guidance on several contract requirements that aim to increase transparency and cost-effectiveness. One requirement provided guidance on how the PBM pass-through pricing model was to be implemented and administrative expenses reported. In accordance with contract requirements, the AHCCCS DHCM Actuarial Team has incorporated savings to medical expense costs associated with the removal of administrative spread from CalYr19 base period encounters. The percentages used to adjust pharmacy encounters for the removal of PBM administrative spread from the base data encounters were developed based on additional data provided by the Contractors through surveys, supplemental data requests, and additional clarifying communications between AHCCCS and the Contractors. The non-benefit costs included in the CYE 22 capitation rates reflect the requirements for transparency in reporting PBM administrative expenses.

The amount of the base data adjustment for PBM administrative spread removal for the ACC Program is shown below in Table 7e. Totals may not add up due to rounding.

Table 7e: PBM Administrative Spread Removal

GSA	Dollar Impact	PMPM Impact
North	($2,232,172)	($1.08)
Central	($30,704,313)	($2.22)
South	($9,962,556)	($1.91)
Total	**($42,899,041)**	**($2.03)**

Pharmacy and Therapeutics Committee Recommendations – Base Year *

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CalYr19 that impacted utilization and unit costs of Contractors' pharmacy costs in the base period. 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.

Since CalYr19 is the base data year, the actuaries have normalized utilization and unit cost data by rate cell and GSA for the partial year before the P&T Committee changes were implemented to ensure the base year data is consistent with the current recommendations.

For CYE 22 rate development for the ACC Program, the actuaries additionally included other drug coverage decision impacts with the base period P&T Committee recommendations. These include covering Trikafta for treatment of cystic fibrosis and covering the drugs Oxbryta and Adakveo for treatment of sickle cell disease. Trikafta and other drugs for cystic fibrosis are included in the covered drug list for AHCCCS' biologics reinsurance case type, and the impacts to the reinsurance offset due to their inclusion are discussed in Section I.4.C.ii.(c)(iv).

The combined impacts to the ACC Program of the adopted P&T Committee recommendations are displayed below in Table 7f. Totals may not add up due to rounding.

Table 7f: P&T Committee Recommendations Base Year

GSA	Dollar Impact	PMPM Impact
North	$2,913,301	$1.41
Central	$19,160,809	$1.39
South	$3,101,157	$0.59
Total	**$25,175,267**	**$1.19**

Applied Behavior Analysis *

AHCCCS policy was updated effective November 1, 2019 to include clarifying language on the requirement for the ACC and RBHA Programs to provide covered Applied Behavior Analysis (ABA) services to children not receiving these services through another program. The policy clarification is consistent with CMS guidance dated July 7, 2014, which directs states to cover medically necessary services for treatment of autism spectrum disorder as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for children under 21 years of age. The policy guidance is expected to gradually raise awareness and increase utilization of these covered ABA services.

To estimate the impact in the contract period, the AHCCCS DHCM financial analysts reviewed ABA encounters adjusted with completion factors for dates of service from October 1, 2018 through December 31, 2020. A summary of encounter data provided by the Oregon Health Authority (OHA) was also reviewed. The analysts, therefore, determined that it was reasonable to use annualized utilization in the period July 1, 2020 to December 31, 2020, to project use of services during CYE 22. The adjustment to CYE 22 rates for ABA services represents the increase in projected CYE 22 use.

The impact of the ABA program change by GSA is displayed below in Table 7g. Totals may not add up due to rounding.

Table 7g: Applied Behavior Analysis

GSA	Dollar Impact	PMPM Impact
North	$0	$0.00
Central	$8,461,467	$0.61
South	$1,396,341	$0.27
Total	**$9,857,808**	**$0.47**

Other Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less for every individual rate cell across all GSAs, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 7h. Totals may not add up due to rounding. Brief descriptions of the individual program changes requiring base data adjustment are provided below.

- **BH PPC/State Only Removal**
  Prior Period Coverage (PPC) members who are transitioning to Title XIX from RBHA non-Title XIX (state only) eligibility do not receive behavioral health services during the PPC timeframe from the ACC plans. The RBHAs are responsible for these members' behavioral health services in the PPC timeframe and those behavioral health costs are thus removed from the base period data.
- **3D Mammography ***
  Effective June 1, 2019, upon recommendation of the AHCCCS DHCM CQM Team, AHCCCS began covering digital breast tomosynthesis (3D mammograms) for preventive screening and diagnosis of adults 21 years of age and older. The AHCCCS DHCM CQM Team made the recommendation in recognition of studies that find use of 3D mammograms in addition to or in place of 2D services has at times improved detection of breast cancer in some populations. Contractors are permitted to use prior authorization criteria in evaluating medical necessity of 3D services for members.
- **Behavioral Health Residential Facilities (BHRF) Personal Care Differential ***
  Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team established a differentiated FFS rate for BHRF that are licensed by ADHS to provide personal care services.
- **Pay and Chase Guidance ***
  Federal regulation 42 CRF 433.139, Payment of Claims, requires agencies and their Contractors to pay and chase claims for preventive pediatric care services, including EPSDT services, regardless of the existence of third-party liability at the time the claim is filed. Preventive pediatric care refers to screening and diagnostic services to identify congenital, physical, mental health routine examinations performed in the absence of complaints and screening or treatment designed to avert various infectious and communicable diseases from occurring in

children under 21 years of age. As a result of questions to AHCCCS regarding coordination of benefits for members with Autism Spectrum Disorder, the agency provided additional clarification to Contractors in CalYr19 on preventive services that must be reimbursed on a pay and chase basis. This clarification is anticipated to increase costs of Contractors in situations in which they are unable to successfully recover funding from liable third parties.

- **Substance Use Disorder Assessment ***
  Effective October 1, 2018, AHCCCS updated provider fee schedules to include a targeted increase to providers who conduct a computer-guided, structured interview utilizing American Society of Addiction Medicine (ASAM) software. The service enables providers to determine the appropriate level of treatment based upon a set of medically accepted criteria. Slower-than-anticipated adoption of the ASAM software caused by compatibility issues with provider electronic health record (EHR) systems limited use of ASAM in the base period. To raise adoption of the software during CYE 22, AHCCCS is providing a differential adjusted payment for providers that submit a letter of intent to complete integration of ASAM with their EHR system. For CYE 22 rate development, additional impacts for the fee schedule and incentivized adoption of ASAM are included above any base period encounters.
- **Transportation Network Companies ***
  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.

Table 7h: Other Base Data Adjustments

GSA	Dollar Impact	PMPM Impact
North	($94,458)	($0.05)
Central	($2,175,558)	($0.16)
South	($197,589)	($0.04)
Total	**($2,467,604)**	**($0.12)**

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

The data book ensured that all non-covered services were excluded from the encounter data used for developing the CYE 22 capitation rates. Other base data adjustments which excluded services from the data (i.e. crisis removal and BH PPC/state only removal) are described above in Section I.2.B.iii.(d).

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2022 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) and 42 CFR § 438.3(e).

I.3.A.ii. 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.iii. In-Lieu-Of Services

There are no in-lieu-of services allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an Institution for Mental Disease (IMD) in lieu of services in an inpatient hospital. For enrollees aged 21-64, for inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.6(e) and this is described below in Section I.3.A.iv.

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

The projected benefit costs include costs for members aged 21-64 that have a stay of no more than 15 cumulative days within a month in an IMD in accordance with 42 CFR § 438.6(e).

Costs Associated with an Institution for Mental Disease stay

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

The data used to determine the base data adjustment was the CalYr19 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CalYr19 encounter data, the AHCCCS DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the Non-IMD price-per-day. The Non-IMD price-per-day used in the analysis was $890.14 and was derived from the CalYr19 encounter data for similar IMD services that occurred within a Non-IMD setting. The encounter

data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a Non-IMD setting which may not be fully captured within the AHCCCS FFS fee schedule per diem rate. The costs associated with institutional stays at an IMD that were repriced in the base data are displayed by GSA below in Table 8a. Totals may not add up due to rounding.

Table 8a: Reprice of Costs for all IMD Stays

GSA	Dollar Impact	PMPM Impact
North	$363,787	$0.18
Central	$6,612,492	$0.48
South	$1,490,336	$0.29
Total	**$8,466,615**	**$0.40**

The AHCCCS DHCM Actuarial Team identified all members aged 21-64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed by GSA below in Table 8b. Totals may not add up due to rounding.

Table 8b: Removal of Repriced Stays More Than 15 Cumulative Days in a Month

GSA	Dollar Impact	PMPM Impact
North	($231,077)	($0.11)
Central	($5,717,334)	($0.41)
South	($725,229)	($0.14)
Total	**($6,673,640)**	**($0.32)**

Once a member was identified as having an IMD stay(s) greater than 15 cumulative days in a month, all encounter data for the member was pulled for the timeframe(s) they were in the IMD in order to remove those additional medical service costs from rate development. The associated costs removed from the base data are displayed by GSA below in Table 8c. Totals may not add up due to rounding.

Table 8c: Removal of Related Costs for IMD Stays of More Than 15 Cumulative Days in a Month

GSA	Dollar Impact	PMPM Impact
North	($81,692)	($0.04)
Central	($1,077,243)	($0.08)
South	($111,496)	($0.02)
Total	**($1,270,431)**	**($0.06)**

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

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

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

The section provides information on the projected benefit costs included in the CYE 22 capitation rates for the ACC Program.

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

The base data described in Section I.2.B.ii. was summarized by GSA and rate cell. Adjustments were made to the base data to reflect the completion, and all base data changes described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in Section I.3.A.iv. The adjusted base data PMPMs were trended forward 33 months, from the midpoint of the CalYr19 time period to the midpoint of the CYE 22 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below. Appendix 4 contains the base data and base data adjustments by GSA and rate cell. Appendix 5 contains the projected benefit cost trends by GSA and rate cell. Appendix 6 contains the development of the gross medical expense from the adjusted base data, including all prospective programmatic and fee schedule changes, by GSA and rate cell, including the impact of the DAP. Appendix 7 contains the development of the certified capitation rates from the projected gross medical expense, including risk adjustment factors, reinsurance offsets, underwriting (UW) gain, administrative expense, and premium tax by GSA, Contractor, and rate cell.

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

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

Following national and state emergency declarations in March 2020, AHCCCS has sought authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. As of this writing, Appendix K authorities are projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end, while other select 1115 waiver changes are approved from March 1, 2020 until 60 days after the end of the federal emergency declaration. For CYE 22 rate development, the actuaries have incorporated projected impacts of these authorities and other AHCCCS responses to the COVID-19 outbreak for portions of the contract period, these are indicated by a ≠ symbol.

Expanded Telehealth Use * ‡

To ensure access to care during the COVID-19 PHE, AHCCCS expanded coverage of telephonic codes and telehealth (TPTH) and mandated that services delivered through TPTH are reimbursed at the same rates as for in-person services, for both physical and behavioral health services. A review of encounters from April 1, 2020 to December 31, 2020 indicates that use of TPTH services has been essential for continued provision of services and represented annualized growth of 1,049% above base period use. Most growth in the use of these services is expected to represent a cost-neutral shift from use of in-person services. Increased use of TPTH services in the rating period are, however, expected to reduce the rate of missed appointments and lower use of NEMT, emergency department (ED) visits, and specialty visits.

For purposes of projecting TPTH use during the rating period, AHCCCS DHCM financial analysts relied on a national projection developed by McKinsey & Co. of potential TPTH use following the PHE. The AHCCCS percent share of McKinsey's national projection was estimated to equal AHCCCS' percent share of 2018 National Health Expenditures. It was further assumed that use would be phased in at 67% of long-run AHCCCS projected TPTH services during the rating period. The projection suggests that 76% of annualized TPTH service growth encountered between April 1, 2020 and December 31, 2020 would be maintained in CYE 22.

As more services shift from being provided in person to through TPTH, the rate of missed appointments is expected to decrease, resulting in additional program service use. Based on a literature review, it was assumed that the missed appointment rate for TPTH-eligible services was 25% during the base period. Based on findings from additional studies, it was assumed that TPTH-provided services could result in a 50% reduction in missed appointments compared to in-person appointments. Combining these assumptions, the AHCCCS DHCM financial analysts estimated that 14.3% of growth in TPTH during CYE 22 would represent new services.

Use of TPTH is expected to reduce the need for NEMT services. AHCCCS DHCM financial analysts determined that 11.0% of claims for in-person services of the most heavily used TPTH codes were accompanied by same day use of NEMT during FFY 19. It was therefore, estimated that 11.0% of the increase to TPTH services in CYE 22 would result in a reduction in NEMT rides. Cost savings was calculated using the average trip and mileage costs of NEMT rides multiplied by the estimated reduction in rides.

Use of TPTH is additionally expected to reduce the use of low-to-moderate severity ED visits. The McKinsey & Co. national projection noted above assumed that 20% of all ED visits could transition to TPTH following the PHE. Consistent with the 67% phase-in assumption above for projected TPTH services, AHCCCS DHCM financial analysts projected a 13.4% reduction (67% phase-in of a 20% reduction) in ED visits in CYE 22 resulting from TPTH use. Cost savings from the change was calculated using the cost reduction of TPTH services relative to the cost of low-to-moderate severity ED visits, multiplied by the estimated reduction in ED visits.

For CYE 22 rate development, the projected impact of growth in TPTH services was allocated across rate cells and GSAs using base period encounters of TPTH-eligible services, NEMT, and ED visits. The overall impact of the change by GSA is displayed below in Table 9a. Totals may not add up due to rounding.

Table 9a: Net Impacts of Expanded Telehealth Use

GSA	Dollar Impact	PMPM Impact
North	$180,492	$0.09
Central	$6,180,818	$0.45
South	$3,430,420	$0.66
Total	**$9,791,731**	**$0.46**

Opioid Treatment Program Reimbursement *

Pursuant to final rule 2019-24086, Medicare began reimbursing Opioid Treatment Programs (OTPs) for opioid use disorder (OUD) treatment services provided to individuals with Medicare Part B insurance on and after January 1, 2020. Under the change, reimbursement of OTP services and Medication Assisted Treatment (MAT) drugs to members dually enrolled in Medicare and Medicaid for treatment of OUD are shifting from AHCCCS Contractors and Medicare Part D to Medicare Part B. Medicare OTP services on and after January 1, 2020 are not subject to the traditional Medicare Part B 20% coinsurance during the contract period.

To estimate the impact for CYE 21 capitation rates, the AHCCCS DHCM financial analysts reviewed encounters of services and MAT drugs prescribed or administered by OTPs and their affiliated practitioners for OUD treatment of dually enrolled members in FFY 2018. Applicable OTP providers were identified using the Substance Abuse and Mental Health Services Administration (SAMHSA) OTP Directory and OUD services were identified by diagnoses codes. MAT drug utilization was identified based on applicable OTP providers and prescribers with matching tax identification numbers. The AHCCCS DHCM financial analysts deemed the original estimates developed for the CYE 21 capitation rates as appropriate for continued use in developing CYE 22 rates.

For CYE 22 rate development, the projected change was allocated across rate cells and GSAs using encounter data in CalYr19 for OTP services and MAT drugs for dually enrolled members. The overall impact of the change by GSA is displayed below in Table 9b. Totals may not add up due to rounding.

Table 9b: Opioid Treatment Program Reimbursement

GSA	Dollar Impact	PMPM Impact
North	($57,330)	($0.03)
Central	($602,807)	($0.04)
South	($301,801)	($0.06)
Total	**($961,938)**	**($0.05)**

Alzheimer's Drug Approval *

On June 7, 2021, the FDA gave accelerated approval to Aduhelm for the treatment of patients with mild cognitive impairment or mild dementia stage of Alzheimer's disease (AD). Continued approval of the drug is contingent on additional trials that show clinical benefit of the drug. The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Aduhelm on June 15, 2021.

To estimate prevalence of AD in the AHCCCS membership, the AHCCCS DHCM financial analysts first reviewed encounters with use of diagnosis codes for AD or cognitive impairment. It was determined that some codes for cognitive impairment also include non-AD diagnoses and would not be appropriate for determining the prevalence. The analysts reviewed 2021 studies by the Alzheimer's Association, which included estimates of Arizona residents with AD and the percent of individuals with AD that were enrolled in their state's Medicaid program. These report findings were then used to project the number of AHCCCS members with AD. Biogen, maker of Aduhelm, has projected that about 16-32% of AD cases nationwide may meet the drug's indication for mild forms of AD. Using the low end of Biogen's range, the AHCCCS DHCM financial analysts assumed that 16% of AHCCCS members with AD may be considered candidates for receiving the drug. Due to potential questions of the drug's efficacy, it was further assumed that only 25% of drug candidates would begin treatment in CYE 22. After forecasting the number of members that would use Aduhelm, the AHCCCS DHCM financial analysts estimated annual costs of the drug, infusion services, and neuroimaging that would be provided to representative recipients as part of the drug regimen. Costs for dual eligible members were assumed to be covered under Medicare at 80%, and the remaining 20% coinsurance was included for capitation rate development.

For CYE 22 rate development, the projected impact was allocated across rate cells and GSAs using base period distribution of members with used of certain AD diagnosis code. The overall impact of the change by GSA is displayed below in Table 9c. Totals may not add up due to rounding.

Table 9c: Alzheimer's Drug Approval

GSA	Dollar Impact	PMPM Impact
North	$661,750	$0.32
Central	$8,633,550	$0.62
South	$1,746,429	$0.33
Total	**$11,041,729**	**$0.52**

COVID-19 Tests * ‡

Since February 2020, AHCCCS has covered a range of medically necessary diagnostic and antibody tests for detecting COVID-19. The AHCCCS DHCM Actuarial Team is adjusting CYE 22 rates to reflect the projected use of these tests, which were not covered during the base period.

To estimate the impact in the contract period, the AHCCCS DHCM financial analysts first reviewed encounters for COVID-19 test codes for March 1, 2020 through December 31, 2020. Upon review, the analysts chose to use average monthly test reimbursement observed in the period May 1, 2020 through December 31, 2020 as the projected baseline monthly test use in the contract period. This baseline forecast represents a hypothetical scenario of test use in the absence of COVID-19 vaccinations and is adjusted below for more realistic assumptions.

The analysts assumed that use of tests would continue to gradually decrease after December 2020, as growing COVID-19 vaccination rates began to reduce the number of symptomatic cases and lower public concern of the virus. The AHCCCS DHCM financial analysts projected that approximately 68% of members would be vaccinated by the mid-point of CYE 22. That program-wide vaccination rate includes 75% of members 16 years of age or older and 55% of members under 16 years of age. It was assumed that this build-up in the member vaccination rate would reduce the projected monthly baseline use of tests by 90% by the midpoint of CYE 22. On an annual basis, the test projections used for CYE 22 rate setting are approximately 86% less than the hypothetical baseline forecast of tests in the absence of vaccines. The rate adjustments assume some amount of testing will continue after peak vaccination rates are reached by mid CYE 22, due partly to new variants of the virus and less than full vaccination of the population.

For CYE 22 rate development, the projected use of COVID-19 tests was allocated across rate cells and GSAs using encounter data of tests from March 1, 2020 to December 31, 2020. The overall impact of the change by GSA is displayed below in Table 9d. Totals may not add up due to rounding.

Table 9d: COVID-19 Tests

GSA	Dollar Impact	PMPM Impact
North	$568,712	$0.28
Central	$7,045,991	$0.51
South	$2,335,085	$0.45
Total	**$9,949,788**	**$0.47**

Pharmacy and Therapeutics Committee Recommendations – Post Base Year *

On the recommendations of the P&T Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 22. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

To estimate the impact of adopted P&T Committee changes, the AHCCCS DHCM financial analysts largely relied on projections of drug utilization prepared by Magellan Rx Management, the agency's provider of drug rebate administrative services. Magellan has a nationwide vantage point that was drawn from in projecting how recommendations would impact drug utilization by AHCCCS members. In instances where Magellan did not provide a projected impact of an adopted change, the actuaries relied

upon the judgement of AHCCCS DHCM financial analysts to project the impact. For CYE 22 rate development, the aggregate impact of adopted changes was allocated across rate cells and GSAs using CalYr19 encounter data for the affected drug classes.

For CYE 22 rate development for the ACC Program, the actuaries additionally included other drug coverage decision impacts with the P&T Committee recommendations. These include the removal of substance use remission requirements before receiving Hepatitis C direct acting antiviral medications, covering the generic version of the Kuvan drug for treatment of Phenylketonuria (PKU), covering the immunotherapy drug Palforzia for treatment of peanut allergy in children 4 to 17 years of age, and covering Evrysdi for the treatment of Spinal Muscular Atrophy (SMA) in patients 2 months and older. The generic version of Kuvan along with Evrysdi were also added to the covered drug list for AHCCCS' biologics reinsurance case type, and the impacts to the reinsurance offset due to their inclusion are discussed in Section I.4.C.ii.(c)(iv).

The combined impacts to the ACC Program of the adopted P&T Committee recommendations are displayed below in Table 9e. Totals may not add up due to rounding.

Table 9e: Pharmacy and Therapeutics Committee Recommendations – Post Base Year

GSA	Dollar Impact	PMPM Impact
North	($606,795)	($0.29)
Central	($4,122,771)	($0.30)
South	($1,701,193)	($0.33)
Total	**($6,430,758)**	**($0.30)**

Rx Rebates Adjustment

An adjustment was made to reflect the impact of Rx Rebates reported within the Contractors' financial statements, as pharmacy encounter data does not include these adjustments. The data that the AHCCCS DHCM Actuarial Team reviewed was the CYE 18 annual financial statement reports (from the Acute, CRS, and RBHA Contractors in those contract years), the CYE19, CYE 20, CYE 21 Q1 financial statement reports (from ACC Contractors), and the CalYr19 supplemental rebate information provided by the ACC Contractors. From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment to the Pharmacy data to reflect a level of reported Rx Rebates. From the review of the above data, the AHCCCS DHCM Actuarial Team assumed 2.0% for Rx Rebates and applied that to the projected CYE 22 Pharmacy category of service.

The overall impact of the Rx Rebates adjustment program change by GSA is displayed below in Table 9f. Totals may not add up due to rounding.

Table 9f: Rx Rebates Adjustment

GSA	Dollar Impact	PMPM Impact
North	($2,803,504)	($1.36)
Central	($20,320,719)	($1.47)
South	($6,338,026)	($1.22)
Total	**($29,462,250)**	**($1.40)**

AHCCCS FFS Fee Schedule Updates

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

Additionally, the contract has requirements that the Contractors reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates program change includes a fee schedule adjustment to bring the encounter base data from CalYr19 FQHC PPS rates up to projected CYE 22 FQHC PPS rates.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 22 capitation rates have been adjusted to reflect these fee schedule changes. For CYE 22 capitation rate development, the actuaries used data provided by the AHCCCS DHCM Rates & Reimbursement Team to determine the impact of the annual October 1 fee schedule changes which should be applied to the base data year CalYr19. The impacts applied are the October fee schedule changes for 2019 through 2021. The CalYr19 data required nine months of the October 2019 change, and the full year impacts of the October 2020 and October 2021 fee schedule changes, to bring the data to the rating period. Additional detail on specific changes within the fee schedules are addressed below.

For the duration of the COVID-19 PHE, CMS expanded the range of Medicare codes that may be billed for services provided by a resident without the direct supervision of a primary care physician, using the GE modifier. AHCCCS has aligned with CMS by expanding the set of codes for which resident-provided services can be billed using the GE modifier. The AHCCCS DHCM Actuarial Team applied the impacts by program as part of the fee schedule changes as the change is non-material for each program and rate cell when considered alone.

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

The October 1, 2020 fee schedule changes incorporated increased base reimbursement rates for services reimbursed under the dental fee schedule and physician fee schedule, not including the physician drug fee schedule, to restore provider rates to those in existence prior to reductions implemented in state fiscal year 2009, per Arizona State HB 2668 (Laws 2020, Chapter 46).

In the 2021 legislative session, the legislature passed a general appropriations bill which included funding for ACC to implement HCBS and NF provider fee schedule increases. Consistent with the additional funding, the DHCM Rates and Reimbursement Team increased HCBS and NF provider reimbursement rates by 7.2% effective October 1, 2021.

AHCCCS will transition from version 34 to version 38 of the APR-DRG payment classification system on October 1, 2021. AHCCCS has used v34 APR-DRG national weights published by 3M since January 1, 2018 until present. In addition to updating to version 38, AHCCCS will rebase the inpatient system and update to APR-DRG v38 effective October 1, 2021. Rebasing involves updating the DRG grouper version, relative weights and DRG base rates via payment simulations modeling using more recent data. Guidehouse did the rebase of the AHCCCS DRG system. The rebase followed the same methodology as that used in the January 2018 rebase, included here for reference:

> "Rebasing calculations included updated base rates (both standardized amounts and wage indices), relative weights, 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)."

After adjusting the base rates and wage indices to maintain a budget neutral rebase, AHCCCS adjusted one service policy adjustor during the rebase to meet program funding goals. The high acuity pediatric policy adjuster was increased from 2.3 to 2.4 in this rebase process. The AHCCCS DHCM Actuarial Team relied upon Guidehouse and the AHCCCS DHCM Rates & Reimbursement Team for the reasonableness of the changes. The combined impact for the rebase and policy adjustor change has been included with the fee schedule changes already discussed.

Effective October 1, 2021, AHCCCS is increasing reimbursement for administration of Vaccine for Children (VFC) program vaccines to the maximum fee permitted to be reimbursed by the state under federal rule 77 FR 66669.

AHCCCS also increases some fee schedule rates effective January 1 of each year to recognize the annual minimum wage increase resulting from the passing of Proposition 206. The increased costs for this

change have been included with the fee schedule changes already discussed as the minimum wage change is non-material for the ACC Program when considered alone.

The overall impact of the AHCCCS FFS fee schedule updates by GSA is illustrated below in Table 9g. Totals may not add up due to rounding.

Table 9g: Aggregate AHCCCS FFS Fee Schedule Updates

GSA	Dollar Impact	PMPM Impact
North	$26,626,734	$12.89
Central	$228,398,581	$16.52
South	$83,903,973	$16.09
Total	**$338,929,289**	**$16.06**

Combined Miscellaneous Program Changes

The rate development spreadsheet includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less for every individual rate cell across all GSAs, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 9h. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Off Campus Hospital Outpatient Department Reimbursement ***
  Effective October 1, 2020, AHCCCS is reimbursing services billed at off campus hospital outpatient departments on a UB form with PO or PN modifiers according to the physician or ambulatory surgical center fee schedules. The change will represent a decrease in reimbursement relative to outpatient hospital fee schedule rates that providers billed before the change.
- **Outpatient Psychiatric Hospital Reimbursement ***
  Beginning October 1, 2020, AHCCCS is implementing an outpatient hospital fee schedule reimbursement methodology for outpatient services provided by psychiatric hospitals. Prior to this change, AHCCCS manually approved Contractor payments to psychiatric hospitals for outpatient services, which were not subject to a specific reimbursement methodology. To estimate the impact, the AHCCCS DHCM financial analysts repriced base period encounters at outpatient hospital fee schedule rates.
- **Adult Hepatitis C Screening Recommendation ***
  On March 2, 2020, the U.S. Preventive Services Task Force (USPSTF) published a final recommendation that all adults 19 to 79 years of age be screened for hepatitis C. This represents an expansion of recommended screening from the previous guidance that adults

born between 1945 and 1965 be screened. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the USPSTF final recommendation on hepatitis screenings for adults.

- **Adult Human Papillomavirus Immunization Guidance ***
  On August 16, 2019, the CDC Advisory Committee on Immunizations (ACIP) released a recommendation that adults 27 to 45 years of age at risk of contracting human papillomavirus immunization (HPV) are vaccinated. This represents an expansion to previous guidance, which recommended HPV immunizations for adults 19 to 26 years of age. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the ACIP recommendation on HPV immunizations for adults.
- **Increased Frequency of Dental Fluoride Visits ***
  Beginning February 1, 2020, AHCCCS increased the maximum number of dental fluoride varnish applications that members may receive, from two to four applications a year.
- **Inpatient Dental Hygienist Teeth Cleanings ***
  As part of the 2019 Legislative session, the Arizona Legislature passed HB 2058 which permits dental hygienists to provide services in an inpatient hospital setting under supervision of a physician. The legislation is expected to increase provision of inpatient teeth cleanings for prevention of ventilator associated pneumonia.
- **Depression and Anxiety Screening Codes ***
  Effective August 1, 2020, AHCCCS began coverage of procedure code 96127 for brief emotional or behavioral assessments.
- **EPSDT Development Screen ***
  Effective October 1, 2021, AHCCCS is revising policy to better align EPSDT visits and developmental screening requirements with CMS Core Measures and recommendations from the American Academy of Pediatrics. The policy revisions require an additional EPSDT visit for child members at 30 months of age and two specialized developmental screens at the child member's 18-month and 24-month EPSDT visits.
- **Dental Counseling Codes ***
  On the recommendation of the Office of the Director's Chief Medical Officer, AHCCCS began covering dental services for tobacco counseling effective October 1, 2020 and high-risk substance use counseling effective January 1, 2021. An estimated 26.1% of AHCCCS adults use tobacco while an estimated 17.7% of high-school aged AHCCCS members use electronic cigarettes. The CYE 22 capitation rates include adjustments for the projected use of these dental counseling services.
- **Cell-Free DNA Testing ***
  Effective March 1, 2021, AHCCCS began covering cell-free DNA tests (cfDNA) for pregnant women at high risk of delivering a baby with chromosomal abnormalities. These tests are generally more extensive, accurate, and expensive than covered fetal nuchal translucency (NT) test. Based on member age and studies on prevalence of chromosomal abnormalities, AHCCCS DHCM financial analysts assumed that 10.5% of base period NT screens occur in high risk

pregnancies and would transition to cfDNA tests in CYE 22. The CYE 22 capitation rates include adjustments for the higher reimbursement rates provided for cfDNA tests than for NT tests.

- **Bus Passes ***
  Effective October 1, 2021, AHCCCS is revising policy to clarify that Contractors may reimburse public transport passes as NEMT. Passes would generally be billed with procedure code A0110. When offering a public transport pass, contractors should consider such things as location of the member, location of the member's provider, public transportation schedules, and member ability to travel alone. CYE 22 adjustments to rates include projected costs of bus passes and increased use of medical services due to greater members options for transport, partly offset by savings from reduced use of more expensive alternative forms of NEMT.
- **High Needs Therapeutic Foster Care Rates ***
  Effective October 1, 2021, AHCCCS is establishing increased FFS rates for Therapeutic Foster Care (TFC) services provided in a licensed family setting to higher needs foster children under 18 years of age.
- **Administration of CAR-T Cell Therapy ***
  Effective May 3, 2021, AHCCCS began covering service codes for the administration of chimeric antigen receptor T cell therapy (0537T – 0540T).
- **Genetic Testing for Cardiovascular Disorders ***
  AHCCCS began covering genetic tests for rare inherited cardiovascular disorders effective October 23, 2020. The tests are primarily recommended for identification of Long QT syndrome (LQTS) in first degree relatives of individuals with the disorder. To estimate the impact of coverage, the AHCCCS DHCM financial analysts first reviewed FFY 19 encounters to identify members with an LQTS diagnosis. The analysts then projected the number of first-degree relatives of those individuals that are also AHCCCS members and that would receive the tests. Lastly, the analysts applied FFS fee schedule pricing to the projected quantity of tests to estimate total cost of coverage.
- **Emergency Triage, Treat, and Transport ***
  Effective October 1, 2021, AHCCCS will implement an Emergency Triage, Treat, and Transport (ET3) model that is similar to the ET3 program that Medicare began in FFY 21. Under the state's program, emergency service providers may begin billing for trips that result in delivery of on-site or telehealth services by a partner health professional or for trips to an outpatient non-emergency department provider. The AHCCCS DHCM financial analysts project that cost savings of diverting unnecessary emergency department visits to lower acuity settings under the ET3 model will be offset by additional costs of reimbursing emergency service providers for trips in which no or limited reimbursement was previously paid.
- **Vaxelis Immunization ***
  Effective January 1, 2021, AHCCCS began covering Vaxelis as a combination immunization for children ages 6 weeks through 4 years against diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B, and disease due to haemophiles influenzae type b. The vaccination is administered in a series of three shots and is anticipated to substitute for anywhere from 7 to 16 shots of the

previously available vaccinations for the diseases above. The federal Vaccines for Children program funds costs of the vaccines while AHCCCS and its contractors reimburse for administration of the vaccines. The CYE 22 rates include a reduction for the projected decrease in vaccine shots that will be administered to children.

- **Cancer Profiling Testing ***
  Effective July 1, 2021, AHCCCS began covering two medically necessary cancer profiling tests. The tests can assist providers in determining the most appropriate course of treatment for a patient's cancer.
- **Child Flu Shots at Pharmacies ***
  Effective September 1, 2020, AHCCCS modified policy guidance to permit pharmacists to administer influenza vaccinations to children ages 3 to 18 years old. Prior to the change, policy limited pharmacist-administered influenza vaccines to adults 19 years and older.

Table 9h: Combined Miscellaneous

GSA	Dollar Impact	PMPM Impact
North	$614,584	$0.30
Central	$3,951,157	$0.29
South	($299,389)	($0.06)
Total	**$4,266,351**	**$0.20**

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

Any changes to the data, assumptions, or methodologies used to develop the projected benefit costs since the last rating period have been described within the relevant subsections of this certification.

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

The ACC Program Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuaries to set the CYE 22 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2017 through early March 2021 and adjudicated and approved through the first encounter cycle in March 2021. The data was truncated to avoid including any COVID-19 time period which had large and varied impacts on most categories of service which are not anticipated to be continued into the rating period, making the COVID-19 time period data inappropriate for use in

developing trend projections. The trend was developed primarily with actual experience from the Medicaid population.

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

The encounter data was summarized by GSA, rate cell, month, and category of service, and by utilization per 1000, unit cost, and PMPM values. The encounter data was adjusted for completion and the encounter data issues described in Section I.2.B.iii.(c). Additionally, the encounter data was adjusted to normalize for previous program changes. Projected benefit cost trends were developed to project the base data forward 33 months, from the midpoint of CalYr19 (July 1, 2019) to the midpoint of the rating period for CYE 22 (April 1, 2022). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. Projected benefit cost trends were based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results.

For all GSAs and rate cells, except Delivery Supplemental Payment, projected benefit cost trends were developed for the following categories of service (Inpatient and LTC, Physician, Other Professional Services, Pharmacy, and Outpatient) at a GSA and rate cell level. For the following categories of service (Transportation, Lab and Radiology Services, Dental, and FQHC) the projected benefit costs trends were developed by GSA but not at the rate cell level.

For the Delivery Supplemental Payment rate cell, the following categories of service (Transportation, Other Professional Services, Pharmacy, Outpatient, Lab and Radiology Services, Dental, and FQHC) were aggregated to develop the projected benefit costs trends at a GSA level.

The different methodologies were determined to be reasonable given the volume of services and variation within the major category of services.

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

No comparisons were made against other AHCCCS programs due to the unique aspects of the ACC Program. Comparisons were made against the trends used in the previous rating period, and the change in trends by categories of service was deemed reasonable considering the change in the base data time period, the rating period, and the intervening COVID-19 pandemic. Trends were also compared between GSAs and variances were determined to be reasonable and appropriate.

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

The 2022 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuaries defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. No trends in the CYE 22 capitation rate development crossed the outlier threshold.

The actuaries assumed negative trends for the unit cost trend in the North GSA Age 1-20 rate cell and the North SSIWO rate cell for Other Professional Services category of service, in the South SSIWO rate cell for Physician category of service, and for the utilization trend in the South GSA SSIWO rate cell for

Pharmacy category of service. These negative trend assumptions were based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. For every rate cell with a negative unit cost or utilization trend assumption, all regression lines for the unit cost or utilization data are negatively sloped and the negative slopes are more extreme than the utilization trend rate assumed in 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 projected benefit cost trends by GSA, rate cell and major category of service for utilization per 1000, unit cost, and PMPM values are included in Appendix 5. The aggregate projected benefit cost trends, excluding the Delivery Supplemental Payment rate cell, by GSA for utilization per 1000, unit cost, and PMPM values are included below in Table 10.

Table 10: CYE 22 Annualized Trends

GSA	Utilization Per 1000	Unit Cost	PMPM
North	1.25%	2.19%	3.47%
Central	1.65%	1.58%	3.26%
South	1.80%	1.62%	3.45%
Total	**1.65%**	**1.65%**	**3.32%**

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

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

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

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

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

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

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

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

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

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

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS DHCM Medical Management Team reviews updated Contractor analysis to determine if

additional services are necessary to comply with parity standards. As of August 11, 2021, no additional services have been identified as necessary services to comply with MHPAEA.

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

There are no in-lieu-of services allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an Institution for Mental Disease (IMD) in lieu of services in an inpatient hospital. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the capitation rate development has complied with the requirements of 42 CFR § 438.6(e) described above in Section I.3.A.iv.

I.3.B.vi. Retrospective Eligibility Periods

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

AHCCCS provides PPC for the period of time prior to the member's enrollment during which the member is eligible for covered services. 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 ACC Contractor. The ACC Contractor receives notification from AHCCCS of the member's enrollment. The ACC Contractor is responsible for payment of all claims for medically necessary services covered by the ACC Program and provided to members during PPC, with the exception of members transitioning to Title XIX from RBHA non-Title XIX (state-only) eligibility, as noted in Sections I.1.A.iii.(c)(i)(B) and I.2.B.iii.(d).

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

Encounter data related to PPC 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 PPC 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 22 capitation rates for the ACC Program, given that the encounter and enrollment data are already included within the base data used for capitation rate development.

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

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

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

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

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

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

"The Contractor shall 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 shall be submitted."

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

Material adjustments related to provider payment requirements under State Directed Payments are discussed in Section I.4.D of this rate certification. Additionally, provider payment requirements related to FQHCs are described in Section I.3.B.ii.

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

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

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

There were no material adjustments made related to litigation.

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

All material and non-material changes have been included in the capitation rate development process and all requirements in this section of the 2022 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

Alternative Payment Model Initiative – Performance Based Payments

The CYE 22 capitation rates for the ACC Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2), called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the ACC Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the ACC Contractors that are aimed at quality improvement, such as reducing costs, improving health outcomes, or improving access to care. For reference, the ACC Program CYE 21 APM Initiative – Performance Based Payment amounts are anticipated to be $37.4 million.

Alternative Payment Model Initiative – Quality Measure Performance

The incentive arrangement for the APM Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of AHCCCS performance measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement. The maximum incentive pool possible is approximately $85 million, which is the amount that would be available if every Contractor earned exactly 0% of the withhold described below. This is not anticipated to happen; thus, the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

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

The time period of the incentive arrangements described herein is twelve months.

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

Alternative Payment Model Initiative – Performance Based Payments

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

The ACC Contractors provider contracts must include performance measures for quality and/or cost efficiency.

Alternative Payment Model Initiative – Quality Measure Performance
The incentive arrangement includes performance measures impacting well visits for children and adolescents, prenatal care, breast cancer screening, and follow-up after hospitalization for mental illness. All adult and child enrollees utilizing the services addressed in the performance measures, and providers of these services, are covered by the incentive arrangement unless specifically stated otherwise.

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

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

Alternative Payment Model Initiative – Quality Measure Performance
The purpose of the APM Initiative – Quality Measure Performance incentive arrangement is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings. Contractors are required to meet a targeted percentage of total expenses under an APM contract arrangement in order to participate in the APM Initiative – Quality Measure Performance incentive.

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

The total payments under the incentive arrangements for the ACC Program (i.e., capitation rate payments plus incentive payments) will not exceed 105% of the capitation payments to comply with 42 CFR § 438.6(b)(2).

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

Alternative Payment Model Initiative – Performance Based Payments
Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 22 capitation rates and had no effect on the development of the capitation rates for the ACC Program. The incentive payments will be paid by AHCCCS to the ACC Contractors through lump sum payments after the completion of the CYE 22 contract year.

Alternative Payment Model Initiative – Quality Measure Performance
Incentive payments for the APM Initiative – Quality Measure Performance incentive arrangement are not included in the CYE 22 capitation rates and had no effect on the development of the capitation rates. AHCCCS does not have analysis on the amount of the anticipated incentive payment, since it is dependent on the amount of unearned withhold across all Contractors, and that has yet to be determined. Incentive payments for the APM Initiative will be paid by AHCCCS to the Contractors

through lump sum payments after the completion of the contract year and the computation of the performance measures, and after the withhold payments are distributed and the value of the incentive pool determined.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2022 Guide provides information on the definition and requirements of a withhold arrangement.

I.4.B.ii. Appropriate Documentation

I.4.B.ii.(a) Description of Any Withhold Arrangements

The ACC Program includes a percentage of capitation withhold arrangement which the Contractor may earn back. Contractors are required to engage in a minimally-set targeted percentage of total expenses under an APM purchasing arrangement in order to receive any payment from the APM payment withhold.

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

The time period of the withhold arrangements coincides with the rating period.

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

All enrollees, services, and providers are covered by this withhold arrangement.

I.4.B.ii.(a)(iii) Purpose of the Withhold

The purpose of the ACC Program withhold is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health.

I.4.B.ii.(a)(iv) Description of Percentage of Capitation Rates Withheld

AHCCCS has established a quality withhold of 1% of the Contractor's capitation and a percentage (up to 100%) of the withheld amount will be paid to the Contractor for performance on select performance measures. AHCCCS will determine the portion of the withheld amount to be returned based on a review of each Contractor's data and the Contractor's compliance with these performance measures.

I.4.B.ii.(a)(v) Percentage of the Withheld Amount Not Reasonably Achievable

It is highly unlikely that a Contractor will not receive some portion of the withhold back. The only scenario where a Contractor would earn none of the withhold back is if they failed to meet the targeted percentage of total expenses under an APM purchasing arrangement. However, the AHCCCS DHCM Actuarial Team does not have the information needed to develop an estimate of the withheld amount that is not reasonably achievable.

I.4.B.ii.(a)(vi) Description of Reasonableness of Withhold Arrangement

The actuaries relied upon the AHCCCS DHCM Finance & Reinsurance Team's review. That review of the total withhold percentage of 1% of capitation revenue indicated that it is reasonable within the context of the capitation rate development and that the magnitude of the withhold does not have a detrimental impact on the Contractors' financial operating needs and capital reserves. The AHCCCS DHCM Finance & Reinsurance Team's interpretation of financial operating needs relates to cash flow needs for the Contractors to pay claims and administer benefits for its covered populations. The AHCCCS DHCM Finance & Reinsurance Team evaluated the reasonableness of the withhold within this context by reviewing the Contractors' cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by AHCCCS. To evaluate the reasonableness of the withhold in relation to capitalization levels, the AHCCCS DHCM Finance & Reinsurance Team reviewed the surplus above the equity per member requirement, the performance bond amounts, and the financial stability of each Contractor to pay all obligations. The AHCCCS DHCM Finance & Reinsurance Team reviewed cash and cash equivalent levels in relation to the withhold arrangement and has indicated the withhold arrangement is reasonable based on current cash levels.

I.4.B.ii.(a)(vii) Effect on Capitation Rate Development

The capitation rates shown in this rate certification are illustrated before offset for the withhold amount. The withhold amount is not considered within capitation rate development.

I.4.B.ii.(b) Certifying Rates less Expected Unachieved Withhold as Actuarially Sound

The CYE 22 capitation rates documented in this rate certification are actuarially sound even if none of the withhold is earned back.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2022 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 22 capitation rates for the ACC Program will include risk corridors. There is also a cost-settlement type arrangement for the administration of COVID-19 vaccines for the CYE 22 rating period.

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

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 22 capitation rates will continue AHCCCS' long-standing program policy and will include risk corridors. This rate certification will use the term risk corridor to be consistent with the 2022 Guide. The ACC contract refers to the risk corridors as either a risk corridor or reconciliation.

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

There are two risk corridor type arrangements in the ACC Program. The first is a reconciliation of costs to reimbursement (tiered reconciliation) and the second is a fixed administrative cost component reconciliation associated with projected versus actual enrollment.

The tiered risk corridor will reconcile each Contractor's medical cost expenses to the net capitation paid to each Contractor. Net capitation is equal to the capitation rates paid less the administrative component and premium tax, plus any reinsurance payments. Each Contractor's medical cost expenses are equal to the Contractor's fully adjudicated encounters and sub-capitated/block purchase expenses as reported by the Contractor's financial statements with dates of service during the contract year. Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically computed no sooner than 15 months after the contract year. This risk corridor will limit each Contractor's ACC statewide profits and losses as listed in Table 11 below.

Table 11: Tiered Risk Corridor Risk Bands

Profit	MCO Share	State Share	Max MCO Profit	Cumulative MCO Profit
<= 2%	100%	0%	2%	2%
> 2% and <= 6%	50%	50%	2%	4%
> 6%	0%	100%	0%	4%
Loss	**MCO Share**	**State Share**	**Max MCO Loss**	**Cumulative MCO Loss**
<= 2%	100%	0%	2%	2%
> 2%	0%	100%	0%	2%

The fixed administrative cost component reconciliation will reconcile each Contractor's fixed administrative cost component by comparing the actual member months to the member months that were assumed in the calculation of the administrative PMPM. If the Contractor's actual member months are different than assumed member months, AHCCCS will recoup or reimburse the difference in the fixed administrative PMPM attributable to any difference in member months, subject to medical loss ratio requirements. This risk corridor has no limits in either direction and will be performed as described above. The threshold is zero, the reimbursement or recoupment will happen for all levels of discrepancy between actual member months and assumed member months.

The cost-settlement will reimburse the Contractor's for the administration of COVID-19 vaccines via a periodic cost-settlement based upon adjudicated/approved encounter data subject to the two-year claiming rule.

Additional information regarding the risk corridors can be found in the Compensation section of the ACC Program contract.

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

The risk corridors did not have any effect on the development of the CYE 22 capitation rates for the ACC Program.

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

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

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

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

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

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

AHCCCS provides a reinsurance program to the ACC Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what you would see in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biological drugs. Additionally, rather than the Contractors paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical expenses. One could view the reinsurance offset as a premium.

The AHCCCS reinsurance program has been in place since 1982 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 ACC Contractors for covered services incurred above the deductible. The deductible is the responsibility of the ACC Contractors. The deductible for CYE 22 Regular reinsurance cases is $50,000, an increase from previous years of the program. The limit on other catastrophic reinsurance is $1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

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

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

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

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

The methodology for setting the reinsurance offset has changed from the CYE 21 ACC capitation rates, due to the base period CalYr19 crossing two contract years (reinsurance payments are made based on encounters in contract years, not calendar years) and the change in the regular reinsurance deductible for CYE 22. The data used to develop the reinsurance offset for CYE 22 are historical reinsurance payments to the Contractors for services incurred during CYE 19 and CYE 20. The actuaries developed a pseudo-calendar year set of data from these payments for each of the major reinsurance case types (Regular, Biological, and Catastrophic). For the Biological and Catastrophic reinsurance case types, these reinsurance payments were divided by the CalYr19 member months to develop a PMPM offset before completion. This was done at the rate cell and GSA level. For the Regular reinsurance case type, the actuaries first repriced, at the case level, all reinsurance payments in the Regular reinsurance data set using the increase in deductible from $35,000 to $50,000. Reinsurance cases which were below the higher deductible threshold were removed, and reinsurance cases which were above the higher deductible were repriced. These revised regular reinsurance payments were then divided by the CalYr19 member months to develop a PMPM offset before completion. The reinsurance PMPMs were then completed and adjusted for any adjustments that impacted CalYr19 base encounter data as described above in Section I.2.B.iii.(d). The adjusted reinsurance PMPMs were trended forward to CYE 22 using medical trend rates for the appropriate categories. Regular reinsurance case type used the Inpatient and LTC category of service trend, Biological reinsurance case type used the Pharmacy category of service trend, and Catastrophic reinsurance case type used aggregated trend rates by rate cell and GSA across all categories of service.

The adjusted and trended reinsurance PMPMs were then further modified to account for changes to the reinsurance program from CalYr19 to CYE 22, to account for similar adjustments as those described above in Section I.3.B.(ii)(a), and for deductible leveraging to arrive at the CYE 22 reinsurance PMPMs. Other changes to the reinsurance program from CalYr19 to CYE22 included adding several drugs to the list of drugs covered by the AHCCCS reinsurance program.

The projected costs of drugs added to the Biological case type after the base period was calculated by taking the projected costs for CYE 22 for those drugs and applying a zero dollar deductible and

coinsurance limit of 85% to get the dollar impact to the reinsurance offset. The combined dollar impact to the reinsurance offsets for the ACC Program is $15 million.

Appendix 7 displays the reinsurance offset PMPMs by Contractor, GSA, and rate cell.

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

This section of the 2022 Guide provides information on delivery system and provider payment initiatives (i.e., state directed payments) authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

I.4.D.ii.(a) Description of State Directed Payments

The only pre-prints addressed in this certification are the ones related to ACC. Those pre-prints are DAP, APSI, PSI, and HEALTHII. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The potential rate increases range from 0.5% to 18.5%, depending on the provider type.

Access to Professional Services Initiative

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

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

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

Pediatric Services Initiative

The PSI seeks to provide enhanced support to ensure financial viability of the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The PSI provides a uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

DAP are the only directed payments incorporated in the capitation rates. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

All ACC rate cells are affected.

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

For DAP see Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell.

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

Differential Adjusted Payments

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.0% increase), Critical Access Hospitals (eligible for up to 10.5% increase), other hospitals and inpatient facilities (eligible for up to 5.0% 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 (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 8.5% increase on all services provided), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), and HCBS providers (eligible for up to 1.0% increase on specified services for some provider types, and all services for other provider

types). 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 20 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 22 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 22 (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

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

AHCCCS has submitted the DAP §438.6(c) pre-print 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-print under CMS review.

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

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

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

The APSI, PSI, and HEALTHII are not included in the ACC certified capitation rates and will be paid out via lump sum payments. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $137.3 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Services Initiative

Anticipated payments including premium tax for PSI are approximately $44.9 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 22 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments including premium tax for HEALTHII are approximately $1.22 billion. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 22 utilization will be used to redistribute the payments.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

Appendix 8 contains estimated PMPMs including premium tax by rate cell for informational purposes only; these payments are not made on a PMPM basis.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

Access to Professional Services Initiative

After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

Pediatric Services Initiative

After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

Hospital Enhanced Access Leading to Health Improvements Initiative

After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

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

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

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

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

I.4.E. Pass-Through Payments

I.4.E.i. Rate Development Standards

This section of the 2022 Guide provides information on the pass-through payments, as defined in 42 CFR § 438.6(a), including information on the transition periods, base amount calculations and allowable pass-through payments under 42 CFR § 438.6(d).

I.4.E.ii. Appropriate Documentation

I.4.E.ii.(a) Existing Pass-Through Payments

This section contains the required information for documenting pass-through payments.

I.4.E.ii.(a)(i) Description of Pass-Through Payments

The Rural Hospital Inpatient Fund was established in Arizona Revised Statute (A.R.S.) § 36-2905.02 by the Arizona State Legislature in 2005 in response to a 2002 hospital inpatient study that showed rural hospital inpatient cost structures were higher than urban hospital cost structures for inpatient services. The Rural Hospital Inpatient Fund was designed to supplement rural hospital inpatient payments and is paid out by the Contractors to the rural hospitals as a pass-through payment. Additional information regarding the pass-through payment for rural hospitals can be found in the A.R.S. § 36-2905.02 and in the Arizona Administrative Code (A.A.C.) R9-22-712.07.

- A.R.S.§36-2905.02: http://www.azleg.gov/viewdocument/?docName=http://www.azleg.gov/ars/36/02905-02.htm
- A.A.C. R9-22-712.07: http://apps.azsos.gov/public_services/Title_09/9-22.pdf

I.4.E.ii.(a)(ii) Description of How the Pass-Through Payments Will Be Made

The pass-through payment will be made as an aggregate lump sum payment.

I.4.E.ii.(a)(iii) Amount of Pass-Through Payments

The total amount before premium tax of the pass-through payment for rural hospitals is $12,158,100. The total amount with 2% premium tax is $12,406,224.

I.4.E.ii.(a)(iv) Programs that Include the Pass-Through Payments

The only pass-through AHCCCS has is the pass-through payment for rural hospitals. The ACC Program is the only program which includes the rural hospital pass-through payment.

I.4.E.ii.(a)(v) Providers Receiving Pass-Through Payments

The providers receiving the pass-through payment are the rural hospitals that meet the state regulatory definition of a rural hospital. For the purpose of this payment, a rural hospital is defined in the A.A.C. R9-22-712.07 as, "*A health care institution that is licensed as an acute care hospital by the Arizona Department of Health Services for the previous state fiscal year and is not an IHS hospital or a tribally owned or operated facility and: a. Has 100 or fewer PPS beds, not including beds reported as sub provider beds on the hospital's Medicare Cost Report, and is located in a county with a population of less*

than 500,000 persons, or b. Is designated as a critical access hospital for the majority of the previous state fiscal year."

I.4.E.ii.(a)(vi) Financing Mechanism Pass-Through Payments

This section contains the required information for documenting financing mechanism of pass-through payments.

I.4.E.ii.(a)(vi)(A) Description of Non-Federal Share

The non-federal share of the rural hospital supplemental payments are financed through a state General Fund appropriation as specified in A.R.S. § 36-2905.02 and the annual appropriation bill.

I.4.E.ii.(a)(vi)(B) Payments Funded by Intergovernmental Transfers – Not Applicable

I.4.E.ii.(a)(vi)(C) Identification of any §438.6(c) Directed Payments that Target Same Providers

There are two §438.6(c)directed payment arrangements that could impact the same providers as the rural hospital pass-through payment. Those §438.6(c) directed payment arrangements are DAP and HEALTHII.

I.4.E.ii.(b) Description of the Aggregate Pass-Through Payments

This section documents the aggregate pass-through payment amounts.

I.4.E.ii.(b)(i) Amount of the Aggregate Pass-Through Payments

There is only one existing pass-through payment for the ACC Program. The total amount before premium tax of the pass-through payments is $12,158,100. The total amount with 2% premium tax is $12,406,224.

I.4.E.ii.(b)(ii) Documentation of Historical Pass-Through Amounts

The total amount before premium tax of the pass-through payment for rural hospitals in the Acute Care CYE 16 capitation rates was $12,158,100. The CYE 16 contract and certification for rural hospitals was submitted to CMS on February 29, 2016. The Acute Care CYE 16 capitation rates covered the period from October 1, 2015 through September 30, 2016 and therefore included the date of July 5, 2016 and were submitted to CMS prior to July 5, 2016 as required by 42 CFR § 438.6(d).

I.4.E.ii.(b)(iv) States Transitioning from FFS to Managed Care – Not Applicable

I.4.E.ii.(c) Base Amount Information

This section documents the data, assumptions, and methodology to calculate the base amount. All amounts listed in this section are before premium tax.

I.4.E.ii.(c)(i) Data, Assumptions, Methodology to Develop Base Amount

The data, assumptions, and methodology align with the requirements of 42 CFR § 438.6(d). The base amount is calculated on an annual basis and is recalculated annually in accordance with 42 CFR § 438.6(d)(2)(iii).

The CYE 20 encounter and FFS claims data for inpatient services incurred at the rural hospitals was used for the base amount calculation. The AHCCCS DHCM Actuarial Team also used CMS 2552 Hospital Cost Reports provided by the AHCCCS DHCM Rate & Reimbursement Team. The CMS 2552 Hospital Cost Reports were used to get the Medicare FFS inpatient charge and payment amounts to calculate a Medicare FFS payment-to-charge ratio for each rural hospital.

The Medicare FFS inpatient charge amounts were from Worksheet D, Part IV, Line 200, Column 10 of the CMS 2552 Hospital Cost Reports. The Medicare FFS inpatient payment amounts were from Worksheet E, Part A, Lines 1.00 through 2.02, Column 1 and Worksheet E-3, Part V, Line 4, Column 1 of the CMS 2552 Hospital Cost Reports. The Medicare FFS payment-to-charge ratios were applied to the CYE 20 inpatient encounter data and the CYE 20 inpatient FFS claims data for each rural hospital to get estimates of what would had been paid had Medicare FFS paid for the inpatient services.

There were no adjustments made to the base data used to calculate amounts for 42 CFR §§ 438.6(d)(2)(i)(A), (i)(B),(ii)(A), and (ii)(B). The only §438.6(c) directed payments that could have affected rural hospitals during the 12-month period immediately 2 years prior to the rating period would have been DAP. No adjustment was made to remove DAP from the base data calculation, so any such payment amounts are included when calculating amounts for I.4.E.i.(d)(i)(B). There were no changes to the methodology utilized for the base amount calculation from prior years' calculations.

I.4.E.ii.(c)(ii) Aggregate Amounts

The aggregate amounts for the base amount calculation are provided below.

- For 42 CFR § 438.6(d)(2)(i)(A) - $60,839,718
- For 42 CFR § 438.6(d)(2)(i)(B) - $35,940,209
- For 42 CFR § 438.6(d)(2)(ii)(A) - $22,204,022
- For 42 CFR § 438.6(d)(2)(ii)(B) - $9,911,060

The difference between $60,839,718 and $35,940,209 is $24,899,509. The difference between $22,204,022 and $9,911,060 is $12,292,962. The base amount is the sum of these differences and is $37,192,471.

I.4.E.ii.(c)(iii) Trend Adjustments – Not Applicable

Not applicable. The state did not include any trend adjustments when calculating the amounts listed in I.4.E.ii.(c)(ii).

I.4.E.ii.(c)(iv) Calculated Base Amount Applicable Percentage

The resulting base amount was estimated to be $37,192,471 and 60% of the base amount was estimated to be $22,315,483. As described by 42 CFR § 438.6(d)(3), the total dollar amount of the pass-through payment for rural hospitals for the CYE 22 capitation rates may not exceed the lesser of 60% of the base amount and the pass-through payment for rural hospitals in the CYE 16 capitation rates.

The result from this lesser of calculation is that pass-through payment for rural hospitals may not exceed $12,158,100 for the CYE 22 capitation rates.

I.4.E.ii.(c)(v) Amount of any §438.6(c) Directed Payments

DAP was the only directed payment arrangements made to hospitals during CYE 20 which is the 12-month period immediately 2 years prior to the rating period. The CYE 20 amount for DAP for rural hospitals is approximately $2.1 million. DAP is reflected in the CYE 20 encounters, and no adjustment was made to remove the amounts, therefore the amounts are reflected in the calculations of the amounts in I.4.E.i.(d)(i)(B).

I.4.E.ii.(d) States Transitioning from FFS to Managed Care – Not Applicable

Not applicable. The State of Arizona Medicaid program has operated as managed care since inception in 1982.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2022 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 primary data source used to develop the administrative component of the CYE 22 capitation rates for the ACC Program was the administrative expense data submitted by the Contractors per a supplemental data request, as noted in Section I.2.B.ii.(b)(ii). The CYE 20 financial statements and CYE 21 Q1 financial statements were also reviewed. Other sources of data reviewed and utilized in the development of the non-benefit cost projections were trends and forecasts for various Consumer Price Indices (CPI) and Employment Cost Indices (ECI) data from IHS Markit.

The Contractors' supplemental administrative data request included amounts for administrative expenses for CYE 20 actuals, CYE 21 year-to-date (through 12/31/20) actuals, actual/projected amounts for CYE 21, and projected amounts for CYE 22. This data request included administrative breakouts into different categories, breakdowns of fixed and variable administrative costs, and the Contractors' member months for each of the time frames.

The actuaries developed and reviewed several methodologies for projecting administrative expenses for the ACC Contractors, comparing the results across the methodologies, reviewing the results as a percentage of capitation rates, and comparing the results to national information[1] on Medicaid administrative costs. The ACC administrative PMPMs included in the capitation rates were developed primarily using the Contractors' supplemental administrative data and both the Contractor and AHCCCS' CYE 22 projected member months. For the fixed administrative expenses, the PMPM was developed by using each Contractor's projected costs divided by AHCCCS projected member months. For variable administrative costs, the PMPM was developed by using each Contractor's projected costs and member months for CYE 22, with limits imposed on any Contractor whose administrative expenses were not reasonable when compared to the various combinations of data, assumptions and methodologies reviewed by the actuaries and other members of the AHCCCS DHCM Actuarial Team. Additional administrative expenses were included in the projected administration costs for additional requirements identified by AHCCCS for the upcoming contract year.

[1] For comparable statistics of national Medicaid information including administrative costs, the actuaries referred to the Milliman research report titled "Medicaid managed care financial results for 2019" available at: https://us.milliman.com/-/media/milliman/pdfs/articles/medicaid-managed-care-financial-results-for-2019.ashx

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

The data, assumptions, and methodology used to develop the CYE 22 projected administrative costs are similar to the previous rating period and have been documented above. The previous methodology is documented in the CYE 21 actuarial rate certification.

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

No other material adjustments were applied to the projected non-benefit expenses included in the capitation rate.

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

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

The administrative component of the CYE 22 capitation rates for the ACC Program is described above in Section I.5.B.i.(a). The PMPM amounts assumed can be found in Appendix 7.

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

The CYE 22 capitation rates for the ACC Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 22 capitation rate for the ACC Program includes a provision for margin (i.e. UW gain). The UW gain has changed from CYE 21 since CYE 22 is the fourth year of the ACC contract and the UW gain was bid by the Contractors for the first three years of the ACC contract. The CYE 22 capitation rates for the ACC Program include a provision of 1.0% for UW gain.

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

No other material or non-material non-benefit costs not already addressed in previous sections are reflected in the CYE 22 capitation rates for the ACC Program.

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

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

I.6. Risk Adjustment and Acuity Adjustments

I.6.A. Rate Development Standards

I.6.A.i. Risk Adjustment

AHCCCS contracts with Wakely Consulting Group to assist in the development of the AHCCCS risk adjustment model. AHCCCS relies on Wakely Consulting Group to maintain and recalibrate the AHCCCS risk adjustment model. The AHCCCS DHCM Actuarial Team reviewed the results from the AHCCCS risk adjustment model and provided contractor specific files to each of the Contractors.

The CYE 22 capitation rates have risk adjustment factors applied to them. The risk adjustment factors in this certification are based on December 2020 through January 2021 member assignment and an experience period of January 1, 2019 through December 31, 2019. The experience period has been intentionally selected to omit 2020 experience affected by the COVID-19 pandemic and thereby potentially skewing utilization and risk marker prevalence during Calendar Year 2020.

AHCCCS intends to rerun the risk adjustment model with an updated snapshot period to determine whether there is a material impact to results after member choice due to the merger of Centene and WellCare in the central GSA. AHCCCS may adjust the capitation rates for the change in risk adjustment. If AHCCCS updates the capitation rates only for a risk adjustment update, AHCCCS does not intend to submit a revised rate certification as referenced in § 438.7(b)(5)(iii) since the documentation below describes the risk adjustment process. A new contract with the revised capitation rates will be submitted as required under § 438.7(b)(5)(iii).

I.6.A.ii. Budget Neutrality

In accordance with 42 CFR § 438.5(g), risk adjustment will be applied in a budget neutral manner.

I.6.A.iii. Acuity Adjustment – Not Applicable

Not applicable. The CYE 22 capitation rates for the ACC Program do not include acuity adjustment.

I.6.B. Appropriate Documentation

I.6.B.i. Prospective Risk Adjustment

I.6.B.i.(a) Data and Data Adjustments

Encounter and member data are used for the risk adjustment factors. AHCCCS regularly performs testing on encounters to identify any potential areas of concern. If AHCCCS identifies any encounter gaps, AHCCCS contacts the Contractor and works with them to improve encounter submissions. AHCCCS monitors the encounters by reviewing encounter data by date of service and form type to identify potential issues. The results of these analyses assist in determining if any encounter data is deemed unusable for the risk adjustment process and if any adjustments to the encounter data are required.

I.6.B.i.(b) Model and Model Adjustments

AHCCCS is using risk scores resulting from Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) Version 6.4 prospective risk adjustment model. CDPS+Rx is developed by the University of California, San Diego, to assign the condition markers to each enrollee based on a combination of the diagnoses and National Drug Code (NDC) data.

The CDPS+Rx model assigns one or more of the condition-based categories based on diagnostic and procedural information available on medical and pharmacy claims, as well as demographic categories based on age and gender. A relative health status weight is associated with each age, gender, and condition category.

Wakely Consulting Group developed and produced the AHCCCS risk adjustment model which uses the risk markers from the CDPS+Rx model. AHCCCS provided all encounters, membership, and capitation rates data for the appropriate time frames to Wakely Consulting Group to perform the analysis. The AHCCCS risk adjustment model was calibrated by Wakely Consulting Group in 2020 for the ACC Program.

The following costs were not reflected in the condition or demographic weights in the calibrated AHCCCS risk adjustment model:

1. Costs above reinsurance thresholds for which the Contractors were not at risk
2. Maternity costs covered by the Delivery Supplement payment
3. Costs that were offset by pharmacy rebates

The diagnosis codes on all encounters, except all laboratory and radiology codes, are used for purposes of identifying conditions, but the costs not at risk (identified above) were excluded for purposes of determining the risk weights. This process captures the additional complexity/cost for at-risk conditions due to the presence of an underlying not-at-risk condition.

The AHCCCS risk adjustment model modified CDPS+Rx version 6.4 with the inclusion of social determinants of health (SDoH) as additional risk markers in order to more equitably account for risk and cost differences for socially vulnerable cohorts. Two additional markers were included to capture PPC and CRS designated members.

Risk weights were developed by age and gender category, all of the CDPS+Rx condition categories, and the additional markers. Three sets of risk weights were developed for the state specific markers (AGE <1 was modeled differently – see section below): 1) AGE 1-20, 2) AGE 21+, Expansion Adults, Proposition 204 Childless Adults, and 3) SSI without Medicare. Only members with at least six months of experience in the base period and at least one month of experience in the projection period were used in the calibration. Each member's contribution to the regression model, and therefore the risk weights, was weighted according to the number of months that member was enrolled during the prospective period. The AHCCCS risk adjustment model weights were based on statewide data.

Risk scores calculated during the experience period will follow the individual during the rating period.

A credibility adjustment was applied to the CYE 22 risk adjustment factors, where applicable. To be fully credible a Contractor had to have greater than 500 members during the experience period (January 2019 through December 2019). For any rate cell that is not fully credible, the risk factor is set to 1.00.

I.6.B.i.(c) Relative Risk Factor Methodology

The risk adjustment method described below is reasonable and appropriate in measuring the risk factors of the respective population.

The only two rate cells that will not be risk adjusted are Duals and Delivery Supplemental Payments.

Risk Adjustment for All Rate Cells, except AGE < 1

Only members with at least six months of enrollment during the experience period ('long' cohort) are given an encounters-based risk adjustment factor (average State Specific risk score). Members with less than six months of enrollment during the experience period ('short' cohort) are given a risk factor that is equal to 50% of their pure age and gender factor plus 50% of an adjusted plan factor. The adjusted plan factor is calculated by taking the average Contractor Specific risk score of the long cohort and dividing by the pure age and gender factor of the long cohort (relative health factor) and then multiplying by the pure age and gender factor of the short cohort. The weighted average of the long cohort and the short cohort results in the average risk score for each Contractor, which is then divided by the GSA average risk score to calculate the relative risk score. The relative risk score is adjusted for budget neutrality to calculate the risk score used to adjust the capitation rates.

I.6.B.i.(d) Magnitude of Adjustment by MCO

The magnitude of risk adjustment on the CYE 22 capitation rates is displayed by Contractor below in Table 12. These values may change whenever risk adjustment is updated.

Table 12: Magnitude of Risk Adjustment

Contractor	Magnitude of Risk Adjustment
Arizona Complete Health - Complete Care Plan	-3.27%
Banner - University Family Care	-0.63%
Care 1st Health Plan Arizona, Inc.	1.65%
Molina Healthcare of Arizona, Inc.	-1.28%
Mercy Care	3.60%
Health Choice Arizona, Inc.	-1.83%
UnitedHealthcare Community Plan	0.79%

I.6.B.i.(e) Predictive Value Assessment

Wakely Consulting Group used R-squared statistic and cohort-based predictive ratios to evaluate the predictive value of the model. The R-squared and predictive ratio statistics calculated during the model calibration process by population are shown below.

Table 13: R-Squared Results

Rate Cell Grouping	R-Squared
Age 1-20	0.1645
Adults	0.2787
SSIWO	0.2425

Table 14: Predictive Ratios for Select Cohorts

Cohort	Age 1-20	Adults	SSIWO
Ages 1-4	100%	100%	100%
Females, Age 5-14	100%	N/A	97%
Males, Age 5-14	100%	N/A	97%
Females, Age 15-24	100%	N/A	97%
Males, Age 15-24	100%	103%	107%
Females, Age 25-44	100%	103%	101%
Males, Age 25-44	N/A	102%	103%
Females, Age 45-64	N/A	101%	100%
Males, Age 45-64	N/A	98%	99%
Ages 65 and over	N/A	98%	98%
Housing Problems	N/A	115%	108%
Parent Problems	99%	100%	97%
Family Problems	99%	100%	96%
Criminal Problems	99%	100%	94%
CRS	99%	101%	98%
Socially Vulnerable Geo Area	100%	100%	99%
PPC	100%	100%	101%

The R-squared statistics presented above are considered in the upper range for such types of models consistent with similar models in the industry[2] for the specific populations in question. These R-squared statistics and predictive ratios are unchanged from the CYE 21 capitation rates since the risk adjustment model has not been re-calibrated. The Adults rate cell grouping includes the following rate cells: Age 21+, Prop 204 Childless Adults, and Expansion Adults.

[2] For comparable statistics of other risk adjustment models in the industry, please refer to the Society of Actuaries 2016 research report titled "Accuracy of Claims-Based Risk Scoring Models ", Table 4.2.2: R-Squared and MAE, Prospective Models, available at: https://www.soa.org/globalassets/assets/Files/Research/research-2016-accuracy-claims-based-risk-scoring-models.pdf

I.6.B.i.(f) Actuarial Concerns

The actuaries have no concerns with the risk adjustment process.

I.6.B.ii. Retrospective Risk Adjustment

I.6.B.ii.(a) The Party Calculating

Wakely Consulting Group developed and produced the AHCCCS risk adjustment model for the AGE < 1 rate cell.

I.6.B.ii.(b) Data and Data Adjustments

Encounter and member data are used for the risk adjustment factors. AHCCCS regularly performs testing on encounters to identify any potential areas of concern. If AHCCCS identifies any encounter gaps, AHCCCS contacts the Contractor and works with them to improve encounter submissions. AHCCCS monitors the encounters by reviewing encounter data by date of service and form type to identify potential issues. The results of these analyses assist in determining if any encounter data is deemed unusable for the risk adjustment process and if any adjustments to the encounter data are required.

I.6.B.ii.(c) Model and Model Adjustments

Risk adjustment for AGE < 1 rate cell (newborns) is necessarily different than risk adjustment for other rate cells. Instead of an individual approach where risk adjustment factors follow individual members, an aggregate, concurrent approach is used. This approach assumes that historic relationships in newborn risk will continue into the future. While the specific newborns in any Contractor will change from the experience period to the rating period, this approach assumes that Contractors attract newborns with a consistent health status mix.

Based on encounter data provided by AHCCCS to Wakely Consulting Group for the newborn Medicaid populations, a series of conditions that resulted in material variations among newborns due to the frequency, cost, and nature of those conditions were identified. This analysis resulted in 11 general risk marker categories that are used to differentiate the health status and therefore risk of newborns. Calibration of the weights for the 11 selected newborn risk markers is based on a concurrent, rather than prospective, methodology.

Newborns with sufficient experience are identified during the experience period (January 1, 2019 through December 31, 2019). Sufficient experience is defined as being born in the experience period, with at least three months of enrollment during the experience period or enrolled at the time of death. Newborns with sufficient experience are assigned a risk score.

Newborns not meeting the enrollment criteria described above are assigned 50% of the average risk adjustment for those meeting the eligibility criteria and 50% of the average for that GSA. Each Contractor's risk score for newborns within a GSA is calculated as the weighted average of the risk scores for newborns who met the above eligibility criteria during the experience period and those who did not to develop the relative risk score. The relative risk score is adjusted for budget neutrality to calculate the risk score used to adjust the capitation rates.

I.6.B.ii.(d) Timing and Frequency

The CYE 22 capitation rates have risk adjustment factors applied to them. AHCCCS intends to rerun the risk adjustment model with an updated snapshot period to determine whether there is a material impact to results after member choice due to the merger of Centene and WellCare in the central GSA. AHCCCS may adjust the capitation rates for the change in risk adjustment. If AHCCCS updates the capitation rates only for a risk adjustment update, AHCCCS does not intend to submit a revised rate certification as referenced in § 438.7(b)(5)(iii) since the documentation below describes the risk adjustment process. A new contract with the revised capitation rates will be submitted as required under § 438.7(b)(5)(iii).

I.6.B.ii.(e) Actuarial Concerns

The actuaries have no concerns with the risk adjustment process.

I.6.B.iii. Additional Items on Risk Adjustment

I.6.B.iii.(a) Model Changes Since Last Rating Period

The model assumptions and methodology have not changed from the last rating period. The only change is to the data for the updated experience and snapshot period.

I.6.B.iii.(b) Budget Neutrality

The model is budget neutral in accordance with 42 CFR §438.5(g). The budget neutrality adjustment is the last step to calculate the final risk adjustment factor. To calculate the final risk adjustment factor, the relative risk score is divided by the budget neutrality adjustment. The budget neutrality adjustment is calculated by taking the rating period capitation rates before risk adjustment times the rating period member months and dividing by the rating period capitation rates times the relative risk score times the rating period member months.

I.6.B.iv. Acuity Adjustment Description – Not Applicable

Not applicable. The CYE 22 capitation rates for the ACC Program do not include an acuity adjustment.

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

Section II of the 2022 Medicaid Managed Care Rate Development Guide is not applicable to the ACC Program. Managed long-term services and supports, as defined at 42 CFR § 438.2(a), are not covered services under the ACC Program. The ACC 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 2022 Medicaid Managed Care Rate Development Guide is applicable to the ACC Program.

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

The ACC Program capitation rates include separate rate cells for the Adult Expansion and Childless Adult Restoration populations, which are labeled throughout this certification as “Prop 204 Childless Adults” (formerly Adults <=106% FPL”) and “Adult Expansion ” (formerly Adults > 106% FPL) respectively. The capitation rates for these rate cells are developed the same way as the rates for the other rate cells. The new adult group represents approximately 43.5% of expenditures for the ACC Program. See Section I for the rate development of the ACC Program capitation rates. The rate cells that make up the new adult group have been treated the same as any other ACC Program rate cell.

III.1. Data

III.1.A. Description of Data for Rate Development

The CYE 22 capitation rates for the new adult group rely on the same types and sources of data used for the other rate cells and described in Section I.2.

III.1.B. Documentation

III.1.B.i. New Data

All data related to the CYE 22 capitation rates for the ACC Program is described in Section I.2.

III.1.B.ii. Monitoring of Costs and Experience

The AHCCCS DHCM Actuarial Team, along with the AHCCCS DHCM Finance & Reinsurance Team, monitors the costs and experience for all rate cells for the ACC Program. AHCCCS did not develop plans to monitor costs and experience specifically for the new adult group beyond the monitoring done for all rate cells of the ACC Program.

III.1.B.iii. Actual Experience vs. Projected Experience

AHCCCS Complete Care is an integrated care program entering its fourth year for CYE 22. Table 15 below is the same as shown in the CYE 21 ACC capitation rate certification, because the base encounter data for CYE 22 capitation rate is CalYr19, and capitation rates are set on a FFY basis rather than a calendar year basis, so the comparison between CYE 19 capitation rates and CYE 19 medical experience is still appropriate for this purpose.

Table 15: Projected and Actual Gross Medical Expense (GME) PMPM for CYE 19

GSA	Rate Cell	Projected GME in CYE 19 Cap Rates	Actual CYE 19 GME from Completed Encounter Data	Percentage Impact
North	Prop 204 Childless Adults	$528.49	$506.38	-4.18%
North	Expansion Adults	$377.46	$390.32	3.41%
Central	Prop 204 Childless Adults	$622.87	$604.79	-2.90%
Central	Expansion Adults	$388.02	$400.33	3.17%
South	Prop 204 Childless Adults	$512.69	$518.68	1.17%
South	Expansion Adults	$345.70	$362.62	4.90%

III.1.B.iv. Adjustments Based Upon Actual Experience vs. Projected Experience

As described throughout Section I, the CYE 22 capitation rates were developed as a rebase using CalYr19 as the starting point for projections to CYE 22. No specific adjustments were made to the CYE 22 capitation rates for the ACC Program, or the new adult group in particular, to reflect differences between projected and actual experience from previous rating periods of the ACC Program. Due to the

rebase, differences between projected and actual experience for the new adult group, and all rate cells within the ACC Program, are implicitly adjusted for in CYE 22 rate development as CalYr19 actual experience is used as the base data for the capitation rates, and adjusted as described in Section I.

III.2. Projected Benefit Costs

III.2.A. Description of Projected Benefit Costs

III.2.A.i. Documentation if State Previously Covered the New Adult Group

III.2.A.i.(a) Previous Data and Experience Used

The projected benefit costs for the CYE 22 capitation rates for the ACC Program are described in Section I.3. The capitation rates for each rate cell were developed using the CalYr19 encounter data specific to each rate cell as the base. Only data specific to the new adult group rate cells was used to develop the rates for the new adult group rate cells.

III.2.A.i.(b) Changes in Data Sources, Assumptions, and Methodologies

The projected benefit costs for the CYE 22 capitation rates for the ACC Program are described in Section I.3. The data and assumptions for each rate cell were specific to each rate cell and the same methodology was used to develop projected benefit costs for each rate cell. Any changes in data sources, assumptions or methodologies have already been addressed in Section I.

III.2.A.i.(c) Change in Key Assumptions

There are no changes in key assumptions since the last rating period. All variations in assumptions used to develop the projected benefit costs for all covered populations are based upon valid capitation rate development standards and not based on the rate of federal financial participation for any covered population. There were no adjustments made for acuity, pent-up demand, adverse selection, or for the demographics of the new adult group. The AHCCCS fee schedule does not include any differences based on rate cell. All changes or adjustments, including any changes to the new adult group, for programmatic and fee schedule changes in the base data period through the rating period have been addressed above in Section I, as the new adult group rate cells are not treated any differently in rate development than any other rate cells.

III.2.A.ii. Documentation if State Did Not Previously Cover the New Adult Group – Not Applicable

Not applicable. The new adult group was covered in previous rate setting periods.

III.2.A.iii. Key Assumptions

The CYE 22 capitation rates for the ACC Program used a base data time period of CalYr19. This time period has 12 months of actual experience for the new adult group. Additionally, the CalYr19 time period is 60 months past the effective date of the Adult Expansion population. The CYE 22 capitation rates for the ACC Program do not include any of the following adjustments to specifically address the new adult group population: acuity or health status, pent-up demand, adverse selection, demographics, provider reimbursement rates, or any other material adjustments to specifically address the new adult group population.

III.2.B. Any Other Material Changes

Any other material changes or adjustments to projected benefit costs are described in Section I.3.

III.3. Projected Non-Benefit Costs

III.3.A. Description of Issues

III.3.A.i. Changes in Data Sources, Assumptions, Methodologies

The development of the projected non-benefit costs, including any changes in data, assumptions, or methodologies since the last rate certification, for the CYE 22 capitation rates for the ACC Program, including the new adult group, are described in Section I.5.

III.3.A.ii. Changes in Assumptions from Previous Rating Period

AHCCCS Complete Care is an integrated care program entering its third year for CYE 22. No changes in assumptions were made to the new adult group for any item in this section, except those changes in assumptions made to all rate cells, as described above in Section I.5.

III.3.B. Differences between Populations – Not Applicable

Not applicable. There are no differences in administrative costs assumptions, care coordination and care management assumptions, UW gain assumptions, or premium tax assumptions between populations for the CYE 22 capitation rates for the ACC Program. There are no other material non-benefit costs to specifically address the new adult group population.

III.4. Final Certified Rates

III.4.A. Documentation

III.4.A.i. Comparison of Rates

The comparison to certified rates from the previous rating period are shown in Appendix 3.

III.4.A.ii. Description of Material Changes

There are no other material changes to specifically address the new adult group population in the CYE 22 capitation rates for the ACC Program.

III.5. Risk Mitigation Strategies

III.5.A. New Adult Rates Risk Mitigation

Risk mitigation strategies for new adult group population are the same as all other rate cells. There are no risk mitigation strategies specific to the new adult group population.

III.5.B. Documentation

As noted in Section I.4.C.ii.(a)(ii), there has been one change to the risk mitigation strategies for CYE 22, for all populations, including the new adult group population, from the previous rating period. The change is a periodic cost-settlement for the expenses associated with the administration of the COVID-19 vaccines; projected expenses for COVID-19 vaccine administration are not included in the CYE 22 capitation rates for any risk group.

Appendix 1: Actuarial Certification

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

The capitation rates included with this rate certification are considered actuarially sound according to the following criteria from 42 CFR § 438.4(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 22 capitation rates for the ACC Program have been documented according to the guidelines established by CMS in the 2022 Guide. The CYE 22 capitation rates for the ACC Program are effective for the 12-month time period from October 1, 2021 through September 30, 2022.

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, the Acute Care Contractors, the CRS Contractor and the RBHA 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	August 11, 2021
Windy J. Marks	Date
Fellow, Society of Actuaries	
Member, American Academy of Actuaries	

SIGNATURE ON FILE	August 11, 2021
Erica Johnson	Date
Associate, Society of Actuaries	
Member, American Academy of Actuaries	

Appendix 2: Certified Capitation Rates

GSA	Contractor	AGE < 1	AGE 1-20	AGE 21+	Duals	SSIWO	Prop 204 Childless Adults	Expansion Adults	Delivery Supplemental Payments
North	Care1st Health Plan Arizona, Inc.	$641.41	$218.81	$377.11	$141.73	$1,200.85	$631.92	$541.38	$6,612.14
North	Health Choice Arizona, Inc.	$682.72	$205.96	$362.88	$132.81	$1,184.87	$611.85	$509.30	$6,612.14
Central	Arizona Complete Health - Complete Care Plan	$649.50	$206.03	$408.97	$153.30	$1,224.72	$699.49	$500.05	$6,442.76
Central	Banner - University Family Care	$643.86	$211.19	$408.89	$149.10	$1,260.17	$690.71	$501.65	$6,442.76
Central	Molina Healthcare of Arizona, Inc.	$708.67	$236.00	$396.72	$176.43	$1,350.86	$756.92	$511.66	$6,442.76
Central	Mercy Care	$674.46	$210.05	$450.09	$147.15	$1,449.16	$772.95	$528.12	$6,442.76
Central	Health Choice Arizona, Inc.	$673.70	$207.67	$417.98	$152.17	$1,280.26	$701.09	$500.28	$6,442.76
Central	UnitedHealthcare Community Plan	$664.31	$211.81	$430.56	$147.96	$1,336.38	$711.68	$511.02	$6,442.76
South	Arizona Complete Health - Complete Care Plan	$686.32	$215.11	$376.73	$149.53	$1,284.67	$615.24	$440.87	$6,730.21
South	Banner - University Family Care	$684.42	$214.34	$378.56	$145.74	$1,286.49	$622.82	$455.10	$6,730.21
South	UnitedHealthcare Community Plan (Pima Only)	$680.50	$227.63	$405.35	$143.85	$1,373.10	$632.45	$462.60	$6,730.21

Appendix 3: Fiscal Impact Summary

GSA	Rate Cell	CYE 22 Projected MMs	Weighted CYE 21 Cap Rate	CYE 21 Projected Expenditures	Weighted CYE 22 Cap Rate	CYE 22 Projected Expenditures	Percentage Impact
North	AGE < 1	41,134	$606.70	$24,956,126	$665.67	$27,381,805	9.72%
North	AGE 1-20	769,277	$206.38	$158,764,762	$211.77	$162,907,910	2.61%
North	AGE 21+	344,162	$357.04	$122,878,574	$369.03	$127,007,416	3.36%
North	Duals	188,314	$121.13	$22,810,248	$137.37	$25,868,480	13.41%
North	SSIWO	71,990	$1,176.28	$84,679,670	$1,192.27	$85,830,945	1.36%
North	Prop 204 Childless Adults	473,645	$600.27	$284,316,512	$620.73	$294,004,178	3.41%
North	Expansion Adults	176,789	$481.88	$85,190,655	$523.64	$92,574,249	8.67%
North	Delivery Supplemental Payments	2,866	$6,427.53	$18,421,304	$6,612.14	$18,950,384	2.87%
North	**Total** [1,2]	2,065,310		$802,017,851		$834,525,366	4.05%
Central	AGE < 1	335,447	$617.59	$207,168,194	$666.69	$223,640,658	7.95%
Central	AGE 1-20	6,103,801	$199.64	$1,218,578,283	$210.35	$1,283,956,514	5.37%
Central	AGE 21+	2,266,255	$416.26	$943,352,656	$428.92	$972,041,027	3.04%
Central	Duals	866,512	$137.78	$119,391,261	$149.90	$129,893,957	8.80%
Central	SSIWO	422,320	$1,306.83	$551,898,615	$1,338.66	$565,344,167	2.44%
Central	Prop 204 Childless Adults	2,734,101	$713.45	$1,950,650,801	$726.45	$1,986,181,251	1.82%
Central	Expansion Adults	1,100,558	$493.04	$542,619,742	$512.47	$564,007,610	3.94%
Central	Delivery Supplemental Payments	21,174	$6,389.96	$135,301,002	$6,442.76	$136,418,977	0.83%
Central	**Total** [1,2]	13,828,994		$5,668,960,554		$5,861,484,161	3.40%
South	AGE < 1	106,387	$626.07	$66,605,914	$684.02	$72,770,827	9.26%
South	AGE 1-20	1,986,869	$210.30	$417,834,342	$218.15	$433,438,216	3.73%
South	AGE 21+	895,825	$375.95	$336,783,389	$385.06	$344,944,684	2.42%
South	Duals	494,365	$135.87	$67,168,698	$146.47	$72,410,320	7.80%
South	SSIWO	178,733	$1,256.98	$224,663,510	$1,309.38	$234,029,059	4.17%
South	Prop 204 Childless Adults	1,088,062	$615.43	$669,621,609	$623.06	$677,926,482	1.24%
South	Expansion Adults	463,732	$441.39	$204,685,901	$452.60	$209,884,972	2.54%
South	Delivery Supplemental Payments	7,604	$6,752.89	$51,348,956	$6,730.21	$51,176,489	-0.34%
South	**Total** [1,2]	5,213,974		$2,038,712,320		$2,096,581,049	2.84%
Total	AGE < 1	482,969	$618.53	$298,730,234	$670.42	$323,793,290	8.39%
Total	AGE 1-20	8,859,947	$202.62	$1,795,177,386	$212.23	$1,880,302,640	4.74%
Total	AGE 21+	3,506,241	$400.15	$1,403,014,619	$411.84	$1,443,993,127	2.92%
Total	Duals	1,549,191	$135.15	$209,370,207	$147.29	$228,172,756	8.98%
Total	SSIWO	673,042	$1,279.62	$861,241,795	$1,315.23	$885,204,170	2.78%
Total	Prop 204 Childless Adults	4,295,809	$676.14	$2,904,588,922	$688.60	$2,958,111,910	1.84%
Total	Expansion Adults	1,741,079	$478.15	$832,496,298	$497.66	$866,466,831	4.08%
Total	Delivery Supplemental Payments	31,644	$6,480.57	$205,071,262	$6,527.17	$206,545,851	0.72%
Total	**Total** [1,2]	21,108,279		$8,509,690,725		$8,792,590,575	3.32%

1) Total Projected MMs doesn't include delivery supplemental payment members
2) Totals may not add up due to rounding

Appendix 4: Base Data and Base Data Adjustments

GSA: North
Rate Cell: AGE < 1
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 44,965
Projection Period Member Months: 41,134

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$363.21	0.9673	1.0000	$375.51	0.00%	-2.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$364.66
Behavioral Health Inpatient and LTC	$0.05	0.9476	1.0000	$0.05	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.05
Physical Health Physician	$103.93	0.9904	1.0000	$104.94	0.00%	0.00%	-7.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$97.58
Behavioral Health Physician	$0.41	0.9884	1.0000	$0.41	0.00%	-0.57%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.41
Transportation	$25.26	0.9897	1.0000	$25.52	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$25.52
Other Professional Services	$31.84	0.9898	1.0000	$32.16	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$32.17
Pharmacy	$6.38	0.9994	1.0000	$6.39	0.00%	0.00%	0.00%	-0.92%	-1.83%	0.00%	-0.06%	0.00%	0.00%	0.00%	0.00%	$6.21
Outpatient Facility	$14.83	0.9959	1.0000	$14.89	0.00%	-9.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.55
Emergency Facility	$24.63	0.9956	1.0000	$24.74	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$24.74
Laboratory and Radiology Services	$5.44	0.9906	1.0000	$5.49	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$5.49
Dental	$0.31	0.9875	1.0000	$0.31	0.00%	-0.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.31
FQHC	$19.86	0.9899	1.0000	$20.06	0.00%	-0.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$19.95
Gross Medical	**$596.15**			**$610.48**												**$590.64**

GSA: North
Rate Cell: AGE 1-20
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 706,270
Projection Period Member Months: 769,277

	Base Data																
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$12.25	0.9668	1.0000	$12.67	0.00%	-3.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$12.20
Behavioral Health Inpatient and LTC	$8.91	0.9633	1.0000	$9.25	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$9.25
Physical Health Physician	$17.36	0.9898	1.0000	$17.54	0.00%	-0.01%	-5.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$16.56
Behavioral Health Physician	$24.62	0.9898	1.0000	$24.88	0.00%	-0.08%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.11%	0.00%	0.00%	0.00%	$24.83
Transportation	$7.60	0.9896	1.0000	$7.68	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$7.68
Other Professional Services	$18.36	0.9897	1.0000	$18.55	-1.48%	-0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.96%	0.00%	0.00%	0.00%	$18.44
Pharmacy	$19.68	0.9995	1.0000	$19.69	0.00%	0.00%	0.00%	-1.84%	-1.83%	0.00%	10.91%	0.00%	0.00%	0.00%	0.00%	$21.04
Outpatient Facility	$9.37	0.9955	1.0000	$9.41	0.00%	-7.86%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	$8.67
Emergency Facility	$13.57	0.9954	1.0000	$13.63	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.63
Laboratory and Radiology Services	$2.59	0.9903	1.0000	$2.61	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.61
Dental	$18.22	0.9899	1.0000	$18.40	0.00%	-0.11%	-0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$18.38
FQHC	$6.77	0.9897	1.0000	$6.84	0.00%	-0.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$6.80
Gross Medical	**$159.29**			**$161.15**												**$160.10**

GSA: North
Rate Cell: AGE 21+
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 319,702
Projection Period Member Months: 344,162

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$36.41	0.9641	1.0000	$37.76	0.00%	-4.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.42%	-0.14%	0.00%	$36.30
Behavioral Health Inpatient and LTC	$4.76	0.9633	1.0000	$4.94	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.49%	0.00%	0.00%	0.00%	$4.87
Physical Health Physician	$40.55	0.9899	1.0000	$40.96	0.00%	0.00%	-0.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$40.59
Behavioral Health Physician	$15.62	0.9888	1.0000	$15.80	0.00%	-0.12%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.17%	0.00%	0.00%	0.00%	$15.75
Transportation	$14.21	0.9899	1.0000	$14.36	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.36
Other Professional Services	$20.54	0.9898	1.0000	$20.75	-2.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.13%	0.00%	0.00%	-0.07%	$20.20
Pharmacy	$61.05	0.9995	1.0000	$61.08	0.00%	0.00%	0.00%	-3.08%	-1.83%	0.00%	0.18%	0.00%	0.00%	0.00%	0.00%	$58.22
Outpatient Facility	$37.00	0.9956	1.0000	$37.17	0.00%	-5.81%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$35.01
Emergency Facility	$33.23	0.9956	1.0000	$33.38	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$33.38
Laboratory and Radiology Services	$14.23	0.9902	1.0000	$14.37	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.31%	0.00%	0.00%	0.00%	$14.41
Dental	$1.29	0.9899	1.0000	$1.30	0.00%	-0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.30
FQHC	$11.71	0.9899	1.0000	$11.83	0.00%	-0.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$11.77
Gross Medical	**$290.59**			**$293.69**												**$286.16**

GSA: North
Rate Cell: Duals
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 156,608
Projection Period Member Months: 188,314

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$12.50	0.9659	1.0000	$12.95	0.00%	-2.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.00%	-0.22%	0.00%	$12.77
Behavioral Health Inpatient and LTC	$1.94	0.9635	1.0000	$2.02	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.35%	0.00%	0.00%	0.00%	$2.01
Physical Health Physician	$17.36	0.9909	1.0000	$17.52	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$17.52
Behavioral Health Physician	$11.52	0.9902	1.0000	$11.64	0.00%	-0.15%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.20%	0.00%	0.00%	0.00%	$11.60
Transportation	$15.87	0.9896	1.0000	$16.03	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$16.03
Other Professional Services	$9.35	0.9904	1.0000	$9.44	-8.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.25%	0.00%	0.00%	-0.01%	$8.63
Pharmacy	$2.81	0.9995	1.0000	$2.82	0.00%	0.00%	0.00%	0.00%	-1.83%	0.00%	0.14%	0.00%	0.00%	0.00%	0.00%	$2.77
Outpatient Facility	$19.30	0.9955	1.0000	$19.39	0.00%	-3.83%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$18.64
Emergency Facility	$6.39	0.9957	1.0000	$6.42	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$6.42
Laboratory and Radiology Services	$3.25	0.9907	1.0000	$3.28	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.21%	0.00%	0.00%	0.00%	$3.29
Dental	$0.66	0.9895	1.0000	$0.67	0.00%	-0.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.67
FQHC	$2.33	0.9907	1.0000	$2.35	0.00%	-0.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.34
Gross Medical	**$103.28**			**$104.51**												**$102.68**

GSA: North
Rate Cell: SSIWO
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 66,245
Projection Period Member Months: 71,990

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$199.17	0.9652	1.0000	$206.36	0.00%	-2.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.16%	-0.01%	0.00%	$201.10
Behavioral Health Inpatient and LTC	$18.19	0.9657	1.0000	$18.84	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.48%	0.00%	0.00%	0.00%	$18.75
Physical Health Physician	$115.51	0.9901	1.0000	$116.66	0.00%	-0.01%	-1.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$114.37
Behavioral Health Physician	$43.84	0.9901	1.0000	$44.28	0.00%	-0.11%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.11%	0.00%	0.00%	0.00%	$44.18
Transportation	$57.78	0.9899	1.0000	$58.38	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$58.38
Other Professional Services	$77.20	0.9906	1.0000	$77.94	-2.09%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	1.02%	0.00%	0.00%	-0.01%	$77.07
Pharmacy	$306.95	0.9995	1.0000	$307.10	0.00%	0.00%	0.00%	-2.59%	-1.83%	0.00%	1.22%	0.00%	0.00%	0.00%	0.00%	$297.27
Outpatient Facility	$120.58	0.9954	1.0000	$121.13	0.00%	-4.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$116.15
Emergency Facility	$54.46	0.9956	1.0000	$54.70	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$54.70
Laboratory and Radiology Services	$23.85	0.9904	1.0000	$24.08	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.34%	0.00%	0.00%	0.00%	$24.17
Dental	$4.25	0.9898	1.0000	$4.29	0.00%	-0.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$4.29
FQHC	$14.88	0.9899	1.0000	$15.03	0.00%	-0.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.95
Gross Medical	**$1,036.65**			**$1,048.78**												**$1,025.35**

GSA: North
Rate Cell: Prop 204 Childless Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 408,696
Projection Period Member Months: 473,645

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$96.01	0.9646	1.0000	$99.53	0.00%	-2.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.51%	-0.44%	0.00%	$96.82
Behavioral Health Inpatient and LTC	$17.49	0.9637	1.0000	$18.15	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.67%	0.00%	0.00%	0.00%	$17.84
Physical Health Physician	$61.53	0.9899	1.0000	$62.16	0.00%	0.00%	-0.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$61.55
Behavioral Health Physician	$34.10	0.9883	1.0000	$34.51	0.00%	-0.11%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.77%	0.00%	0.00%	0.00%	$34.20
Transportation	$31.84	0.9898	1.0000	$32.17	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$32.17
Other Professional Services	$34.82	0.9897	1.0000	$35.18	-6.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.15%	0.00%	0.00%	-0.46%	$32.69
Pharmacy	$104.53	0.9995	1.0000	$104.58	0.00%	0.00%	0.00%	-2.84%	-1.83%	0.00%	0.86%	0.00%	0.00%	0.00%	0.00%	$100.60
Outpatient Facility	$50.01	0.9955	1.0000	$50.24	0.00%	-5.41%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.03%	0.00%	0.00%	0.00%	$47.51
Emergency Facility	$40.25	0.9956	1.0000	$40.43	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$40.43
Laboratory and Radiology Services	$15.91	0.9900	1.0000	$16.07	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.43%	0.00%	0.00%	0.00%	$16.14
Dental	$1.88	0.9894	1.0000	$1.90	0.00%	-0.09%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.89
FQHC	$11.91	0.9901	1.0000	$12.03	0.00%	-0.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$11.97
Gross Medical	**$500.28**			**$506.94**												**$493.80**

GSA: North
Rate Cell: Expansion Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 102,079
Projection Period Member Months: 176,789

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$69.92	0.9609	1.0000	$72.76	0.00%	-2.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%	0.00%	0.00%	$70.92
Behavioral Health Inpatient and LTC	$6.33	0.9697	1.0000	$6.53	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.30%	0.00%	0.00%	0.00%	$6.38
Physical Health Physician	$60.02	0.9900	1.0000	$60.63	0.00%	0.00%	-0.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$60.23
Behavioral Health Physician	$12.91	0.9901	1.0000	$13.04	0.00%	-0.14%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.75%	0.00%	0.00%	0.00%	$12.92
Transportation	$14.03	0.9894	1.0000	$14.18	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.18
Other Professional Services	$26.81	0.9899	1.0000	$27.08	-2.35%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.10%	0.00%	0.00%	0.00%	$26.47
Pharmacy	$94.46	0.9995	1.0000	$94.51	0.00%	0.00%	0.00%	-2.63%	-1.83%	0.00%	3.89%	0.00%	0.00%	0.00%	0.00%	$93.85
Outpatient Facility	$59.80	0.9955	1.0000	$60.07	0.00%	-4.46%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.03%	0.00%	0.00%	0.00%	$57.37
Emergency Facility	$28.37	0.9957	1.0000	$28.50	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$28.50
Laboratory and Radiology Services	$15.48	0.9901	1.0000	$15.63	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.51%	0.00%	0.00%	0.00%	$15.71
Dental	$1.71	0.9898	1.0000	$1.73	0.00%	-0.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.73
FQHC	$12.51	0.9904	1.0000	$12.64	0.00%	-0.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$12.57
Gross Medical	**$402.35**			**$407.29**												**$400.83**

GSA: Central
Rate Cell: AGE < 1
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 380,638
Projection Period Member Months: 335,447

	Base Data																
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$304.47	0.9674	1.0000	$314.72	0.00%	-3.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$303.88
Behavioral Health Inpatient and LTC	$0.00	0.9548	1.0000	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Physical Health Physician	$114.84	0.9815	1.0000	$117.00	0.00%	-0.19%	-9.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$105.65
Behavioral Health Physician	$0.18	0.9811	1.0000	$0.18	0.00%	-0.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.18
Transportation	$6.12	0.9809	1.0000	$6.24	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$6.24
Other Professional Services	$29.48	0.9809	1.0000	$30.06	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$30.06
Pharmacy	$21.29	0.9996	1.0000	$21.30	0.00%	0.00%	0.00%	-1.65%	-3.35%	0.00%	-0.05%	0.00%	0.00%	0.00%	0.00%	$20.24
Outpatient Facility	$20.24	0.9746	1.0000	$20.76	0.00%	-8.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$18.94
Emergency Facility	$29.13	0.9724	1.0000	$29.95	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$29.95
Laboratory and Radiology Services	$6.13	0.9812	1.0000	$6.25	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$6.25
Dental	$0.30	0.9809	0.6923	$0.44	0.00%	-0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.44
FQHC	$35.57	0.9808	0.9991	$36.30	0.00%	-0.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$35.94
Gross Medical	**$567.75**			**$583.21**												**$557.77**

GSA: Central
Rate Cell: AGE 1-20
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 5,561,132
Projection Period Member Months: 6,103,801

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$15.46	0.9661	1.0000	$16.00	0.00%	-4.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$15.26
Behavioral Health Inpatient and LTC	$6.27	0.9659	1.0000	$6.49	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.29%	0.00%	0.00%	0.00%	$6.47
Physical Health Physician	$24.40	0.9811	1.0000	$24.87	0.00%	-0.26%	-9.36%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$22.48
Behavioral Health Physician	$17.84	0.9808	1.0000	$18.19	0.00%	-0.10%	0.00%	0.00%	0.00%	5.81%	0.00%	-0.17%	0.00%	0.00%	0.00%	$19.19
Transportation	$2.74	0.9806	1.0000	$2.80	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	$2.80
Other Professional Services	$18.13	0.9808	1.0000	$18.49	-2.18%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.81%	0.00%	0.00%	0.00%	$18.23
Pharmacy	$23.62	0.9998	1.0000	$23.63	0.00%	0.00%	0.00%	-3.35%	-3.35%	0.00%	4.38%	0.00%	0.00%	0.00%	0.00%	$23.03
Outpatient Facility	$11.72	0.9720	1.0000	$12.06	0.00%	-7.54%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.02%	0.00%	0.00%	0.00%	$11.15
Emergency Facility	$14.06	0.9714	1.0000	$14.47	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.47
Laboratory and Radiology Services	$3.25	0.9811	1.0000	$3.32	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3.32
Dental	$13.63	0.9810	0.8219	$16.91	0.00%	-0.10%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$16.89
FQHC	$9.36	0.9809	0.9933	$9.61	0.00%	-0.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$9.52
Gross Medical	**$160.49**			**$166.83**												**$162.81**

GSA: Central
Rate Cell: AGE 21+
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 2,035,882
Projection Period Member Months: 2,266,255

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$39.33	0.9660	1.0000	$40.72	0.00%	-5.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.90%	-0.26%	0.00%	$38.87
Behavioral Health Inpatient and LTC	$6.09	0.9669	1.0000	$6.30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.63%	0.00%	0.00%	0.00%	$6.26
Physical Health Physician	$59.99	0.9810	1.0000	$61.15	0.00%	-0.21%	-3.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$59.14
Behavioral Health Physician	$15.20	0.9805	1.0000	$15.50	0.00%	-0.03%	0.00%	0.00%	0.00%	0.06%	0.00%	-0.23%	0.00%	0.00%	0.00%	$15.47
Transportation	$7.96	0.9803	1.0000	$8.12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.03%	0.00%	0.00%	0.00%	$8.12
Other Professional Services	$27.16	0.9805	1.0000	$27.70	-2.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.08%	0.00%	0.00%	-0.05%	$26.93
Pharmacy	$73.75	0.9998	1.0000	$73.77	0.00%	0.00%	0.00%	-4.07%	-3.35%	0.00%	0.51%	0.00%	0.00%	0.00%	0.00%	$68.74
Outpatient Facility	$30.10	0.9715	1.0000	$30.98	0.00%	-6.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$28.89
Emergency Facility	$33.00	0.9715	1.0000	$33.97	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$33.97
Laboratory and Radiology Services	$26.02	0.9810	1.0000	$26.52	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.39%	0.00%	0.00%	0.00%	$26.63
Dental	$1.58	0.9805	0.8257	$1.95	0.00%	-0.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.95
FQHC	$14.93	0.9809	0.9993	$15.23	0.00%	-0.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$15.10
Gross Medical	**$335.11**			**$341.92**												**$330.07**

GSA: Central
Rate Cell: Duals
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 732,357
Projection Period Member Months: 866,512

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$19.13	0.9669	1.0000	$19.79	0.00%	-2.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.67%	-0.43%	0.00%	$19.50
Behavioral Health Inpatient and LTC	$1.99	0.9646	1.0000	$2.06	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.25%	0.00%	0.00%	0.00%	$2.02
Physical Health Physician	$27.99	0.9823	1.0000	$28.49	0.00%	-0.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$28.44
Behavioral Health Physician	$11.55	0.9807	1.0000	$11.78	0.00%	-0.04%	0.00%	0.00%	0.00%	0.16%	0.00%	-0.56%	0.00%	0.00%	0.00%	$11.73
Transportation	$13.97	0.9810	1.0000	$14.24	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.07%	0.00%	0.00%	0.00%	$14.23
Other Professional Services	$11.38	0.9813	1.0000	$11.60	-13.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.15%	0.00%	0.00%	-0.09%	$10.09
Pharmacy	$3.28	0.9998	1.0000	$3.28	0.00%	0.00%	0.00%	0.00%	-3.35%	0.00%	0.19%	0.00%	0.00%	0.00%	0.00%	$3.17
Outpatient Facility	$13.75	0.9717	1.0000	$14.15	0.00%	-3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	$13.65
Emergency Facility	$5.80	0.9717	1.0000	$5.97	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$5.97
Laboratory and Radiology Services	$8.09	0.9814	1.0000	$8.24	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.49%	0.00%	0.00%	0.00%	$8.28
Dental	$0.83	0.9785	0.8285	$1.02	0.00%	-0.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.02
FQHC	$3.00	0.9806	0.9990	$3.06	0.00%	-0.83%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3.04
Gross Medical	**$120.76**			**$123.69**												**$121.13**

GSA: Central
Rate Cell: SSIWO
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 390,780
Projection Period Member Months: 422,320

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$279.51	0.9675	1.0000	$288.91	0.00%	-3.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.22%	-0.29%	0.00%	$279.66
Behavioral Health Inpatient and LTC	$21.70	0.9667	1.0000	$22.45	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.74%	0.00%	0.00%	0.00%	$22.06
Physical Health Physician	$167.40	0.9811	1.0000	$170.63	0.00%	-0.21%	-5.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$161.43
Behavioral Health Physician	$44.69	0.9809	1.0000	$45.56	0.00%	-0.06%	0.00%	0.00%	0.00%	10.28%	0.00%	-0.40%	0.00%	0.00%	0.00%	$50.01
Transportation	$32.88	0.9807	1.0000	$33.53	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.03%	0.00%	0.00%	0.00%	$33.51
Other Professional Services	$84.52	0.9805	1.0000	$86.19	-3.51%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.68%	0.00%	0.00%	-0.26%	$83.51
Pharmacy	$334.37	0.9998	1.0000	$334.44	0.00%	0.00%	0.00%	-4.01%	-3.35%	0.00%	4.15%	0.00%	0.00%	0.00%	0.00%	$323.15
Outpatient Facility	$125.87	0.9721	1.0000	$129.49	0.00%	-4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$124.27
Emergency Facility	$49.10	0.9715	1.0000	$50.54	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$50.54
Laboratory and Radiology Services	$36.51	0.9808	1.0000	$37.23	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.33%	0.00%	0.00%	0.00%	$37.35
Dental	$4.41	0.9806	0.8316	$5.40	0.00%	-0.09%	-0.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$5.39
FQHC	$21.43	0.9813	0.9991	$21.86	0.00%	-0.81%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$21.68
Gross Medical	**$1,202.39**			**$1,226.23**												**$1,192.56**

GSA: Central
Rate Cell: Prop 204 Childless Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 2,153,877
Projection Period Member Months: 2,734,101

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$109.95	0.9664	1.0000	$113.77	0.00%	-3.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.56%	-1.55%	0.00%	$109.23
Behavioral Health Inpatient and LTC	$33.45	0.9658	1.0000	$34.64	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.86%	0.00%	0.00%	0.00%	$33.99
Physical Health Physician	$88.89	0.9808	1.0000	$90.63	0.00%	-0.21%	-3.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$87.67
Behavioral Health Physician	$37.43	0.9800	1.0000	$38.20	0.00%	-0.02%	0.00%	0.00%	0.00%	0.02%	0.00%	-1.32%	0.00%	0.00%	0.00%	$37.69
Transportation	$21.21	0.9802	1.0000	$21.64	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.05%	0.00%	0.00%	0.00%	$21.63
Other Professional Services	$47.07	0.9798	1.0000	$48.04	-9.60%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.14%	0.00%	0.00%	-0.70%	$43.19
Pharmacy	$133.47	0.9998	1.0000	$133.50	0.00%	0.00%	0.00%	-3.51%	-3.35%	0.00%	1.29%	0.00%	0.00%	0.00%	0.00%	$126.11
Outpatient Facility	$38.60	0.9717	1.0000	$39.73	0.00%	-6.52%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.07%	0.00%	0.00%	0.00%	$37.12
Emergency Facility	$40.18	0.9714	1.0000	$41.36	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$41.36
Laboratory and Radiology Services	$25.93	0.9807	1.0000	$26.44	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.38%	0.00%	0.00%	0.00%	$26.54
Dental	$2.25	0.9806	0.8284	$2.78	0.00%	-0.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.77
FQHC	$15.65	0.9808	0.9992	$15.96	0.00%	-0.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$15.84
Gross Medical	**$594.08**			**$606.68**												**$583.14**

GSA: Central
Rate Cell: Expansion Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 551,378
Projection Period Member Months: 1,100,558

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$54.85	0.9664	1.0000	$56.75	0.00%	-3.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.60%	-0.22%	0.00%	$54.95
Behavioral Health Inpatient and LTC	$6.43	0.9669	1.0000	$6.65	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.32%	0.00%	0.00%	0.00%	$6.56
Physical Health Physician	$74.10	0.9810	1.0000	$75.54	0.00%	-0.21%	-2.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$73.71
Behavioral Health Physician	$10.90	0.9805	1.0000	$11.12	0.00%	-0.04%	0.00%	0.00%	0.00%	0.08%	0.00%	-0.89%	0.00%	0.00%	0.00%	$11.03
Transportation	$7.11	0.9803	1.0000	$7.26	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.02%	0.00%	0.00%	0.00%	$7.25
Other Professional Services	$30.41	0.9806	1.0000	$31.01	-2.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.08%	0.00%	0.00%	-0.09%	$30.22
Pharmacy	$112.38	0.9998	1.0000	$112.40	0.00%	0.00%	0.00%	-3.41%	-3.35%	0.00%	2.28%	0.00%	0.00%	0.00%	0.00%	$107.33
Outpatient Facility	$38.15	0.9711	1.0000	$39.29	0.00%	-5.44%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.02%	0.00%	0.00%	0.00%	$37.14
Emergency Facility	$26.60	0.9714	1.0000	$27.38	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$27.38
Laboratory and Radiology Services	$23.68	0.9808	1.0000	$24.14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.56%	0.00%	0.00%	0.00%	$24.28
Dental	$2.10	0.9808	0.8403	$2.55	0.00%	-0.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.55
FQHC	$13.81	0.9810	0.9992	$14.09	0.00%	-0.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.97
Gross Medical	**$400.53**			**$408.18**												**$396.37**

GSA: South
Rate Cell: AGE < 1
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 123,004
Projection Period Member Months: 106,387

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$305.01	0.9565	1.0000	$318.87	0.00%	-3.57%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$307.50
Behavioral Health Inpatient and LTC	$0.00	0.9573	1.0000	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Physical Health Physician	$111.21	0.9823	1.0000	$113.21	0.00%	-0.38%	-17.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$92.64
Behavioral Health Physician	$0.33	0.9833	1.0000	$0.34	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.34
Transportation	$10.42	0.9816	1.0000	$10.61	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$10.61
Other Professional Services	$20.00	0.9817	1.0000	$20.37	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.12%	0.00%	0.00%	0.00%	$20.39
Pharmacy	$10.79	1.0000	1.0000	$10.79	0.00%	0.00%	0.00%	-4.59%	-3.39%	0.00%	0.10%	0.00%	0.00%	0.00%	0.00%	$9.95
Outpatient Facility	$11.90	0.9669	1.0000	$12.31	0.00%	-9.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$11.17
Emergency Facility	$18.36	0.9651	1.0000	$19.03	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$19.03
Laboratory and Radiology Services	$6.14	0.9818	1.0000	$6.26	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$6.26
Dental	$0.24	0.9824	0.8992	$0.27	0.00%	-0.17%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.27
FQHC	$83.94	0.9817	0.9964	$85.82	0.00%	-0.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$85.08
Gross Medical	**$578.34**			**$597.87**												**$563.24**

GSA: South
Rate Cell: AGE 1-20
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 1,861,328
Projection Period Member Months: 1,986,869

	Base Data																
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$11.53	0.9579	1.0000	$12.03	0.00%	-4.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$11.52
Behavioral Health Inpatient and LTC	$6.52	0.9579	1.0000	$6.80	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.23%	0.00%	0.00%	0.00%	$6.79
Physical Health Physician	$18.31	0.9821	1.0000	$18.65	0.00%	-0.76%	-11.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$16.29
Behavioral Health Physician	$20.40	0.9815	1.0000	$20.78	0.00%	-0.01%	0.00%	0.00%	0.00%	1.71%	0.00%	-0.16%	0.00%	0.00%	0.00%	$21.10
Transportation	$4.28	0.9813	1.0000	$4.36	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$4.36
Other Professional Services	$18.41	0.9811	1.0000	$18.76	-4.11%	-0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.95%	0.00%	0.00%	0.00%	$18.16
Pharmacy	$23.21	1.0000	1.0000	$23.21	0.00%	0.00%	0.00%	-3.89%	-3.39%	0.00%	3.84%	0.00%	0.00%	0.00%	0.00%	$22.38
Outpatient Facility	$9.18	0.9647	1.0000	$9.52	0.00%	-7.58%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.03%	0.00%	0.00%	0.00%	$8.80
Emergency Facility	$10.85	0.9643	1.0000	$11.26	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$11.26
Laboratory and Radiology Services	$3.03	0.9818	1.0000	$3.09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3.09
Dental	$12.40	0.9812	0.9293	$13.60	0.00%	-0.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.59
FQHC	$27.63	0.9813	0.9698	$29.03	0.00%	-0.72%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$28.82
Gross Medical	**$165.75**			**$171.10**												**$166.14**

GSA: South
Rate Cell: AGE 21+
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 846,622
Projection Period Member Months: 895,825

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$31.10	0.9575	1.0000	$32.48	0.00%	-5.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.67%	-0.21%	0.00%	$30.93
Behavioral Health Inpatient and LTC	$3.68	0.9595	1.0000	$3.84	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.21%	0.00%	0.00%	0.00%	$3.83
Physical Health Physician	$42.51	0.9819	1.0000	$43.29	0.00%	-0.69%	-11.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$37.92
Behavioral Health Physician	$16.78	0.9810	1.0000	$17.10	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.14%	0.00%	0.00%	0.00%	$17.08
Transportation	$8.43	0.9812	1.0000	$8.59	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	$8.59
Other Professional Services	$24.53	0.9814	1.0000	$24.99	-3.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.11%	0.00%	0.00%	-0.04%	$24.14
Pharmacy	$59.13	1.0000	1.0000	$59.13	0.00%	0.00%	0.00%	-3.59%	-3.39%	0.00%	0.39%	0.00%	0.00%	0.00%	0.00%	$55.29
Outpatient Facility	$35.58	0.9643	1.0000	$36.90	0.00%	-6.09%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	$34.65
Emergency Facility	$28.38	0.9641	1.0000	$29.43	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$29.43
Laboratory and Radiology Services	$20.90	0.9820	1.0000	$21.28	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.13%	0.00%	0.00%	0.00%	$21.31
Dental	$0.69	0.9803	0.9198	$0.77	0.00%	-0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.77
FQHC	$31.03	0.9813	0.9946	$31.79	0.00%	-0.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$31.55
Gross Medical	**$302.72**			**$309.59**												**$295.50**

GSA: South
Rate Cell: Duals
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 418,879
Projection Period Member Months: 494,365

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$14.12	0.9592	1.0000	$14.73	0.00%	-2.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.76%	-0.17%	0.00%	$14.59
Behavioral Health Inpatient and LTC	$1.29	0.9547	1.0000	$1.35	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.35
Physical Health Physician	$20.18	0.9836	1.0000	$20.52	0.00%	-0.57%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$20.40
Behavioral Health Physician	$11.99	0.9812	1.0000	$12.23	0.00%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.34%	0.00%	0.00%	0.00%	$12.18
Transportation	$18.53	0.9816	1.0000	$18.87	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	$18.87
Other Professional Services	$9.09	0.9827	1.0000	$9.25	-15.81%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.27%	0.00%	0.00%	-0.07%	$7.80
Pharmacy	$2.83	1.0000	1.0000	$2.83	0.00%	0.00%	0.00%	0.00%	-3.39%	0.00%	0.91%	0.00%	0.00%	0.00%	0.00%	$2.76
Outpatient Facility	$17.85	0.9647	1.0000	$18.50	0.00%	-3.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$17.86
Emergency Facility	$5.12	0.9636	1.0000	$5.31	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$5.31
Laboratory and Radiology Services	$4.23	0.9830	1.0000	$4.30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.24%	0.00%	0.00%	0.00%	$4.32
Dental	$0.65	0.9782	0.9508	$0.70	0.00%	-0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.70
FQHC	$9.06	0.9819	0.9937	$9.29	0.00%	-0.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$9.23
Gross Medical	**$114.94**			**$117.87**												**$115.37**

GSA: South
Rate Cell: SSIWO
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 159,330
Projection Period Member Months: 178,733

	Base Data																
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$229.22	0.9558	1.0000	$239.81	0.00%	-3.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.23%	0.00%	0.00%	$232.98
Behavioral Health Inpatient and LTC	$18.00	0.9559	1.0000	$18.83	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%	0.00%	0.00%	0.00%	$18.74
Physical Health Physician	$135.71	0.9819	1.0000	$138.21	0.00%	-0.50%	-9.16%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$124.93
Behavioral Health Physician	$50.27	0.9807	1.0000	$51.26	0.00%	-0.01%	0.00%	0.00%	0.00%	7.57%	0.00%	-0.25%	0.00%	0.00%	0.00%	$55.00
Transportation	$46.32	0.9815	1.0000	$47.19	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	$47.19
Other Professional Services	$90.11	0.9811	1.0000	$91.85	-4.53%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.31%	0.00%	0.00%	0.00%	$87.94
Pharmacy	$313.06	1.0000	1.0000	$313.07	0.00%	0.00%	0.00%	-3.48%	-3.39%	0.00%	0.86%	0.00%	0.00%	0.00%	0.00%	$294.43
Outpatient Facility	$132.16	0.9633	1.0000	$137.20	0.00%	-4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$131.67
Emergency Facility	$45.56	0.9641	1.0000	$47.26	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$47.26
Laboratory and Radiology Services	$31.71	0.9819	1.0000	$32.30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.09%	0.00%	0.00%	0.00%	$32.33
Dental	$3.13	0.9811	0.9180	$3.47	0.00%	-0.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3.47
FQHC	$42.18	0.9813	0.9925	$43.31	0.00%	-0.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$43.00
Gross Medical	**$1,137.43**			**$1,163.75**												**$1,118.92**

GSA: South
Rate Cell: Prop 204 Childless Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 915,641
Projection Period Member Months: 1,088,062

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$84.99	0.9581	1.0000	$88.71	0.00%	-3.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.01%	-0.67%	0.00%	$85.85
Behavioral Health Inpatient and LTC	$21.28	0.9567	1.0000	$22.24	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.12%	0.00%	0.00%	0.00%	$21.99
Physical Health Physician	$61.47	0.9819	1.0000	$62.60	0.00%	-0.48%	-9.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$56.65
Behavioral Health Physician	$41.95	0.9805	1.0000	$42.78	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.56%	0.00%	0.00%	0.00%	$42.54
Transportation	$21.67	0.9810	1.0000	$22.09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	0.00%	0.00%	0.00%	$22.08
Other Professional Services	$46.20	0.9808	1.0000	$47.10	-9.94%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.17%	0.00%	0.00%	-0.19%	$42.41
Pharmacy	$99.02	1.0000	1.0000	$99.02	0.00%	0.00%	0.00%	-3.39%	-3.39%	0.00%	0.53%	0.00%	0.00%	0.00%	0.00%	$92.91
Outpatient Facility	$45.31	0.9636	1.0000	$47.02	0.00%	-5.79%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.04%	0.00%	0.00%	0.00%	$44.28
Emergency Facility	$32.71	0.9638	1.0000	$33.94	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$33.94
Laboratory and Radiology Services	$20.48	0.9816	1.0000	$20.87	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.13%	0.00%	0.00%	0.00%	$20.89
Dental	$1.36	0.9801	0.9189	$1.51	0.00%	-0.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.51
FQHC	$28.33	0.9813	0.9926	$29.09	0.00%	-0.75%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$28.87
Gross Medical	**$504.76**			**$516.97**												**$493.93**

GSA: South
Rate Cell: Expansion Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 260,539
Projection Period Member Months: 463,732

	Base Data															
Category of Service	PMPM	Completion	Encounter Issue	Adjusted PMPM	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
Inpatient and LTC	$47.89	0.9562	1.0000	$50.08	0.00%	-3.35%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.38%	0.00%	0.00%	$48.58
Behavioral Health Inpatient and LTC	$3.55	0.9588	1.0000	$3.71	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.21%	0.00%	0.00%	0.00%	$3.70
Physical Health Physician	$57.25	0.9822	1.0000	$58.29	0.00%	-0.50%	-7.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$53.83
Behavioral Health Physician	$11.79	0.9810	1.0000	$12.02	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.68%	0.00%	0.00%	0.00%	$11.94
Transportation	$7.40	0.9817	1.0000	$7.54	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$7.54
Other Professional Services	$24.04	0.9815	1.0000	$24.49	-3.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.09%	0.00%	0.00%	0.00%	$23.75
Pharmacy	$84.34	1.0000	1.0000	$84.34	0.00%	0.00%	0.00%	-3.46%	-3.39%	0.00%	0.74%	0.00%	0.00%	0.00%	0.00%	$79.24
Outpatient Facility	$46.26	0.9644	1.0000	$47.96	0.00%	-4.97%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.02%	0.00%	0.00%	0.00%	$45.57
Emergency Facility	$22.85	0.9647	1.0000	$23.69	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$23.69
Laboratory and Radiology Services	$19.58	0.9822	1.0000	$19.94	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%	0.00%	0.00%	0.00%	$19.97
Dental	$1.16	0.9809	0.9213	$1.28	0.00%	-0.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.28
FQHC	$29.61	0.9816	0.9944	$30.34	0.00%	-0.75%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$30.11
Gross Medical	**$355.72**			**$363.67**												**$349.20**

GSA: North
Rate Cell: Delivery Supplemental Payments
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 2,968
Projection Period Member Months: 2,866

	Base Data															
Category of Service	PMPD	Completion	Encounter Issue	Adjusted PMPD	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPD
Inpatient	$3,194.97	0.9641	1.0000	$3,313.78	0.00%	-0.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3,281.98
Physician	$1,546.66	0.9896	1.0000	$1,562.88	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1,562.88
Transportation	$147.65	0.9893	1.0000	$149.24	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$149.24
Other Professional Services	$161.82	0.9900	1.0000	$163.46	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$163.46
Pharmacy	$34.98	0.9996	1.0000	$35.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$35.00
Outpatient	$18.86	0.9951	1.0000	$18.95	0.00%	-0.34%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$18.88
Laboratory and Radiology Services	$32.67	0.9899	1.0000	$33.00	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$33.00
FQHC	$4.34	0.9900	1.0000	$4.39	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$4.39
Gross Medical	**$5,141.96**			**$5,280.70**												**$5,248.84**

GSA: Central
Rate Cell: Delivery Supplemental Payments
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 21,929
Projection Period Member Months: 21,174

	Base Data															
Category of Service	PMPD	Completion	Encounter Issue	Adjusted PMPD	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPD
Inpatient	$3,119.40	0.9662	1.0000	$3,228.52	0.00%	-0.91%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3,199.05
Physician	$1,633.16	0.9809	1.0000	$1,664.98	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1,664.98
Transportation	$32.23	0.9807	1.0000	$32.87	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$32.87
Other Professional Services	$94.03	0.9803	1.0000	$95.92	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$95.92
Pharmacy	$46.03	0.9999	1.0000	$46.04	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$46.04
Outpatient	$10.71	0.9701	1.0000	$11.04	0.00%	-0.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$10.98
Laboratory and Radiology Services	$25.62	0.9803	1.0000	$26.14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$26.14
FQHC	$3.78	0.9808	1.0000	$3.86	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3.86
Gross Medical	**$4,964.97**			**$5,109.36**												**$5,079.84**

GSA: South
Rate Cell: Delivery Supplemental Payments
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 7,875
Projection Period Member Months: 7,604

	Base Data															
Category of Service	PMPD	Completion	Encounter Issue	Adjusted PMPD	Crisis Removal	DAP Removal	APSI Removal	Pharmacy Reimb. Savings	PBM Admin Spread Removal	Applied Behavior Analysis	P & T Committee	Other Base Data Adjustments	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPD
Inpatient	$3,135.46	0.9568	1.0000	$3,277.09	0.00%	-0.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$3,245.15
Physician	$1,596.77	0.9818	1.0000	$1,626.32	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1,626.32
Transportation	$67.70	0.9806	1.0000	$69.05	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$69.05
Other Professional Services	$152.63	0.9817	1.0000	$155.48	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$155.48
Pharmacy	$36.91	1.0000	1.0000	$36.91	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$36.91
Outpatient	$24.84	0.9659	1.0000	$25.72	0.00%	-0.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$25.61
Laboratory and Radiology Services	$23.95	0.9837	1.0000	$24.35	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$24.35
FQHC	$9.02	0.9816	1.0000	$9.19	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$9.19
Gross Medical	**$5,047.28**			**$5,224.10**												**$5,192.04**

Appendix 5: Projected Benefit Cost Trends

North				
Risk Group	Trend COS	Utilization per 1000	Unit Cost	PMPM
AGE < 1	Inpatient and LTC	2.0%	0.5%	2.5%
AGE < 1	Physician	0.0%	2.5%	2.5%
AGE < 1	Transportation	0.5%	3.0%	3.5%
AGE < 1	Other Professional Services	2.0%	1.0%	3.0%
AGE < 1	Pharmacy	0.0%	3.0%	3.0%
AGE < 1	Outpatient	1.5%	0.5%	2.0%
AGE < 1	Lab and Radiology Services	1.0%	1.0%	2.0%
AGE < 1	Dental	1.0%	1.0%	2.0%
AGE < 1	FQHC	3.0%	0.0%	3.0%
AGE 1-20	Inpatient and LTC	3.5%	0.5%	4.0%
AGE 1-20	Physician	1.5%	0.0%	1.5%
AGE 1-20	Transportation	0.5%	3.0%	3.5%
AGE 1-20	Other Professional Services	4.5%	-0.5%	4.0%
AGE 1-20	Pharmacy	1.0%	4.0%	5.0%
AGE 1-20	Outpatient	2.0%	2.5%	4.6%
AGE 1-20	Lab and Radiology Services	1.0%	1.0%	2.0%
AGE 1-20	Dental	1.0%	1.0%	2.0%
AGE 1-20	FQHC	3.0%	0.0%	3.0%
AGE 21+	Inpatient and LTC	2.5%	1.0%	3.5%
AGE 21+	Physician	2.5%	0.5%	3.0%
AGE 21+	Transportation	0.5%	3.0%	3.5%
AGE 21+	Other Professional Services	1.5%	0.5%	2.0%
AGE 21+	Pharmacy	0.5%	6.0%	6.5%
AGE 21+	Outpatient	1.0%	1.0%	2.0%
AGE 21+	Lab and Radiology Services	1.0%	1.0%	2.0%
AGE 21+	Dental	1.0%	1.0%	2.0%
AGE 21+	FQHC	3.0%	0.0%	3.0%
Duals	Inpatient and LTC	0.0%	1.0%	1.0%
Duals	Physician	0.5%	2.0%	2.5%
Duals	Transportation	0.5%	3.0%	3.5%
Duals	Other Professional Services	0.0%	1.5%	1.5%
Duals	Pharmacy	0.5%	1.0%	1.5%
Duals	Outpatient	0.5%	1.0%	1.5%
Duals	Lab and Radiology Services	1.0%	1.0%	2.0%
Duals	Dental	1.0%	1.0%	2.0%
Duals	FQHC	3.0%	0.0%	3.0%
SSIWO	Inpatient and LTC	2.0%	0.5%	2.5%
SSIWO	Physician	2.0%	0.0%	2.0%
SSIWO	Transportation	0.5%	3.0%	3.5%
SSIWO	Other Professional Services	1.5%	-0.5%	1.0%
SSIWO	Pharmacy	0.4%	1.7%	2.1%
SSIWO	Outpatient	1.0%	2.0%	3.0%
SSIWO	Lab and Radiology Services	1.0%	1.0%	2.0%
SSIWO	Dental	1.0%	1.0%	2.0%
SSIWO	FQHC	3.0%	0.0%	3.0%
Prop 204 Childless Adults	Inpatient and LTC	5.0%	0.0%	5.0%
Prop 204 Childless Adults	Physician	0.5%	4.0%	4.5%
Prop 204 Childless Adults	Transportation	0.5%	3.0%	3.5%
Prop 204 Childless Adults	Other Professional Services	3.0%	0.0%	3.0%
Prop 204 Childless Adults	Pharmacy	0.0%	5.0%	5.0%
Prop 204 Childless Adults	Outpatient	0.0%	1.5%	1.5%
Prop 204 Childless Adults	Lab and Radiology Services	1.0%	1.0%	2.0%
Prop 204 Childless Adults	Dental	1.0%	1.0%	2.0%
Prop 204 Childless Adults	FQHC	3.0%	0.0%	3.0%
Expansion Adults	Inpatient and LTC	5.0%	0.5%	5.5%
Expansion Adults	Physician	3.0%	0.0%	3.0%
Expansion Adults	Transportation	0.5%	3.0%	3.5%
Expansion Adults	Other Professional Services	2.5%	0.5%	3.0%
Expansion Adults	Pharmacy	2.0%	4.5%	6.6%
Expansion Adults	Outpatient	2.0%	3.0%	5.1%
Expansion Adults	Lab and Radiology Services	1.0%	1.0%	2.0%
Expansion Adults	Dental	1.0%	1.0%	2.0%
Expansion Adults	FQHC	3.0%	0.0%	3.0%
Delivery Supplemental Payments	Inpatient and LTC	4.0%	2.0%	6.1%
Delivery Supplemental Payments	Physician	1.5%	0.5%	2.0%
Delivery Supplemental Payments	Transportation	3.0%	1.0%	4.0%
Delivery Supplemental Payments	Other Professional Services	3.0%	1.0%	4.0%
Delivery Supplemental Payments	Pharmacy	3.0%	1.0%	4.0%
Delivery Supplemental Payments	Outpatient	3.0%	1.0%	4.0%
Delivery Supplemental Payments	Lab and Radiology Services	3.0%	1.0%	4.0%
Delivery Supplemental Payments	Dental	3.0%	1.0%	4.0%
Delivery Supplemental Payments	FQHC	3.0%	1.0%	4.0%

Central				
Risk Group	Trend COS	Utilization per 1000	Unit Cost	PMPM
AGE < 1	Inpatient and LTC	3.0%	0.0%	3.0%
AGE < 1	Physician	1.0%	0.5%	1.5%
AGE < 1	Transportation	2.5%	1.0%	3.5%
AGE < 1	Other Professional Services	2.0%	0.5%	2.5%
AGE < 1	Pharmacy	0.2%	3.0%	3.2%
AGE < 1	Outpatient	0.5%	0.5%	1.0%
AGE < 1	Lab and Radiology Services	1.5%	0.5%	2.0%
AGE < 1	Dental	0.5%	1.5%	2.0%
AGE < 1	FQHC	3.0%	0.0%	3.0%
AGE 1-20	Inpatient and LTC	4.0%	0.5%	4.5%
AGE 1-20	Physician	1.0%	0.0%	1.0%
AGE 1-20	Transportation	2.5%	1.0%	3.5%
AGE 1-20	Other Professional Services	3.0%	0.0%	3.0%
AGE 1-20	Pharmacy	0.5%	5.5%	6.0%
AGE 1-20	Outpatient	2.0%	2.0%	4.0%
AGE 1-20	Lab and Radiology Services	1.5%	0.5%	2.0%
AGE 1-20	Dental	0.5%	1.5%	2.0%
AGE 1-20	FQHC	3.0%	0.0%	3.0%
AGE 21+	Inpatient and LTC	4.0%	0.5%	4.5%
AGE 21+	Physician	3.0%	0.0%	3.0%
AGE 21+	Transportation	2.5%	1.0%	3.5%
AGE 21+	Other Professional Services	4.5%	0.0%	4.5%
AGE 21+	Pharmacy	0.0%	3.5%	3.5%
AGE 21+	Outpatient	2.0%	2.0%	4.0%
AGE 21+	Lab and Radiology Services	1.5%	0.5%	2.0%
AGE 21+	Dental	0.5%	1.5%	2.0%
AGE 21+	FQHC	3.0%	0.0%	3.0%
Duals	Inpatient and LTC	2.0%	0.5%	2.5%
Duals	Physician	0.5%	2.0%	2.5%
Duals	Transportation	2.5%	1.0%	3.5%
Duals	Other Professional Services	1.0%	0.0%	1.0%
Duals	Pharmacy	0.0%	1.0%	1.0%
Duals	Outpatient	1.0%	0.0%	1.0%
Duals	Lab and Radiology Services	1.5%	0.5%	2.0%
Duals	Dental	0.5%	1.5%	2.0%
Duals	FQHC	3.0%	0.0%	3.0%
SSIWO	Inpatient and LTC	3.0%	0.5%	3.5%
SSIWO	Physician	1.5%	0.5%	2.0%
SSIWO	Transportation	2.5%	1.0%	3.5%
SSIWO	Other Professional Services	3.5%	0.0%	3.5%
SSIWO	Pharmacy	0.5%	1.0%	1.5%
SSIWO	Outpatient	2.0%	1.5%	3.5%
SSIWO	Lab and Radiology Services	1.5%	0.5%	2.0%
SSIWO	Dental	0.5%	1.5%	2.0%
SSIWO	FQHC	3.0%	0.0%	3.0%
Prop 204 Childless Adults	Inpatient and LTC	3.0%	0.0%	3.0%
Prop 204 Childless Adults	Physician	3.0%	0.0%	3.0%
Prop 204 Childless Adults	Transportation	2.5%	1.0%	3.5%
Prop 204 Childless Adults	Other Professional Services	5.5%	0.0%	5.5%
Prop 204 Childless Adults	Pharmacy	0.0%	4.0%	4.0%
Prop 204 Childless Adults	Outpatient	1.0%	1.5%	2.5%
Prop 204 Childless Adults	Lab and Radiology Services	1.5%	0.5%	2.0%
Prop 204 Childless Adults	Dental	0.5%	1.5%	2.0%
Prop 204 Childless Adults	FQHC	3.0%	0.0%	3.0%
Expansion Adults	Inpatient and LTC	6.0%	0.5%	6.5%
Expansion Adults	Physician	2.0%	0.5%	2.5%
Expansion Adults	Transportation	2.5%	1.0%	3.5%
Expansion Adults	Other Professional Services	4.5%	0.0%	4.5%
Expansion Adults	Pharmacy	0.0%	6.0%	6.0%
Expansion Adults	Outpatient	3.5%	1.5%	5.1%
Expansion Adults	Lab and Radiology Services	1.5%	0.5%	2.0%
Expansion Adults	Dental	0.5%	1.5%	2.0%
Expansion Adults	FQHC	3.0%	0.0%	3.0%
Delivery Supplemental Payments	Inpatient and LTC	2.5%	3.5%	6.1%
Delivery Supplemental Payments	Physician	1.0%	1.5%	2.5%
Delivery Supplemental Payments	Transportation	2.5%	1.0%	3.5%
Delivery Supplemental Payments	Other Professional Services	2.5%	1.0%	3.5%
Delivery Supplemental Payments	Pharmacy	2.5%	1.0%	3.5%
Delivery Supplemental Payments	Outpatient	2.5%	1.0%	3.5%
Delivery Supplemental Payments	Lab and Radiology Services	2.5%	1.0%	3.5%
Delivery Supplemental Payments	Dental	2.5%	1.0%	3.5%
Delivery Supplemental Payments	FQHC	2.5%	1.0%	3.5%

South				
Risk Group	Trend COS	Utilization per 1000	Unit Cost	PMPM
AGE < 1	Inpatient and LTC	3.0%	0.5%	3.5%
AGE < 1	Physician	0.8%	1.5%	2.3%
AGE < 1	Transportation	3.0%	1.0%	4.0%
AGE < 1	Other Professional Services	0.0%	2.0%	2.0%
AGE < 1	Pharmacy	0.0%	2.0%	2.0%
AGE < 1	Outpatient	2.0%	0.5%	2.5%
AGE < 1	Lab and Radiology Services	2.0%	0.0%	2.0%
AGE < 1	Dental	0.0%	3.5%	3.5%
AGE < 1	FQHC	3.5%	0.0%	3.5%
AGE 1-20	Inpatient and LTC	4.0%	0.5%	4.5%
AGE 1-20	Physician	1.5%	0.0%	1.5%
AGE 1-20	Transportation	3.0%	1.0%	4.0%
AGE 1-20	Other Professional Services	3.0%	0.5%	3.5%
AGE 1-20	Pharmacy	0.5%	5.0%	5.5%
AGE 1-20	Outpatient	4.0%	0.0%	4.0%
AGE 1-20	Lab and Radiology Services	2.0%	0.0%	2.0%
AGE 1-20	Dental	0.0%	3.5%	3.5%
AGE 1-20	FQHC	3.5%	0.0%	3.5%
AGE 21+	Inpatient and LTC	3.5%	0.0%	3.5%
AGE 21+	Physician	3.0%	0.0%	3.0%
AGE 21+	Transportation	3.0%	1.0%	4.0%
AGE 21+	Other Professional Services	3.0%	0.5%	3.5%
AGE 21+	Pharmacy	0.0%	4.0%	4.0%
AGE 21+	Outpatient	3.5%	0.5%	4.0%
AGE 21+	Lab and Radiology Services	2.0%	0.0%	2.0%
AGE 21+	Dental	0.0%	3.5%	3.5%
AGE 21+	FQHC	3.5%	0.0%	3.5%
Duals	Inpatient and LTC	1.5%	0.0%	1.5%
Duals	Physician	0.0%	2.0%	2.0%
Duals	Transportation	3.0%	1.0%	4.0%
Duals	Other Professional Services	1.5%	0.0%	1.5%
Duals	Pharmacy	0.5%	1.0%	1.5%
Duals	Outpatient	2.0%	0.0%	2.0%
Duals	Lab and Radiology Services	2.0%	0.0%	2.0%
Duals	Dental	0.0%	3.5%	3.5%
Duals	FQHC	3.5%	0.0%	3.5%
SSIWO	Inpatient and LTC	2.0%	2.0%	4.0%
SSIWO	Physician	2.5%	-0.5%	2.0%
SSIWO	Transportation	3.0%	1.0%	4.0%
SSIWO	Other Professional Services	2.0%	1.0%	3.0%
SSIWO	Pharmacy	-0.5%	2.0%	1.5%
SSIWO	Outpatient	3.0%	1.0%	4.0%
SSIWO	Lab and Radiology Services	2.0%	0.0%	2.0%
SSIWO	Dental	0.0%	3.5%	3.5%
SSIWO	FQHC	3.5%	0.0%	3.5%
Prop 204 Childless Adults	Inpatient and LTC	4.5%	0.0%	4.5%
Prop 204 Childless Adults	Physician	3.0%	0.0%	3.0%
Prop 204 Childless Adults	Transportation	3.0%	1.0%	4.0%
Prop 204 Childless Adults	Other Professional Services	5.0%	0.5%	5.5%
Prop 204 Childless Adults	Pharmacy	0.0%	3.0%	3.0%
Prop 204 Childless Adults	Outpatient	3.0%	0.0%	3.0%
Prop 204 Childless Adults	Lab and Radiology Services	2.0%	0.0%	2.0%
Prop 204 Childless Adults	Dental	0.0%	3.5%	3.5%
Prop 204 Childless Adults	FQHC	3.5%	0.0%	3.5%
Expansion Adults	Inpatient and LTC	5.0%	0.5%	5.5%
Expansion Adults	Physician	2.0%	0.0%	2.0%
Expansion Adults	Transportation	3.0%	1.0%	4.0%
Expansion Adults	Other Professional Services	2.5%	0.0%	2.5%
Expansion Adults	Pharmacy	0.0%	6.0%	6.0%
Expansion Adults	Outpatient	5.0%	0.0%	5.0%
Expansion Adults	Lab and Radiology Services	2.0%	0.0%	2.0%
Expansion Adults	Dental	0.0%	3.5%	3.5%
Expansion Adults	FQHC	3.5%	0.0%	3.5%
Delivery Supplemental Payments	Inpatient and LTC	4.5%	1.5%	6.1%
Delivery Supplemental Payments	Physician	2.0%	0.5%	2.5%
Delivery Supplemental Payments	Transportation	0.5%	3.0%	3.5%
Delivery Supplemental Payments	Other Professional Services	0.5%	3.0%	3.5%
Delivery Supplemental Payments	Pharmacy	0.5%	3.0%	3.5%
Delivery Supplemental Payments	Outpatient	0.5%	3.0%	3.5%
Delivery Supplemental Payments	Lab and Radiology Services	0.5%	3.0%	3.5%
Delivery Supplemental Payments	Dental	0.5%	3.0%	3.5%
Delivery Supplemental Payments	FQHC	0.5%	3.0%	3.5%

Appendix 6: Gross Medical Capitation Rate Development

GSA: North
Rate Cell: AGE < 1
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 44,965
Projection Period Member Months: 41,134

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$364.66	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	4.23%	0.00%	0.00%	$406.89
Behavioral Health Inpatient and LTC	$0.05	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.06
Physical Health Physician	$97.58	2.50%	0.32%	0.00%	0.00%	0.00%	0.00%	15.62%	-0.40%	0.00%	$120.64
Behavioral Health Physician	$0.41	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.33%	0.00%	0.00%	$0.44
Transportation	$25.52	3.51%	-0.52%	0.00%	0.00%	0.00%	0.00%	4.35%	2.29%	0.00%	$29.80
Other Professional Services	$32.17	3.02%	0.00%	0.00%	0.00%	0.00%	0.00%	21.96%	0.03%	0.00%	$42.59
Pharmacy	$6.21	3.00%	0.00%	0.00%	0.00%	0.00%	1.10%	0.00%	0.00%	-2.00%	$6.67
Outpatient Facility	$13.55	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.14%	-2.10%	0.00%	$13.99
Emergency Facility	$24.74	2.01%	-7.95%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$24.01
Laboratory and Radiology Services	$5.49	2.01%	0.00%	0.00%	0.00%	3.16%	0.00%	7.27%	0.00%	0.00%	$6.41
Dental	$0.31	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.11%	0.42%	0.00%	$0.38
FQHC	$19.95	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.04%	0.00%	0.00%	$23.38
Gross Medical	**$590.64**	**2.56%**	**-0.30%**	**0.00%**	**0.00%**	**0.03%**	**0.01%**	**6.95%**	**-0.01%**	**-0.02%**	**$675.26**

Total DAP	**$11.49**
Total Gross Medical PMPM	**$686.76**

GSA: North
Rate Cell: AGE 1-20
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 706,270
Projection Period Member Months: 769,277

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$12.20	4.02%	0.00%	0.00%	0.00%	0.00%	0.00%	1.73%	0.00%	0.00%	$13.83
Behavioral Health Inpatient and LTC	$9.25	4.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$10.31
Physical Health Physician	$16.56	1.50%	5.92%	0.00%	0.00%	0.00%	0.00%	12.72%	1.26%	0.00%	$20.86
Behavioral Health Physician	$24.83	1.50%	1.32%	0.00%	0.00%	0.00%	0.00%	5.03%	0.01%	0.00%	$27.53
Transportation	$7.68	3.51%	-7.14%	0.00%	0.00%	0.00%	0.00%	4.09%	2.51%	0.00%	$8.37
Other Professional Services	$18.44	3.98%	0.00%	0.00%	0.00%	0.00%	0.00%	4.14%	1.30%	0.00%	$21.66
Pharmacy	$21.04	5.04%	0.00%	0.00%	0.00%	0.00%	-0.67%	0.00%	0.00%	-2.00%	$23.45
Outpatient Facility	$8.67	4.55%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	-2.46%	0.00%	$9.54
Emergency Facility	$13.63	4.55%	-4.39%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$14.71
Laboratory and Radiology Services	$2.61	2.01%	0.00%	0.00%	0.00%	7.46%	0.00%	7.44%	0.00%	0.00%	$3.19
Dental	$18.38	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.29%	0.12%	0.00%	$22.21
FQHC	$6.80	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.18%	0.00%	0.00%	$7.98
Gross Medical	**$160.10**	**3.26%**	**0.05%**	**0.00%**	**0.00%**	**0.12%**	**-0.09%**	**4.93%**	**0.28%**	**-0.26%**	**$183.63**

Total DAP	**$2.63**
Total Gross Medical PMPM	**$186.26**

GSA: North
Rate Cell: AGE 21+
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 319,702
Projection Period Member Months: 344,162

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$36.30	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	4.28%	0.00%	0.00%	$41.64
Behavioral Health Inpatient and LTC	$4.87	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	$5.36
Physical Health Physician	$40.59	3.01%	2.65%	0.00%	0.00%	0.00%	0.00%	14.92%	0.68%	0.00%	$52.31
Behavioral Health Physician	$15.75	3.01%	2.28%	0.00%	0.00%	0.00%	0.00%	2.55%	0.04%	0.00%	$17.94
Transportation	$14.36	3.51%	-4.37%	0.00%	0.00%	0.00%	0.00%	5.07%	1.56%	0.00%	$16.11
Other Professional Services	$20.20	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	3.47%	0.12%	0.00%	$22.10
Pharmacy	$58.22	6.53%	0.00%	0.00%	0.41%	0.00%	-0.44%	0.00%	0.00%	-2.00%	$67.87
Outpatient Facility	$35.01	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	-0.96%	0.00%	$36.56
Emergency Facility	$33.38	2.01%	-2.77%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$34.21
Laboratory and Radiology Services	$14.41	2.01%	0.00%	0.00%	0.00%	2.69%	0.00%	8.02%	0.00%	0.00%	$16.88
Dental	$1.30	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.30%	0.05%	0.00%	$1.57
FQHC	$11.77	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.20%	0.00%	0.00%	$13.82
Gross Medical	**$286.16**	**3.48%**	**-0.04%**	**0.00%**	**0.09%**	**0.14%**	**-0.10%**	**4.07%**	**0.07%**	**-0.42%**	**$326.37**

Total DAP	**$4.77**
Total Gross Medical PMPM	**$331.14**

GSA: North
Rate Cell: Duals
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 156,608
Projection Period Member Months: 188,314

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$12.77	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.81%	0.00%	0.00%	$13.75
Behavioral Health Inpatient and LTC	$2.01	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.07
Physical Health Physician	$17.52	2.51%	2.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.76%	0.00%	$19.44
Behavioral Health Physician	$11.60	2.51%	1.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.10%	0.00%	$12.60
Transportation	$16.03	3.51%	-1.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.54%	0.00%	$17.41
Other Professional Services	$8.63	1.50%	0.00%	-3.37%	0.00%	0.00%	0.00%	0.32%	0.55%	0.00%	$8.76
Pharmacy	$2.77	1.51%	0.00%	0.00%	14.23%	0.00%	0.26%	0.00%	0.00%	-2.00%	$3.24
Outpatient Facility	$18.64	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.13%	0.00%	$19.21
Emergency Facility	$6.42	1.50%	-6.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$6.27
Laboratory and Radiology Services	$3.29	2.01%	0.00%	0.00%	0.00%	0.46%	0.00%	0.00%	0.00%	0.00%	$3.49
Dental	$0.67	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.30%	0.43%	0.00%	$0.81
FQHC	$2.34	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.38%	0.00%	0.00%	$2.57
Gross Medical	**$102.68**	**2.09%**	**-0.02%**	**-0.28%**	**0.38%**	**0.01%**	**0.01%**	**0.73%**	**0.08%**	**-0.06%**	**$109.62**

Total DAP	**$1.55**
Total Gross Medical PMPM	**$111.16**

GSA: North
Rate Cell: SSIWO
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 66,245
Projection Period Member Months: 71,990

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$201.10	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.94%	0.00%	0.00%	$206.80
Behavioral Health Inpatient and LTC	$18.75	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	$20.07
Physical Health Physician	$114.37	2.00%	1.81%	0.00%	0.00%	0.00%	0.00%	12.88%	0.36%	0.00%	$139.29
Behavioral Health Physician	$44.18	2.00%	1.56%	0.00%	0.00%	0.00%	0.00%	4.61%	0.04%	0.00%	$49.59
Transportation	$58.38	3.51%	-2.01%	0.00%	0.00%	0.00%	0.00%	4.63%	0.30%	0.00%	$66.01
Other Professional Services	$77.07	0.99%	0.00%	0.00%	0.00%	0.00%	0.00%	8.46%	1.43%	0.00%	$87.12
Pharmacy	$297.27	2.11%	0.00%	0.00%	0.72%	0.00%	-0.69%	0.00%	0.00%	-2.00%	$308.60
Outpatient Facility	$116.15	3.02%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.07%	-0.52%	0.00%	$125.32
Emergency Facility	$54.70	3.02%	-1.56%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$58.33
Laboratory and Radiology Services	$24.17	2.01%	0.00%	0.00%	0.00%	0.93%	0.00%	9.27%	0.00%	0.00%	$28.15
Dental	$4.29	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.23%	0.29%	0.00%	$5.19
FQHC	$14.95	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.21%	0.00%	0.00%	$17.54
Gross Medical	**$1,025.35**	**2.34%**	**0.06%**	**0.00%**	**0.20%**	**0.02%**	**-0.20%**	**2.15%**	**0.11%**	**-0.56%**	**$1,112.01**

Total DAP	**$12.61**
Total Gross Medical PMPM	**$1,124.62**

GSA: North
Rate Cell: Prop 204 Childless Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 408,696
Projection Period Member Months: 473,645

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$96.82	5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.19%	0.00%	0.00%	$110.50
Behavioral Health Inpatient and LTC	$17.84	5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	$20.41
Physical Health Physician	$61.55	4.52%	2.11%	0.00%	0.00%	0.00%	0.00%	14.43%	0.45%	0.00%	$81.57
Behavioral Health Physician	$34.20	4.52%	1.26%	0.00%	0.00%	0.00%	0.00%	2.40%	0.04%	0.00%	$40.07
Transportation	$32.17	3.51%	-2.44%	0.00%	0.00%	0.00%	0.00%	4.87%	0.55%	0.00%	$36.39
Other Professional Services	$32.69	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.63%	0.16%	0.00%	$36.80
Pharmacy	$100.60	5.00%	0.00%	0.00%	0.42%	0.00%	-0.32%	0.00%	0.00%	-2.00%	$112.86
Outpatient Facility	$47.51	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.16%	-0.98%	0.00%	$48.93
Emergency Facility	$40.43	1.50%	-1.86%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$41.26
Laboratory and Radiology Services	$16.14	2.01%	0.00%	0.00%	0.00%	1.80%	0.00%	8.61%	0.00%	0.00%	$18.85
Dental	$1.89	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.29%	0.34%	0.00%	$2.29
FQHC	$11.97	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.18%	0.00%	0.00%	$14.04
Gross Medical	**$493.80**	**3.91%**	**0.06%**	**0.00%**	**0.08%**	**0.06%**	**-0.07%**	**3.03%**	**0.02%**	**-0.41%**	**$563.98**

Total DAP	**$6.69**
Total Gross Medical PMPM	**$570.67**

GSA: North
Rate Cell: Expansion Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 102,079
Projection Period Member Months: 176,789

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$70.92	5.53%	0.00%	0.00%	0.00%	0.00%	0.00%	1.50%	0.00%	0.00%	$83.46
Behavioral Health Inpatient and LTC	$6.38	5.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	$7.39
Physical Health Physician	$60.23	3.00%	1.16%	0.00%	0.00%	0.00%	0.00%	13.94%	0.23%	0.00%	$75.48
Behavioral Health Physician	$12.92	3.00%	1.80%	0.00%	0.00%	0.00%	0.00%	3.45%	0.05%	0.00%	$14.77
Transportation	$14.18	3.51%	-2.86%	0.00%	0.00%	0.00%	0.00%	5.02%	0.63%	0.00%	$16.01
Other Professional Services	$26.47	3.01%	0.00%	0.00%	0.00%	0.00%	0.00%	5.65%	0.08%	0.00%	$30.37
Pharmacy	$93.85	6.59%	0.00%	0.00%	0.49%	0.00%	-0.27%	0.00%	0.00%	-2.00%	$109.86
Outpatient Facility	$57.37	5.06%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.16%	-0.30%	0.00%	$65.41
Emergency Facility	$28.50	5.06%	-1.02%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$32.25
Laboratory and Radiology Services	$15.71	2.01%	0.00%	0.00%	0.00%	1.84%	0.00%	8.66%	0.00%	0.00%	$18.37
Dental	$1.73	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.30%	0.19%	0.00%	$2.09
FQHC	$12.57	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.19%	0.00%	0.00%	$14.75
Gross Medical	**$400.83**	**4.76%**	**0.05%**	**0.00%**	**0.12%**	**0.07%**	**-0.07%**	**3.51%**	**0.02%**	**-0.47%**	**$470.20**

Total DAP	**$5.58**
Total Gross Medical PMPM	**$475.79**

GSA: Central
Rate Cell: AGE < 1
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 380,638
Projection Period Member Months: 335,447

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$303.88	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.67%	0.00%	0.00%	$345.02
Behavioral Health Inpatient and LTC	$0.00	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Physical Health Physician	$105.65	1.50%	0.96%	0.00%	0.00%	0.00%	0.00%	16.50%	-0.65%	0.00%	$128.63
Behavioral Health Physician	$0.18	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	1.15%	0.00%	0.00%	$0.19
Transportation	$6.24	3.53%	-6.84%	0.00%	0.00%	0.00%	0.00%	4.99%	10.57%	0.00%	$7.42
Other Professional Services	$30.06	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	11.42%	0.09%	0.00%	$35.88
Pharmacy	$20.24	3.21%	0.00%	0.00%	0.00%	0.00%	-0.14%	0.00%	0.00%	-2.00%	$21.60
Outpatient Facility	$18.94	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.12%	-1.56%	0.00%	$19.14
Emergency Facility	$29.95	1.00%	-9.68%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$27.75
Laboratory and Radiology Services	$6.25	2.01%	0.00%	0.00%	0.00%	3.25%	0.00%	6.40%	0.00%	0.00%	$7.25
Dental	$0.44	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	12.64%	0.00%	0.00%	$0.52
FQHC	$35.94	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.64%	0.00%	0.00%	$42.35
Gross Medical	**$557.77**	**2.52%**	**-0.40%**	**0.00%**	**0.00%**	**0.04%**	**-0.01%**	**6.97%**	**-0.05%**	**-0.07%**	**$635.78**

Total DAP	**$10.47**
Total Gross Medical PMPM	**$646.25**

GSA: Central
Rate Cell: AGE 1-20
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 5,561,132
Projection Period Member Months: 6,103,801

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$15.26	4.52%	0.00%	0.00%	0.00%	0.00%	0.00%	1.07%	0.00%	0.00%	$17.42
Behavioral Health Inpatient and LTC	$6.47	4.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$7.31
Physical Health Physician	$22.48	1.00%	5.26%	0.00%	0.00%	0.00%	0.00%	17.33%	1.19%	0.00%	$28.88
Behavioral Health Physician	$19.19	1.00%	2.06%	0.00%	0.00%	0.00%	0.00%	3.56%	0.08%	0.00%	$20.86
Transportation	$2.80	3.53%	-23.35%	0.00%	0.00%	0.00%	0.00%	4.55%	8.02%	0.00%	$2.66
Other Professional Services	$18.23	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.52%	0.16%	0.00%	$20.90
Pharmacy	$23.03	6.03%	0.00%	0.00%	0.00%	0.00%	0.07%	0.00%	0.00%	-2.00%	$26.53
Outpatient Facility	$11.15	4.04%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	-1.67%	0.00%	$12.20
Emergency Facility	$14.47	4.04%	-4.26%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$15.42
Laboratory and Radiology Services	$3.32	2.01%	0.00%	0.00%	0.00%	9.75%	0.00%	6.10%	0.00%	0.00%	$4.08
Dental	$16.89	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.25%	0.13%	0.00%	$20.41
FQHC	$9.52	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.57%	0.00%	0.00%	$11.22
Gross Medical	**$162.81**	**3.19%**	**0.12%**	**0.00%**	**0.00%**	**0.19%**	**0.01%**	**5.60%**	**0.19%**	**-0.29%**	**$187.88**

Total DAP	**$2.63**
Total Gross Medical PMPM	**$190.51**

GSA: Central
Rate Cell: AGE 21+
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 2,035,882
Projection Period Member Months: 2,266,255

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$38.87	4.52%	0.00%	0.00%	0.00%	0.00%	0.00%	4.64%	0.00%	0.00%	$45.93
Behavioral Health Inpatient and LTC	$6.26	4.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	$7.07
Physical Health Physician	$59.14	3.00%	2.82%	0.00%	0.00%	0.00%	0.00%	14.77%	0.64%	0.00%	$76.18
Behavioral Health Physician	$15.47	3.00%	3.59%	0.00%	0.00%	0.00%	0.00%	5.74%	0.15%	0.00%	$18.40
Transportation	$8.12	3.53%	-11.94%	0.00%	0.00%	0.00%	0.00%	4.18%	2.05%	0.00%	$8.36
Other Professional Services	$26.93	4.50%	0.00%	0.00%	0.00%	0.00%	0.00%	6.47%	0.09%	0.00%	$32.39
Pharmacy	$68.74	3.50%	0.00%	0.00%	0.39%	0.00%	-0.66%	0.00%	0.00%	-2.00%	$73.85
Outpatient Facility	$28.89	4.04%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.16%	-0.84%	0.00%	$31.89
Emergency Facility	$33.97	4.04%	-1.47%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$37.26
Laboratory and Radiology Services	$26.63	2.01%	0.00%	0.00%	0.00%	2.94%	0.00%	8.01%	0.00%	0.00%	$31.27
Dental	$1.95	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.29%	0.01%	0.00%	$2.36
FQHC	$15.10	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.48%	0.00%	0.00%	$17.77
Gross Medical	**$330.07**	**3.56%**	**0.22%**	**0.00%**	**0.08%**	**0.23%**	**-0.14%**	**5.21%**	**0.10%**	**-0.39%**	**$382.73**

Total DAP	**$4.77**
Total Gross Medical PMPM	**$387.49**

GSA: Central
Rate Cell: Duals
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 732,357
Projection Period Member Months: 866,512

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$19.50	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	3.17%	0.00%	0.00%	$21.53
Behavioral Health Inpatient and LTC	$2.02	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$2.16
Physical Health Physician	$28.44	2.51%	1.76%	0.00%	0.00%	0.00%	0.00%	0.00%	1.04%	0.00%	$31.31
Behavioral Health Physician	$11.73	2.51%	1.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.54%	0.00%	$12.80
Transportation	$14.23	3.53%	-2.02%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.19%	0.00%	$15.30
Other Professional Services	$10.09	1.00%	0.00%	-6.66%	0.00%	0.00%	0.00%	0.51%	0.78%	0.00%	$9.80
Pharmacy	$3.17	1.00%	0.00%	0.00%	30.92%	0.00%	-0.87%	0.00%	0.00%	-2.00%	$4.15
Outpatient Facility	$13.65	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.70%	0.00%	$13.79
Emergency Facility	$5.97	1.00%	-4.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$5.83
Laboratory and Radiology Services	$8.28	2.01%	0.00%	0.00%	0.00%	0.26%	0.00%	0.00%	0.00%	0.00%	$8.77
Dental	$1.02	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.32%	0.09%	0.00%	$1.24
FQHC	$3.04	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.45%	0.00%	0.00%	$3.31
Gross Medical	**$121.13**	**2.20%**	**0.08%**	**-0.54%**	**0.77%**	**0.02%**	**-0.02%**	**0.69%**	**0.16%**	**-0.07%**	**$130.00**

Total DAP	**$1.26**
Total Gross Medical PMPM	**$131.26**

GSA: Central
Rate Cell: SSIWO
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 390,780
Projection Period Member Months: 422,320

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$279.66	3.51%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.98%	0.00%	0.00%	$301.45
Behavioral Health Inpatient and LTC	$22.06	3.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	$24.26
Physical Health Physician	$161.43	2.01%	1.88%	0.00%	0.00%	0.00%	0.00%	13.31%	0.37%	0.00%	$197.57
Behavioral Health Physician	$50.01	2.01%	2.03%	0.00%	0.00%	0.00%	0.00%	3.98%	0.22%	0.00%	$56.16
Transportation	$33.51	3.53%	-5.13%	0.00%	0.00%	0.00%	0.00%	3.35%	0.10%	0.00%	$36.18
Other Professional Services	$83.51	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	9.53%	0.22%	0.00%	$100.77
Pharmacy	$323.15	1.50%	0.00%	0.00%	3.23%	0.00%	-0.97%	0.00%	0.00%	-2.00%	$337.33
Outpatient Facility	$124.27	3.53%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.02%	-0.36%	0.00%	$136.19
Emergency Facility	$50.54	3.53%	-1.22%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$54.82
Laboratory and Radiology Services	$37.35	2.01%	0.00%	0.00%	0.00%	1.23%	0.00%	9.17%	0.00%	0.00%	$43.60
Dental	$5.39	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.32%	0.05%	0.00%	$6.52
FQHC	$21.68	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.41%	0.00%	0.00%	$25.50
Gross Medical	**$1,192.56**	**2.65%**	**0.13%**	**0.00%**	**0.82%**	**0.04%**	**-0.25%**	**2.77%**	**0.04%**	**-0.52%**	**$1,320.33**

Total DAP	**$14.34**
Total Gross Medical PMPM	**$1,334.67**

GSA: Central
Rate Cell: Prop 204 Childless Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 2,153,877
Projection Period Member Months: 2,734,101

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$109.23	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.73%	0.00%	0.00%	$119.35
Behavioral Health Inpatient and LTC	$33.99	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	$36.87
Physical Health Physician	$87.67	3.00%	2.10%	0.00%	0.00%	0.00%	0.00%	13.96%	0.46%	0.00%	$111.16
Behavioral Health Physician	$37.69	3.00%	1.63%	0.00%	0.00%	0.00%	0.00%	4.38%	0.16%	0.00%	$43.43
Transportation	$21.63	3.53%	-4.97%	0.00%	0.00%	0.00%	0.00%	3.63%	0.29%	0.00%	$23.50
Other Professional Services	$43.19	5.50%	0.00%	0.00%	0.00%	0.00%	0.00%	5.24%	0.16%	0.00%	$52.74
Pharmacy	$126.11	4.00%	0.00%	0.00%	0.55%	0.00%	-0.34%	0.00%	0.00%	-2.00%	$137.96
Outpatient Facility	$37.12	2.52%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.11%	-1.19%	0.00%	$39.22
Emergency Facility	$41.36	2.52%	-1.34%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$43.61
Laboratory and Radiology Services	$26.54	2.01%	0.00%	0.00%	0.00%	2.14%	0.00%	7.95%	0.00%	0.00%	$30.91
Dental	$2.77	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.29%	0.25%	0.00%	$3.36
FQHC	$15.84	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.31%	0.00%	0.00%	$18.61
Gross Medical	**$583.14**	**3.31%**	**0.14%**	**0.00%**	**0.12%**	**0.10%**	**-0.07%**	**3.71%**	**0.03%**	**-0.42%**	**$660.73**

Total DAP	**$7.87**
Total Gross Medical PMPM	**$668.60**

GSA: Central
Rate Cell: Expansion Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 551,378
Projection Period Member Months: 1,100,558

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$54.95	6.53%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.20%	0.00%	0.00%	$65.26
Behavioral Health Inpatient and LTC	$6.56	6.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	$7.81
Physical Health Physician	$73.71	2.51%	1.36%	0.00%	0.00%	0.00%	0.00%	14.18%	0.21%	0.00%	$91.53
Behavioral Health Physician	$11.03	2.51%	3.03%	0.00%	0.00%	0.00%	0.00%	6.60%	0.15%	0.00%	$12.98
Transportation	$7.25	3.53%	-7.94%	0.00%	0.00%	0.00%	0.00%	4.28%	0.87%	0.00%	$7.73
Other Professional Services	$30.22	4.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.43%	0.07%	0.00%	$37.01
Pharmacy	$107.33	6.00%	0.00%	0.00%	0.32%	0.00%	-0.30%	0.00%	0.00%	-2.00%	$123.48
Outpatient Facility	$37.14	5.05%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.13%	-0.30%	0.00%	$42.35
Emergency Facility	$27.38	5.05%	-0.72%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$31.07
Laboratory and Radiology Services	$24.28	2.01%	0.00%	0.00%	0.00%	2.37%	0.00%	8.07%	0.00%	0.00%	$28.36
Dental	$2.55	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.29%	0.18%	0.00%	$3.08
FQHC	$13.97	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.43%	0.00%	0.00%	$16.43
Gross Medical	**$396.37**	**4.67%**	**0.13%**	**0.00%**	**0.09%**	**0.14%**	**-0.08%**	**4.19%**	**0.03%**	**-0.54%**	**$467.09**

Total DAP	**$4.67**
Total Gross Medical PMPM	**$471.76**

GSA: South
Rate Cell: AGE < 1
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 123,004
Projection Period Member Months: 106,387

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$307.50	3.51%	0.00%	0.00%	0.00%	0.00%	0.00%	4.94%	0.00%	0.00%	$354.85
Behavioral Health Inpatient and LTC	$0.00	3.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00
Physical Health Physician	$92.64	2.31%	1.20%	0.00%	0.00%	0.00%	0.00%	15.24%	-0.38%	0.00%	$114.61
Behavioral Health Physician	$0.34	2.31%	0.00%	0.00%	0.00%	0.00%	0.00%	1.14%	0.00%	0.00%	$0.36
Transportation	$10.61	4.03%	-4.44%	0.00%	0.00%	0.00%	0.00%	4.49%	5.81%	0.00%	$12.50
Other Professional Services	$20.39	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.31%	0.12%	0.00%	$24.00
Pharmacy	$9.95	2.00%	0.00%	0.00%	0.00%	0.00%	1.17%	0.00%	0.00%	-2.00%	$10.42
Outpatient Facility	$11.17	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	-11.01%	0.00%	$10.62
Emergency Facility	$19.03	2.51%	-21.11%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$16.04
Laboratory and Radiology Services	$6.26	2.00%	0.00%	0.00%	0.00%	3.94%	0.00%	6.69%	0.00%	0.00%	$7.33
Dental	$0.27	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	13.83%	0.00%	0.00%	$0.33
FQHC	$85.08	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.37%	0.00%	0.00%	$101.35
Gross Medical	**$563.24**	**3.17%**	**-0.59%**	**0.00%**	**0.00%**	**0.04%**	**0.02%**	**7.07%**	**-0.16%**	**-0.03%**	**$652.42**

Total DAP	**$9.91**
Total Gross Medical PMPM	**$662.32**

GSA: South
Rate Cell: AGE 1-20
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 1,861,328
Projection Period Member Months: 1,986,869

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$11.52	4.52%	0.00%	0.00%	0.00%	0.00%	0.00%	3.78%	0.00%	0.00%	$13.50
Behavioral Health Inpatient and LTC	$6.79	4.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$7.67
Physical Health Physician	$16.29	1.50%	10.06%	0.00%	0.00%	0.00%	0.00%	16.64%	1.20%	0.00%	$22.04
Behavioral Health Physician	$21.10	1.50%	2.59%	0.00%	0.00%	0.00%	0.00%	5.72%	0.07%	0.00%	$23.86
Transportation	$4.36	4.03%	-20.76%	0.00%	0.00%	0.00%	0.00%	4.93%	4.77%	0.00%	$4.23
Other Professional Services	$18.16	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	5.37%	0.74%	0.00%	$21.19
Pharmacy	$22.38	5.53%	0.00%	0.00%	0.00%	0.00%	-0.37%	0.00%	0.00%	-2.00%	$25.33
Outpatient Facility	$8.80	4.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	-5.19%	0.00%	$9.27
Emergency Facility	$11.26	4.00%	-7.30%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$11.60
Laboratory and Radiology Services	$3.09	2.00%	0.00%	0.00%	0.00%	9.81%	0.00%	5.84%	0.00%	0.00%	$3.79
Dental	$13.59	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	14.30%	0.18%	0.00%	$17.10
FQHC	$28.82	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.23%	0.00%	0.00%	$34.29
Gross Medical	**$166.14**	**3.50%**	**0.19%**	**0.00%**	**0.00%**	**0.17%**	**-0.05%**	**6.06%**	**0.06%**	**-0.27%**	**$193.88**

Total DAP	**$2.29**
Total Gross Medical PMPM	**$196.17**

GSA: South
Rate Cell: AGE 21+
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 846,622
Projection Period Member Months: 895,825

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$30.93	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.28%	0.00%	0.00%	$36.82
Behavioral Health Inpatient and LTC	$3.83	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	$4.21
Physical Health Physician	$37.92	3.00%	5.44%	0.00%	0.00%	0.00%	0.00%	15.20%	0.83%	0.00%	$50.38
Behavioral Health Physician	$17.08	3.00%	4.02%	0.00%	0.00%	0.00%	0.00%	5.70%	0.04%	0.00%	$20.37
Transportation	$8.59	4.03%	-13.78%	0.00%	0.00%	0.00%	0.00%	4.86%	2.29%	0.00%	$8.86
Other Professional Services	$24.14	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	5.62%	0.21%	0.00%	$28.10
Pharmacy	$55.29	4.00%	0.00%	0.00%	0.12%	0.00%	-0.71%	0.00%	0.00%	-2.00%	$60.00
Outpatient Facility	$34.65	4.02%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	-1.57%	0.00%	$37.94
Emergency Facility	$29.43	4.02%	-2.21%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$32.02
Laboratory and Radiology Services	$21.31	2.00%	0.00%	0.00%	0.00%	3.29%	0.00%	7.13%	0.00%	0.00%	$24.90
Dental	$0.77	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	14.30%	0.05%	0.00%	$0.96
FQHC	$31.55	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.19%	0.00%	0.00%	$37.53
Gross Medical	**$295.50**	**3.52%**	**0.29%**	**0.00%**	**0.02%**	**0.23%**	**-0.13%**	**5.19%**	**0.01%**	**-0.36%**	**$342.08**

Total DAP	**$4.71**
Total Gross Medical PMPM	**$346.79**

GSA: South
Rate Cell: Duals
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 418,879
Projection Period Member Months: 494,365

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$14.59	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	3.96%	0.00%	0.00%	$15.80
Behavioral Health Inpatient and LTC	$1.35	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$1.40
Physical Health Physician	$20.40	2.00%	3.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.80%	0.00%	$22.46
Behavioral Health Physician	$12.18	2.00%	1.91%	0.00%	0.00%	0.00%	0.00%	0.00%	0.15%	0.00%	$13.13
Transportation	$18.87	4.03%	-2.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.09%	0.00%	$20.62
Other Professional Services	$7.80	1.50%	0.00%	-7.41%	0.00%	0.00%	0.00%	0.33%	1.35%	0.00%	$7.66
Pharmacy	$2.76	1.51%	0.00%	0.00%	29.67%	0.00%	-1.39%	0.00%	0.00%	-2.00%	$3.60
Outpatient Facility	$17.86	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.30%	0.00%	$18.43
Emergency Facility	$5.31	2.00%	-5.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$5.28
Laboratory and Radiology Services	$4.32	2.00%	0.00%	0.00%	0.00%	0.25%	0.00%	0.00%	0.00%	0.00%	$4.57
Dental	$0.70	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	14.31%	0.24%	0.00%	$0.88
FQHC	$9.23	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.80%	0.00%	0.00%	$10.23
Gross Medical	**$115.37**	**2.35%**	**0.18%**	**-0.50%**	**0.68%**	**0.01%**	**-0.03%**	**0.67%**	**-0.09%**	**-0.06%**	**$124.05**

Total DAP	**$1.31**
Total Gross Medical PMPM	**$125.36**

GSA: South
Rate Cell: SSIWO
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 159,330
Projection Period Member Months: 178,733

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$232.98	4.04%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.06%	0.00%	0.00%	$259.63
Behavioral Health Inpatient and LTC	$18.74	4.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	$20.90
Physical Health Physician	$124.93	1.99%	3.19%	0.00%	0.00%	0.00%	0.00%	13.74%	0.32%	0.00%	$155.28
Behavioral Health Physician	$55.00	1.99%	2.41%	0.00%	0.00%	0.00%	0.00%	4.56%	0.07%	0.00%	$62.21
Transportation	$47.19	4.03%	-4.71%	0.00%	0.00%	0.00%	0.00%	3.84%	0.09%	0.00%	$52.10
Other Professional Services	$87.94	3.02%	0.00%	0.00%	0.00%	0.00%	0.00%	8.58%	0.33%	0.00%	$103.96
Pharmacy	$294.43	1.49%	0.00%	0.00%	1.34%	0.00%	-0.86%	0.00%	0.00%	-2.00%	$301.93
Outpatient Facility	$131.67	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.09%	-0.81%	0.00%	$145.45
Emergency Facility	$47.26	4.03%	-1.48%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$51.81
Laboratory and Radiology Services	$32.33	2.00%	0.00%	0.00%	0.00%	1.21%	0.00%	8.28%	0.00%	0.00%	$37.41
Dental	$3.47	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	14.36%	0.15%	0.00%	$4.37
FQHC	$43.00	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.16%	0.00%	0.00%	$51.12
Gross Medical	**$1,118.92**	**2.89%**	**0.19%**	**0.00%**	**0.33%**	**0.04%**	**-0.22%**	**3.18%**	**-0.03%**	**-0.49%**	**$1,246.19**

Total DAP	**$13.93**
Total Gross Medical PMPM	**$1,260.12**

GSA: South
Rate Cell: Prop 204 Childless Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 915,641
Projection Period Member Months: 1,088,062

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$85.85	4.50%	0.00%	0.00%	0.00%	0.00%	0.00%	1.89%	0.00%	0.00%	$98.73
Behavioral Health Inpatient and LTC	$21.99	4.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	$24.83
Physical Health Physician	$56.65	3.00%	4.26%	0.00%	0.00%	0.00%	0.00%	14.06%	0.52%	0.00%	$73.44
Behavioral Health Physician	$42.54	3.00%	1.89%	0.00%	0.00%	0.00%	0.00%	4.63%	0.04%	0.00%	$49.22
Transportation	$22.08	4.03%	-6.28%	0.00%	0.00%	0.00%	0.00%	4.40%	0.46%	0.00%	$24.20
Other Professional Services	$42.41	5.52%	0.00%	0.00%	0.00%	0.00%	0.00%	4.60%	0.21%	0.00%	$51.53
Pharmacy	$92.91	3.00%	0.00%	0.00%	0.43%	0.00%	-0.38%	0.00%	0.00%	-2.00%	$98.81
Outpatient Facility	$44.28	3.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.15%	-1.64%	0.00%	$47.17
Emergency Facility	$33.94	3.00%	-1.77%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$36.09
Laboratory and Radiology Services	$20.89	2.00%	0.00%	0.00%	0.00%	2.17%	0.00%	7.11%	0.00%	0.00%	$24.15
Dental	$1.51	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	14.30%	0.39%	0.00%	$1.91
FQHC	$28.87	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.24%	0.00%	0.00%	$34.35
Gross Medical	**$493.93**	**3.59%**	**0.24%**	**0.00%**	**0.08%**	**0.09%**	**-0.07%**	**3.78%**	**-0.04%**	**-0.36%**	**$564.43**

Total DAP	**$6.83**
Total Gross Medical PMPM	**$571.26**

GSA: South
Rate Cell: Expansion Adults
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 260,539
Projection Period Member Months: 463,732

Category of Service	Adjusted Base PMPM	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient and LTC	$48.58	5.53%	0.00%	0.00%	0.00%	0.00%	0.00%	2.92%	0.00%	0.00%	$57.97
Behavioral Health Inpatient and LTC	$3.70	5.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.00%	0.00%	$4.29
Physical Health Physician	$53.83	2.00%	2.42%	0.00%	0.00%	0.00%	0.00%	12.88%	0.25%	0.00%	$65.88
Behavioral Health Physician	$11.94	2.00%	3.64%	0.00%	0.00%	0.00%	0.00%	7.71%	0.03%	0.00%	$14.07
Transportation	$7.54	4.03%	-9.66%	0.00%	0.00%	0.00%	0.00%	4.68%	1.03%	0.00%	$8.03
Other Professional Services	$23.75	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.94%	0.14%	0.00%	$27.73
Pharmacy	$79.24	6.00%	0.00%	0.00%	0.15%	0.00%	-0.52%	0.00%	0.00%	-2.00%	$90.82
Outpatient Facility	$45.57	5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.13%	-0.71%	0.00%	$51.67
Emergency Facility	$23.69	5.00%	-1.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$26.77
Laboratory and Radiology Services	$19.97	2.00%	0.00%	0.00%	0.00%	2.64%	0.00%	6.85%	0.00%	0.00%	$23.13
Dental	$1.28	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	14.30%	0.27%	0.00%	$1.62
FQHC	$30.11	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	8.17%	0.00%	0.00%	$35.80
Gross Medical	**$349.20**	**4.26%**	**0.19%**	**0.00%**	**0.03%**	**0.15%**	**-0.12%**	**4.35%**	**-0.02%**	**-0.45%**	**$407.79**

Total DAP	**$4.66**
Total Gross Medical PMPM	**$412.45**

GSA: North
Rate Cell: Delivery Supplemental Payments
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 2,968
Projection Period Member Months: 2,866

Category of Service	Adjusted Base PMPD	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient	$3,281.98	6.08%	0.00%	0.00%	0.00%	0.00%	0.00%	4.19%	0.00%	0.00%	$4,021.99
Physician	$1,562.88	2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	14.92%	0.00%	0.00%	$1,897.05
Transportation	$149.24	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	5.07%	0.00%	0.00%	$174.80
Other Professional Services	$163.46	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	3.42%	0.00%	0.00%	$188.45
Pharmacy	$35.00	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$39.01
Outpatient	$18.88	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$21.01
Laboratory and Radiology Services	$33.00	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	8.02%	0.00%	0.00%	$39.74
FQHC	$4.39	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$4.89
Gross Medical	**$5,248.84**	**4.74%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**7.14%**	**0.00%**	**0.00%**	**$6,386.94**

Total DAP	**$28.15**
Total Gross Medical PMPD	**$6,415.10**

GSA: Central
Rate Cell: Delivery Supplemental Payments
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 21,929
Projection Period Member Months: 21,174

Category of Service	Adjusted Base PMPD	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient	$3,199.05	6.09%	0.00%	0.00%	0.00%	0.00%	0.00%	4.54%	0.00%	0.00%	$3,934.63
Physician	$1,664.98	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	14.77%	0.00%	0.00%	$2,045.69
Transportation	$32.87	3.53%	0.00%	0.00%	0.00%	0.00%	0.00%	4.18%	0.00%	0.00%	$37.67
Other Professional Services	$95.92	3.53%	0.00%	0.00%	0.00%	0.00%	0.00%	6.40%	0.00%	0.00%	$112.28
Pharmacy	$46.04	3.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$50.65
Outpatient	$10.98	3.53%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.16%	0.00%	0.00%	$12.06
Laboratory and Radiology Services	$26.14	3.53%	0.00%	0.00%	0.00%	0.00%	0.00%	8.01%	0.00%	0.00%	$31.06
FQHC	$3.86	3.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$4.24
Gross Medical	**$5,079.84**	**4.83%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**7.69%**	**0.00%**	**0.00%**	**$6,228.28**

Total DAP	**$22.49**
Total Gross Medical PMPD	**$6,250.76**

GSA: South
Rate Cell: Delivery Supplemental Payments
Base Period: January 1, 2019 through December 31, 2019
Projection Period: October 1, 2021 through September 30, 2022
Base Period Member Months: 7,875
Projection Period Member Months: 7,604

Category of Service	Adjusted Base PMPD	Trend	Telehealth	Opioid Treatment Program	Alzheimer's Drug Approval	COVID-19 Tests	P & T Committee	Aggregate Fee Schedule Updates	Combined Misc. Changes	Rx Rebates	Gross Medical
Inpatient	$3,245.15	6.07%	0.00%	0.00%	0.00%	0.00%	0.00%	8.20%	0.00%	0.00%	$4,128.83
Physician	$1,626.32	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	15.20%	0.00%	0.00%	$2,005.71
Transportation	$69.05	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	4.86%	0.00%	0.00%	$79.62
Other Professional Services	$155.48	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	5.56%	0.00%	0.00%	$180.51
Pharmacy	$36.91	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$40.59
Outpatient	$25.61	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.18%	0.00%	0.00%	$28.12
Laboratory and Radiology Services	$24.35	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	7.13%	0.00%	0.00%	$28.68
FQHC	$9.19	3.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$10.11
Gross Medical	**$5,192.04**	**4.82%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**10.03%**	**0.00%**	**0.00%**	**$6,502.16**

Total DAP	**$27.48**
Total Gross Medical PMPD	**$6,529.65**

Appendix 7: Capitation Rate Development

Rate Cell: AGE < 1

		Before Risk Adjustment			After Risk Adjustment							
GSA	MCO	Gross Medical Plus DAP	RI Offset	Risk Adj Factor	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
North	Care1st Health Plan Arizona, Inc.	$ 686.76	$ (89.30)	0.9680	$ 664.76	$ (86.44)	$ 578.32	$ 43.98	1.00%	$ 6.29	$ 12.83	$ 641.41
North	Health Choice Arizona, Inc.	$ 686.76	$ (89.30)	1.0225	$ 702.21	$ (91.31)	$ 610.90	$ 51.47	1.00%	$ 6.69	$ 13.65	$ 682.72
Central	Arizona Complete Health - Complete Care Plan	$ 646.25	$ (50.73)	0.9728	$ 628.68	$ (49.35)	$ 579.33	$ 50.82	1.00%	$ 6.37	$ 12.99	$ 649.50
Central	Banner - University Family Care	$ 646.25	$ (50.73)	0.9867	$ 637.67	$ (50.06)	$ 587.61	$ 37.06	1.00%	$ 6.31	$ 12.88	$ 643.86
Central	Molina Healthcare of Arizona, Inc.	$ 646.25	$ (50.73)	1.0340	$ 668.23	$ (52.46)	$ 615.77	$ 71.78	1.00%	$ 6.94	$ 14.17	$ 708.67
Central	Mercy Care	$ 646.25	$ (50.73)	1.0070	$ 650.79	$ (51.09)	$ 599.70	$ 54.67	1.00%	$ 6.61	$ 13.49	$ 674.46
Central	Health Choice Arizona, Inc.	$ 646.25	$ (50.73)	1.0164	$ 656.82	$ (51.56)	$ 605.26	$ 48.37	1.00%	$ 6.60	$ 13.47	$ 673.70
Central	UnitedHealthcare Community Plan	$ 646.25	$ (50.73)	1.0008	$ 646.77	$ (50.77)	$ 596.00	$ 48.52	1.00%	$ 6.51	$ 13.29	$ 664.31
South	Arizona Complete Health - Complete Care Plan	$ 662.32	$ (47.30)	0.9934	$ 657.93	$ (46.99)	$ 610.94	$ 54.93	1.00%	$ 6.73	$ 13.73	$ 686.32
South	Banner - University Family Care	$ 662.32	$ (47.30)	1.0111	$ 669.68	$ (47.83)	$ 621.85	$ 42.17	1.00%	$ 6.71	$ 13.69	$ 684.42
South	UnitedHealthcare Community Plan (Pima Only)	$ 662.32	$ (47.30)	0.9922	$ 657.14	$ (46.93)	$ 610.21	$ 50.00	1.00%	$ 6.67	$ 13.61	$ 680.50

Notes

Underwriting (UW) Gain is equal to 1.0% of the pre-tax capitation rate. Premium Tax is 2.0% of the final capitation rate.

Rate Cell: AGE 1-20

		Before Risk Adjustment			After Risk Adjustment							
GSA	MCO	Gross Medical Plus DAP	RI Offset	Risk Adj Factor	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
North	Care1st Health Plan Arizona, Inc.	$ 186.26	$ (5.89)	1.0166	$ 189.35	$ (5.99)	$ 183.36	$ 28.93	1.00%	$ 2.14	$ 4.38	$ 218.81
North	Health Choice Arizona, Inc.	$ 186.26	$ (5.89)	0.9863	$ 183.70	$ (5.81)	$ 177.89	$ 21.93	1.00%	$ 2.02	$ 4.12	$ 205.96
Central	Arizona Complete Health - Complete Care Plan	$ 190.51	$ (7.18)	0.9639	$ 183.63	$ (6.92)	$ 176.71	$ 23.18	1.00%	$ 2.02	$ 4.12	$ 206.03
Central	Banner - University Family Care	$ 190.51	$ (7.18)	1.0168	$ 193.72	$ (7.30)	$ 186.42	$ 18.47	1.00%	$ 2.07	$ 4.22	$ 211.19
Central	Molina Healthcare of Arizona, Inc.	$ 190.51	$ (7.18)	1.0001	$ 190.53	$ (7.18)	$ 183.35	$ 45.61	1.00%	$ 2.31	$ 4.72	$ 236.00
Central	Mercy Care	$ 190.51	$ (7.18)	1.0093	$ 192.29	$ (7.24)	$ 185.05	$ 18.74	1.00%	$ 2.06	$ 4.20	$ 210.05
Central	Health Choice Arizona, Inc.	$ 190.51	$ (7.18)	0.9793	$ 186.56	$ (7.03)	$ 179.54	$ 21.94	1.00%	$ 2.04	$ 4.15	$ 207.67
Central	UnitedHealthcare Community Plan	$ 190.51	$ (7.18)	1.0180	$ 193.95	$ (7.31)	$ 186.64	$ 18.85	1.00%	$ 2.08	$ 4.24	$ 211.81
South	Arizona Complete Health - Complete Care Plan	$ 196.17	$ (5.76)	0.9686	$ 190.01	$ (5.58)	$ 184.43	$ 24.27	1.00%	$ 2.11	$ 4.30	$ 215.11
South	Banner - University Family Care	$ 196.17	$ (5.76)	0.9891	$ 194.02	$ (5.69)	$ 188.33	$ 19.62	1.00%	$ 2.10	$ 4.29	$ 214.34
South	UnitedHealthcare Community Plan (Pima Only)	$ 196.17	$ (5.76)	1.0550	$ 206.95	$ (6.07)	$ 200.88	$ 19.97	1.00%	$ 2.23	$ 4.55	$ 227.63

Notes

Underwriting (UW) Gain is equal to 1.0% of the pre-tax capitation rate. Premium Tax is 2.0% of the final capitation rate.

Rate Cell: AGE 21+

		Before Risk Adjustment			After Risk Adjustment							
GSA	MCO	Gross Medical Plus DAP	RI Offset	Risk Adj Factor	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
North	Care1st Health Plan Arizona, Inc.	$ 331.14	$ (4.70)	1.0179	$ 337.06	$ (4.78)	$ 332.27	$ 33.60	1.00%	$ 3.70	$ 7.54	$ 377.11
North	Health Choice Arizona, Inc.	$ 331.14	$ (4.70)	0.9864	$ 326.62	$ (4.64)	$ 321.99	$ 30.08	1.00%	$ 3.56	$ 7.26	$ 362.88
Central	Arizona Complete Health - Complete Care Plan	$ 387.49	$ (5.33)	0.9477	$ 367.24	$ (5.05)	$ 362.19	$ 34.59	1.00%	$ 4.01	$ 8.18	$ 408.97
Central	Banner - University Family Care	$ 387.49	$ (5.33)	0.9698	$ 375.77	$ (5.16)	$ 370.61	$ 26.10	1.00%	$ 4.01	$ 8.18	$ 408.89
Central	Molina Healthcare of Arizona, Inc.	$ 387.49	$ (5.33)	0.8669	$ 335.93	$ (4.62)	$ 331.32	$ 53.58	1.00%	$ 3.89	$ 7.93	$ 396.72
Central	Mercy Care	$ 387.49	$ (5.33)	1.0496	$ 406.72	$ (5.59)	$ 401.13	$ 35.54	1.00%	$ 4.41	$ 9.00	$ 450.09
Central	Health Choice Arizona, Inc.	$ 387.49	$ (5.33)	0.9756	$ 378.02	$ (5.20)	$ 372.83	$ 32.70	1.00%	$ 4.10	$ 8.36	$ 417.98
Central	UnitedHealthcare Community Plan	$ 387.49	$ (5.33)	1.0099	$ 391.32	$ (5.38)	$ 385.95	$ 31.78	1.00%	$ 4.22	$ 8.61	$ 430.56
South	Arizona Complete Health - Complete Care Plan	$ 346.79	$ (3.30)	0.9658	$ 334.92	$ (3.18)	$ 331.74	$ 33.76	1.00%	$ 3.69	$ 7.53	$ 376.73
South	Banner - University Family Care	$ 346.79	$ (3.30)	0.9914	$ 343.82	$ (3.27)	$ 340.56	$ 26.72	1.00%	$ 3.71	$ 7.57	$ 378.56
South	UnitedHealthcare Community Plan (Pima Only)	$ 346.79	$ (3.30)	1.0559	$ 366.16	$ (3.48)	$ 362.68	$ 30.59	1.00%	$ 3.97	$ 8.11	$ 405.35

Notes

Underwriting (UW) Gain is equal to 1.0% of the pre-tax capitation rate. Premium Tax is 2.0% of the final capitation rate.

Rate Cell: Duals

		Before Risk Adjustment			After Risk Adjustment							
GSA	MCO	Gross Medical Plus DAP	RI Offset	Risk Adj Factor	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
North	Care1st Health Plan Arizona, Inc.	$ 111.16	$ (0.11)	1.0000	$ 111.16	$ (0.11)	$ 111.06	$ 26.45	1.00%	$ 1.39	$ 2.83	$ 141.73
North	Health Choice Arizona, Inc.	$ 111.16	$ (0.11)	1.0000	$ 111.16	$ (0.11)	$ 111.06	$ 17.80	1.00%	$ 1.30	$ 2.66	$ 132.81
Central	Arizona Complete Health - Complete Care Plan	$ 131.26	$ (2.46)	1.0000	$ 131.26	$ (2.46)	$ 128.80	$ 19.93	1.00%	$ 1.50	$ 3.07	$ 153.30
Central	Banner - University Family Care	$ 131.26	$ (2.46)	1.0000	$ 131.26	$ (2.46)	$ 128.80	$ 15.86	1.00%	$ 1.46	$ 2.98	$ 149.10
Central	Molina Healthcare of Arizona, Inc.	$ 131.26	$ (2.46)	1.0000	$ 131.26	$ (2.46)	$ 128.80	$ 42.37	1.00%	$ 1.73	$ 3.53	$ 176.43
Central	Mercy Care	$ 131.26	$ (2.46)	1.0000	$ 131.26	$ (2.46)	$ 128.80	$ 13.96	1.00%	$ 1.44	$ 2.94	$ 147.15
Central	Health Choice Arizona, Inc.	$ 131.26	$ (2.46)	1.0000	$ 131.26	$ (2.46)	$ 128.80	$ 18.83	1.00%	$ 1.49	$ 3.04	$ 152.17
Central	UnitedHealthcare Community Plan	$ 131.26	$ (2.46)	1.0000	$ 131.26	$ (2.46)	$ 128.80	$ 14.75	1.00%	$ 1.45	$ 2.96	$ 147.96
South	Arizona Complete Health - Complete Care Plan	$ 125.36	$ (0.33)	1.0000	$ 125.36	$ (0.33)	$ 125.04	$ 20.03	1.00%	$ 1.47	$ 2.99	$ 149.53
South	Banner - University Family Care	$ 125.36	$ (0.33)	1.0000	$ 125.36	$ (0.33)	$ 125.04	$ 16.36	1.00%	$ 1.43	$ 2.91	$ 145.74
South	UnitedHealthcare Community Plan (Pima Only)	$ 125.36	$ (0.33)	1.0000	$ 125.36	$ (0.33)	$ 125.04	$ 14.52	1.00%	$ 1.41	$ 2.88	$ 143.85

Notes

Underwriting (UW) Gain is equal to 1.0% of the pre-tax capitation rate. Premium Tax is 2.0% of the final capitation rate.

Rate Cell: SSI Without Medicare

		Before Risk Adjustment			After Risk Adjustment							
GSA	MCO	Gross Medical Plus DAP	RI Offset	Risk Adj Factor	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
North	Care1st Health Plan Arizona, Inc.	$ 1,124.62	$ (35.35)	1.0153	$ 1,141.87	$ (35.89)	$ 1,105.98	$ 59.09	1.00%	$ 11.77	$ 24.02	$ 1,200.85
North	Health Choice Arizona, Inc.	$ 1,124.62	$ (35.35)	0.9868	$ 1,109.75	$ (34.88)	$ 1,074.86	$ 74.69	1.00%	$ 11.61	$ 23.70	$ 1,184.87
Central	Arizona Complete Health - Complete Care Plan	$ 1,334.67	$ (132.36)	0.9154	$ 1,221.73	$ (121.16)	$ 1,100.57	$ 87.65	1.00%	$ 12.00	$ 24.49	$ 1,224.72
Central	Banner - University Family Care	$ 1,334.67	$ (132.36)	0.9635	$ 1,285.94	$ (127.53)	$ 1,158.41	$ 64.20	1.00%	$ 12.35	$ 25.20	$ 1,260.17
Central	Molina Healthcare of Arizona, Inc.	$ 1,334.67	$ (132.36)	1.0000	$ 1,334.67	$ (132.36)	$ 1,202.31	$ 108.29	1.00%	$ 13.24	$ 27.02	$ 1,350.86
Central	Mercy Care	$ 1,334.67	$ (132.36)	1.0730	$ 1,432.11	$ (142.02)	$ 1,290.09	$ 115.88	1.00%	$ 14.20	$ 28.98	$ 1,449.16
Central	Health Choice Arizona, Inc.	$ 1,334.67	$ (132.36)	0.9635	$ 1,285.90	$ (127.52)	$ 1,158.38	$ 83.72	1.00%	$ 12.55	$ 25.61	$ 1,280.26
Central	UnitedHealthcare Community Plan	$ 1,334.67	$ (132.36)	1.0005	$ 1,335.36	$ (132.43)	$ 1,202.93	$ 93.62	1.00%	$ 13.10	$ 26.73	$ 1,336.38
South	Arizona Complete Health - Complete Care Plan	$ 1,260.12	$ (73.23)	0.9725	$ 1,225.49	$ (71.22)	$ 1,154.27	$ 92.12	1.00%	$ 12.59	$ 25.69	$ 1,284.67
South	Banner - University Family Care	$ 1,260.12	$ (73.23)	0.9929	$ 1,251.12	$ (72.71)	$ 1,178.41	$ 69.75	1.00%	$ 12.61	$ 25.73	$ 1,286.49
South	UnitedHealthcare Community Plan (Pima Only)	$ 1,260.12	$ (73.23)	1.0433	$ 1,314.71	$ (76.41)	$ 1,238.30	$ 93.88	1.00%	$ 13.46	$ 27.46	$ 1,373.10

Notes

Underwriting (UW) Gain is equal to 1.0% of the pre-tax capitation rate. Premium Tax is 2.0% of the final capitation rate.

Rate Cell: Prop 204 Childless Adults

		Before Risk Adjustment			After Risk Adjustment							
GSA	MCO	Gross Medical Plus DAP	RI Offset	Risk Adj Factor	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
North	Care1st Health Plan Arizona, Inc.	$ 570.67	$ (10.97)	1.0214	$ 582.91	$ (11.20)	$ 571.70	$ 41.39	1.00%	$ 6.19	$ 12.64	$ 631.92
North	Health Choice Arizona, Inc.	$ 570.67	$ (10.97)	0.9830	$ 560.97	$ (10.78)	$ 550.19	$ 43.43	1.00%	$ 6.00	$ 12.24	$ 611.85
Central	Arizona Complete Health - Complete Care Plan	$ 668.60	$ (16.30)	0.9612	$ 642.63	$ (15.67)	$ 626.96	$ 51.69	1.00%	$ 6.86	$ 13.99	$ 699.49
Central	Banner - University Family Care	$ 668.60	$ (16.30)	0.9698	$ 648.43	$ (15.81)	$ 632.62	$ 37.51	1.00%	$ 6.77	$ 13.81	$ 690.71
Central	Molina Healthcare of Arizona, Inc.	$ 668.60	$ (16.30)	1.0149	$ 678.57	$ (16.55)	$ 662.02	$ 72.35	1.00%	$ 7.42	$ 15.14	$ 756.92
Central	Mercy Care	$ 668.60	$ (16.30)	1.0590	$ 708.03	$ (17.27)	$ 690.76	$ 59.15	1.00%	$ 7.57	$ 15.46	$ 772.95
Central	Health Choice Arizona, Inc.	$ 668.60	$ (16.30)	0.9694	$ 648.12	$ (15.80)	$ 632.32	$ 47.88	1.00%	$ 6.87	$ 14.02	$ 701.09
Central	UnitedHealthcare Community Plan	$ 668.60	$ (16.30)	0.9831	$ 657.30	$ (16.03)	$ 641.27	$ 49.21	1.00%	$ 6.97	$ 14.23	$ 711.68
South	Arizona Complete Health - Complete Care Plan	$ 571.26	$ (10.04)	0.9773	$ 558.31	$ (9.81)	$ 548.50	$ 48.40	1.00%	$ 6.03	$ 12.30	$ 615.24
South	Banner - University Family Care	$ 571.26	$ (10.04)	1.0094	$ 576.63	$ (10.13)	$ 566.50	$ 37.76	1.00%	$ 6.10	$ 12.46	$ 622.82
South	UnitedHealthcare Community Plan (Pima Only)	$ 571.26	$ (10.04)	1.0135	$ 578.99	$ (10.17)	$ 568.82	$ 44.79	1.00%	$ 6.20	$ 12.65	$ 632.45

Notes

Underwriting (UW) Gain is equal to 1.0% of the pre-tax capitation rate. Premium Tax is 2.0% of the final capitation rate.

Rate Cell: Expansion Adults

		Before Risk Adjustment			After Risk Adjustment							
GSA	MCO	Gross Medical Plus DAP	RI Offset	Risk Adj Factor	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
North	Care1st Health Plan Arizona, Inc.	$ 475.79	$ (5.87)	1.0357	$ 492.79	$ (6.08)	$ 486.71	$ 38.53	1.00%	$ 5.31	$ 10.83	$ 541.38
North	Health Choice Arizona, Inc.	$ 475.79	$ (5.87)	0.9711	$ 462.04	$ (5.70)	$ 456.34	$ 37.79	1.00%	$ 4.99	$ 10.19	$ 509.30
Central	Arizona Complete Health - Complete Care Plan	$ 471.76	$ (14.05)	0.9720	$ 458.55	$ (13.66)	$ 444.89	$ 40.26	1.00%	$ 4.90	$ 10.00	$ 500.05
Central	Banner - University Family Care	$ 471.76	$ (14.05)	0.9976	$ 470.65	$ (14.02)	$ 456.63	$ 30.07	1.00%	$ 4.92	$ 10.03	$ 501.65
Central	Molina Healthcare of Arizona, Inc.	$ 471.76	$ (14.05)	0.9539	$ 449.99	$ (13.40)	$ 436.59	$ 59.83	1.00%	$ 5.01	$ 10.23	$ 511.66
Central	Mercy Care	$ 471.76	$ (14.05)	1.0284	$ 485.14	$ (14.45)	$ 470.70	$ 41.69	1.00%	$ 5.18	$ 10.56	$ 528.12
Central	Health Choice Arizona, Inc.	$ 471.76	$ (14.05)	0.9787	$ 461.72	$ (13.75)	$ 447.97	$ 37.41	1.00%	$ 4.90	$ 10.01	$ 500.28
Central	UnitedHealthcare Community Plan	$ 471.76	$ (14.05)	1.0021	$ 472.75	$ (14.08)	$ 458.68	$ 37.12	1.00%	$ 5.01	$ 10.22	$ 511.02
South	Arizona Complete Health - Complete Care Plan	$ 412.45	$ (7.20)	0.9622	$ 396.84	$ (6.93)	$ 389.91	$ 37.82	1.00%	$ 4.32	$ 8.82	$ 440.87
South	Banner - University Family Care	$ 412.45	$ (7.20)	1.0149	$ 418.58	$ (7.31)	$ 411.27	$ 30.27	1.00%	$ 4.46	$ 9.10	$ 455.10
South	UnitedHealthcare Community Plan (Pima Only)	$ 412.45	$ (7.20)	1.0229	$ 421.88	$ (7.37)	$ 414.51	$ 34.31	1.00%	$ 4.53	$ 9.25	$ 462.60

Notes

Underwriting (UW) Gain is equal to 1.0% of the pre-tax capitation rate. Premium Tax is 2.0% of the final capitation rate.

Rate Cell: Delivery Supplemental Payments

		Before Risk Adjustment			After Risk Adjustment							
GSA	MCO	Gross Medical Plus DAP	RI Offset	Risk Adj Factor	Gross Medical Plus DAP	RI Offset	Net Medical	Admin PMPD	UW Gain Percent	UW Gain PMPD	Premium Tax	Capitation Rate PMPD
North	Care1st Health Plan Arizona, Inc.	$ 6,415.10	$ -	-	$ 6,415.10	$ -	$ 6,415.10	$ -	1.00%	$ 64.80	$ 132.24	$ 6,612.14
North	Health Choice Arizona, Inc.	$ 6,415.10	$ -	-	$ 6,415.10	$ -	$ 6,415.10	$ -	1.00%	$ 64.80	$ 132.24	$ 6,612.14
Central	Arizona Complete Health - Complete Care Plan	$ 6,250.76	$ -	-	$ 6,250.76	$ -	$ 6,250.76	$ -	1.00%	$ 63.14	$ 128.86	$ 6,442.76
Central	Banner - University Family Care	$ 6,250.76	$ -	-	$ 6,250.76	$ -	$ 6,250.76	$ -	1.00%	$ 63.14	$ 128.86	$ 6,442.76
Central	Molina Healthcare of Arizona, Inc.	$ 6,250.76	$ -	-	$ 6,250.76	$ -	$ 6,250.76	$ -	1.00%	$ 63.14	$ 128.86	$ 6,442.76
Central	Mercy Care	$ 6,250.76	$ -	-	$ 6,250.76	$ -	$ 6,250.76	$ -	1.00%	$ 63.14	$ 128.86	$ 6,442.76
Central	Health Choice Arizona, Inc.	$ 6,250.76	$ -	-	$ 6,250.76	$ -	$ 6,250.76	$ -	1.00%	$ 63.14	$ 128.86	$ 6,442.76
Central	UnitedHealthcare Community Plan	$ 6,250.76	$ -	-	$ 6,250.76	$ -	$ 6,250.76	$ -	1.00%	$ 63.14	$ 128.86	$ 6,442.76
South	Arizona Complete Health - Complete Care Plan	$ 6,529.65	$ -	-	$ 6,529.65	$ -	$ 6,529.65	$ -	1.00%	$ 65.96	$ 134.60	$ 6,730.21
South	Banner - University Family Care	$ 6,529.65	$ -	-	$ 6,529.65	$ -	$ 6,529.65	$ -	1.00%	$ 65.96	$ 134.60	$ 6,730.21
South	UnitedHealthcare Community Plan (Pima Only)	$ 6,529.65	$ -	-	$ 6,529.65	$ -	$ 6,529.65	$ -	1.00%	$ 65.96	$ 134.60	$ 6,730.21

Notes

Underwriting (UW) Gain is equal to 1.0% of the pre-tax capitation rate. Premium Tax is 2.0% of the final capitation rate.

Appendix 8a: State Directed Payments – CMS Prescribed Tables

CMS Prescribed Table for I.4.D.ii.(a)(i)

Control name of the state directed payment	Type of payment - Section I.4.D.ii.(a)(i)(A)	Brief description - Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.d.ii.(a)(iii)
AZ_Fee_IP.OP.PC_Renewal_20211001-20220931 (a.k.a. DAP)	Uniform Percentage Increase	Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.	Rate Adjustment
AZ_Fee_AMC_Renewal_20211001-20220930 (a.k.a. APSI)	Uniform Percentage Increase	62% increase to otherwise contracted rates for professional services provided by qualified practitioners affiliated with designated hospitals.	Separate Payment Term
AZ_Fee_IP.OP1_Renewal_20211001-20220930 (a.k.a. PSI)	Uniform Percentage Increase	Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The uniform percentage increase is based on a fixed total payment amount, and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_IP.OP2_Renewal_20211001-20220930 (a.k.a. HEALTHII)	Uniform Percentage Increase	Uniform percentage increase for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class' aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term

CMS Prescribed Table for I.4.D.ii.(a)(ii)

Control name of the state directed payment	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Impact - Section I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
AZ_Fee_IP.OP.PC_Renewal_20211001-20220931 (a.k.a. DAP)	All ACC rate cells are affected.	See Appendix 6 for medical impact by rate cell and Appendix 8b for total impact by rate cell.	The qualifying providers receiving the payments include: Hospitals subject to APR-DRG reimbursement (eligible for up to 3.0% increase), Critical Access Hospitals (eligible for up to 10.5% increase), Other Hospitals and Inpatient Facilities (eligible for up to 5.0% 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 (eligible for a 1.0% increase), Behavioral Health Outpatient Clinics and Integrated Clinics (eligible for up to 8.5% increase on all services provided), Physicians, Physician Assistants, and Registered Nurse Practitioners (eligible for up to 3.5% increase), Behavioral Health Providers (eligible for up to 1.0% increase), Dental Providers (eligible for up to 2.0% increase), and HCBS Providers (eligible for up to 1.0% increase on specified services for some provider types, and all services for other provider types). 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 20 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 22 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 22 (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).	AHCCCS has submitted the Differential Adjusted Payments (DAP) §438.6(c) pre-print to CMS, but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the pre-print under CMS review.	Not applicable.

CMS Prescribed Table for I.4.D.ii.(a)(iii)

Control name of the state directed payment	Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20211001-20220930 (a.k.a. APSI)	$137,275,049	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b	AHCCCS has submitted the Access to Professional Services Initiative (APSI) §438.6(c) pre-print to CMS, but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IP.OP1_Renewal_20211001-20220930 (a.k.a. PSI)	$44,914,808	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b	AHCCCS has submitted the Pediatric Service Initiative (PSI) §438.6(c) pre-print to CMS, but has not yet received approval. The PSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IP.OP2_Renewal_20211001-20220930 (a.k.a. HEALTHII)	$1,152,469,105	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) §438.6(c) pre-print to CMS, but has not yet received approval. The HEALTHII payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

Appendix 8b: State Directed Payments – Estimated PMPMs

		CYE 22 DAP PMPM [1]							
GSA	MCO	Age < 1	AGE 1-20	Age 21+	Duals	SSIWO	Prop 204 Childless Adults	Expansion Adults	Delivery Supplemental Payments
North	Care1st Health Plan Arizona, Inc.	$11.46	$2.75	$5.00	$1.59	$13.20	$7.04	$5.96	$29.02
North	Health Choice Arizona, Inc.	$12.11	$2.67	$4.85	$1.59	$12.83	$6.78	$5.59	$29.02
Central	Arizona Complete Health - Complete Care Plan	$10.50	$2.62	$4.66	$1.30	$13.53	$7.79	$4.68	$23.18
Central	Banner - University Family Care	$10.65	$2.76	$4.76	$1.30	$14.24	$7.86	$4.80	$23.18
Central	Molina Healthcare of Arizona, Inc.	$11.16	$2.71	$4.26	$1.30	$14.78	$8.23	$4.59	$23.18
Central	Mercy Care	$10.87	$2.74	$5.16	$1.30	$15.86	$8.59	$4.95	$23.18
Central	Health Choice Arizona, Inc.	$10.97	$2.66	$4.79	$1.30	$14.24	$7.86	$4.71	$23.18
Central	UnitedHealthcare Community Plan	$10.80	$2.76	$4.96	$1.30	$14.79	$7.97	$4.82	$23.18
South	Arizona Complete Health - Complete Care Plan	$10.14	$2.29	$4.69	$1.35	$13.96	$6.88	$4.62	$28.33
South	Banner - University Family Care	$10.32	$2.33	$4.82	$1.35	$14.26	$7.11	$4.88	$28.33
South	UnitedHealthcare Community Plan (Pima County Only)	$10.13	$2.49	$5.13	$1.35	$14.98	$7.14	$4.91	$28.33

1) The PMPMs here are inclusive of premium tax, underwriting gain, and risk adjustment. These PMPMs will not match the medical PMPMs in Appendix 6.

		CYE 22 Estimated APSI PMPM [1]							
GSA	MCO	Age < 1	AGE 1-20	Age 21+	Duals	SSIWO	Prop 204 Childless Adults	Expansion Adults	Delivery Supplemental Payments
North	Care1st Health Plan Arizona, Inc.	$11.65	$2.59	$1.08	$0.05	$5.64	$1.83	$0.77	$0.00
North	Health Choice Arizona, Inc.	$15.17	$1.51	$1.18	$0.23	$4.39	$1.72	$0.96	$0.00
Central	Arizona Complete Health - Complete Care Plan	$25.92	$4.39	$5.15	$0.43	$23.26	$7.90	$2.86	$0.00
Central	Banner - University Family Care	$29.64	$3.82	$6.38	$0.44	$20.51	$10.31	$4.19	$0.00
Central	Molina Healthcare of Arizona, Inc.	$16.51	$2.38	$3.38	$2.03	$10.88	$8.29	$3.89	$0.00
Central	Mercy Care	$28.94	$5.20	$7.11	$0.45	$24.96	$9.66	$3.74	$0.00
Central	Health Choice Arizona, Inc.	$36.74	$5.42	$5.31	$0.39	$19.30	$7.56	$3.24	$0.00
Central	UnitedHealthcare Community Plan	$29.94	$5.01	$5.23	$0.40	$22.88	$6.24	$3.26	$0.00
South	Arizona Complete Health - Complete Care Plan	$39.23	$3.70	$7.23	$0.53	$19.18	$8.24	$3.32	$0.00
South	Banner - University Family Care	$55.52	$4.95	$11.62	$0.30	$27.03	$13.69	$6.48	$0.00
South	UnitedHealthcare Community Plan (Pima County Only)	$74.22	$6.64	$14.09	$0.32	$29.22	$11.07	$5.48	$0.00

1) The PMPMs here are inclusive of premium tax.

		CYE 22 Estimated PSI PMPM [1]							
GSA	MCO	Age < 1	AGE 1-20	Age 21+	Duals	SSIWO	Prop 204 Childless Adults	Expansion Adults	Delivery Supplemental Payments
North	Care1st Health Plan Arizona, Inc.	$27.41	$2.45	$0.02	$0.00	$6.63	$0.06	$0.13	$0.00
North	Health Choice Arizona, Inc.	$17.70	$1.81	$0.09	$0.00	$2.84	$0.02	$0.01	$0.00
Central	Arizona Complete Health - Complete Care Plan	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Central	Banner - University Family Care	$11.97	$2.07	$0.01	$0.00	$15.53	$0.12	$0.09	$0.00
Central	Molina Healthcare of Arizona, Inc.	$6.38	$1.65	$0.02	$0.00	$2.68	$0.02	$0.01	$0.00
Central	Mercy Care	$25.29	$5.56	$0.42	$0.00	$13.88	$0.24	$0.05	$0.00
Central	Health Choice Arizona, Inc.	$24.84	$4.09	$0.08	$0.00	$40.94	$0.20	$0.07	$0.00
Central	UnitedHealthcare Community Plan	$37.97	$5.42	$0.04	$0.00	$19.05	$0.12	$0.54	$0.00
South	Arizona Complete Health - Complete Care Plan	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
South	Banner - University Family Care	$16.66	$1.10	$0.06	$0.00	$7.06	$0.01	$0.00	$0.00
South	UnitedHealthcare Community Plan (Pima County Only)	$14.84	$0.36	$0.00	$0.00	$7.99	$0.00	$0.00	$0.00

1) The PMPMs here are inclusive of premium tax.

		CYE 22 Estimated HEALTHII PMPM [1]							
GSA	MCO	Age < 1	AGE 1-20	Age 21+	Duals	SSIWO	Prop 204 Childless Adults	Expansion Adults	Delivery Supplemental Payments
North	Care1st Health Plan Arizona, Inc.	$240.10	$20.66	$92.90	$18.34	$237.57	$119.39	$71.70	$0.00
North	Health Choice Arizona, Inc.	$285.09	$21.14	$94.59	$23.26	$211.43	$115.79	$65.88	$0.00
Central	Arizona Complete Health - Complete Care Plan	$216.06	$14.78	$75.68	$12.14	$192.28	$102.70	$38.70	$0.00
Central	Banner - University Family Care	$188.42	$14.76	$60.73	$18.24	$173.49	$91.52	$37.89	$0.00
Central	Molina Healthcare of Arizona, Inc.	$129.23	$6.34	$34.04	$13.09	$82.75	$72.02	$32.55	$0.00
Central	Mercy Care	$213.62	$16.90	$85.88	$22.09	$221.14	$104.16	$40.28	$0.00
Central	Health Choice Arizona, Inc.	$319.65	$19.65	$91.72	$26.17	$258.60	$116.58	$45.21	$0.00
Central	UnitedHealthcare Community Plan	$234.63	$14.92	$74.30	$9.10	$191.24	$83.00	$38.29	$0.00
South	Arizona Complete Health - Complete Care Plan	$229.58	$21.63	$82.82	$15.26	$209.43	$90.66	$46.08	$0.00
South	Banner - University Family Care	$280.27	$21.77	$85.11	$21.31	$216.29	$113.26	$54.15	$0.00
South	UnitedHealthcare Community Plan (Pima County Only)	$288.99	$17.44	$75.23	$10.84	$225.57	$83.40	$39.50	$0.00

1) The PMPMs here are inclusive of premium tax.