Contract Year Ending 2019 Arizona Long Term Care System Department of Economic Security/Division of Developmental Disabilities Capitation Rate Certification

July 1, 2018 through September 30, 2019

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies used in the development of the revision to the July 1, 2018 through June 30, 2019 (Contract Year Ending 2019 or CYE 19) actuarially sound capitation rates for the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) program. In accordance with a change to the contract period, the rates are further revised in order to be actuarially sound for the period July 1, 2018 through September 30, 2019. Hereafter, the term “CYE 19” will refer to the 15-month rating period ending September 30, 2019. Comparisons to prior rates in this certification refer to the previously submitted actuarial memorandums for capitation rates as signed by Matthew C. Varitek on January 1, 2018, May 15, 2018, and August 21, 2018. This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 of 81 FR 27497 applicable to this rate certification, the 2019 Medicaid Managed Care Rate Development Guide (2019 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2019 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 2019 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

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

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

As stated on page 2 of the 2019 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 2019 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The revised CYE 19 capitation rates for the ALTCS DES/DDD Program are effective for the fifteen month time period from July 1, 2018 through September 30, 2019 in order to accommodate multiple changes described below. In total, there are three distinct time frames for capitation rates for the fifteen month period from July 1, 2018 through September 30, 2019. The time frames coincide with separate fee schedule or programmatic changes and the last time frame includes a contract extension period. The time frames are defined as the three months from July 1, 2018 through September 30, 2018, the three months from October 1, 2018 through December 31, 2018, and the nine months from January 1, 2019 through September 30, 2019.

In prior years, the LTSS portion of the ALTCS DES/DDD capitation rate was evaluated and developed on a state fiscal year (SFY) basis (from July 1 through June 30), while the Acute portion of the capitation rate was developed on a federal fiscal year basis (FFY) basis. AHCCCS and ALTCS DES/DDD have agreed to align the contract periods, extending the current LTSS rating period to the end of the federal fiscal year, thus allowing future years' rate development process to evaluate both portions of the ALTCS DES/DDD capitation rates on a FFY basis. At the same time, AHCCCS has received and reviewed additional data from ALTCS DES/DDD that shows that a backlog of authorized but not assigned services has been reduced, resulting in an increase in utilization that was not known or accounted for during the original rate development process for the capitation rates submitted in May 2018. Accordingly, the LTSS portion of the capitation rate is updated in this certification to be actuarially sound for the period from July 1, 2018 to September 30, 2019, while the change to the Acute portion of the capitation rate is updated in this certification to be actuarially sound for the period from October 1, 2018 to September 30, 2019. The Acute portion of the rates from July 1, 2018 to September 30, 2018 has not been changed and is still actuarially sound.

I.1.A.ii. Required Elements

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

The actuarial certification letter for the revised CYE 19 capitation rates for the ALTCS DES/DDD Program, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854, provided below for reference.

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

Mr. Varitek certifies that the revised CYE 19 capitation rates for the ALTCS DES/DDD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 of 81 FR 27497.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ALTCS DES/DDD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856. The ALTCS DES/DDD 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 of 81 FR 27497 and the 2019 Guide.

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

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

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

ALTCS DES/DDD is the only managed care plan for this program. They subcontract a portion of their responsibilities, including acute care for all members enrolled in managed care and CRS specialty care and behavioral health services for members with Children's Rehabilitative Services (CRS) conditions to other managed care organizations (MCOs). Those components of the capitation rate are set on a different time basis since ALTCS DES/DDD runs on a state fiscal year basis, but their subcontractors run on a federal fiscal year (FFY) basis. This certification covers a fifteen month time frame in order to align both components to a federal fiscal year basis going forward.

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

The following is a general description of services covered under the ALTCS DES/DDD Program. Additional information regarding covered services can be found in the Scope of Services section of the ALTCS DES/DDD contract.

Services covered by ALTCS DES/DDD have traditionally included long-term care services, physical health services and limited behavioral health services (i.e. treatment for ADHD, anxiety and depression when provided by the member's primary care physician) for most members. Effective October 1, 2018, coverage of services also includes CRS specialty care and comprehensive behavioral health services for child members who have a CRS qualifying condition, as coverage of those services are shifting from the CRS Program. Targeted Case Management (TCM) services are covered for those members who do not meet the functional requirements for ALTCS services.

ALTCS DES/DDD members who do not have a CRS condition receive behavioral health services through a Regional Behavioral Health Authority (RBHA), or for American Indians, through a Tribal Regional Behavioral Health Authority (TRBHA) or an Indian Health Services (IHS) provider, or a 638 Tribal Facility. Except for members with CRS conditions, expenses for behavioral health services are included in the capitation rates for the RBHA Program and paid fee-for-service for TRBHAs, IHS providers, and 638 Tribal Facilities. Therefore, most behavioral health services are excluded from ALTCS DES/DDD. Additional information regarding the excluded behavioral health services, along with the coordination of behavioral

health services for ALTCS DES/DDD enrolled members, can be found in the Behavioral Health Services section of the ALTCS DES/DDD contract.

I.1.A.ii.(c)(i)(C) Area of State Covered and Lifetime of Program

ALTCS DES/DDD operates on a statewide basis and has been the health plan for individuals with developmental disabilities (DD) since the late 1980s.

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

The revised CYE 19 capitation rates for ALTCS DES/DDD are effective for the three month time period from July 1, 2018 through September 30, 2018, the three month time period from October 1, 2018 through December 31, 2018, and the nine month time period from January 1, 2019 through September 30, 2019.

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

The populations covered under ALTCS DES/DDD are individuals with a qualifying developmental disability.

ALTCS DES/DDD capitation rates are developed for two distinct rate cells.

The first rate cell (regular DDD capitation rate) includes the costs of providing long-term care and Acute covered services for DD members. Effective October 1, 2018, this rate cell also includes CRS specialty care and behavioral health services of members with CRS conditions, as well as a rebase of the acute rate component (including the Acute reinsurance offset and administrative expenses for the Acute sub-contractors) and other prospective changes. The capitation rate incorporates an additional increase effective January 1, 2019 for the impact of the minimum wage change.

The second rate cell is for Targeted Case Management (TCM) and includes the costs of providing case management services for members who have a DD diagnosis and meet the financial eligibility of Title XIX or Title XXI programs, but do not meet the functional requirements of ALTCS. This rate is adjusted October 1, 2018 to incorporate the impact of planned changes to caseload ratios. The actuary relied on cost projections provided by ALTCS DES/DDD for TCM staffing and services in developing the TCM capitation rate. The caseload ratio change applied only to a portion (approximately 70%) of the TCM members who were being served via a caseload ratio of 1:60; not all TCM members are served via the same caseload ratios. The caseload ratios applicable to the members in the Regular DDD rate cell were not affected. Additional information regarding covered populations can be found in the Enrollment and Disenrollment section of the ALTCS DES/DDD contract.

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

ALTCS DES/DDD determines eligibility for ALTCS/DD services through four diagnoses: cerebral palsy, epilepsy, autism, or a cognitive disability.

There are 3 types of DDD eligibility.

Members who are DDD State Only receive Support Coordination and direct services based on assessed need and availability of state funds. These members are not eligible for Targeted Case Management or ALTCS, and are not considered in this rate certification.

Members who are Targeted Case Management are eligible for Title XIX or Title XXI acute care services including Early Periodic Screening Diagnosis and Treatment (EPSDT), but do not meet the functional requirements of ALTCS. Members in this category receive Support Coordination.

Members who are ALTCS eligible receive Support Coordination and direct services based on assessed need including medical necessity and cost effectiveness, and acute services including EPSDT. Members eligible for ALTCS have choice with regards to which ALTCS DES/DDD sub-contracted Acute health plan they wish to enroll in.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the revised CYE 19 capitation rates are:

- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- APM Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

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

The actuary is certifying to retroactive adjustments to previous capitation rates and AHCCCS is submitting the corresponding contract amendment in accordance with 42 CFR § 438.7(c)(2).

I.1.A.ii.(c)(vi)(A) Retroactive Adjustment: Rationale

The following items were identified subsequent to the development of previous rates and are corrected or revised in this certification:

- LTSS components effective July 1, 2018 due to backlog at ALTCS DES/DDD of authorized but unassigned services
- Three month extension of the contract year end, changing from June 30, 2019 to September 30, 2019
- Acute non-CRS and Acute CRS components effective October 1, 2018 due to revision in membership basis, which impacts multiple steps within development of these components, including DAP

- Acute non-CRS and Acute CRS reinsurance offsets effective October 1, 2018 due to correction of accumulating all Acute non-CRS and Acute CRS Inpatient services towards the ALTCS DES/DDD regular reinsurance deductible
- Acute CRS component effective October 1, 2018 due to changes to the PMPM impacts of programmatic and fee schedule changes

I.1.A.ii.(c)(vi)(B) Retroactive Adjustment: Data, Assumptions and Methodology

Backlog

At the time of the original rate development process, AHCCCS and the actuary were unaware of the backlog at ALTCS DES/DDD of authorized but unassigned services. ALTCS DES/DDD has been working through the backlog and while a minor increase in utilization occurred in the final quarter of calendar year 2017 (the original base data time frame), the majority of the increased utilization occurred after the start of calendar year 2018.

The actuary is updating the base data time frame for the retroactive capitation rates to include state fiscal year 2018 (July 1, 2017 through June 30, 2018) to capture the increased utilization in the base data medical expense for Institutional and HCBS services, and revising the trend rate development to include this later time frame, as well as aligning the model of trend analysis with that used on other AHCCCS programs.

Extension of the Contract Year

The contract year is being extended so the Institutional and HCBS components of the gross medical expense assumption are being trended forward to the midpoint of the extended contract year.

Acute non-CRS and Acute CRS components

The base data (encounters incurred from October 1, 2016 to September 30, 2017) and trend assumptions for Acute non-CRS and Acute CRS services are not being revised from those contained in the ALTCS DES/DDD actuarial certification dated August 21, 2018, although some PMPM cost estimates are changing due to a revision of the membership basis for the PMPM calculations. Within the actuarial certification dated August 21, 2018, the projected costs were distributed among the forecasted number of members who will receive services through Acute subcontractor MCOs. As the certified capitation rates paid to ALTCS DES/DDD are paid for all members enrolled in the DES/DDD program, including American Indian members who are not enrolled with Acute subcontractors, the revised PMPM amounts for these components reflect the corrected membership basis.

Acute non-CRS and Acute CRS reinsurance offsets

The Acute non-CRS and Acute CRS reinsurance offsets are being revised to correct oversights, as identified in Section I.4.C.ii.(c)(iv) of this certification, in the development of the reinsurance offsets for each component found in the ALTCS DES/DDD actuarial certification dated August 21, 2018.

Acute CRS component

The actuary is including changes to the impacts included for base data adjustments and programmatic and fee schedule changes for the Acute CRS component, as identified in Sections I.2.B.iii.(d) and I.3.B.ii.(a) of this certification.

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

Proposed differences among the revised CYE 19 capitation rates for the ALTCS DES/DDD Program are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the ALTCS DES/DDD Program.

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

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

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

The effective dates of changes to the ALTCS DES/DDD Program are consistent with the assumptions used to develop the revised CYE 19 capitation rates for the ALTCS DES/DDD Program.

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

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

In the actuary's judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate and attainable costs. To the actuary's knowledge, all reasonable, appropriate and attainable costs have been included in the rate certification.

I.1.A.vi.(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.vi.(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 revised CYE 19 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not Applicable. Capitation rates from previous rating periods are not used in the development of the revised CYE 19 capitation rates for the ALTCS DES/DDD Program.

I.1.A.viii. Rate Certification Procedures

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

This rate certification documents that the ALTCS DES/DDD Program capitation rates will be changing effective July 1, 2018, October 1, 2018, and January 1, 2019.

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

Not Applicable. This rate certification will retroactively change the ALTCS DES/DDD Program capitation rates effective July 1, 2018, October 1, 2018, and January 1, 2019.

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

This section of the 2019 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell, in accordance with 42 CFR §438.7(c)(3), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii).

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

A contract amendment will be submitted to CMS to reflect the ALTCS DES/DDD Program capitation rates changing effective July 1, 2018, October 1, 2018, and January 1, 2019.

I.1.B. Appropriate Documentation

I.1.B.i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the revised CYE 19 capitation rates for the ALTCS DES/DDD Program.

I.1.B.ii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2019 Guide. Sections of the 2019 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.iii. Differences in Federal Medical Assistance Percentage

The covered populations under the ALTCS DES/DDD Program receive the regular FMAP. ALTCS DES/DDD Program receives some Children's Health Insurance Program (CHIP) funding for TCM for those acute enrolled members who are TXXI.

I.1.B.iv. Comparison of Rates

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

The comparisons between the previously certified CYE 18 ALTCS DES/DDD Program capitation rates, and the revised CYE 19 capitation rates being certified in this actuarial rate certification are available in Appendix 3a. The comparisons between the previously submitted CYE 19 ALTCS DES/DDD Program capitation rates, and the revised CYE 19 capitation rates being certified in this actuarial rate certification are available in Appendix 3b.

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

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

I.2. Data

This section provides documentation for the Data section of the 2019 Guide.

I.2.A. Rate Development Standards

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

AHCCCS has provided validated encounter data and audited financial reports demonstrating experience for the populations to be served by the health plan(s) to the actuary developing the capitation rates, for at least the three most recent and complete years prior to the rating period. The actuary is using the most appropriate base data, specific to the Medicaid population to be covered under the program, to develop the capitation rates. No exception request is required as the data being used to develop rates is no older than the three most recent and complete years prior to the rating period.

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

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

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

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

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

The types of data that AHCCCS relied upon for developing the revised CYE 19 capitation rates for the ALTCS DES/DDD program were:

- Adjudicated and approved encounter data submitted by ALTCS DES/DDD and the CRS Contractor;
- Reinsurance payments for FFY 17 (used as base for reinsurance offset);
- Historical and projected enrollment data for ALTCS DES/DDD members and TCM members;
- Supplemental nursing facility (NF) and home and community based services (HCBS) expenses provided by the ALTCS DES/DDD program;
- Quarterly and annual financial statements submitted by ALTCS DES/DDD and the CRS Contractor;
- Historical and projected targeted case management expenses provided by ALTCS DES/DDD; and
- Historical and projected administrative and case management expenses from ALTCS DES/DDD and the CRS Contractor.

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

The Institutional and HCBS portion of the DDD capitation rates used encounter data incurred during state fiscal year 2018 (July 1, 2017 to June 30, 2018) and paid through October 2018 as the base experience in the revised CYE 19 capitation rate development process. For the purposes of trend development and analyzing historical experience, AHCCCS also reviewed encounter data from state fiscal year 2016 (July 1, 2015 through June 30, 2016) and 2017 (July 1, 2016 through June 30, 2017).

The Acute non-CRS portion and the Acute CRS portion of the DDD capitation rates used encounter data incurred during contract year 2017 (October 1, 2016 to September 30, 2017) and paid through March 2018 as the base experience in the CYE 19 capitation rate development process. For the purposes of trend development and analyzing historical experience, AHCCCS also reviewed encounter data from contract year 2015 (October 1, 2014 through September 30, 2015) and 2016 (October 1, 2015 through September 30, 2016).

The historical enrollment data for ALTCS DES/DDD and TCM members aligned with the encounter data time periods. The projected enrollment data for CYE 19 was provided by the AHCCCS Division of Business and Finance (DBF).

The financial statement data reviewed as part of the rate development process included financial statements for state fiscal years 2016, 2017, and 2018 for the Institutional and HCBS components and financial statements for federal fiscal years 2015, 2016, and 2017 for Acute non-CRS and Acute CRS components. The historical TCM expenses were from July 1, 2015 through June 30, 2018.

The historical administration and case management expense data were from calendar years 2015, 2016, and 2017, and the projected expenses for administration and case management were for SFY 18 and SFY 19.

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

The enrollment and encounter data were provided from the AHCCCS PMMIS mainframe. The financial statement data were submitted by ALTCS DES/DDD, the ALTCS DES/DDD Acute subcontractors and the CRS Contractor and reviewed by the AHCCCS Finance & Reinsurance team. The supplemental NF and HCBS expense data, TCM data, administration and case management data were provided by ALTCS DES/DDD.

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

For LTSS (NF/HCBS), ALTCS DES/DDD does not use sub-capitated arrangements. The program utilizes staff models for the Arizona Training Program Coolidge (ATPC), Institutional Care Facility/Individuals with Intellectual Disabilities (ICF/IID), and State Operated Group Homes (SOGH) which account for approximately 2.6% of the LTSS medical expenses and those services are reflected in the supplemental expense information from ALTCS DES/DDD.

ALTCS DES/DDD Acute sub-contractors, and the CRS contractor responsible for providing CRS specialty care and behavioral health services to ALTCS DES/DDD members with a CRS qualifying condition, have sub-capitated/block purchasing arrangements which account for approximately 14.4% of Acute services inclusive of the CRS services. The Acute (including Acute-CRS) component of the DDD capitation rate is set on a federal fiscal year basis to correspond with the ALTCS DES/DDD contract with their Acute sub-contractors and the CRS contractor.

The sub-capitated arrangements between the Acute non-CRS sub-contractors, the CRS contractor, 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 subcapitated 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. subcapitated)) encounters to estimate a health plan valued amount for these encounters. The repricing methodology used in the rate development process for the Acute component differs between the Acute non-CRS subcontractors and the CRS contractor. For the CRS Contractor 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 to estimate a health plan valued amount. For the Acute non-CRS subcontractors, the encounters are re-priced to match the financial statements detailing sub-capitated expenditures for each Acute non-CRS subcontractor. These different repricing methodologies have been tested and found to be the most appropriate for capturing accurate costs by the different Contractors (aligning to reported financial statements detailing sub-capitated expenditures). The units of service data from the sub-capitated encounters and the repriced amounts were used for the basis of calculating utilization and unit cost for the Acute non-CRS and Acute-CRS components, in conjunction with the regular encounters.

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

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

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

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

ALTCS DES/DDD, their Acute subcontractors, and the CRS Contractor know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides ALTCS DES/DDD and the CRS Contractor with the “Encounter Monthly Data File” (aka the “magic” file) which contains the previous 36 months of encounter data. ALTCS DES/DDD is responsible for providing the “magic” file to

the Acute subcontractors. Data fields contained in this file include, but are not limited to, adjudication status, AHCCCS ID, Claim Reference Number (CRN), Provider ID and various cost amounts. The adjudication status has five types: adjudicated/approved, adjudicated/plan denied, adjudicated/AHCCCS denied, pended and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters, but providing this file to ALTCS DES/DDD and the CRS Contractor allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions. No pended data was used to develop the capitation rates.

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

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

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

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

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

Through the DHCM Actuarial Team review of the encounter data provided from the AHCCCS PMMIS mainframe, the team ensured that only encounter data with valid AHCCCS member IDs was used in developing the revised CYE 19 capitation rates for the ALTCS DES/DDD program. Additionally, the team ensured that only services covered under the state plan were included.

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

The AHCCCS DHCM Actuarial Team reviewed the encounter data for consistency by viewing month over month, year over year as well as encounter data versus financial statements. For acute non-CRS services, the total expenses reported in FFY 2017 financial statements differed from the total expenses from completed encounter data for that time frame by 0.07%. For institutional and HCBS services, the total expenses reported in SFY 2018 financial statements differed from the total expenses from completed encounter data for that time frame by 0.45% The contractor for the CRS program does not separately report the costs specific to ALTCS DES/DDD members in financial statements. As a result, CRS specialty care encounter data being incorporated into the ALTCS DES/DDD program could not be compared directly to the financial statements. For the entire CRS program, the total expenses reported in FFY 2017 financial statements differed from the total expenses from completed encounter data by 0.86%. As such, the encounter data was deemed to be consistent for capitation rate setting.

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

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon encounter data submitted by ALTCS DES/DDD, their Acute subcontractors, and the CRS Contractor 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 ALTCS DES/DDD, their Acute subcontractors, and the CRS Contractor and reviewed by the AHCCCS Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

AHCCCS has determined the FFY 2017 encounter data and the SFY 2018 encounter data, as described in Section I.2.B.ii.(a)(ii), to be appropriate for the purposes of developing the appropriate components for the revised CYE 19 capitation rates for the ALTCS DES/DDD program. Additionally, the FFY 2015 and FFY 2016 and SFY 2016 and SFY 2017 encounter data was deemed appropriate for use in trends for the appropriate components in conjunction with the base data time periods.

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

There are no concerns with the availability or quality of the data used.

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

The FFY 2017 encounter data for Acute non-CRS and Acute CRS services, and the SFY 2018 encounter data for LTSS, were appropriate to use as the base data for developing the revised CYE 19 capitation rates for the ALTCS DES/DDD program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the revised CYE 19 capitation rates for the ALTCS DES/DDD program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the revised CYE 19 capitation rates for the ALTCS DES/DDD program.

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

Not applicable. The AHCCCS DHCM Actuarial Team did not rely on a data book to develop the revised CYE 19 capitation rates.

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

Adjustments were made to the data to estimate completion and to normalize historical encounters to current provider reimbursement levels.

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

No credibility adjustment was necessary.

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

An adjustment was made to the encounter data to reflect the level of completion. For the institutional and HCBS components, AHCCCS calculated completion factors using the development method with monthly encounter data from July 1, 2015 through June 30, 2018, paid through October 2018. The monthly completion factors were applied to the encounter data on a monthly basis. The aggregated SFY

2018 completion factors are shown in Appendix 4a. For the Acute non-CRS and Acute CRS components, AHCCCS calculated completion factors using the development method with monthly encounter data from October 1, 2014 through September 30, 2017, paid through March 2018. The monthly completion factors were applied to the encounter data on a monthly basis. The aggregated FFY 2017 completion factors are shown in Appendix 4b.

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

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

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

Table 1 summarizes the PMPM impacts by category of service for historical program and reimbursement changes used to adjust base data and to normalize experience data for trend analysis. The PMPM impacts included in Table 1 for the Acute CRS base data adjustments and trend normalization are changed from the adjustments used in the rate development described in the ALTCS DES/DDD actuarial certification dated August 21, 2018. The TCM column is included for completeness but none of the listed items have any impact on the TCM capitation rate.

Table 1: PMPM Impacts of Historical Program/Reimbursement Changes

Change and Effective Date	Institutional	HCBS	Acute Non-CRS	Acute CRS	TCM
LTSS					
Proposition 206 Reimbursement Rate Changes effective 1/1/2017	$1.44	$136.18	$0.00	$0.00	$0.00
Proposition 206 Reimbursement Rate Changes effective 7/1/2017	$0.12	$34.83	$0.00	$0.00	$0.00
Proposition 206 Reimbursement Rate Changes effective 1/1/2018	$0.37	$35.07	$0.00	$0.00	$0.00
Acute including CRS					
High-Acuity Pediatrics effective 1/1/2017	$0.00	$0.00	$1.87	$0.79	$0.00
Emergency Dental for Adults 21+ effective 10/1/2017	$0.00	$0.00	$1.22	$0.00	$0.00
Provider Fee Schedule Changes effective 10/1/2017	$0.00	$0.00	$1.22	$0.10	$0.00
DRG reimbursement rate changes effective 1/1/2018	$0.00	$0.00	$3.46	$2.11	$0.00
Hepatitis C Treatment effective 1/1/2018	$0.00	$0.00	-$0.19	$0.00	$0.00

LTSS:

Proposition 206 Reimbursement Rate Changes

Effective January 1, 2017, July 1, 2017, and January 1, 2018, AHCCCS increased fee schedule rates for select Home and Community-Based Services (HCBS) procedure codes, all Nursing Facility (NF) revenue codes, and all Alternative Living Facility (ALF) procedure codes, to address the increased labor costs resulting from minimum wage increases approved on November 8, 2016 by the state's voters under Proposition 206 and by city of Flagstaff voters under Proposition 414. This assures that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the

general population in the geographic area. Through continued discussion with ALTCS DES/DDD, AHCCCS knows the increased rates are similarly adopted by ALTCS DES/DDD.

Historical encounter data for relevant HCBS procedure codes, NF revenue codes, and ALF procedure codes was used to develop adjustments for the minimum wage increases. The magnitude of each adjustment varied by the percentage of services for which reimbursement rates were adjusted and the amount by which each service was adjusted. The PMPM impacts to Institutional and HCBS services, as provided in Table 1, were incorporated into base data adjustment and trend development as appropriate.

Acute including CRS:

High-Acuity Pediatrics

The AHCCCS All Patient Refined Diagnosis Related Group (APR-DRG) payment system includes several policy adjustors. One such adjustor applies a factor of 1.25 to the reimbursement amount that would otherwise apply for "claims for members under age 19," so long as the claim is not subject to one of the other policy adjustors. On January 1, 2016, AHCCCS addressed the costs associated with high-acuity pediatric cases by using an adjustment factor of 1.60 in place of the above pediatric policy adjustor in the following instances only: for inpatient stays, where an APR-DRG assignment of level 3 or 4 Severity of Illness is indicated. Effective January 1, 2017, AHCCCS will change the adjustment factor of 1.60 established January 1, 2016 to 1.945. The PMPM impacts to Acute non-CRS and Acute CRS services, as provided in Table 1, were incorporated into trend development.

Emergency Dental for Adults (Aged 21 and Over)

As part of the 2017 Legislative session, the Arizona Legislature passed SB 1527, reinstating emergency adult dental services and extractions up to a limit of $1,000 annually, a covered service prior to October 1, 2010. AHCCCS restored this as a covered service effective October 1, 2017.

The AHCCCS DHCM Actuarial Team reviewed actual encounter data from the time period October 1, 2016 to April 30, 2018 to determine the change in expenditures based on the reinstatement of emergency adult dental, and found the original estimate described in CYE 18 certifications of approximately $1.22 PMPM to Acute non-CRS services to be appropriate in determining the PMPM cost for restoration of this benefit, and is continuing the same estimated PMPM for CYE 19 capitation rates. The language from the CYE 18 certifications is copied here for convenience of review.

> “To estimate the impact of restoring emergency adult dental services, the AHCCCS DHCM Actuarial Team used historical adult (21 and over) dental encounter data and member month data for the time frame October 1, 2009 through September 2011. While this data is outside of the requirement under §438.5(c) to use data from the most recent three years of the rating period to develop capitation rates, the AHCCCS DHCM Actuarial Team determined that this data was reasonable to use to estimate the impact of restoring the benefit. The time frame of October 1, 2009 through September 2011 includes the final year (FFY 10 (10/1/09 – 09/30/10)) AHCCCS covered emergency

adult dental services and the first year (FFY 11 (10/1/10 – 09/30/11)) AHCCCS did not cover emergency adult dental services.

The AHCCCS DHCM Actuarial Team developed dental PMPMs by rate cell and GSA for both the FFY10 and FFY11 time frames. The difference between FFY 10 PMPMs and FFY 11 PMPMs was assumed to be the impact of removing the emergency adult dental services. This difference between the FFY 10 PMPMs and FFY 11 PMPMs was trended forwarded to FFY 18 using an annualized trend of 2.0%. The 2.0% trend was derived using actuarial judgement with consideration of the following information:

- Consumer Price Index - data from IHS Global Insight that was provided to the AHCCCS DHCM Rates & Reimbursement Team;
- National Health Expenditures;
- Encounter data for children dental; and
- AHCCCS FFS fee schedule changes."

The PMPM impact to Acute non-CRS services, as provided in Table 1, was incorporated into base data adjustment.

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, 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 their fee schedules.

The PMPM impacts to Acute non-CRS and Acute CRS services effective October 1, 2017, as provided in Table 1, were incorporated into base data adjustment.

DRG Reimbursement Rate Changes

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

The AHCCCS DHCM Actuarial Team estimated and incorporated the impact of the DRG rebase in CYE 18 capitation rates. The method used to develop the CYE 18 capitation rates was deemed appropriate for continued use in developing CYE 19 capitation rates. This method was described in the CYE 18 certification and the language has been copied here for convenience of review.

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

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

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

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

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

The PMPM impacts to Acute non-CRS and Acute CRS services, as provided in Table 1, were incorporated into base data adjustment.

Hepatitis C (HCV) Treatment

In 2017, the AHCCCS Pharmacy and Therapeutics (P&T) Committee reviewed the HCV Direct Acting Antiviral Agents (DAA) and recommended Mavyret as the sole preferred agent to treat HCV based on both clinical efficacy and cost effectiveness. AHCCCS accepted the P&T's recommendation and also removed fibrosis level requirements that were previously necessary in order to access treatment and removed a one treatment per lifetime limitation effective January 1, 2018.

The AHCCCS DHCM Actuarial Team estimated and incorporated the impact of these changes to HCV Treatment in CYE 18 capitation rates. The method used to develop the CYE 18 capitation rates was deemed appropriate for continued use in developing CYE 19 capitation rates and the method description from the CYE 18 revised actuarial certification is included below for convenience of review.

> "The actuary extracted data for encounters and enrollment, grouped by rate cell and GSA for dates of service from October 1, 2016 through June 30, 2017. It was assumed that the encounter data required no adjustment for completion given historical run out patterns specific to HCV DAAs. The actuary then applied the anticipated unit cost for Mavyret treatment as provided by AHCCCS, in conjunction with the P&T Committee, to the encounter data to calculate a revised expenditure for the existing utilization. The actuary inflated the expected Mavyret utilization by 50%, relying on an assumption from the P&T Committee regarding the impact of removing the liver fibrosis requirement, to calculate a revised expenditure for the time period of encounter data and used the enrollment data from the time period of the encounter data to convert to the PMPM. The adjustment to Acute Care capitation rates is therefore the calculated PMPM expenditure by rate cell and GSA using the new assumptions less the observed PMPM expenditure by rate cell and GSA from encounter data."

The PMPM impact to Acute non-CRS services, as provided in Table 1, was incorporated into base data adjustment.

Removal of DAP from Base Period

CYE 17 capitation rates funded Differential Adjusted Payments (DAP) made from October 1, 2016 through September 30, 2017 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, 2017, AHCCCS has removed the impact of CYE 17 DAP payments from the base period. The PMPM impacts to Acute non-CRS and Acute CRS services, as provided in Appendix 4b, were incorporated into base data adjustment. The impacts are corrected from those provided within the certification dated August 21, 2018. See section I.4.D.ii below for information on adjustments included in CYE 19 rates for DAP that are effective from July 1, 2018 through September 30, 2019.

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

The AHCCCS DHCM Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the revised CYE 19 capitation rates.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2019 Guide.

I.3.A. Rate Development Standards

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

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

I.3.A.ii. Variations in Assumptions

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

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

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

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

AHCCCS programs have historically utilized Institution for Mental Diseases (IMD) settings to provide medically appropriate and cost effective in-lieu-of services, as allowed in 42 CFR § 438.3(e)(2) of 81 FR 27497, for inpatient treatment for behavioral health.

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

Not applicable. Institution for mental disease (IMD) payments in accordance with 42 CFR § 438.6(e) of 81 FR 27497 are for behavioral health services. During the base data period, IMD in-lieu-of services were covered under the RBHA program. Therefore, no adjustment was made to the ALTCS DES/DDD encounter data or capitation rate.

I.3.A.vi. Section 12002 of the 21st Century Cures Act (P.L. 114-255)

This is not applicable to the ALTCS DES/DDD Program, since there was no utilization of IMDs for enrollees aged 21 to 64 in the encounter data used for the development of the capitation rate.

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

See Appendix 4b for final projected benefit costs paid through Acute non-CRS and the CRS subcontractors. The sum of the final projected benefit costs for the Acute non-CRS and Acute CRS components does not equal the Acute Services amounts shown in Appendices 5a and 5b due to the inclusion of projected expenses for Acute costs paid on a fee-for-service basis for American Indian

members not enrolled with Acute subcontractors. This inclusion also holds true for the Acute Services Reinsurance offset in Appendices 5a and 5b.

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

This section provides information on the projected benefit costs included in the revised CYE 19 capitation rates for the ALTCS DES/DDD Program.

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

The data described in Section I.2.B.ii.(a) was adjusted to reflect assumed completion, benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The per-member-per-month (PMPM) expenditures for each LTSS COS in the base year (SFY 18) were trended forward to the midpoint of the 15-month rating period by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a). The PMPM expenditures for the Acute non-CRS and Acute CRS COS in the base year (FFY 17) were trended forward to the midpoint of the FFY 19 by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a). As noted in Section I.1.A.i., the Acute non-CRS component for the time period July 1, 2018 through September 30, 2018 is still actuarially sound and has not been adjusted.

The capitation rates were adjusted for all program and reimbursement changes, whether material or non-material. The actuary defines "non-material" as an impact of less than 0.2% to total capitation.

Table 2 summarizes the PMPM impacts by category of service for prospective program and reimbursement changes effective at any point during the CYE 19 rating period. The PMPM impacts included in Table 2 for prospective program and reimbursement changes for both the Institutional component and the Acute CRS component differ from the impacts used in the rate development described in the ALTCS DES/DDD actuarial certification dated August 21, 2018. The TCM column is included for completeness but none of the listed items have any impact on the TCM capitation rate.

Table 2: PMPM Impacts of Prospective Program/Reimbursement Changes

Change and Effective Date	Institutional	HCBS	Acute Non-CRS	Acute CRS	TCM
LTSS					
Provider Fee Schedule Changes effective 7/1/2018	-$5.56	$0.00	$0.00	$0.00	$0.00
Skilled Nursing Facility Rate Increase effective 10/1/2018	$0.47	$0.00	$0.00	$0.00	$0.00
Proposition 206 Reimbursement Rate Changes effective 1/1/2019	$0.22	$37.30	$0.00	$0.00	$0.00
Acute including CRS					
CRS Specialty & BH Services effective 10/1/2018	$0.00	$0.00	$0.00	$184.81	$0.00
Genetic Testing effective 10/1/2018	$0.00	$0.00	$4.95	$0.27	$0.00
Social Determinants of Health effective 10/1/2018	$0.00	$0.00	$0.08	$0.00	$0.00
Provider Fee Schedule Changes effective 10/1/2018	$0.00	$0.00	$2.60	$0.28	$0.00

LTSS:

Provider Fee Schedule Changes

Effective July 1, 2018, ALTCS DES/DDD negotiated an aggregate 13.22% decrease to the provider reimbursement rates for one specific Intermediate Care Facility. This decrease was not known at the time of rate development for the certification dated May 15, 2018. The retroactive change to the capitation rate effective July 1, 2018 incorporates this adjustment. The PMPM impact to Institutional services, as provided in Table 2, was incorporated into expense projections for the rating period.

Skilled Nursing Facility Rate Increase

As part of the 2018 Legislative session, the Arizona Legislature passed SB 1520 which includes an appropriation to increase reimbursement by 3% for skilled nursing facilities and assisted living facilities. AHCCCS covers nursing facility services provided in institutional settings and assisted living facility services provided in home and community based settings to ALTCS DES/DDD members. AHCCCS is adjusting CYE 19 capitation rates effective October 1, 2018 for the 3% rate increase.

To estimate the impact, the AHCCCS DHCM Actuarial Team multiplied projected medical expenses for applicable skilled nursing facilities and assisted living facilities by the 3% provider rate increase. The PMPM impact to Institutional services, as provided in Table 2, was incorporated into expense projections for the rating period. This impact is different than that found in the actuarial certification dated August 21, 2018, because the provider increase was improperly applied to all Institutional services in that certification.

Proposition 206 Reimbursement Rate Changes

Effective January 1, 2019, AHCCCS is increasing fee schedule rates for select Home and Community-Based Services (HCBS) procedure codes, all Nursing Facility (NF) revenue codes, and all Alternative Living Facility (ALF) procedure codes, to address the increased labor costs resulting from minimum wage increases approved on November 8, 2016 by the state's voters under Proposition 206 and by city of Flagstaff voters under Proposition 414. This assures that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. Through continued discussion with ALTCS DES/DDD, AHCCCS knows the increased rates are similarly adopted by ALTCS DES/DDD.

The data used to develop an adjustment for the minimum wage increase was the CYE 17 encounter data for the HCBS procedure codes, NF revenue codes, and the ALF procedure codes. For HCBS, a 1.4% increase was applied to the encounter data to reflect a January 1, 2019 minimum wage adjustment. For NF and ALF, a 0.7% increase was applied to the encounter data to reflect a January 1, 2019 minimum wage adjustment. The PMPM impacts to Institutional and HCBS services, as provided in Table 2, were incorporated into expense projections for the rating period.

Acute including CRS:

CRS Specialty and Behavioral Health Services

Effective October 1, 2018, CRS specialty care and behavioral health services provided to ALTCS DES/DDD members are shifted from the CRS Program to the ALTCS DES/DDD. The PMPM impact to Acute CRS services, as provided in Table 2, was incorporated into expense projections for the rating period. Table 3 below provides the PMPM impact net of reinsurance to the statewide rate. There is no need to establish a separate rate cell for CRS members in the DDD capitation rate; the costs associated with these services are included in the development of the regular DDD capitation rate, but the rate that ALTCS DES/DDD pays to the subcontractor that administers services for these members reflects the higher PMPM expenses of this subset of the membership.

Table 3: PMPM Impacts (10/1/18 – 6/30/19) to Medical Expenditures and Reinsurance (RI) Offsets

Rate Cell	Projected FFY 19 (Oct-Sep) Member Months	Increase to Medical Expense PMPM (10/1/18)	Increase to RI Offset PMPM (10/1/18)	Net Impact to Medical Expense PMPM (10/1/18)
Statewide	400,692	$184.81	($6.12)	$178.69

Amounts in Table 3 reflect adjusted base costs of CRS specialty care and behavioral health services and include trend, program, reimbursement, and other adjustments made to the service data that are discussed elsewhere in the certification. Additional adjustments for DAP and APSI are not reflected in this table, but are included in Appendix 4b.

The projected medical expenditures are not assumed to change as a result of these services being integrated into the ALTCS DES/DDD program, because there was no reasonable basis for predicting how utilization or unit costs would be affected by the integration. Another reason to expect no change to utilization or unit cost of CRS services is that the Contractor providing CRS services for DES/DDD members in CYE 19 is the same Contractor that was providing CRS services for DES/DDD members in CYE 18 under the separate CRS program.

Genetic Testing

AHCCCS policy guidance changed to clarify that covered genetic testing services include specific chromosomal tests for diagnosing developmental delays in infants and children. The policy guidance is expected to lead to increased use of these currently covered services in FFY 19. The estimated impact was determined by analyzing prior year encounters and projecting increase in use of genetic testing services. The PMPM impacts to Acute non-CRS and Acute CRS services, as provided in Table 2, were incorporated into expense projections for the rating period.

Social Determinants of Health

The Targeted Investments Program has benchmarks for screening members for the presence of social determinants of health (SDOH). These benchmarks are expected to result in increased use of the covered screening services in FFY 19. The PMPM impact to Acute non-CRS services, as provided in Table 2, was incorporated into expense projections for the rating period.

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, 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 their fee schedules.

Effective October 1, 2018, AHCCCS will be updating provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 19 capitation rates have been adjusted effective October 1, 2018 to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to CYE 19 capitation rates was the CYE 17 encounter data across all programs. The AHCCCS DHCM Rates & Reimbursement Team applied the AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 19 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. The PMPM impacts to Acute non-CRS and Acute CRS services, as provided in Table 2, were incorporated into expense projections for the rating period.

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

There were no material changes to the data, assumptions or methodologies used to develop the capitation rates apart from the inclusion of the CRS specialty and behavioral health services provided to ALTCS DES/DDD members with CRS health conditions already addressed elsewhere in this rate certification.

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

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

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

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

Please see Section I.2.B.ii.(a) for the types of data that AHCCCS relied upon for developing the projected benefit cost trends for the revised CYE 19 capitation rates for the ALTCS DES/DDD Program.

All data used was specific to the ALTCS DES/DDD population.

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

Historical utilization, unit cost, and PMPM data from FFY 2015, 2016, and 2017 were organized by incurred year and month and category of service (COS) for Acute non-CRS and Acute-CRS services. Similarly, historical utilization, unit cost, and PMPM data from SFY 2016, 2017, and 2018 were organized by incurred year and month and COS for LTSS services. In all cases, the three years of data were

normalized for historical program and fee schedule changes. Trend rates were developed to adjust the Acute non-CRS and Acute-CRS base data (midpoint April 1, 2017) forward 24 months to the midpoint of the Acute non-CRS and Acute-CRS contract period (April 1, 2019), and to adjust the LTSS base data (midpoint January 1, 2018) forward 13.5 months to the midpoint of the extended contract period (February 15, 2019). Projected benefit cost trends were based on actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. No simple formulaic solution exists to determine future trend; actuarial judgment is required. Each category of service was analyzed in the same manner.

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

All revised PMPM trend assumptions for the affected COS were compared to similar assumptions made in CYE 18 for ALTCS DES/DDD and CRS Program capitation rates and judged reasonable to assume for projection to CYE 19.

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

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

The trend assumptions were developed by unit cost and utilization. Trend rates by COS may vary from year to year simply because different years of data are being used to develop the assumptions. In particular, the trend assumptions for Habilitative Residential ("Hab Res" below) and Day Treatment COS were affected by increased utilization associated with processing the backlog of unassigned services described in Section I.1.A.i. The negative utilization trends assumed for Pharmacy, Dental, and Inpatient services under Acute Services (Excluding CRS) reflect observed decreases in utilization during the three-year experience period. Given the assumed increases in unit costs associated with those COS, the actuary judged the resulting PMPM trend assumptions to be reasonable in aggregate. Regarding Acute-CRS services for Inpatient and Nursing Facility, the service units and costs were combined for trend analysis, since nursing facility utilization by CRS members is essentially zero.

Appendix 6 contains the components of the projected benefit cost trend assumptions.

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

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

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

No other components were used in the development of the annualized trend assumptions provided in Appendix 6.

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

Projected benefit cost trends do not vary except by category of service.

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

No other material adjustments were made to the trend assumptions.

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

No other adjustments were made to the trend assumptions.

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

The AHCCCS DHCM Medical Management Team, the AHCCCS Office of Administrative Legal Services (OALS) Team, and the AHCCCS Office of the Director have completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA.

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

This is not applicable because in-lieu-of services, as defined in 42 CFR § 438.3(e)(2) of 81 FR 27497, were not used in developing the revised CYE 19 capitation rates for the ALTCS DES/DDD program.

I.3.B.vi. Retrospective Eligibility Periods

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

AHCCCS provides prior period coverage for the period of time prior to the member's enrollment during which the member is eligible for covered services. Prior period coverage 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 ALTCS DES/DDD. ALTCS DES/DDD receives notification from AHCCCS of the member's enrollment. ALTCS DES/DDD is responsible for payment of all claims for medically necessary services covered by ALTCS DES/DDD and provided to members during prior period coverage.

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

Encounters delivered during the prior period coverage (PPC) timeframe for each member are included in the base encounter data used for setting capitation rates.

I.3.B.vi.(c) Enrollment Data Included in Base Data

Member months during the PPC timeframe are included in the base enrollment data used for setting capitation rates.

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

Due to limited number of members in the PPC time frame, a separate PPC capitation rate was not developed and all covered expenses and member months are included in the regular DDD capitation rate cell.

I.3.B.vii. Impact of All Material Changes

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

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

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

Base period data was not adjusted to reflect recoveries of overpayments made to providers because Contractors are required to adjust encounters for recovery of overpayments, per the following contract requirement:

"The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted."

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

Adjustments related to provider reimbursement changes are discussed in Section I.3.B.ii.(a).

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

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

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

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

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

Documentation regarding all changes for this rate revision, whether material and non-material, has been provided above in Section I.3.B.ii.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

This section of the 2019 Guide provides information on the definition and requirements of an incentive arrangement.

I.4.A.ii. Appropriate Documentation

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

The APM Initiative - Performance Based Payments incentive arrangement is a special provision for payment where the Contractor may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractor that are aimed at improving access to care. This incentive arrangement does not exceed 105% of the capitation payments.

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

The time period of the incentive arrangement coincides with the rating period.

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

All enrollees, children and adults, may be covered by this incentive arrangement. Network providers offering direct care services have the opportunity to participate in the APM arrangements.

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

The purpose of the APM Initiative - Performance Based Payments incentive arrangement is to align incentives between the Contractor and providers to ensure members continued access to care.

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

Incentive payments for the APM Initiative - Performance Based Payments are not included in the certified capitation rates nor had any effect on the development of the capitation rates. Anticipated incentive payments are approximately $36.5 million. Incentive payments for the APM Initiative – Performance Based Payments will be paid by AHCCCS to ALTCS DES/DDD through four lump sum payments to ALTCS DES/DDD during the contract year.

I.4.B. Withhold Arrangements

This is not applicable because withhold arrangements, as defined in 42 CFR § 438.6(a) of 81 FR 27497, were not developed for the revised CYE 19 capitation rates for the ALTCS DES/DDD program.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2019 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 revised CYE 19 capitation rates for the ALTCS DES/DDD Program will include risk corridors for Children's Rehabilitative Services (CRS) medical expenses and APSI payments. Additionally, see section I.4.C.ii.(c) on reinsurance below.

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

AHCCCS has a long-standing program policy of including risk corridors within many of the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 19 capitation rates are consistent with AHCCCS' long-standing program policy and will include risk corridors for CRS medical costs and APSI payments. This rate certification will use the term risk corridor to be consistent with the 2019 Guide. The DES/DDD Contract refers to the CRS and APSI risk corridors as reconciliations.

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

DES/DDD will reconcile the CRS Subcontractor for CRS medical expenses to CRS medical capitation paid to the CRS Subcontractor in accordance with DES/DDD's contract with the CRS Subcontractor. The risk corridor provides for 100% payment or recoupment outside a 1% band, with a 100% plan share for any gain or loss within the 1% band.

Per AHCCCS' contract with ALTCS DES/DDD,

> "ADES/DDD will reconcile (1) all Acute Care Subcontractors and the CRS Subcontractor for the Access to Professional Services Initiative (APSI) in accordance with Paragraph 84, Special Provisions for Payment of this Section and ACOM Policy 325 and (2) the CRS Subcontractor for CRS medical expenses to CRS medical capitation paid to the CRS Subcontractor in accordance with ADES/DDD's contract with the CRS Subcontractor. AHCCCS shall reconcile DDD by drawing down Federal funds for excess losses to be reimbursed to the Acute Care Subcontractors and/or CRS Subcontractor. State match funds for excess losses will be provided by ADES/DDD for the APSI and CRS reconciliations. In the case of APSI, AHCCCS will provide the required state match funds to DES/DD via an interagency transfer of funds. The total amount of any excess profits to be recouped from the Acute Care Subcontractors and/or the CRS Subcontractor must be returned to AHCCCS; AHCCCS shall return the Federal share to CMS."

APSI is a relatively new initiative and utilization of Qualified Practitioners will vary across Contracts. For this reason, the APSI reconciliation is established as a no-risk arrangement to the Acute subcontractors or the CRS subcontractor.

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

This is not applicable because the contract does not include a remittance or payment requirement for being above or below a specified medical loss ratio (MLR).

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

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

AHCCCS provides a reinsurance program to ALTCS DES/DDD for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen 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 of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than ALTCS DES/DDD paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical. One could view the reinsurance offset as a premium. Historical reinsurance experience is the basis of the reinsurance offset.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with General Fund for 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 ALTCS DES/DDD for covered services incurred above the deductible. The deductible is the responsibility of ALTCS DES/DDD. There has been no change to the deductible or coinsurance factors applicable to the regular reinsurance program since the last rate setting period. Effective October 1, 2018, the threshold at which a reinsurance case becomes eligible for high-dollar catastrophic coverage is increased from $650,000 to $1 million.

Effective October 1, 2018, Acute-CRS services for DES/DDD members, which previously accumulated toward a $75,000 deductible associated with the CRS program, now combine with Acute non-CRS services to accumulate toward the $50,000 deductible associated with the ALTCS DES/DDD program.

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

This component of the rate cell has been updated with an effective date of October 1, 2018 to incorporate costs of rebasing the Acute component; to include CRS specialty services provided to ALTCS DES/DDD members with CRS-qualifying health conditions, as described in section I.3.B; and to reflect the changes to the development of the reinsurance offset described in Section I.4.C.ii.(c)(iv).

For additional information, including all deductibles and coinsurance amounts, on the reinsurance program refer to the Reinsurance section of the ALTCS DES/DDD 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 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 capitation rates are adjusted by subtracting the reinsurance offset amounts from the gross medical expenses since ALTCS DES/DDD will receive payment from AHCCCS for reinsurance cases. The data used for the reinsurance offset amounts are actual RI payments made on encounters incurred during CYE 17. In the ALTCS DES/DDD Program Rate Certification dated August 21, 2018, the changes to the reinsurance program effective October 1, 2018 were not quantified and were assumed to have a non-material impact to the total capitation rate. Subsequent analysis performed within CMS rate review determined that adjustments should be made to the projected reinsurance offset amount for CYE 19 in order to reflect the accumulation of all services, including the CRS services for which ALTCS DES/DDD assumed responsibility, towards the reinsurance deductible; the increase to the threshold for high-dollar catastrophic reinsurance, as described in section I.4.C.ii.(c)(i); and an estimated impact of deductible leveraging when applying PMPM expense trends to historical encounter data. The revised CYE 19 capitation rates include adjustments for each of those considerations.

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

I.4.D.i. Rate Development Standards

This section of the 2019 Guide provides information on delivery system and provider payment initiatives.

I.4.D.ii. Appropriate Documentation

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

The only pre-prints addressed in this certification are the ones related to ALTCS DES/DDD. Those pre-prints are Uniform Increase for FQHCs, Differential Adjusted Payments, and the Access to Professional Services Initiative. This certification combines the Uniform Increase for FQHCs under the Differential Adjusted Payments language.

I.4.D.ii.(a)(i) Description

Differential Adjusted Payments

The Differential Adjusted Payment (DAP) initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 10%, depending on the provider type.

Access to Professional Services Initiative

The Access to Professional Services Initiative (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 40% 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.

I.4.D.ii.(a)(ii) Amount

Differential Adjusted Payments

For the period July 1, 2018 through September 30, 2018, the total amount of DAP payments before premium tax, admin or underwriting gain included as an adjustment to the capitation rates is approximately $67,000 per calendar quarter ($268,000 annualized) or $0.70 PMPM. The Uniform Increase to FQHCs did not apply during this time frame.

For the period October 1, 2018 through September 30, 2019, the total amount of DAP payments before premium tax, admin or underwriting gain included as an October 1, 2018 adjustment to the capitation rates is approximately $480,000 per calendar quarter ($1.92 million annualized) or $4.79 PMPM. The individual PMPM amounts by component are displayed in Appendices 4a and 4b.

Access to Professional Services Initiative

APSI payments were implemented for ALTCS DES/DDD effective October 1, 2018. For the period October 1, 2018 through September 30, 2019, the total amount of APSI payments, before premium tax or administrative expenses, included as an adjustment to the CYE 19 capitation rates is approximately $4.57 million or $11.40 PMPM.

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

Differential Adjusted Payments

For the period July 1, 2018 through September 30, 2018, the qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for a 0.5% increase), other hospitals and inpatient facilities (eligible for a 0.5% increase), nursing facilities (eligible for up to 2% increase), integrated clinics (eligible for a 10% increase on a limited set of codes), physicians, physician assistants, and registered nurse practitioners (all eligible for a 1% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

For the period October 1, 2018 through September 30, 2019, the qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to a 3.5% increase), other hospitals and inpatient facilities (eligible for up to a 3.0% increase), nursing facilities (eligible for up to a 2.0% increase), integrated clinics (eligible for a 10% increase on a limited set of codes), physicians, physician assistants, and registered nurse practitioners (all eligible for a 1.0% increase), and federally qualified health centers (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

Access to Professional Services Initiative

For the period October 1, 2018 through September 30, 2019, the qualifying providers receiving the payment increase include physicians, including doctors of medicine and doctors of osteopathic medicine; certified registered nurse anesthetists; certified registered nurse practitioners; physician assistants; certified nurse midwives; clinical social workers; clinical psychologists; dentists; and optometrists.

I.4.D.ii.(a)(iv) Effect on Capitation Rate Development

Differential Adjusted Payments

For the period July 1, 2018 through September 30, 2018, 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 was the FFY 16 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 FFY 18 time period, part of which falls within CYE 19 for CMDP rating purposes. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. AHCCCS describes the methodology, data and assumptions related to DAP within the approved 438.6(c) pre-print.

For the period October 1, 2018 through September 30, 2019, 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 was the CYE 17 encounter data across all programs for the providers who qualify for DAP. The data included relevant rate cell and program information to be able to distribute into the individual rate cells. 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 FFY 19 time period, part of which falls within CYE 19 for ALTCS

DES/DDD rating purposes. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program). AHCCCS describes the methodology, data and assumptions related to DAP within the approved 438.6(c) pre-prints.

Access to Professional Services Initiative

For the period October 1, 2018 through September 30, 2019, the AHCCCS DHCM Actuarial Team relied upon information provided by the APSI Hospital Coalition and their consultants in estimating cost impacts of APSI. The information provided by the APSI Hospital Coalition and their consultants included Billing Provider Tax IDs, which were used to identify the hospital provider groups within the CYE 17 encounter data, and Average Commercial Rates (ACR) for these hospital provider groups. The AHCCCS DHCM Actuarial Team was unable to determine the reasonableness of the ACR data provided without performing a substantial amount of work and has relied upon the APSI Hospital Coalition and their consultants for the reasonability of the ACR data.

For CYE 19 capitation rates, the 40% fee schedule increase that was determined for CYE 18 capitation rates was maintained. The language from the CYE 18 certifications on how the 40% was determined is copied here for convenience of review.

> "The methodology to determine the 40% fee schedule increase followed the upper payment limit calculation using an ACR. The data used for this analysis was the CYE 17 encounter data for the hospital provider groups to be included in the initiative. The CYE 17 encounter data was repriced with both the ACRs and with the AHCCCS fee schedule. Under this repriced comparison, the ACR amounts were approximately 53% higher than the AHCCCS fee schedule amounts. The 40% increase for the APSI was then determined through collaborative meetings with the AHCCCS Office of the Director and subsequent meetings with the Hospital Coalition."

The 40 percent uniform percentage increase was applied to CYE 17 encounters for the providers who were participating in the Access to Professional Services Initiative. The providers were identified by Billing Provider Tax IDs in AHCCCS encounter system. The encounter data excluded any subcapitated/block purchasing arrangements (identified by CN1 Code 05 on the encounters), any encounters for dual members and was limited to Form CMS-1500s and dental encounters. The encounter data included relevant rate cell and program information to be able to distribute into the individual rate cells. AHCCCS describes the methodology, data and assumptions related to the APSI within the approved 438.6(c) pre-print.

I.4.D.ii.(a)(v) Description of How the Payments are Included in the Capitation Rates

Differential Adjusted Payments

Funding for DAP is included in the certified capitation rates.

Access to Professional Services Initiative

Funding for APSI is included in the certified capitation rates.

I.4.E. Pass-Through Payments

Not applicable. There are no pass-through payments in the revised CYE 19 capitation rates for the ALTCS DES/DDD Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2019 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

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

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

The projected administrative expenses PMPM for Institutional and HCBS services were informed by DES/DDD's funding request for SFY 19, actual expenses reported by DES/DDD for SFY 17 and SFY 18, and financial reporting for calendar years 2016 and 2017. The actuary reviewed the funding request from DES/DDD for SFY 19 and revised it downwards. The revision was reasonable based on trending forward CYE 16 and CYE 17 financial reporting amounts, and review of the actual expense reporting in the YTD CYE 18 financials. The assumed administrative expense in the CYE 19 capitation rate is higher than what was assumed in the SFY 18 rate, in part due to improved employee retention rates and actual expenditures being higher than assumed in the previous year's capitation rate development. Appendix 5a notes the magnitude of growth from the amount built into the SFY 18 rates.

The administrative expenses PMPM for each Acute subcontractor are developed as a percentage of the subcontractor's gross medical expenses. The percentage varies by subcontractor and is judged reasonable by comparing to subcontractors' financial reporting. Effective October 1, 2018, the administrative component of the final capitation rate, shown in Appendices 5a and 5b, includes projected expenses associated with administering CRS specialty care and behavioral health services. Appendix 5b shows that the combined administrative expense projection is being revised from that shown in the certification dated August 21, 2018. The revision is primarily to correct a misstatement of the administrative expenses PMPM for Acute services as a result of the revision to the membership basis, as described in Section I.1.A.ii.(c)(vi)(B).

The projected case management expenses PMPM within the regular DDD capitation rate were informed by DES/DDD's funding request for SFY 19, financial reporting for calendar years 2016 and 2017, and results from a case management expense model utilized by the AHCCCS Actuarial Team incorporating data provided by DES/DDD. The projection was judged reasonable in comparison to financial reporting for prior years. Appendix 5b shows that the case management expense projection is not being revised from that shown in the certification dated August 21, 2018.

The TCM capitation rate received its regular annual revision effective July 1, 2018. The SFY 19 projected TCM expense PMPM was developed as the arithmetic average of the actual TCM expenditure PMPM reported during the first six months of SFY 18, and the ALTCS DES/DDD forecasted expenditure PMPM for SFY 19. The percentage increase in the TCM expense PMPM from the SFY 18 capitation rate to the SFY 19 capitation rate is similar to the trend rate assumed when developing administrative expense projections from financial reporting.

The TCM expense PMPMs were adjusted effective October 1, 2018 to incorporate cost impacts of scheduled ALTCS DES/DDD increases to caseload ratios, from 1:60 to 1:80 during CYE 19. Actuarial judgment was used in determining the reasonableness of ALTCS DES/DDD projected cost reductions from the change. Once the projection was determined to be reasonable by AHCCCS, an adjustment to the TCM expense PMPM was calculated using projected member months for the nine months from October 1, 2018 through June 30, 2019. Appendix 5b shows that the TCM rate effective on July 1, 2018 is not being revised from the rate shown in the certification dated May 15, 2018, nor is the TCM rate effective on October 1, 2018 being revised from the rate shown in the certification dated August 21, 2018. The TCM rate is assumed to be actuarially sound for the extended contract period, given no projected increase in TCM expenditures in the three month period subsequent to June 30, 2019.

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

There were no other material changes to data, assumption or methodologies for projected non-benefit costs since the last rate certification.

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

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

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

The projected non-benefit costs for each of the listed categories of costs in the 2019 Guide are shown in Appendices 5a and 5b for the revised CYE 19 capitation rates.

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

The administrative component of the revised CYE 19 capitation rates for the ALTCS DES/DDD Program is described above in Section I.5.B.i.(a).

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

The revised CYE 19 capitation rates for the ALTCS DES/DDD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. No other taxes, fees, or assessments are applicable for this filing.

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

The revised CYE 19 capitation rate for the ALTCS DES/DDD Program includes a provision of 1% for risk margin (i.e. underwriting gain).

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

No other material or non-material non-benefit costs are reflected in the revised CYE 19 capitation rates for the ALTCS DES/DDD Program.

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

AHCCCS will not be adjusting the capitation rates for the Health Insurance Providers Fee (HIPF) at this time. The HIPF is addressed by AHCCCS each year in a separate certification specific to the program and year, except in years for which there is a federally mandated moratorium on the fee.

I.6. Risk Adjustment and Acuity Adjustments

This section of the 2019 Guide is not applicable to the ALTCS DES/DDD Program. The ALTCS DES/DDD Program does not have risk adjustments or acuity adjustments. This is not anticipated to change.

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

Section II of the 2019 Guide is applicable to the ALTCS DES/DDD Program because the revised CYE 19 capitation rates for ALTCS DES/DDD are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 at 81 FR 27858 and the ALTCS DES/DDD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. CMS Expectations

The rate development standards and appropriate documentation described in Section I of the 2019 Guide are applicable to the MLTSS rate development process.

II.1.B. Rate Development Standards

II.1.B.i. Rate Cell Structure

This section of the 2019 Guide provides the two most common approaches to structuring the rate cells.

II.1.B.i.(a) Blended Capitation Rate

The monthly capitation rate for each rate cell is developed as a blended rate payable for each enrolled member.

II.1.B.i.(b) Non-Blended Capitation Rate

This is not applicable because a member's long-term care setting does not determine the capitation paid for that member.

II.1.C. Appropriate Documentation

II.1.C.i. Considerations

II.1.C.i.(a) Rate Cell Structure

The monthly capitation rate for each rate cell is developed as a blended rate payable for each enrolled member.

II.1.C.i.(b) Data, Assumptions, Methodologies

Data, assumptions and methodologies used for the development of projected gross medical expenses, administrative expenses, and case management expenses are described above in Sections I.3 and I.5.

II.1.C.i.(c) Other Payment Structures, Incentives, or Disincentives

There are no other payment structures, incentives or disincentives to pay ALTCS DES/DDD Contractors other than what has already been described above in Sections I.4.A and I.4.C.

II.1.C.i.(d) Effect of MLTSS on Utilization and Unit Cost

The ALTCS DES/DDD Program operates as managed care. No data is available that would quantify the impacts of care management on utilization or unit costs.

II.1.C.i.(e) Effect of MLTSS on Setting of Care

The ALTCS DES/DDD Program operates as managed care. No data is available that quantifies the effect that the management of this care is expected to have on the level of care within each care setting.

II.1.C.ii. Projected Non-benefit Costs

The development of projected non-benefit costs is described in Section I.5.B of this certification.

II.1.C.iii. Additional Information

No additional information beyond the types and sources of data described in Section I.2.B.ii of this certification was considered.

Section III New Adult Group Capitation Rates

Section III of the 2019 Guide is not applicable to the ALTCS DES/DDD Program.

Appendix 1: Actuarial Certification

I, Matthew C. Varitek, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established 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 at 81 FR 27858:

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

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 revised CYE 19 capitation rates for the ALTCS DES/DDD Program have been documented according to the guidelines established by CMS in the 2019 Guide. The revised CYE 19 capitation rates for the ALTCS DES/DDD Program are effective for the three month time period from July 1, 2018 through September 30, 2018, the three month time period from October 1, 2018 through December 31, 2018, and the nine month period from January 1, 2019 through September 30, 2019.

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

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

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Rate Cell	Capitation Rates Effective 07/01/18 - 09/30/18	Capitation Rates Effective 10/01/18 - 12/31/18	Capitation Rates Effective 01/01/19 - 09/30/19
Regular DDD	$3,959.18	$4,155.65	$4,194.32
Targeted Case Management	$164.41	$154.28	$154.28

Appendix 3a: Fiscal Impact Summary Compared to CYE 18

Rate Cell	Projected CYE 19 (Jul-Sep 2018) Member Months	CYE 18 (1/1/18) Capitation Rates	CYE 19 Revised Capitation Rates Effective 07/01/18 - 09/30/18	CYE 18 Projected Expenditures (based on 1/1/18 Rates)	CYE 19 Projected Expenditures (based on 7/1/18 rates)	Dollar Impact	Percentage Impact
Regular DDD	97,979	$3,804.90	$3,959.18	$372,801,814	$387,918,778	$15,116,964	4.1%
Targeted Case Management	15,530	$160.11	$164.41	$2,486,537	$2,553,332	$66,795	2.7%
Total				$375,288,351	$390,472,110	$15,183,759	4.0%

Rate Cell	Projected CYE 19 (Oct-Dec 2018) Member Months	CYE 19 Revised Capitation Rates Effective 07/01/18 - 09/30/18	CYE 19 Revised Capitation Rates Effective 10/01/18 - 12/31/18	CYE 19 Projected Expenditures (based on 7/1/18 rates)	CYE 19 Projected Expenditures (based on 10/1/18 rates)	Dollar Impact	Percentage Impact
Regular DDD	99,180	$3,959.18	$4,155.65	$392,671,222	$412,156,880	$19,485,658	5.0%
Targeted Case Management	15,696	$164.41	$154.28	$2,580,686	$2,421,597	($159,089)	-6.2%
Total				$395,251,908	$414,578,477	$19,326,568	4.9%

Rate Cell	Projected CYE 19 (Jan-Sep 2019) Member Months	CYE 19 Revised Capitation Rates Effective 10/01/18 - 12/31/18	CYE 19 Revised Capitation Rates Effective 01/01/19 - 09/30/19	CYE 19 Projected Expenditures (based on 10/1/18 rates)	CYE 19 Projected Expenditures (based on 1/1/19 rates)	Dollar Impact	Percentage Impact
Regular DDD	301,512	$4,155.65	$4,194.32	$1,252,980,667	$1,264,640,807	$11,660,139	0.9%
Targeted Case Management	48,087	$154.28	$154.28	$7,418,796	$7,418,796	$0	0.0%
Total				$1,260,399,463	$1,272,059,603	$11,660,139	0.9%

Rate Cell	Projected CYE 19 (Jul 18 -Sept 19) Member Months	CYE 18 (1/1/18) Capitation Rates	CYE 19 Revised Blended Capitation Rates	CYE 18 Projected Expenditures (based on 1/1/18 Rates)	CYE 19 Projected Expenditures (based on Revised Blended Rates)	Dollar Impact	Percentage Impact
Regular DDD	498,672	$3,804.90	$4,140.43	$1,897,394,558	$2,064,716,465	$167,321,907	8.8%
Targeted Case Management	79,313	$160.11	$156.26	$12,699,066	$12,393,725	($305,342)	-2.4%
Total				$1,910,093,625	$2,077,110,190	$167,016,565	8.7%

Appendix 3b: Fiscal Impact Summary Compared to CYE 19 Prior Submission

Rate Cell	Projected CYE 19 (Jul-Sep 2018) Member Months	CYE 19 Prior Submitted Rate (7/1/18)	CYE 19 Revised Capitation Rates Effective 07/01/18 - 09/30/18	CYE 19 Projected Expenditures (based on prior 7/1/18 rates)	CYE 19 Projected Expenditures (based on revised 7/1/18 rates)	Dollar Impact	Percentage Impact
Regular DDD	97,979	$3,892.14	$3,959.18	$381,350,066	$387,918,778	$6,568,712	1.7%
Targeted Case Management	15,530	$164.41	$164.41	$2,553,332	$2,553,332	$0	0.0%
Total				$383,903,398	$390,472,110	$6,568,712	1.7%

Rate Cell	Projected CYE 19 (Oct-Dec 2018) Member Months	CYE 19 Prior Submitted Rate (10/1/18)	CYE 19 Revised Capitation Rates Effective 10/01/18 - 12/31/18	CYE 19 Projected Expenditures (based on prior 10/1/18 rates)	CYE 19 Projected Expenditures (based on revised 10/1/18 rates)	Dollar Impact	Percentage Impact
Regular DDD	99,180	$4,098.51	$4,155.65	$406,489,396	$412,156,880	$5,667,484	1.4%
Targeted Case Management	15,696	$154.28	$154.28	$2,421,597	$2,421,597	$0	0.0%
Total				$408,910,993	$414,578,477	$5,667,484	1.4%

Rate Cell	Projected CYE 19 (Jan-Sep 2019) Member Months	CYE 19 Prior Submitted Rate (1/1/19)	CYE 19 Revised Capitation Rates Effective 01/01/19 - 09/30/19	CYE 19 Projected Expenditures (based on prior 1/1/19 rates)	CYE 19 Projected Expenditures (based on revised 1/1/19 rates)	Dollar Impact	Percentage Impact
Regular DDD	301,512	$4,137.17	$4,194.32	$1,247,408,313	$1,264,640,807	$17,232,493	1.4%
Targeted Case Management	48,087	$154.28	$154.28	$7,418,796	$7,418,796	$0	0.0%
Total				$1,254,827,109	$1,272,059,603	$17,232,493	1.4%

Rate Cell	Projected CYE 19 (Jul 18 -Sept 19) Member Months	CYE 19 Prior Submitted Blended Capitation Rates	CYE 19 Revised Blended Capitation Rates	CYE 19 Projected Expenditures (based on Prior Submitted Blended Rates)	CYE 19 Projected Expenditures (based on Revised Blended Rates)	Dollar Impact	Percentage Impact
Regular DDD	498,672	$4,081.34	$4,140.43	$2,035,247,775	$2,064,716,465	$29,468,690	1.4%
Targeted Case Management	79,313	$156.26	$156.26	$12,393,725	$12,393,725	$0	0.0%
Total				$2,047,641,500	$2,077,110,190	$29,468,690	1.4%

Appendix 4a: Base Data, Adjustments, and Projected Benefit Costs for Long-Term Support Services

Detail COS	Data Source	SFY 18 Unadjusted Base Data	Adjustments to Unadjusted Base Data to Bring to Current: CFs	Reimbursement Changes incl Prop 206/DAP	Program Changes	Adjusted Base Data
Institutional	Encounters	$ 54.67	96.4%	0.5%	0.0%	$ 57.01
ICF/IID[1]	DDD Supplemental Information	$ 50.57	100.0%	1.4%	0.0%	$ 51.29
Total Institutional		$ 105.24				$ 108.30
Attendant Care	Encounters	$ 300.22	98.4%	0.6%	0.0%	$ 306.82
Respite	Encounters	$ 284.64	98.5%	0.7%	0.0%	$ 290.99
Hab Res Per Diem	Encounters	$ 1,039.98	98.5%	0.6%	0.0%	$ 1,062.68
Hab Res Per 15 mins	Encounters	$ 328.05	98.5%	0.7%	0.0%	$ 335.44
Day Treatment	Encounters	$ 338.48	98.4%	0.6%	0.0%	$ 345.88
Self Care Home	Encounters	$ 5.87	98.5%	1.0%	0.0%	$ 6.02
Therapy and Evals	Encounters	$ 142.71	98.5%	0.6%	0.0%	$ 145.84
Transportation	Encounters	$ 51.21	98.5%	0.7%	0.0%	$ 52.35
Nursing	Encounters	$ 141.10	98.5%	0.6%	0.0%	$ 144.19
Employment	Encounters	$ 83.78	98.5%	0.7%	0.0%	$ 85.65
Misc	Encounters	$ 17.42	98.6%	0.0%	0.0%	$ 17.67
SOGH[2]	DDD Supplemental Information	$ 25.40	100.0%	0.0%	0.0%	$ 25.40
Total HCBS		$ 2,758.87				$ 2,818.95

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Detail COS	Data Source	Adjusted Base Data to bring to Current	PMPM Trends	Prospective Changes: Reimbursement/ Program Changes	Prospective Changes: DAP Payments PMPM	CYE 19 Projected Benefit Costs (7/1/18 - 9/30/18)
Institutional	Encounters	$ 57.01	1.3%	-9.6%	$ 0.19	$ 52.49
ICF/IID[1]	DDD Supplemental Information	$ 51.29	1.0%	0.0%	$ -	$ 51.87
Total Institutional		$ 108.30			$ 0.19	$ 104.36
Attendant Care	Encounters	$ 306.82	7.1%	0.0%	$ -	$ 331.43
Respite	Encounters	$ 290.99	0.3%	0.0%	$ -	$ 291.97
Hab Res Per Diem	Encounters	$ 1,062.68	2.8%	0.0%	$ -	$ 1,096.25
Hab Res Per 15 mins	Encounters	$ 335.44	1.7%	0.0%	$ -	$ 341.88
Day Treatment	Encounters	$ 345.88	4.5%	0.0%	$ -	$ 363.58
Self Care Home	Encounters	$ 6.02	0.3%	0.0%	$ -	$ 6.04
Therapy and Evals	Encounters	$ 145.84	5.3%	0.0%	$ -	$ 154.59
Transportation	Encounters	$ 52.35	1.1%	0.0%	$ -	$ 53.00
Nursing	Encounters	$ 144.19	4.1%	0.0%	$ -	$ 150.90
Employment	Encounters	$ 85.65	0.6%	0.0%	$ -	$ 86.23
Misc	Encounters	$ 17.67	4.9%	0.0%	$ -	$ 18.64
SOGH[2]	DDD Supplemental Information	$ 25.40	0.2%	0.0%	$ -	$ 25.46
Total HCBS		$ 2,818.95			$ -	$ 2,919.98

1) The Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) category includes the ICF operated by the Arizona Training Program Coolidge (ATPC) in addition to all other contracted ICFs.

2) The State Operated Group Home (SOGH) category covers all SOGH facilities including those operated by the ATPC. Previous certifications included ATPC-SOGH within an ATPC/ICF/IID category in the Institutional section.

Appendix 4b: Base Data, Adjustments, and Projected Benefit Costs for Acute Services

Detail	Acute Non-CRS	Acute CRS
CYE 17 Unadjusted Base Data	$299.84	$147.60
Completion Factor	0.9595	0.9604
CYE 17 DAP Payments Removed	-$0.57	-$0.21
Subcapitated Amt Added	$71.86	$7.60
Reimb/Pgm Changes to Bring Current	$7.58	$6.69
High-Acuity Pediatrics Adjustor Change effective 1/1/17	$1.87	$0.79
ER Dental effective 10/1/17	$1.22	$0.00
Provider Fee Schedule changes effective 10/1/17	$1.22	$0.10
DRG rebase effective 1/1/18	$3.46	$2.11
Hep C Rx replacement/criteria change effective 1/1/18	-$0.19	$0.00
Enteral Services moving from DDD to CRS effective 10/1/17	$0.00	$3.69
CYE 17 Adjusted Base Data	$391.38	$167.75
PMPM Expense Trends	3.6%	4.8%
CYE 19 Reimb/Pgm Changes	$7.63	$0.55
CYE 19 Projected Benefit Costs without DAP and APSI	$427.33	$184.81
CYE 19 DAP Payments	$3.51	$1.09
CYE 19 APSI Payments	$4.17	$7.23
CYE 19 Projected Benefit Costs	$435.01	$193.13

Differential Adjustment Payments (DAP)	Acute Non-CRS	Acute CRS
E-Prescribing	$0.17	$0.02
Integrated Clinic	$0.00	$0.00
Inpatient Hospital	$3.26	$1.06
Nursing Facility	$0.06	$0.00
Other Hospital	$0.02	$0.01
FQHC/RHC	$0.00	$0.00
Total DDD DAP	$3.51	$1.09

Appendix 5a: Capitation Rate Development Compared to CYE 18

DES/DDD Capitation Rate	CYE 18 (1/1/18) Capitation Rates	CYE 19 Revised Capitation Rates Effective 07/01/18 - 09/30/18	Percentage Change	CYE 19 Revised Capitation Rates Effective 10/01/18 - 12/31/18	Percentage Change	CYE 19 Revised Capitation Rates Effective 01/01/19 - 09/30/19	Percentage Change
Claim Costs							
Institutional Services	$113.78	$104.36	-8.3%	$104.71	0.3%	$104.92	0.2%
Home and Community Based Services	$2,789.36	$2,919.98	4.7%	$2,919.98	0.0%	$2,957.28	1.3%
Acute Services[1,2]	$447.05	$447.05	0.0%	$634.95	42.0%	$634.95	0.0%
Total Claim Costs	**$3,350.19**	**$3,471.38**	**3.6%**	**$3,659.63**	**5.4%**	**$3,697.15**	**1.0%**
Share of Cost	-$4.70	-$4.57	-2.7%	-$4.57	0.0%	-$4.57	0.0%
Acute Services Reinsurance[1,2]	-$26.60	-$26.60	0.0%	-$39.49	48.5%	-$39.49	0.0%
Total Net Claim Costs	**$3,318.90**	**$3,440.22**	**3.7%**	**$3,615.57**	**5.1%**	**$3,653.08**	**1.0%**
Non-Benefit Costs							
Case Management	$170.74	$176.01	3.1%	$176.01	0.0%	$176.01	0.0%
Administration[1]	$203.95	$227.31	11.5%	$242.61	6.7%	$242.61	0.0%
Underwriting Gain	$35.21	$36.47	3.6%	$38.36	5.2%	$38.73	1.0%
Premium Tax	$76.10	$79.18	4.0%	$83.11	5.0%	$83.89	0.9%
Total Non-Benefit Costs	**$486.00**	**$518.97**	**6.8%**	**$540.09**	**4.1%**	**$541.24**	**0.2%**
DES/DDD Capitation Rate	**$3,804.90**	**$3,959.18**	**4.1%**	**$4,155.65**	**5.0%**	**$4,194.32**	**0.9%**

Targeted Case Management (TCM)	CYE 18 (1/1/18) Capitation Rates	CYE 19 Revised Capitation Rates Effective 07/01/18 - 09/30/18	Percentage Change	CYE 19 Revised Capitation Rates Effective 10/01/18 - 12/31/18	Percentage Change	CYE 19 Revised Capitation Rates Effective 01/01/19 - 09/30/19	Percentage Change
Non-Benefit Costs							
Case Management	$156.91	$161.13	2.7%	$151.19	-6.2%	$151.19	0.0%
Premium Tax	$3.20	$3.29	2.7%	$3.09	-6.2%	$3.09	0.0%
Targeted Case Management Rate	**$160.11**	**$164.41**	**2.7%**	**$154.28**	**-6.2%**	**$154.28**	**0.0%**

1. The Acute Services, Acute Services Reinsurance, and Administration categories of expense include CRS-related costs as of October 1, 2018.
2. Projected Acute fee-for-service expenses and reinsurance amounts for American Indian members not receiving services through the Acute subcontractors have been included in the PMPM amounts shown here.

Appendix 5b: Capitation Rate Development Compared to CYE 19 Prior Submission

AHCCCS
Arizona Health Care Cost Containment System

DES/DDD Capitation Rate	CYE 19 Prior Submitted Rate (7/1/18)	CYE 19 Revised Capitation Rates Effective 07/01/18 - 09/30/18	Pct Change	CYE 19 Prior Submitted Rate (10/1/18)	CYE 19 Revised Capitation Rates Effective 10/01/18 - 12/31/18	Pct Change	CYE 19 Prior Submitted Rate (1/1/19)	CYE 19 Revised Capitation Rates Effective 01/01/19 - 09/30/19	Pct Change
Claim Costs									
Institutional Services	$118.75	$104.36	-12.1%	$120.41	$104.71	-13.0%	$120.63	$104.92	-13.0%
Home and Community Based Services	$2,840.66	$2,919.98	2.8%	$2,840.66	$2,919.98	2.8%	$2,877.96	$2,957.28	2.8%
Acute Services[1,2]	$447.05	$447.05	0.0%	$639.09	$634.95	-0.6%	$639.09	$634.95	-0.6%
Total Claim Costs	**$3,406.46**	**$3,471.38**	**1.9%**	**$3,600.16**	**$3,659.63**	**1.7%**	**$3,637.68**	**$3,697.15**	**1.6%**
Share of Cost	-$4.70	-$4.57	-2.7%	-$4.57	-$4.57	0.0%	-$4.57	-$4.57	0.0%
Acute Services Reinsurance[1,2]	-$26.60	-$26.60	0.0%	-$35.99	-$39.49	9.7%	-$35.99	-$39.49	9.7%
Total Net Claim Costs	**$3,375.16**	**$3,440.22**	**1.9%**	**$3,559.60**	**$3,615.57**	**1.6%**	**$3,597.12**	**$3,653.08**	**1.6%**
Non-Benefit Costs									
Case Management	$176.01	$176.01	0.0%	$176.01	$176.01	0.0%	$176.01	$176.01	0.0%
Administration[1]	$227.31	$227.31	0.0%	$243.17	$242.61	-0.2%	$243.17	$242.61	-0.2%
Underwriting Gain	$35.82	$36.47	1.8%	$37.76	$38.36	1.6%	$38.14	$38.73	1.6%
Premium Tax	$77.84	$79.18	1.7%	$81.97	$83.11	1.4%	$82.74	$83.89	1.4%
Total Non-Benefit Costs	**$516.98**	**$518.97**	**0.4%**	**$538.91**	**$540.09**	**0.2%**	**$540.06**	**$541.24**	**0.2%**
DES/DDD Capitation Rate	**$3,892.14**	**$3,959.18**	**1.7%**	**$4,098.51**	**$4,155.65**	**1.4%**	**$4,137.17**	**$4,194.32**	**1.4%**

Targeted Case Management (TCM)	CYE 19 Prior Submitted Rate (7/1/18)	CYE 19 Revised Capitation Rates Effective 07/01/18 - 09/30/18	Pct Change	CYE 19 Prior Submitted Rate (10/1/18)	CYE 19 Revised Capitation Rates Effective 10/01/18 - 12/31/18	Pct Change	CYE 19 Prior Submitted Rate (1/1/19)	CYE 19 Revised Capitation Rates Effective 01/01/19 - 09/30/19	Pct Change
Non-Benefit Costs									
Case Management	$161.13	$161.13	0.0%	$151.19	$151.19	0.0%	$151.19	$151.19	0.0%
Premium Tax	$3.29	$3.29	0.0%	$3.09	$3.09	0.0%	$3.09	$3.09	0.0%
Targeted Case Management Rate	**$164.41**	**$164.41**	**0.0%**	**$154.28**	**$154.28**	**0.0%**	**$154.28**	**$154.28**	**0.0%**

1. The Acute Services, Acute Services Reinsurance, and Administration categories of expense include CRS-related costs as of October 1, 2018.
2. Projected Acute fee-for-service expenses and reinsurance amounts for American Indian members not receiving services through the Acute subcontractors have been included in the PMPM amounts shown here.

Appendix 6: Assumed Trends by COS

Detail	Data Source	Annual Utilization Trend Rate	Annual Unit Cost Trend Rate	Annual PMPM Trend Rate
Institutional	Encounters	0.3%	1.0%	1.3%
ICF/IID[1]	DDD Supplemental Information	0.4%	0.6%	1.0%
Attendant Care	Encounters	5.0%	2.0%	7.1%
Respite	Encounters	0.2%	0.1%	0.3%
Hab Res Per Diem	Encounters	0.1%	2.7%	2.8%
Hab Res Per 15 mins	Encounters	1.5%	0.2%	1.7%
Day Treatment	Encounters	1.0%	3.5%	4.5%
Self Care Home	Encounters	0.1%	0.2%	0.3%
Therapy and Evals	Encounters	5.0%	0.3%	5.3%
Transportation	Encounters	1.0%	0.1%	1.1%
Nursing	Encounters	3.4%	0.7%	4.1%
Employment	Encounters	0.1%	0.5%	0.6%
Misc	Encounters	0.2%	4.7%	4.9%
SOGH[2]	DDD Supplemental Information	0.1%	0.1%	0.2%
Acute Services (Excluding CRS) - Professional	Encounters	0.5%	0.5%	1.0%
Acute Services (Excluding CRS) - Pharmacy	Encounters	-2.0%	8.0%	5.8%
Acute Services (Excluding CRS) - Dental	Encounters	-5.0%	10.0%	4.5%
Acute Services (Excluding CRS) - Inpatient	Encounters	-6.0%	12.0%	5.3%
Acute Services (Excluding CRS) - NF	Encounters	0.0%	0.0%	0.0%
Acute Services (Excluding CRS) - Outpatient	Encounters	1.0%	3.0%	4.0%
Acute Services (CRS) - Professional	Encounters	3.0%	-2.0%	0.9%
Acute Services (CRS) - Pharmacy	Encounters	2.0%	7.5%	9.7%
Acute Services (CRS) - Dental	Encounters	4.0%	2.0%	6.1%
Acute Services (CRS) - Inpatient	Encounters	0.2%	5.1%	5.3%
Acute Services (CRS) - Nursing Facility	Encounters	0.2%	5.1%	5.3%
Acute Services (CRS) - Outpatient	Encounters	2.0%	-1.8%	0.2%

1) The Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) category includes the ICF operated by the Arizona Training Program Coolidge (ATPC) in addition to all other contracted ICFs.

2) The State Operated Group Home (SOGH) category covers all SOGH facilities including those operated by the ATPC. Previous certifications included ATPC-SOGH within an ATPC/ICF/IID category in the Institutional section.