Contract Year Ending 2021 Arizona Long Term Care System Department of Economic Security/Division of Developmental Disabilities Capitation Rate Certification

October 1, 2020 through September 30, 2021

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

November 13, 2020

AHCCCS
Arizona Health Care Cost Containment System

Table of Contents

Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438 at 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies used in the development of the October 1, 2020 through September 30, 2021 (Contract Year Ending 2021 (CYE 21), or alternatively, Federal Fiscal Year 2021 (FFY 21)) actuarially sound capitation rates for the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Program. Due to one fee schedule change (Proposition 206 Minimum Wage Increase) and the transition for the responsibility for augmentative and alternative communication (AAC) services from ALTCS DES/DDD to its integrated subcontractors which are effective January 1, 2020, this certification will cover two sets of capitation rates. One set will apply for the time frame from October 1, 2020 through December 31, 2020 and another set will apply from January 1, 2021 through September 30, 2021. The rate development process is the same for both sets of capitation rates except the latter set includes the impact of the Proposition 206 Minimum Wage Increase adjustment and the AAC services shift to the integrated subcontractors.

This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

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

This rate certification may also be made available publicly on the AHCCCS website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 at 81 FR 27497 applicable to this rate certification, the 2020-2021 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2020-2021 Medicaid Managed Care Rate Development Guide (2021 Guide) describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2021 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

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

As stated on page 2 of the 2021 Guide, CMS will also use these three principles in applying the regulation standards:

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

I.1. General Information

This section provides documentation for the General Information section of the 2021 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The CYE 21 capitation rates for the ALTCS DES/DDD Program are effective for the 12-month time period from October 1, 2020 through September 30, 2021, with one set of capitation rates being effective for the 3-month time period from October 1, 2020 through December 31, 2020 and the second set of capitation rates being effective for the 9-month time period from January 1, 2021 through September 30, 2021.

I.1.A.ii. Required Elements

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

The actuarial certification letter for the CYE 21 capitation rates for the ALTCS DES/DDD Program, signed by Erica Johnson, ASA, MAAA, is in Appendix 1. Ms. Johnson 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.

Ms. Johnson certifies that the CYE 21 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 at 81 FR 27497.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the 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 at 81 FR 27497 and the 2021 Guide.

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

This section of the rate certification provides a summary of information about the ALTCS DES/DDD Program.

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. Effective October 1, 2019, ALTCS DES/DDD members began receiving integrated physical and behavioral health care under the ALTCS

DES/DDD Program in addition to receiving Long Term Services & Supports (LTSS) under the ALTCS DES/DDD Program, rather than receiving behavioral health services under the separate Regional Behavioral Health Authorities (RBHA) Program. Effective October 1, 2019, ALTCS DES/DDD subcontracted the integrated physical and behavioral services to two integrated subcontractors, and retained the LTSS responsibilities for the ALTCS DES/DDD members, with the exception of LTSS services provided in a nursing facility which were also subcontracted to the integrated subcontractors effective October 1, 2019. Effective October 1, 2020, ALTCS DES/DDD will phase out a DDD-administered service known as Early Childhood Autism (ECA) in favor of applied behavior analysis (ABA) services under the integrated subcontractors in compliance with updated guidance from AHCCCS. Effective January 1, 2021, ALTCS DES/DDD will also subcontract AAC services to the integrated subcontractors.

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 ALTCS DES/DDD contract.

Services covered by ALTCS DES/DDD have traditionally included long-term care services, acute 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 expanded to include Children's Rehabilitative Services (CRS) specialty care and comprehensive behavioral health services for child members who have a CRS qualifying condition, as coverage of those services shifted from the CRS Program. Effective October 1, 2019, coverage of services expanded again to integrate care for all ALTCS DES/DDD members including comprehensive behavioral health services for all members, not just those with a CRS qualifying condition, to be provided through the ALTCS DES/DDD Program as coverage of those services shifted from the RBHA Program. Targeted Case Management services are covered for those members who do not meet the functional requirements for ALTCS services.

ALTCS DES/DDD members who are American Indians have the option to receive their services on a fee-for-service (FFS) basis, paid by ALTCS DES/DDD, rather than through one of the integrated subcontractors. Expenses for all services for all ALTCS DES/DDD members are included in the capitation rates for the ALTCS DES/DDD Program, including those which ALTCS DES/DDD pays on a FFS basis.

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

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 CYE 21 capitation rates for the ALTCS DES/DDD Program are effective for the 3-month time period from October 1, 2020 through December 31, 2020 and the 9-month time period from January 1, 2021 through September 30, 2021.

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

The populations covered under the ALTCS DES/DDD Program 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 covered long-term care, acute care, CRS specialty care for members with a CRS qualifying condition, and behavioral health services for all DD members.

The second rate cell is for Targeted Case Management and includes the costs of providing case management services for members who have a qualifying DD diagnosis and meet the financial eligibility of Title XIX or Title XXI programs, but do not meet the functional requirements of ALTCS. The actuary relied on cost projections provided by ALTCS DES/DDD for Targeted Case Management staffing and services in developing the Targeted Case Management capitation rate.

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

ALTCS DES/DDD has historically determined eligibility for ALTCS/DD services through four diagnoses: cerebral palsy, epilepsy, autism, or a cognitive disability. On April 1, 2020, the Arizona State Supreme Court rejected ALTCS DES' petition to review an Arizona Court of Appeals opinion. The Court of Appeals opinion for Johnson v. DES altered ALTCS DES' interpretation of several eligibility statutes which significantly impact eligibility decisions that would have otherwise been determined denied.

Previously, ALTCS DES/DDD required documentation of an actual qualifying diagnosis of a cognitive disability, cerebral palsy, epilepsy, or autism prior to the age of 18; the Court Opinion and statute only requires manifestation of a cognitive disability before the age of 18 (A.R.S. § 36-551(32): "manifested before the age of eighteen" means that the disability must be apparent and have a substantially limiting effect on a person's functioning before the age of eighteen). Previously, ALTCS DES/DDD required that cognitive deficits be a result of delays in an applicant's childhood developmental milestones; the Court Opinion and statute only require proof of cognitive disability regardless of the origin of impairment (A.R.S. § 36-551(14): "cognitive disability" means a condition that involves subaverage general intellectual functioning, that exists concurrently with deficits in adaptive behavior manifested before the age of eighteen and that is sometimes referred to as intellectual 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 physical and behavioral health services including EPSDT. Members eligible for ALTCS under DES/DDD have choice with regard to which ALTCS DES/DDD sub-contracted integrated health plan they wish to enroll in.

Due to the above referenced Court Opinion, ALTCS DES/DDD estimates that 25% of previously ineligible applicants would be deemed eligible for DDD State Only, Targeted Case Management, or ALTCS based on the new eligibility criteria.

The AHCCCS Division of Health Care Management (DHCM) Actuarial Team and AHCCCS DHCM financial analysts have worked with ALTCS DES/DDD to evaluate expected membership growth based on the revised eligibility criteria in each of the three categories and evaluate the financial impact of that membership growth. The membership projections used in the CYE 21 capitation rate development include membership growth related to the Court Opinion for the Targeted Case Management and ALTCS eligibility groups. The capitation rate development assumes that there will be no difference in the projected costs on average for members deemed eligible under the revised eligibility criteria from those deemed eligible under the previous eligibility criteria.

Additional information regarding covered populations can be found in the Enrollment and Disenrollment section of the ALTCS DES/DDD contract.

Additionally, due to the public health emergency, and the maintenance of effort requirements included in the Families First Coronavirus Response Act, with a few exceptions as noted in the law, members who were eligible at the beginning of the public health emergency, or who become eligible during the public health emergency, will remain treated as eligible for such benefits through the end of the month in which the public health emergency ends. Given the lack of reliable and historical information for this unprecedented public health emergency, the AHCCCS DHCM Actuarial Team made the decision not to predict rates of foregone care, deferred care, and pent-up demand.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE 21 capitation rates are:

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

- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

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

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

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

Proposed differences among the CYE 21 capitation rates for the ALTCS DES/DDD Program are based on valid rate development standards and are not based on the rate of FFP 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 CYE 21 capitation rates for the ALTCS DES/DDD Program.

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

The capitation rates were developed such that ALTCS DES/DDD would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 21.

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

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

In the 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.vii.(b) Rate Setting Process

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 21 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 21 capitation rates for the ALTCS DES/DDD Program.

I.1.A.ix. Rate Certification Procedures

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

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

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

This is a new rate certification that documents that the ALTCS DES/DDD Program capitation rates are changing effective October 1, 2020 and January 1, 2021.

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

Not applicable. This rate certification will change the ALTCS DES/DDD Program capitation rates effective October 1, 2020 and January 1, 2021. Additionally, AHCCCS will be including contract amendments with the submission of this rate certification which remove language which imposed an upper limit on administrative expenses for Pharmacy Benefit Manager (PBM) subcontractors, the capitation rates certified herein were developed without the specified upper limit.

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

This section of the 2021 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell, in accordance with 42 CFR § 438.7(c)(3), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

CMS requires a contract amendment be submitted whenever capitation rates change for any reason other than application of an approved payment term (e.g. risk adjustment methodology) which was included in the initial managed are contract. The state will submit a contract amendment to CMS to reflect the ALTCS DES/DDD Program capitation rates changing effective October 1, 2020 and January 1, 2021.

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

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

I.1.B. Appropriate Documentation

I.1.B.i. Elements

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

I.1.B.ii. Rate Assumptions

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

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

I.1.B.iii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2021 Guide. Sections of the 2021 Guide that do not apply will be marked as "Not Applicable"; any section wherein all subsections are not applicable will be collapsed to the section heading.

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

The covered populations under the ALTCS DES/DDD Program receive the regular Federal Medical Assistance Percentage. The ALTCS DES/DDD Program is eligible to receive Children's Health Insurance Program (CHIP) funding for Targeted Case Management for those acute enrolled members who are TXXI. There have not been any CHIP members provided Targeted Case Management services under the contract since 2015.

I.1.B.v. Comparison of Rates

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

The 2021 Guide requests a comparison to the final certified rates in the previous rate certification. Comparisons between the most recently certified CYE 20 ALTCS DES/DDD Program capitation rates effective January 1, 2020 and the CYE 21 capitation rates being certified in this actuarial rate certification are available in Appendix 3.

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

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

I.1.B.vi. Future Rate Amendments

There are no known amendments anticipated to be provided to CMS in the future which would impact capitation rates.

I.2. Data

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

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

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

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

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

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

The types of data that AHCCCS relied upon for developing the CYE 21 capitation rates for the ALTCS DES/DDD Program were:

- Adjudicated and approved encounter data submitted by ALTCS DES/DDD, ALTCS DES/DDD subcontractors, the CRS Contractor, and the RBHAs and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe;
  - Incurred from October 2016 through early March 2020;
  - Adjudicated and approved through the first encounter cycle in March 2020;
- Reinsurance payments made to ALTCS DES/DDD for services;
  - Incurred from October 2016 through September 2020 paid through September 2020;
- Historical and projected enrollment data for ALTCS DES/DDD members and Targeted Case Management members, provided by ALTCS DES/DDD;
- Supplemental intermediate care facility (ICF), nursing facility (NF), and home and community based services (HCBS) expenses provided by the ALTCS DES/DDD Program;
  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17);
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18);
  - October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19);
- Quarterly and annual financial statements submitted by ALTCS DES/DDD, prior acute subcontractors, the prior CRS subcontractor, the RBHAs, and the integrated subcontractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team;

  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17);
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18);
  - October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19);
  - October 1, 2019 through March 31, 2020 (year-to-date (YTD) CYE 20 or YTD FFY 20);
- AHCCCS FFS fee schedules developed and maintained by the AHCCCS DHCM Rates & Reimbursement Team;
- Data from AHCCCS DHCM Rates & Reimbursement team related to DAP, see Section I.4.D;
- Data from AHCCCS DHCM financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a);
- Historical and projected Targeted Case Management expenses provided by ALTCS DES/DDD;
  - Historical from October 1, 2016 through March 31, 2020;
  - Projected for CYE 21
- Historical and projected administrative and case management expenses from ALTCS DES/DDD, including supplemental information related to an expanded quality management unit within ALTCS DES/DDD;
  - Historical from October 1, 2016 through March 31, 2020;
  - Projected for CYE 21
- Projected administrative expenses from a competitive bid process for ALTCS DES/DDD integrated subcontractors for CYE 21.

Additional sources of data used or reviewed were:

- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CYE 19;
- Projected CYE 21 enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team;
- Integrated subcontractors' membership for determining administrative expense thresholds related to the bids;
- Any additional data used and not identified here will be identified in their applicable sections below.

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

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

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

The sources of the data are listed above in Section 1.2.B.ii.(a)(i).

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

For LTSS provided in either an ICF or HCBS setting, ALTCS DES/DDD does not use sub-capitated arrangements. The program utilizes staff models for some of these LTSS services. The program has staff models for State Operated Group Homes (SOGH) and State Operated Intermediate Care Facilities (SOICF) throughout the State and also for those located at the Arizona Training Program at Coolidge

(ATPC) campus. Encounters are submitted for the LTSS services provided in staff models, with health plan paid amounts of zero. These encounters go through all of the same processes described below in Section I.2.B.ii.(b) and are available to the actuaries through the AHCCCS PMMIS mainframe. The units from the encounters are then matched up with the cost of those services reflected in the supplemental expense information provided by ALTCS DES/DDD for purposes of rate development.

All services under the responsibility of ALTCS DES/DDD's historically subcontracted acute and CRS health plans, and the current subcontracted integrated health plans are also submitted in the same manner as encounters from other health plans, under the ALTCS DES/DDD health plan ID with a Transmission Submitter Number (TSN) to identify the payer as one of the subcontracted health plans. These encounters go through all of the same processes described below in Section I.2.B.ii.(b) and are available to the actuaries through the AHCCCS PMMIS mainframe.

The acute subcontractors, the CRS subcontractor, and the RBHAs (all of which bore responsibility for some portion of care provided to ALTCS DES/DDD members in the base data year, FFY 19, and prior data years, FFY 17 and FFY 18) also use sub-capitated arrangements with some providers which still require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05 and health plan paid of zero (i.e. sub-capitated)) encounters to estimate a health plan valued amount for these encounters. The repricing methodology used in the rate development process for the acute and CRS components differs from the methodology used for the behavioral health component. For the acute and CRS components, 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 behavioral health component, sub-capitated costs are set as the health plan allowed amount less any third party insurance amounts. 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 all 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 per member per month (PMPM) basis looking for anomalous patterns in encounter, unit, or cost totals, such as incurred months where totals are unusually low or high. If any anomalies are found, the AHCCCS Actuarial Team reports the findings to the AHCCCS Office of Data Analytics (ODA) Team, which then works with the health plan to determine causal factors. In addition, the AHCCCS ODA Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

ALTCS DES/DDD, and all other AHCCCS Contractors, know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides ALTCS DES/DDD 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 integrated 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, by extension, their subcontractors allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions.

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

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

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

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

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

The AHCCCS DHCM Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe. The AHCCCS DHCM Actuarial Team ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 21 capitation rates for the ALTCS DES/DDD Program. Additionally, the AHCCCS DHCM Actuarial Team ensured that only services covered under the state plan were included.

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

The AHCCCS DHCM Actuarial Team reviewed encounter data from all relevant Contractors providing services to ALTCS DES/DDD members over the past three years, along with supplemental cost data from ALTCS DES/DDD for state operated facilities, for consistency by viewing month over month, and year over year changes. The AHCCCS DHCM Actuarial Team also compared the aggregated encounter and supplemental cost data to financial statements for all relevant Contractors. This review led to adjustments for encounter submission issues from one of the subcontractors. These adjustments are described below in Section I.2.B.iii.(c). After adjustments, the data was judged to be consistent across data sources.

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, ALTCS DES/DDD acute subcontractors, the prior CRS subcontractor, and the RBHAs and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by ALTCS DES/DDD, ALTCS DES/DDD prior acute subcontractors, the prior CRS subcontractor, the RBHAs, and the integrated subcontractors 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 regard to DAP and fee schedule impacts, on the Public Notice of proposed fee schedule changes for CYE 21 posted by ALTCS DES/DDD to its website, on data provided by the AHCCCS DHCM financial analysts with regard to some program changes, on information and data provided by Mercer consultants with regard to pharmacy reimbursement savings, on information and data provided by Milliman consultants with regard to the HEALTHII program, on data provided by the integrated subcontractors with regard to administrative components, on analysis provided by an actuarial student under direct supervision of the actuary, and on data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

The AHCCCS DHCM Actuarial Team has found the FFY 19 encounter data and supplemental cost data for state operated facilities, with adjustments for the issues identified in Section I.2.B.ii.(b)(i)(C) above, to be appropriate for the purposes of developing the appropriate components for the CYE 21 capitation rates for the ALTCS DES/DDD Program. The development of the encounter issue adjustments are described below in Section I.2.B.iii.(c).

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

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

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

The AHCCCS DHCM Actuarial Team determined that the FFY 19 encounter data for LTSS, acute, CRS, and behavioral services with inclusion of supplemental cost data related to staff models for LTSS provided in

state operated facilities were appropriate to use as the base data for developing the CYE 21 capitation rates for the ALTCS DES/DDD Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 21 capitation rates for the ALTCS DES/DDD Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 21 capitation rates for the ALTCS DES/DDD Program.

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

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

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

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

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

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

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

An adjustment was made to the encounter data to reflect the level of completion. AHCCCS calculated completion factors using the development method with monthly encounter data from October 2016 through early March 2020. The monthly completion factors were applied to the encounter data on a monthly basis. The aggregated FFY 19 completion factor impacts are shown in Table 1 below.

Table 1: Completion Factor Impacts

Rate Component	Before Completion	After Completion	Impact
LTSS	$2,926.74	$2,938.17	0.39%
Integrated Care Services	$774.85	$819.42	5.75%
Total	$3,701.58	$3,757.59	1.51%

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

During the rate development process, it was determined that one of the ALTCS DES/DDD subcontractors incorrectly submitted encounters for ADA – Dental Services (form type D) during the base data year (FFY 19). Encounters were submitted with consistent utilization information, but inconsistent cost information from December 2017 through November 2018. To correct for this issue, the actuary derived a quarterly unit cost assumption by dividing the Dental services cost reported in the subcontractor's financial reporting for the errant period by the utilization information present in encounters during the same period. Encounter costs were then replaced by multiplying the utilization amount in each errant

quarter by the replacement unit cost. The effect of the adjustment relevant to the base year is given in Table 2a below.

Table 2a: Subcontractor Dental Encounter Issue

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,938.17	$2,938.17	0.00%
Integrated Care Services	$819.42	$820.02	0.07%
Total	$3,757.59	$3,758.19	0.02%

Additionally, as of the data retrieval date for the encounter data, the actuary determined that there were missing encounters that would impact the base data year (CYE 19). To account for this missing data, the actuary computed the ratio of the average cost for the unaffected period of the base data year to the average cost of the affected period of the base data year, and used the resulting scalar factor to adjust the affected period to a level consistent with the more complete data of the base data year. The impact of this adjustment is given in Table 2b below.

Table 2b: Subcontractor Missing Encounter Issue

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,938.17	$2,938.17	0.00%
Integrated Care Services	$820.02	$822.09	0.25%
Total	$3,758.19	$3,760.26	0.05%

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2018 through September 30, 2019) are described below, or in Section I.3.A.v. for base data adjustments required with respect to IMD in-lieu-of services. Some adjustments after September 30, 2019 are also included, and were considered in order to normalize data for review and development of trend. In particular, an adjustment for the minimum wage increase effective on January 1, 2020 along with a similar change from January 1, 2019 is included, as well as provider fee schedule changes that took effect October 1, 2019. All other program and fee schedule changes which occurred or are effective on or after October 1, 2019 are described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less for the regular DDD rate cell (base data adjustments do not impact the Targeted Case Management rate cell), that adjustment was deemed non-material and has been grouped in the combined miscellaneous base data adjustment subset below along with a brief description of each adjustment. Some of the impacts for base data adjustment changes described below (indicated by an asterisk *) were developed by AHCCCS DHCM financial analysts with oversight from the AHCCCS DHCM Clinical Quality Management Team and the Office of the Director's Chief Medical Officer. As noted above in Section I.2.B.ii.(b)(ii), the actuary relied upon the professional judgment of the AHCCCS DHCM financial analysts with regard to the reasonableness and

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

Proposition 206 Reimbursement Rate Changes through 1/1/2020

Effective January 1, 2019 and January 1, 2020, AHCCCS increased fee schedule rates for select HCBS procedure codes, all NF revenue codes, and all Assisted 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 AHCCCS DHCM Rates & Reimbursement team used historical encounter data for relevant HCBS procedure codes, NF revenue codes, and ALF procedure codes 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 as well as the amount by which each service was adjusted. The PMPM impacts, as provided in Table 3a below, were incorporated into base data adjustment and trend development as appropriate.

Table 3a: Proposition 206 Reimbursement Rate Changes through 1/1/2020

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,938.17	$3,161.96	7.62%
Integrated Care Services	$822.09	$822.10	0.00%
Total	$3,760.26	$3,984.06	5.95%

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS FFS programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts except where authorized under applicable law, regulation or waiver, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding health plan fee schedules. Additionally, in the 2019 legislative session, the legislature passed a general appropriations bill which outlined funding for ALTCS DES/DDD to implement provider fee schedule increases. The AHCCCS DHCM Rates & Reimbursement Team spread the

legislative funding across HCBS and NF provider reimbursement rates, and the impacts have been included by category of service based on utilization of the specific services in the base year.

The impact of both the legislatively mandated provider fee schedule increases and the annual AHCCCS fee schedule updates through October 1, 2019 is given in Table 3b below.

Table 3b: Provider Fee Schedule Changes

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,161.96	$3,460.18	9.43%
Integrated Care Services	$822.10	$822.10	0.00%
Total	$3,984.06	$4,282.28	7.49%

Combined Miscellaneous Base Data Adjustments

Although all program changes are included in rate development as separate adjustments, if individual program changes have an impact of 0.2% or less, those changes are deemed non-material for the purpose of the actuarial rate certification. The impacts have been aggregated and are provided in table 3c below. Brief descriptions of these aggregated normalization changes are given below.

- **LISAC Mental Health Assessments ***
  Effective November 1, 2018, AHCCCS included Licensed Independent Substance Abuse Counselors (LISAC) among qualifying providers that will be reimbursed for non-physician mental health assessments. The scope of practice for LISAC includes evaluation and treatment of substance abuse disorders, which can require use of mental health assessments. After inadvertently removing the permission for LISAC to bill for these services during the period from July 1, 2017 to October 31, 2018, the change restored that billing authority.
- **Prenatal Syphilis Screening ***
  In September 2018, the Arizona Department of Health Services (ADHS) declared a syphilis outbreak for women and babies in Arizona. In response to the outbreak, AHCCCS issued a joint position statement with ADHS on February 28, 2019 to clarify that AHCCCS covers 3 prenatal syphilis screens during a member's pregnancy. The statement aligns with screening recommendations from the Centers for Disease Control and Prevention (CDC) that all pregnant women receive a screen during their first prenatal visit, and again early in the third trimester and at the time of delivery if they are at high risk of syphilis.
- **Bilateral Cochlear Implants ***
  Effective March 1, 2019, AHCCCS revised policy to specify coverage of bilateral cochlear implants for children 20 years of age or younger. The change recognizes the latest standard of care and a CMS decision memo regarding the appropriateness of bilateral cochlear implants. Prior to the change, policy specified coverage of unilateral cochlear implants for children.
- **Transportation Network Companies for NEMT ***

Beginning May 1, 2019, AHCCCS established a Transportation Network Company (TNC) provider type that delivers non-emergency medical transportation (NEMT) services through a ride-sharing model. The TNC-specific fee schedule is lower than ordinary NEMT base rates.

- **3D Mammography ***
  Effective June 1, 2019, upon recommendation of the AHCCCS Quality Management Team, AHCCS began covering digital breast tomosynthesis (3D mammograms) for preventive screening and diagnosis of adults 21 years of age and older. The AHCCCS Quality Management Team made the recommendation in recognition of studies that find use of 3D mammograms in addition to or in place of 2D services has, at times, improved detection of breast cancer in some populations. Contractors are permitted to use prior authorization criteria in evaluating medical necessity of 3D services for members.
- **Pharmacy & Therapeutics Committee Decisions – Base Year ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 19 that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 21. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness, and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.
- **Pharmacy Reimbursement Savings**
  Analysis of pharmacy claims for all AHCCCS managed care programs and the AHCCCS FFS program identified significant variability across all Contractors, and analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to the lesser of Health Plan Paid amounts or AHCCCS FFS repriced amounts would result in an annual savings of $68.2 million or 5.6% of pharmacy spend for FFY 18 across all programs. Based on continued analysis, for CYE 21, AHCCCS is adjusting the base pharmacy data of each program by 66% of the savings identified in the analysis of CYE 18 pharmacy data. This is consistent with subsequent analysis of the CYE 19 pharmacy data.
- **Removal of Crisis Services from Base Data**
  Effective October 1, 2019, ALTCS DES/DDD began covering most behavioral health services of members, in addition to Long Term Services and Supports (LTSS), acute care services, and CRS services. However, the RBHA Program continues to cover crisis intervention services provided to all members during the first 24 hours following a crisis event. This includes coverage of crisis hotlines, mobile crisis teams, and stabilization services. The actuary removed the cost of these services from the relevant base data encounters.
- **Removal of Access to Professional Services Initiative (APSI)**
  CYE 19 capitation rates for the prior CRS subcontractor (services integrated into ALTCS DES/DDD effective October 1, 2018) funded Access to Professional Services Initiative (APSI) fee schedule increases for claim payments made from October 1, 2018 through September 30, 2019. The enhanced fee schedule was used to provide enhanced support to certain professionals in order

to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. As these enhanced fee schedule payments expired September 30, 2019, AHCCCS removed the impact of CYE 19 APSI from the base period.

- **Removal of Differential Adjusted Payments from Base Data**
  CYE 19 capitation rates for the ALTCS DES/DDD Program and the various other programs integrated into the ALTCS DES/DDD Program funded DAP made from October 1, 2018 through September 30, 2019 to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health, and reduce cost of care growth. As these payments expired September 30, 2019, AHCCCS has removed the impact of CYE 19 DAP from the base period.

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

Table 3c: Combined Miscellaneous Base Data Adjustments

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,460.18	$3,460.17	0.00%
Integrated Care Services	$822.10	$807.45	-1.78%
Total	$4,282.28	$4,267.62	-0.34%

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

The AHCCCS DHCM Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 21 capitation rates.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2021 Guide.

I.3.A. Rate Development Standards

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

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

I.3.A.ii. Variations in Assumptions

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

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

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

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

Any in-lieu-of services (and the specific utilization and unit costs associated with such) provided in the base period have been included in the rate development as is, and treated in the same manner as all other State Plan approved services, with the exception of IMD in-lieu-of services provided to enrollees aged 21-64. For enrollees aged 21-64, for inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.6(e) and this is described below in Section I.3.A.v.

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

The projected benefit costs include costs for members aged 21-64 that have a stay of no more than 15 cumulative days within a month in an IMD in accordance with 42 CFR § 438.3(e) at 81 FR 27861.

Costs Associated with an Institution for Mental Disease stay

The AHCCCS DHCM Actuarial Team adjusted the base data to reprice the costs associated with stays in an IMD for enrollees aged 21-64 in accordance with 42 CFR § 438.6(e) at 81 FR 27861. The AHCCCS DHCM Actuarial Team repriced all utilization of an IMD at the cost of the same services through providers included under the State plan, regardless of length of stay. The AHCCCS DHCM Actuarial Team then removed costs for members aged 21-64 for stays in an IMD exceeding 15 cumulative days in a month, whether through a single stay or multiple within the month. Additionally, the AHCCCS DHCM Actuarial Team removed all associated medical costs that were provided to the member during the IMD stay(s) that exceeded 15 cumulative days in a month.

The data used to determine the base data adjustment was the CYE 19 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 19 encounter data, the AHCCCS

DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the Non-IMD price-per-day. The Non-IMD price-per-day used in the analysis was $874.95 and was derived from the CYE 19 encounter data for similar IMD services that occurred within a Non-IMD setting. The encounter data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a Non-IMD setting which may not be fully captured within the AHCCCS FFS fee schedule per diem rate. The costs associated with institutional stays at an IMD that were repriced in the base data are displayed below in Table 4a. Totals may not add up due to rounding.

Table 4a: IMD Repricing Impact

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,460.17	$3,460.17	0.00%
Integrated Care Services	$807.45	$807.65	0.02%
Total	$4,267.62	$4,267.82	0.00%

The AHCCCS DHCM Actuarial Team identified all members aged 21-64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed below in Table 4b. Totals may not add up due to rounding.

Table 4b: Removal of Repriced Stays Longer than 15 Cumulative Days in a Month

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,460.17	$3,460.17	0.00%
Integrated Care Services	$807.65	$807.33	-0.04%
Total	$4,267.82	$4,267.50	-0.01%

Once a member was identified as having an IMD stay(s) greater than 15 cumulative days in a month, all encounter data for the member was pulled for the timeframe(s) they were in the IMD in order to remove those additional medical service costs from rate development. The associated costs removed from the base data are displayed below in Table 4c. Totals may not add up due to rounding.

Table 4c: Removal of Other Costs Associated with Problematic IMD Stays

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,460.17	$3,460.17	0.00%
Integrated Care Services	$807.33	$807.26	-0.01%
Total	$4,267.50	$4,267.42	0.00%

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

The final projected benefit costs for the regular DDD rate cell are included in Appendix 6.

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

This section provides information on the projected benefit costs included in the CYE 21 capitation rates for the ALTCS DES/DDD Program.

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

The base data described in Section I.2.B.ii. was adjusted to reflect completion and all base data adjustments described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in I.3.A.v. The adjusted base data PMPM expenditures were trended forward 24 months from the midpoint of the CYE 19 time period to the midpoint of the CYE 21 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below. Appendix 4 contains the base data and base data adjustments, Appendix 5 contains the projected benefit cost trends, and Appendix 6 contains the prospective programmatic and fee schedule changes. Additionally, Appendix 6 illustrates the capitation rate development, including DAP, reinsurance offset, administrative expense, underwriting (UW) gain, and premium tax.

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

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

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

Increase to Annual Respite Hour Limit * ‡

CMS approved AHCCCS' requested 1115 Waiver authority to increase the annual limit in covered respite care services that a member may receive from 600 hours to 720 hours a year. The authority is effective retroactively from March 1, 2020 until 60 days after the end of the federal emergency declaration. The estimates assume that the authority will extend for the 12 months of CYE 21. To estimate the impact of this change, the AHCCCS DHCM financial analysts first reviewed base period encounters of respite care services. In projecting the impact of this change, analysts made the assumption that members currently receiving the full 600 hours of services permitted during the base period would begin receiving the full 720 hours of respite services permitted under the expanded 1115 waiver authority during the contract period. Analysts further assumed that use of respite care services by all other members using respite care services during the base period would increase by 20%, which equals the percentage increase in the annual cap. The overall impact of the change is displayed below in Table 5a. Totals may not add up due to rounding.

Table 5a: Increase to Annual Respite Hour Limit

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,629.86	$3,685.69	1.54%
Integrated Care Services	$841.65	$841.65	0.00%
Total	$4,471.51	$4,527.34	1.25%

Supports During School Hours * ‡

Member students receive medically necessary services that are specified in an Individualized Education Program (IEP) from school-based providers participating in the School Based Claiming (SBC) FFS program. Due to virtual learning environments necessitated by the public health emergency, it may not be feasible for schools to provide in-person attendant care and nursing services through SBC. It is therefore anticipated that these services will transition to Contractor provider networks. To estimate the impact of this change, AHCCCS DHCM financial analysts reviewed base period use SBC attendant care and nursing procedure codes. It was assumed these services would transition to Contractor networks during CYE 21 and would be reimbursed at Contractor rates. It was additionally assumed that school aged children 5 to 20 years of age that use attendant care or nursing services, but that do not receive services through the SBC program, would use additional in-home attendant care and nursing services to the same extent as SBC participants. These projected services were similarly priced at average Contractor rates. For CYE 21 rate development, the projected impact of growth in services was allocated using base period claims of SBC attendant care and nursing services and base period encounters of attendant care and nursing services of school-aged members that did not participate in SBC programs. The overall impact of the change is displayed below in Table 5b. Totals may not add up due to rounding.

Table 5b: Supports During School Hours

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,685.69	$3,727.49	1.13%
Integrated Care Services	$841.65	$841.65	0.00%
Total	$4,527.34	$4,569.14	0.92%

ALTCS Home Delivered Meals * ‡

CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to expand the provision of home delivered meals to members enrolled in the ALTCS DES/DDD Program. The authority is effective retroactively from March 13, 2020 until March 31, 2021. Prior to this change, only members in the ALTCS Elderly and Physical Disabilities (ALTCS EPD) Program received coverage of home delivered meals. To estimate the impact of this change, the AHCCCS DHCM financial analysts first reviewed base period encounters of home delivered meals for the ALTCS EPD Program. Analysts assumed that the proportion of ALTCS DES/DDD adult and child members in home placements receiving home delivered meals during the period of flexibility would be 200% of the rate of use for ALTCS EPD adult and child members in home placements observed in the base period. It was further assumed that the average monthly amount of delivered meals per user under the ALTCS DES/DDD Program during the period of flexibilities would equal the average monthly amount of meals per user in the base period under the ALTCS/EPD Program. For CYE 21 rate development, the projected impact under this enhanced flexibility was limited to the period from October 1, 2020 to March 31, 2021. The impact of the change is displayed below in Table 5c.

Table 5c: ALTCS Home Delivered Meals

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,727.49	$3,740.39	0.35%
Integrated Care Services	$841.65	$841.65	0.00%
Total	$4,569.14	$4,582.04	0.28%

AHCCCS FFS Fee Schedule Updates

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

Additionally, the ALTCS DES/DDD Contract has the requirement that ALTCS DES/DDD reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. The AHCCCS

FFS fee schedule updates program change includes a fee schedule adjustment to bring the encounter base data from CYE 19 FQHC PPS rates up to projected CYE 21 FQHC PPS rates.

Effective October 1, 2020, AHCCCS will be updating provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 21 capitation rates have been adjusted to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to the CYE 21 capitation rates was the CYE 19 encounter data. The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program.

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

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

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

Effective January 1, 2020, the All Patients Refined Diagnosis Related Group (APR-DRG) adjustor for burns increased. The increased costs for this change have been included with the fee schedule changes already

discussed as the APR-DRG burn adjustor is non-material for the ALTCS DES/DDD Program when considered alone.

The overall impact of the AHCCCS FFS fee schedule updates is illustrated below in Table 5d. Totals may not add up due to rounding.

Table 5d: Impact of Aggregate AHCCCS FFS Fee Schedule Updates

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,740.39	$3,768.75	0.76%
Integrated Care Services	$841.65	$882.78	4.89%
Total	$4,582.04	$4,651.53	1.52%

Proposition 206 Reimbursement Rate Changes

Effective January 1, 2021, AHCCCS is increasing fee schedule rates for select HCBS procedure codes, all NF revenue codes, and all 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 by the AHCCCS DHCM Rates & Reimbursement team to develop an adjustment for the minimum wage increase was the CYE 19 encounter data for the HCBS procedure codes, NF revenue codes, and the ALF procedure codes. Fee schedule adjustments, effective January 1, 2021, were applied to NF, ALF, and HCBS encounter data as applicable. The PMPM impacts to Institutional and HCBS services, as provided in Table 5e, were incorporated into expense projections for the rating period.

Table 5e: Proposition 206 Reimbursement Rate Changes

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,768.75	$3,797.88	0.77%
Integrated Care Services	$882.78	$883.30	0.06%
Total	$4,651.53	$4,681.18	0.64%

Applied Behavior Analysis

Consistent with the Medical Policy update on November 1, 2019 stipulating coverage of Applied Behavior Analysis (ABA) services, AHCCCS has been working with ALTCS DES/DDD to phase out an earlier version of the service (called 'ECA' by ALTCS DES/DDD) that no longer complies with the guidance and create a new service, delivered through the ALTCS DES/DDD's subcontractors. As part of the phase out, new authorizations for the earlier service will cease effective October 1, 2020, while authorizations for that service still in place at that time will be allowed to expire naturally. Utilization for the new ABA

service is expected to increase throughout CYE 20 and into CYE 21, while utilization for the ECA service is expected to gradually diminish to zero over the same period.

To estimate the impact in the contract period, the AHCCCS DHCM Actuarial Team reviewed utilization and unit cost data for the ECA service, as well as the new ABA service. The team reviewed data on a per-member basis and generated an "active case" count for each service type. For ECA, "active cases" were defined as continuous use of the service by an individual member until either a gap of two months or greater or 12 months from the earliest use date; this definition is an artifact of ALTCS DES/DDD's case management authorization process, whereby members are assigned ECA services for a limited duration of time, usually up to 12 months. For the new ABA service, "active cases" were defined as continuous use of the service until a gap of two months or greater. The "active case" definitions produced counts of active cases in each month during the data review period (FFY 17 through FFY 19), which gave the team an understanding of how many new cases arrive in each month and how many attrition out in each month. Using this information, the team developed a forecast of active cases through the end of the contract period, keeping in mind the freeze on new cases for the ECA service beginning October 1, 2020. Active cases for ECA are expected to diminish to zero by September 30, 2021, while cases for the new ABA services will gradually increase from about 100 at the end of FFY 19 to over 600 at the end of FFY 21. The team then used ordinary least squares regression to estimate the total utilization based on the active case count. The team determined that the results of the regression were reasonable, strongly predictive, and consistent with the assumptions for linear models. Total cost was determined by multiplying the utilization forecast by the average unit price for these services in the FFY 19 base data year and applying growth factors for completion, normalization, trend, and relevant program changes.

The net impact of the ECA phase-out and ABA phase-in is displayed below in Table 5f. Totals may not add up due to rounding.

Table 5f: Applied Behavior Analysis (DDD)

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,797.88	$3,765.68	-0.85%
Integrated Care Services	$883.30	$938.15	6.21%
Total	$4,681.18	$4,703.83	0.48%

Combined Miscellaneous Program Changes

The rate development process includes every individual program and reimbursement change as a separate adjustment. However, as noted earlier in this section, if an individual program or reimbursement change had an impact of 0.2% or less on the rate cell capitation rate, that program change was deemed non-material for the purpose of the actuarial rate certification. The aggregated impacts of all non-material changes are shown below in Table 5g. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Pharmacy & Therapeutics Committee Decisions ***

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

- **Cystic Fibrosis Drug Approval ***
  On October 21, 2019, the Food and Drug Administration (FDA) approved the cystic fibrosis transmembrane conductance regulator (CFTR) modulator drug Trikafta for treatment of cystic fibrosis in individuals aged 12 years and older. The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Trikafta on October 21, 2019. Effective October 1, 2020, all CFTR drugs (Trikafta, Symdeko, and Orkambi) are eligible for reinsurance.
- **Sickle Cell Drugs Approval ***
  In November 2019, the FDA approved the drugs Oxbryta and Adakveo for treatment of sickle cell disease. Collectively, the drugs are approved for treatment of individuals 12 years and older. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Oxbryta and Adakveo on November 25, 2019 and November 20, 2019, respectively.
- **Duchenne Muscular Dystrophy Drug Approval ***
  On December 12, 2019, the FDA approved Vyondys 53 for treatment of Duchenne muscular dystrophy in individuals with a mutation that is amenable to exon 53 skipping. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Vyondys 53 on December 12, 2019.
- **Peanut Allergy Drug Approval ***
  On January 31, 2020, the FDA approved the immunotherapy drug Palforzia for treatment of peanut allergy in children 4 to 17 years of age. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in MDRP, AHCCCS began coverage of Palforzia on January 31, 2020.
- **Mantle Cell Lymphoma Drug Approval ***
  On July 24, 2020, the FDA approved Tecartus for the treatment of adult patients with relapsed or refractory mantle cell lymphoma. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebates agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Tecartus on July 24, 2020. Beginning October 1, 2020, Tecartus will be eligible for reinsurance.
- **Spinal Muscular Atrophy Drug Approval ***

On August 7, 2020, the FDA approved Evrysdi for the treatment of Spinal Muscular Atrophy in patients 2 months and older. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Evrysdi on August 7, 2020. Effective October 1, 2020, Evrysdi is eligible for reinsurance.

- **Advanced Practice Nurse MAT ***
  The Federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) permits Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists to administer Buprenorphine for medication assisted treatment (MAT). The federal law is expected to increase use of MAT and costs to the program.
- **Behavioral Health Residential Facilities ***
  Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team established a differentiated FFS rate for Behavioral Health Residential Facilities that are licensed by ADHS to provide personal care services.
- **Substance Use Disorder Assessment ***
  Effective October 1, 2018, AHCCCS updated provider fee schedules to include a targeted increase to providers who conduct a computer-guided, structured interview utilizing American Society of Addiction Medicine (ASAM) software. The service enables providers to determine the appropriate level of treatment based upon a set of medically accepted criteria. Due to a slower-than-anticipated adoption of the ASAM software, impacts of the change in the base period encounters are limited. For CYE 21 rate development, additional impacts for the change are included above any base period encounters.
- **Opioid Treatment Program Reimbursement ***
  Pursuant to final rule 2019-24086, Medicare began reimbursing Opioid Treatment Programs (OTP) for opioid use disorder (OUD) treatment services provided to individuals with Medicare Part B insurance on and after January 1, 2020. Under the change, reimbursement of OTP services and Medication Assisted Treatment (MAT) drugs to members dually enrolled in Medicare and Medicaid for treatment of OUD will shift from AHCCCS Contractors and Medicare Part D to Medicare Part B. Medicare OTP services on and after January 1, 2020 are not subject to the traditional Medicare Part B 20% coinsurance during the contract period.
- **Off Campus Hospital Outpatient Department Reimbursement ***
  Effective October 1, 2020, AHCCCS is reimbursing services billed at off campus hospital outpatient departments on a UB-04 form with PO or PN modifiers according to the physician or ambulatory surgical center fee schedules. The change will represent a decrease in reimbursement relative to outpatient hospital fee schedule rates that providers billed before the change.
- **Outpatient Psychiatric Hospital Reimbursement ***
  Beginning October 1, 2020, AHCCCS is implementing an outpatient hospital fee schedule reimbursement methodology for outpatient services provided by psychiatric hospitals. Prior to

this change, AHCCCS manually approved Contractor payments to psychiatric hospitals for outpatient services, which were not subject to a specific reimbursement methodology. To estimate the impact, the AHCCCS DHCM financial analysts repriced base period encounters at outpatient hospital fee schedule rates.

- **Adult Hepatitis C Screening Recommendation ***
  On March 2, 2020, the U.S. Preventive Services Task Force (USPSTF) published a final recommendation that all adults 19 to 79 years of age be screened for hepatitis C. This represents an expansion of recommended screening from the previous guidance that adults born between 1945 and 1965 be screened. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the USPSTF final recommendation on hepatitis screenings for adults.
- **Adult Human Papillomavirus Immunization Guidance ***
  On August 16, 2019, the CDC Advisory Committee on Immunizations (ACIP) released a recommendation that adults 27 to 45 years of age at risk of contracting human papillomavirus immunization (HPV) are vaccinated. This represents an expansion to previous guidance, which recommended HPV immunizations for adults 19 to 26 years of age. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the ACIP recommendation on HPV immunizations for adults.
- **Increased Frequency of Dental Fluoride Visits ***
  Beginning February 1, 2020, AHCCCS increased the maximum number of dental fluoride varnish applications that members may receive, from 2 to 4 applications a year.
- **Inpatient Dental Hygienist Teeth Cleanings ***
  As part of the 2019 Legislative session, the Arizona Legislature passed HB 2058 which permits dental hygienists to provide services in an inpatient hospital setting under supervision of a physician. The legislation is expected to increase provision of inpatient teeth cleanings for prevention of ventilator associated pneumonia (VAP).
- **Remove Spouse Caregiver Weekly Hour Limit * ǂ**
  CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to eliminate the 40 hour limit on reimbursable caregiver services provided by a member's spouse during a 7-day period. The authority is effective retroactively from March 13, 2020 until March 31, 2021.
- **Reimbursement for HCBS Delivered by Parents * ǂ**
  CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to reimburse parents or legally responsible individuals for HCBS provided to a child under the age of 18 years. The authority is effective retroactively from March 13, 2020 until March 31, 2021.
- **Flu Vaccine Initiative * ǂ**
  AHCCCS is implementing initiatives in the contract year to support use of influenza vaccinations during the COVID-19 outbreak. Effective September 1, 2020, the agency increased FFS rates on influenza vaccination and administration codes and on administration codes for all Vaccine For Children (VFC) program vaccines by 10%. Effective September 1, 2020, AHCCCS also modified policy guidance to permit pharmacists to administer influenza vaccinations to children ages 3 - 18 years old and to permit qualified emergency medical service providers to administer

influenza vaccinations to members of all ages. Prior to the change, policy limited pharmacist-administered influenza vaccines to adults 19 years and older. Lastly, Contractors are providing a $10 gift card to members that receive an influenza vaccination in the contract period. AHCCCS anticipates this gift card incentive will increase member use of these services. The projected costs to purchase and administer the gift cards are funded separately in the non-benefit portion of the CYE 21 capitation rates.

- **Pay and Chase Guidance ***
  Federal regulation 42 CRF 433.139, Payment of Claims, requires agencies and their Contractors to pay and chase claims for preventive pediatric care services, including EPSDT services, regardless of the existence of third party liability at the time the claim is filed. Preventive pediatric care refers to screening and diagnostic services to identify congenital, physical, mental health routine examinations performed in the absence of complaints and screening or treatment designed to avert various infectious and communicable diseases from occurring in children under 21 years of age. As a result of questions to AHCCCS regarding coordination of benefits for members with Autism Spectrum Disorder, the agency provided additional clarification to Contractors in FFY 20 on preventive services that must be reimbursed on a pay and chase basis. This clarification is anticipated to increase costs of Contractors in situations in which they are unable to successfully recover funding from liable third parties.
- **Depression and Anxiety Screening Codes ***
  Effective August 1, 2020, AHCCCS began coverage of procedure code 96127 for brief emotional or behavioral assessments.
- **Expanded Telehealth Use * ǂ**
  To ensure access to care during the public health emergency, AHCCCS has temporarily expanded coverage of telephonic codes and mandated that services delivered telephonically or through telehealth (TPTH) are reimbursed at the same rates as for in-person services, for both physical and behavioral health services. April and May 2020 data provided by Contractors indicates use of TPTH services has been essential for continued provision of services and represented annualized growth of 1,308% above base period use across all programs. Most growth in the use of these services during the public health emergency is expected to represent a cost-neutral shift from use of in-person services. Increased use of TPTH services are, however, expected to reduce the rate of missed appointments and lower use of NEMT and emergency department visits.
- **Rx Rebates Adjustment**
  An adjustment was made to the base data to reflect the impact of Rx Rebates because the base data does not include any adjustments for Rx Rebates reported within the Contractors' financial statements. The data that the AHCCCS DHCM Actuarial Team reviewed was the CYE 17, CYE 18, and CYE 19 annual financial statement reports and the CYE 20 Q1 and Q2 financial statement reports. From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment. Using the data mentioned, the actuary determined the percent of pharmacy costs represented by reported rebates for CYE 19, for each contractor,

then applied those percentages to the corresponding CYE 19 Pharmacy (form type C) encounter data.

- **Transition of Augmentative and Alternative Communication Device Services**
  Effective January 1, 2021, responsibility for providing AAC will transition from ALTCS DES/DDD to its subcontracted health plans. Both utilization and unit cost are expected to increase overall as a result of this transition.

Table 5g: Combined Miscellaneous Program Changes

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,765.68	$3,757.99	-0.20%
Integrated Care Services	$938.15	$963.02	2.65%
Total	$4,703.83	$4,721.01	0.37%

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

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

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

ALTCS DES/DDD, its subcontractors, and the RBHAs are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuary to set the CYE 21 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2016 through early March 2020 and adjudicated and approved through the first encounter cycle in March 2020, as well as supplemental cost data provided by ALTCS DES/DDD as described in Section I.2.B.ii.(a) for the staff model as noted in Section I.2.B.ii.(a)(iv).

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

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

The encounter and supplemental data was summarized by month and major category of service, and by utilization per 1000, unit costs, and PMPM values. The encounter data was adjusted for completion and the encounter data issues described in Section I.2.B.iii.(c). Additionally, the encounter data was adjusted to normalize for previous program and reimbursement changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 19 (April 1, 2019) to

the midpoint of the rating period for CYE 21 (April 1, 2021). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. 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. Each category of service was analyzed in the same manner.

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

All PMPM trend assumptions were compared to similar assumptions made in CYE 20 for ALTCS DES/DDD capitation rates and judged reasonable to assume for projection to CYE 21, considering the change in the base data time period as well as changes to covered services.

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

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

The actuary assumed negative utilization trends in the following LTSS categories of service: Per Diem Habilitation Services, Employment, HCBS Self Care, State Operated ICF, State Operated Group Homes, State Operated ICF at ATPC, State Operated Group Homes at ATPC, Private ICF. Each of these negative utilization assumptions was based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages and with 12-month, 24-month, and 36-month linear regression results. For every category of service with a negative utilization trend assumption, all regression lines for the utilization data are negatively sloped and the negative slopes are more extreme than the utilization trend rate assumed in capitation rate development.

The actuary also assumed a negative unit cost trend in the HCBS Miscellaneous COS. This assumption was based upon actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages and with 12-month, 24-month and 36-month linear regression results. All regression lines for both utilization and unit cost data for the HCBS_Miscellaneous category of service are negatively sloped and the negative slopes are more extreme than the utilization and unit cost trend rates assumed in capitation rate development.

The only outlier trend is for HCBS Attendant Care services, which has a PMPM trend above 7%. The utilization of the HCBS Attendant Care category of service has been increasing steadily since October 2016. The assumed utilization trend of 8.3% was based upon actuarial judgement with consideration of 3-month, 6-month, and 12-month moving averages and with 12-month, 24-month, and 36-month linear regression results. Given the long-term consistency of the growth in the HCBS Attendant Care services category of service over time, the actuary judged that the assumed utilization and unit cost trends for this category of service are the most appropriate assumptions to reflect expected costs in CYE 21, and the resulting PMPM trend assumption is in line with the most recent twelve months of experience.

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

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

The projected benefit cost trends by major category of service for utilization per 1000, unit cost, and PMPM values are included in Appendix 5. The aggregate projected benefit cost trend impact for the two years of change for the ALTCS DES/DDD Program for utilization per 1000, unit cost, and PMPMs are included below in Table 6.

Table 6: Changes in Price and Utilization

Rate Component	Utilization per 1000	Unit Cost	PMPM
LTSS	2.00%	2.85%	4.90%
Integrated Care Services	0.21%	4.04%	4.26%
Total	1.66%	3.07%	4.78%

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

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

I.3.B.iii.(b)(iii) Other Components – Not Applicable

Not applicable. The projected benefit cost trends did not include other components.

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

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

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

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

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

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

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

The following types of services can be provided as in-lieu-of services per the ALTCS DES/DDD contract: services in alternative inpatient settings licensed by ADHS/DLS in lieu of services in an inpatient hospital (distinct and disparate from in-lieu-of-services provided in an IMD). These services are then included in the ALTCS DES/DDD Program's capitation rate development categories of service. Encounters which are in-lieu-of services are not identified separately in the data. Thus, the actuary cannot define the percentage of cost that in-lieu-of services represent in the capitation rates. However, the in-lieu-of

services are treated exactly the same as all other State Plan approved services in rate development. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.3(e) and this is described above in Section I.3.A.v.

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

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

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

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

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

No specific adjustments are made to the CYE 21 capitation rates for the ALTCS DES/DDD Program for the prior period time frame, given that the encounter and enrollment data are already included within the base data used for rate development.

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

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

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

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

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

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

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

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

Material adjustments related to provider payment requirements under Delivery System and Provider Payment Initiatives are discussed in Section I.4.D. of this rate certification. Additionally, provider requirements related to FQHCs are described in Section I.3.B.ii.

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

The Johnson v DES decision, addressed in Section I.1.A.ii.(c)(iv), will have an impact on eligibility for the ALTCS DES/DDD Program. There are no material changes related to covered benefits or services since the last rate certification related to litigation.

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

All material and non-material changes have been included in the rate development process and all requirements in this section of the 2021 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangement Standards

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

The CYE 21 capitation rates for the ALTCS DES/DDD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2) at 81 FR 27589, called the APM Initiative – Performance Based Payments.

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

The time period of the incentive arrangements described herein coincides with the rating period.

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

All enrollees, children and adults may be covered by this incentive arrangement. Network HCBS agencies exceeding a specified timeliness threshold have the opportunity to participate in the APM arrangements; covered home and community based services are eligible for inclusion.

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

The purpose of the APM Initiative – Performance Based Payments incentive arrangement is to align incentives between ALTCS DES/DDD and network HCBS agencies regarding the timeliness of services provided to ALTCS DES/DDD members by rewarding providers for their performance in quantifiable improved outcomes.

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

The APM Initiative – Performance Based Payments incentive arrangement will not exceed 105% of the capitation payments to comply with 42 CFR § 438.6(b)(2).

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

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 21 capitation rates and had no effect on the development of the capitation rates for the ALTCS DES/DDD Program. Anticipated total incentive payments are approximately $75 million. The anticipated incentive payment amounts will be paid by AHCCCS to the ALTCS DES/DDD Contractor through lump sum payments during the contract year.

I.4.B. Withhold Arrangements – Not Applicable

Not applicable. There are no withhold arrangements in the CYE 21 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 2021 Guide provides information on the requirements for risk-sharing mechanisms.

I.4.C.ii. Appropriate Documentation

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

The CYE 21 capitation rates for the ALTCS DES/DDD Program will include risk corridors for the regular DDD rate cell.

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 21 capitation rates are consistent with AHCCCS' long-standing program policy and include risk corridors for services under the ALTCS DES/DDD Program. This rate certification will use the term risk corridor to be consistent with the 2021 Guide. The DES/DDD Contract refers to the risk corridor as a reconciliation.

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

There are two risk corridor type arrangements in the ALTCS DES/DDD Program. The first is DES/DDD reconciling its Subcontractor costs to reimbursement and the second is the LTSS and AIHP reconciliation of costs to reimbursement.

The Subcontractor costs to reimbursement risk corridor will reconcile Subcontractors medical expenses to medical capitation paid to the Subcontractor in accordance with the ALTCS DES/DDD's contract with the Subcontractor. The risk corridor with the Subcontractor provides for payment or recoupment outside a risk corridor as agreed to in the subcontract. ALTCS DES/DDD will submit the reconciliation for AHCCCS approval and AHCCCS will reconcile with ALTCS DES/DDD by reimbursing excess losses to be paid to the Subcontractor. The total amount of any excess profits to be recouped from the Subcontractor will be returned to AHCCCS.

The LTSS and AIHP costs risk corridor will reconcile ALTCS DES/DDD's LTSS and AIHP medical cost expenses to the net retained capitation paid to ALTCS DES/DDD. Net retained capitation is equal to the retained capitation rates paid less the administrative component, the case management component, and the premium tax plus any reinsurance payments. ALTCS DES/DDD's medical cost expenses are equal to the fully adjudicated encounters, sub-cap/block payment expenses, and staff model expenses for LTSS and AIHP services as reported by ALTCS DES/DDD with dates of service during the contract year. The risk corridor will limit ALTCS DES/DDD profits to 6% and losses to 1%.

Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically computed no sooner than 15 months after the contract year.

Additional information regarding the risk corridors can be found in the ALTCS DES/DDD contract.

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

The risk corridors did not have any effect on the development of the capitation rates for the ALTCS DES/DDD Program.

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

The threshold amounts for the risk corridors were set using actuarial judgement with consideration of conversations and input between the AHCCCS DHCM Actuarial Team, the AHCCCS DHCM Finance & Reinsurance Team, the AHCCCS Office of the Director, and the ALTCS DES/DDD Program leadership.

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

Not applicable. The ALTCS DES/DDD Program contract does not include a medical loss ratio remittance or payment requirement.

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

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

AHCCCS provides a reinsurance program to 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 (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than 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 encounter data which would trigger a reinsurance case based on the applicable reinsurance rules and service responsibility of ALTCS DES/DDD in CYE 21 is the basis of the reinsurance offset.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses 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 or catastrophic reinsurance program since the last rate setting period.

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.

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 to develop the reinsurance offset amounts are historical encounters incurred during FFY 19. Encounter data were adjusted in line with the changes outlined in sections I.2.B.iii, I.3.B.ii, and I.3.B.iii; changes to the eligible drugs added to the biotech reinsurance case type for CYE 21 for Mantle Cell Lymphoma (Tecartus), Spinal Muscular Atrophy (Evrysdi), and Cystic Fibrosis (Trikafta, Symdeko, and Orkambi) were reflected in the encounter data pulled for this analysis, and pharmacy costs (form type C) for those members with prior usage of newly eligible drugs or expected usage of newly eligible drugs were adjusted based on the analysis prepared by AHCCCS DHCM financial analysts as described in section I.3.B.ii.(a). Additionally, these data were adjusted for a contractor reporting factor, representing the rate at which the contractor does not report reinsurance cases that would otherwise merit reimbursement. The contractor reporting factor was developed from historical reinsurance payments as compared to the aggregated encounters for individual members which would have triggered reinsurance payments in each contract year. The historical average for this discrepancy is approximately 98% of “eligible reinsurance cases based on encounters” become “actual reinsurance cases submitted by the contractor”. Costs from the adjusted and trended encounter data were then evaluated for each member individually, repricing the total, by reinsurance case type, to a “reinsurance case value”, using the deductibles and coinsurance percentages specific to each case type as outlined in the contract for CYE 21. The reinsurance offset was derived by taking the sum of the reinsurance case values and dividing by the CYE 21 projected member months.

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

I.4.D.i. Rate Development Standards

This section of the 2021 Guide provides information on delivery system and provider payment initiatives authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

The only pre-prints addressed in this certification are the ones related to ALTCS DES/DDD. Those pre-prints are FQHC Differential Adjusted Payments, Differential Adjusted Payments, Access to Professional Services Initiative, Pediatric Services Initiative, and Hospital Enhanced Access Leading to Health Improvements Initiative. This certification combines the FQHC Differential Adjusted Payments under the Differential Adjusted Payments language.

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

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 20.0%, depending on the provider type.

Access to Professional Services Initiative

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

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

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

DAP are the only directed payments incorporated in the capitation rates.

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

Only the regular DDD rate cell is impacted. There is no impact to the Targeted Case Management rate cell.

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

See Appendix 6 for the gross medical impact to the regular DDD rate cell. See Appendix 7 for total impact including underwriting gain and premium tax.

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

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.5% increase; up to 13.5% for select services), Critical Access Hospitals (eligible for up to 10.0% increase; up to 20.0% for select services), other hospitals and inpatient facilities (eligible for up to 4.5% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 7.0% increase on all services provided), physicians, physician assistants, registered nurse practitioners, dental providers (all eligible for up to 2.0% increase), HCBS providers (eligible for up to 1.0% increase on specified services at specified places of service), and FQHCs (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 19 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 21 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

The amount of medical payments for the DAP included in the CYE 21 capitation rates for the ALTCS DES/DDD Program are displayed below in Table 7. These projected medical payments do not include underwriting gain or premium tax. Totals may not add up due to rounding.

Table 7: DAP CYE 21

Rate Component	Non-FQHC Dollar Impact	FQHC Dollar Impact	Total Dollar Impact
LTSS	$6,302,237	$0	$6,302,237
Integrated Care Services	$3,609,187	$28,756	$3,637,942
Total	$9,911,423	$28,756	$9,940,179

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

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

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

Not applicable. None of the directed payments for the ALTCS DES/DDD Program are based on maximum fee schedules.

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

The APSI, PSI, and HEALTHII are not included in the ALTCS DES/DDD certified capitation rates and will be paid out via lump sum payments.

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $10.2 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase

calculated based on encounter data for the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Pediatric Services Initiative

Anticipated payments including premium tax for PSI are approximately $12.0 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 21 utilization will be used to redistribute the payments. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments including premium tax for HEALTHII are approximately $27.5 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 21 utilization will be used to redistribute the payments. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

Access to Professional Services Initiative

The qualifying providers receiving the uniform percentage increase include the following practitioners: physicians, including doctors of medicine and doctors of osteopathic medicine; certified registered nurse anesthetists; certified registered nurse practitioners; physician assistants; certified nurse midwives; clinical social workers; clinical psychologists; dentists; optometrists; and other providers that bill under Form Type A (Form 1500) and D (Dental).

Pediatric Services Initiative

The qualifying providers receiving the uniform dollar increase for inpatient and outpatient hospital services are freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds.

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

The distribution methodology for PSI for CYE 21 will be based on members' utilization of inpatient and outpatient services at freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The uniform dollar increase will be applied to eligible services performed by providers eligible for the Pediatric Services Initiative (identified in the encounters by Servicing Provider Tax IDs). Eligible services are those submitted on UB-04 Inpatient Hospital and UB-04 Outpatient Hospital. Adjudicated and approved encounter data have been used to allocate the interim PSI payments by capitation rate cell. CYE 19 utilization is the basis for the initial distribution of interim quarterly lump sum payments. After the end of the contract year, with sufficient run out, PSI interim quarterly payments will be reconciled using CYE 21 encounter utilization data to re-distribute the interim lump sum payments in the appropriate amounts. The CYE 21 encounter data will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 19.

Hospital Enhanced Access Leading to Health Improvements Initiative

The distribution methodology for HEALTHII for CYE 21 will be based on the utilization of services by members with providers participating in the HEALTHII program. Adjudicated and approved encounter data have been used to allocate the interim HEALTHII payments by capitation rate cell. CYE 19 utilization

is the basis for the initial distribution of the interim quarterly lump sum payments. After the end of the contract year, with sufficient run out, HEALTHII interim quarterly payments will be reconciled using CYE 21 encounter utilization data to re-distribute the interim lump sum payments in the appropriate amounts. The CYE 21 encounter data will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 19.

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

Appendix 7 contains estimated PMPMs including premium tax.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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

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

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

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

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

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

Not applicable. There are no pass-through payments in the CYE 21 capitation rates for the ALTCS DES/DDD Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

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

I.5.B. Appropriate Documentation

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

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

The projected ALTCS case management expense PMPM within the regular DDD capitation rate was informed by ALTCS DES/DDD's expense projections for CYE 21. The projected PMPMs are derived from a case management expense model utilized by the AHCCCS DHCM Actuarial Team incorporating membership projections from AHCCCS DBF Budget Team, and salary information for case managers, case manager supervisors, and support staff provided by ALTCS DES/DDD along with the contractual and legislative requirements for case management ratios. The CYE 21 projection fully funds the required case management ratios in the contract. The projected PMPM associated with case management expenses for CYE 21 is denoted as Case Management in Appendix 6.

The projected administrative expense PMPMs for LTSS were informed by ALTCS DES/DDD's expense projections for CYE 21, actual expenses reported by ALTCS DES/DDD for FFY 18 and FFY 19, and inflation forecasts provided in the IHS Markit First Quarter 2020 Healthcare Cost Report. The base data used for the administrative expense projection for LTSS was ALTCS DES/DDD administrative expenses reported during FFY 19. The actuary applied an adjustment to the reported expenses to reflect additional staffing required for a reorganization of the quality management unit. After adjustment for the additional staffing, the actuary used fixed and variable percentages reported by ALTCS DES/DDD related to the administrative expenses reported over time and adjusted the variable portion of the administrative expenses with respect to membership growth. The actuary then inflated wage-related expenses by the CPI-W from the IHS Markit Healthcare Cost Report and incorporated estimates for additional administrative requirements in the upcoming contract year, inclusive of administrative costs related to the flu vaccine initiative, to come up with a projected administrative expense amount for CYE 21. This projection was then compared to the CYE 21 expense projection from ALTCS DES/DDD. The actuary's estimated projection of administrative expenses for CYE 21 was similar to the forecast provided by ALTCS DES/DDD for CYE 21. The actuary's CYE 21 projection of administrative expenses for LTSS is denoted as Administration for LTSS in Appendix 6.

The administrative expense PMPM for CYE 21 for the integrated subcontractors are awarded administrative bid amounts from a Request for Proposal (RFP) competitive bid process which ALTCS DES/DDD engaged in to subcontract the Integrated Care Services portion of their overall medical services responsibilities. One of the requirements of the RFP was to submit administrative bid amounts based on membership thresholds for the integrated contract. To produce an estimate of the integrated subcontractor administrative cost, the actuary estimated the projected membership for each integrated

subcontractor for CYE 21 to determine the appropriate bid threshold, based on reported integrated subcontractor enrollment as of February 2020. The actuary added administrative costs associated with the flu vaccine initiative to the bid-threshold amounts. The PMPM for the integrated subcontractor administrative cost was determined by dividing the previously mentioned estimate by the total projected membership for ALTCS DES/DDD in CYE 21. The CYE 21 administrative expense projection for the integrated subcontractors is denoted as Administration for Integrated Care Services in Appendix 6.

The Targeted Case Management capitation rate is updated in this certification and will be effective for the entire 12-month time period from October 1, 2020 through September 30, 2021. Similar to ALTCS case management, Targeted Case Management expenses were determined by incorporating case manager, case manager supervisor, and support staff salary information as well as supplemental staff model expenses provided by ALTCS DES/DDD. However, unlike the ALTCS case management costs, Targeted Case Management used membership projections from ALTCS DES/DDD. The CYE 21 Targeted Case Management projection fully funds the required case management ratios in the contract.

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

There were no other material changes not addressed elsewhere to the data, assumptions, 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

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

The administrative component of the CYE 21 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 CYE 21 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. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 21 capitation rate for the regular DDD rate cell includes a provision of 1% for underwriting gain. There is no provision for underwriting gain in the Targeted Case Management rate cell.

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

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

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

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

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

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

The capitation rates for the ALTCS DES/DDD Program reflected in this rate certification do not incorporate the Health Insurance Providers Fee (HIPF). The HIPF for Fee Year 2020 has been incorporated as a retroactive amendment to the initially certified capitation rates for CYE 20. Fee Year 2020 is the final HIPF, as the Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502 repealed the annual fee for calendar years beginning after December 31, 2020.

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

Not applicable. The HIPF is not incorporated into the CYE 21 capitation rates for the ALTCS DES/DDD Program.

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

Not applicable. The HIPF is not incorporated into the CYE 21 capitation rates for the ALTCS DES/DDD Program.

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

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

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

The PMPM cost included in the CYE 21 capitation rates for the ALTCS DES/DDD Program attributable to long-term care, nursing home care, home health care, or community-based care are located in Tables 8a and 8b below. This information is provided for information purposes only, as the HIPF is repealed, as noted above.

Table 8a: Effective October 1, 2020 to December 31, 2020

Setting	Gross Medical	Underwriting Gain	Premium Tax
HCBS	$3,663.37	$36.63	$75.51
NF	$104.21	$1.04	$2.15
Total	$3,767.58	$37.68	$77.66

Table 8b: Effective January 1, 2021 to September 30, 2021

Setting	Gross Medical	Underwriting Gain	Premium Tax
HCBS	$3,685.16	$36.85	$75.96
NF	$104.31	$1.04	$2.15
Total	$3,789.48	$37.89	$78.11

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

For HIPF that have been paid in 2014, 2015, 2016, 2018, and 2020, the HIPF has been included in the capitation rates as a retroactive amendment to the initially certified capitation rates.

I.6. Risk Adjustment and Acuity Adjustments – Not Applicable

This section of the 2021 Guide is not applicable to the ALTCS DES/DDD Program. The certified capitation rates paid to the ALTCS DES/DDD Program capitation rates are not risk or acuity adjusted.

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

Section II of the 2021 Guide is applicable to the ALTCS DES/DDD Program because the CYE 21 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 2021 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 2021 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 – Not Applicable

Not applicable. A member's individual 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 – Not Applicable

Section III of the 2021 Guide is not applicable to the ALTCS DES/DDD Program.

Appendix 1: Actuarial Certification

I, Erica Johnson, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and an Associate 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.
- § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

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

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

The data, assumptions, and methodologies used to develop the CYE 21 capitation rates for the ALTCS DES/DDD Program have been documented according to the guidelines established by CMS in the 2021 Guide. The CYE 21 capitation rates for the ALTCS DES/DDD Program are effective for the 3-month time period from October 1, 2020 through December 31, 2020 and the 9-month period from January 1, 2021 through September 30, 2021.

The actuarially sound capitation rates are based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rates, 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	November 13, 2020
Erica Johnson	Date

Associate, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

DDD Capitation Rates Effective October 1, 2020 through December 31, 2020	
Regular DDD	$5,263.81
Targeted Case Management	$176.08

DDD Capitation Rates Effective January 1, 2021 through September 30, 2021	
Regular DDD	$5,309.41
Targeted Case Management	$176.08

Appendix 3: Comparisons and Fiscal Impact Summary

DDD Capitation Rates Effective October 1, 2020 through December 31, 2020						
Rate Cell	Rate Effective 1/1/2020	Rate Effective 10/1/2020	% Change		CYE 21 Projected MMs	CYE 21 Projected Expenses
ALTCS DDD	$4,840.31	$5,263.81	8.75%		107,672	$566,763,423
Targeted Case Management	$172.92	$176.08	1.83%		15,328	$2,698,918

DDD Capitation Rates Effective January 1, 2021 through September 30, 2021						
Rate Cell	Rate Effective 10/1/2020	Rate Effective 1/1/2021	% Change		CYE 21 Projected MMs	CYE 21 Projected Expenses
ALTCS DDD	$5,263.81	$5,309.41	0.87%		329,054	$1,747,082,379
Targeted Case Management	$176.08	$176.08	0.00%		46,445	$8,178,127

DDD Capitation Rates CYE 21 Weighted Average						
Rate Cell	Rate Effective 1/1/2020	CYE 21 Average Rate	% Change		CYE 21 Projected MMs	CYE 21 Projected Expenses
ALTCS DDD	$4,840.31	$5,298.17	9.46%		436,726	$2,313,845,802
Targeted Case Management	$172.92	$176.08	1.83%		61,773	$10,877,045

Appendix 4: Base Data and Base Data Adjustments

Category of Service	Base PMPM	Completion	Completed Base PMPM	Subcontractor Encounter Issue	Adjusted PMPM	Prop 206 Normalization	Fee Schedule Normalization	Comb. Misc. Adjustment	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
ATPC_ICF	$34.29	100.00%	$34.29	0.00%	$34.29	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$34.29
ATPC_SOGH	$14.63	100.00%	$14.63	0.00%	$14.63	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.63
Attendant Care	$342.31	99.61%	$343.65	0.00%	$343.65	9.04%	10.06%	0.00%	0.00%	0.00%	0.00%	$412.42
Day Treatment	$345.73	99.62%	$347.06	0.00%	$347.06	7.62%	8.43%	0.00%	0.00%	0.00%	0.00%	$404.98
Employment	$81.45	99.63%	$81.75	0.00%	$81.75	7.67%	8.13%	0.00%	0.00%	0.00%	0.00%	$95.18
Hab - Per 15 Min	$343.27	99.62%	$344.58	0.00%	$344.58	7.59%	6.79%	0.00%	0.00%	0.00%	0.00%	$395.89
Hab - Per Diem	$1,074.98	99.62%	$1,079.07	0.00%	$1,079.07	8.03%	9.87%	0.00%	0.00%	0.00%	0.00%	$1,280.75
InstEnc_ICF	$30.10	97.73%	$30.80	0.00%	$30.80	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$30.80
Misc	$12.68	99.67%	$12.73	0.00%	$12.73	6.52%	4.03%	0.00%	0.00%	0.00%	0.00%	$14.10
Nursing	$129.57	99.63%	$130.06	0.00%	$130.06	7.14%	11.37%	0.00%	0.00%	0.00%	0.00%	$155.18
Respite	$283.77	99.63%	$284.81	0.00%	$284.81	7.42%	9.10%	0.00%	0.00%	0.00%	0.00%	$333.80
SelfCare Home Management	$6.13	99.60%	$6.15	0.00%	$6.15	6.55%	0.32%	0.00%	0.00%	0.00%	0.00%	$6.58
SO_ICF	$13.23	100.00%	$13.23	0.00%	$13.23	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.23
SOGH	$12.50	100.00%	$12.50	0.00%	$12.50	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$12.50
Therapies and Evaluations	$150.47	99.62%	$151.05	0.00%	$151.05	7.70%	18.25%	0.00%	0.00%	0.00%	0.00%	$192.36
Transportation	$51.63	99.61%	$51.83	0.00%	$51.83	7.57%	13.86%	0.00%	0.00%	0.00%	0.00%	$63.47
Integrated Care Services	$774.85	94.56%	$819.42	0.33%	$822.09	0.00%	0.00%	-1.78%	0.02%	-0.04%	-0.01%	$807.26
Gross Medical	**$3,701.58**		**$3,757.59**		**$3,760.26**							**$4,267.42**

Appendix 5: Projected Benefit Cost Trends

Statewide				
Rate Cell	Trend COS	Utilization Per 1000	Unit Cost	PMPM
DES/DDD	ATPC_ICF	-1.00%	0.70%	-0.31%
DES/DDD	ATPC_SOGH	-1.00%	0.70%	-0.31%
DES/DDD	Attendant Care	8.31%	0.62%	8.99%
DES/DDD	Day Treatment	0.63%	0.18%	0.81%
DES/DDD	Employment	-0.90%	1.34%	0.43%
DES/DDD	Hab - Per 15 Min	0.45%	2.15%	2.61%
DES/DDD	Hab - Per Diem	-0.45%	2.68%	2.22%
DES/DDD	InstEnc_ICF	-0.90%	0.10%	-0.80%
DES/DDD	Misc	0.09%	-0.88%	-0.80%
DES/DDD	Nursing	0.09%	0.09%	0.18%
DES/DDD	Respite	0.09%	0.27%	0.36%
DES/DDD	SelfCare Home Management	-0.90%	1.53%	0.61%
DES/DDD	SO_ICF	-0.10%	1.90%	1.80%
DES/DDD	SOGH	-0.80%	1.10%	0.29%
DES/DDD	Therapies and Evaluations	0.72%	0.09%	0.81%
DES/DDD	Transportation	0.27%	0.27%	0.54%
DES/DDD	Integrated Care Services	0.10%	2.00%	2.11%

Appendix 6: CYE 21 Capitation Rate Development

Category of Service	Adjusted Base PMPM	Trend Rates	Trended PMPM	HCIF	COVID - Respite Annual Cap	COVID - School-Based Claiming	COVID - Home Delivered Meals	ABA Transition	Combined Miscellaneous Changes	Gross Medical (10/1/20 - 12/31/20)	Proposition 206 Reimb. Change	AAC Transition	Gross Medical (1/1/21 - 9/30/21)
ATPC_ICF	$34.29	-0.3%	$34.07	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$34.07	0.00%	0.00%	$34.07
ATPC_SOGH	$14.63	-0.3%	$14.54	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.54	0.00%	0.00%	$14.54
Attendant Care	$412.42	9.0%	$489.89	0.00%	0.00%	7.73%	0.00%	0.00%	0.00%	$527.74	1.06%	0.00%	$533.35
Day Treatment	$404.98	0.8%	$411.55	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$411.55	1.08%	0.00%	$415.98
Employment	$95.18	0.4%	$96.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$96.01	1.10%	0.00%	$97.07
Hab - Per 15 Min	$395.89	2.6%	$416.83	0.00%	0.00%	0.00%	0.00%	-7.63%	0.41%	$386.59	1.03%	0.00%	$390.58
Hab - Per Diem	$1,280.75	2.2%	$1,338.24	0.00%	0.00%	0.00%	0.96%	0.00%	0.25%	$1,354.57	1.09%	0.00%	$1,369.35
InstEnc_ICF	$30.80	-0.8%	$30.31	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$30.31	0.00%	0.00%	$30.31
Misc	$14.10	-0.8%	$13.88	0.04%	0.00%	0.00%	0.00%	0.00%	-0.01%	$13.88	1.02%	-88.51%	$1.61
Nursing	$155.18	0.2%	$155.74	0.00%	0.00%	2.54%	0.00%	0.00%	0.00%	$159.69	1.02%	0.00%	$161.32
Respite	$333.80	0.4%	$336.21	0.00%	16.60%	0.00%	0.00%	0.00%	0.00%	$392.03	1.03%	0.00%	$396.05
SelfCare Home Management	$6.58	0.6%	$6.66	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$6.66	1.05%	0.00%	$6.73
SO_ICF	$13.23	1.8%	$13.71	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.71	0.00%	0.00%	$13.71
SOGH	$12.50	0.3%	$12.57	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$12.57	0.00%	0.00%	$12.57
Therapies and Evaluations	$192.36	0.8%	$195.50	14.67%	0.00%	0.00%	0.00%	-0.17%	-0.15%	$223.48	1.01%	-1.97%	$221.28
Transportation	$63.47	0.5%	$64.16	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$64.16	1.07%	0.00%	$64.84
Integrated Care Services	$807.26	2.1%	$841.65	3.82%	0.00%	0.00%	0.00%	6.28%	1.88%	$946.11	0.07%	2.30%	$968.56
Gross Medical	**$4,267.42**		**$4,471.51**							**$4,687.67**			**$4,731.92**

Differential Adjusted Payments (DAP)	
Non-FQHC	$22.69
FQHC	$0.07
Total DAP	**$22.76**

Total DAP	**$22.76**	**$22.76**
Total Gross Medical PMPM	**$4,710.43**	**$4,754.68**
Reinsurance Offset	**($86.04)**	**($86.04)**
Total Net Medical PMPM	**$4,624.39**	**$4,668.64**

Non-benefit Expenses	PMPM	PMPM
Case Management	$186.63	$186.63
Administration for LTSS	$248.31	$248.31
Administration for Integrated Care Services	$54.32	$54.32
Total Medical with Admin and CM	$5,113.66	$5,157.90
Share of Cost	($4.09)	($4.09)
UW Gain	$48.97	$49.41
Pre-tax Capitation PMPM	$5,158.54	$5,203.22
Premium Tax	$105.28	$106.19
Capitation PMPM	**$5,263.81**	**$5,309.41**

Appendix 7: Delivery System and Provider Payment Initiatives

CYE 21 Estimated PMPM				
Directed Payment	Medical	Underwriting Gain	Premium Tax	Total
DAP FQHC	$0.07	$0.00	$0.00	$0.07
DAP Non-FQHC	$22.69	$0.23	$0.47	$23.39
APSI	$22.82	$0.00	$0.47	$23.29
PSI	$26.88	$0.00	$0.55	$27.43
HEALTHII	$61.82	$0.00	$1.26	$63.08