Contract Year Ending 2025
Capitation Rate Certification
Arizona Long Term Care System – Elderly and Physical Disability Program

October 1, 2024 through September 30, 2025

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Business and Finance

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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for Contract Year Ending 2025 (CYE 25) for the Arizona Long Term Care System (ALTCS) Elderly and Physical Disability (ALTCS-EPD) Program. Programs under AHCCCS and their respective contracts have been aligned with the federal fiscal year since October 1, 2018. All contract years referenced below cover the timeframe from October 1 of one year through September 30 of the following year (e.g., CYE 25 covers the timeframe from October 1, 2024, through September 30, 2025).

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

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2024-2025 Medicaid Managed Care Rate Development Guide (2025 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2025 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 2025 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(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

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

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

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

- Actuarial Standards of Practice (ASOPs) applicable to Medicaid managed care rate setting which were effective before the start date of the rating period:
  - ASOP No. 1 – Introductory Actuarial Standard of Practice,
  - ASOP No. 5 – Incurred Health and Disability Claims,
  - ASOP No. 12 – Risk Classification (for All Practice Areas),
  - ASOP No. 23 – Data Quality,
  - ASOP No. 25 – Credibility Procedures,
  - ASOP No. 41 – Actuarial Communications,
  - ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies,
  - ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification, and
  - ASOP No. 56 – Modeling.
- The 2016, 2020, and 2024 Medicaid and CHIP Managed Care Final Rules (CMS-2390-F, CMS-2408-F, and CMS-2439-F)
- FAQs related to payments to MCOs and PIHPs for IMD stays
- The 2024-2025 Medicaid Managed Care Rate Development Guide (2025 Guide) and the Addendum to 2024-2025 Medicaid Managed Care Rate Development Guide (Addendum) published by CMS

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

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

As stated on page 4 of the 2025 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 2025 Guide.

I.1.A. Rate Development Standards

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

The section of the 2025 Guide notes that standards and documentation expectations are not different for capitation rates and capitation rate ranges, except where otherwise stated.

I.1.A.ii. Rating Period

The CYE 25 capitation rates for the ALTCS-EPD Program are effective for the 12-month time period from October 1, 2024, through September 30, 2025.

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 25 capitation rates for the ALTCS-EPD Program, signed by Matthew C. Varitek, FSA, MAAA and Luna Zong, ASA, MAAA, is in Appendix 1. Mr. Varitek and Ms. Zong meet the requirements for the definition of an Actuary described at 42 CFR § 438.2 which is provided below for reference.

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

Mr. Varitek and Ms. Zong certify that the CYE 25 capitation rates for the ALTCS-EPD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

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

The final and certified capitation rates by rate cell are in Appendix 2. Additionally, the ALTCS-EPD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ALTCS-EPD Program contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell when identifying a population at the certified capitation rate level (as shown in Appendices 2, 3, 4, 6, 7a, 7b, and 8b) to be consistent with the applicable provisions of 42 CFR Part 438 and the 2025 Guide and will use the term risk group when identifying a population not at the certified capitation rate level, e.g., the Duals risk group represents members who are dually eligible for Medicare and Medicaid in the ALTCS-EPD Program.

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

This section of the rate certification provides a summary of information about the ALTCS-EPD Program.

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

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

The ALTCS-EPD Program contracts with three managed care organizations. The number of managed care organizations contracted with the Program varies by Geographical Service Area (GSA). Each ALTCS-EPD Program Contractor must have a dual eligible special needs plan (D-SNP) certified by either AHCCCS or Arizona Department of Insurance and Financial Institutions.

Table 1a below provides the counties and zip codes covered in each GSA. Table 1b provides information about the GSAs each Contractor is responsible for, as well as the associated D-SNP for each Contractor.

Table 1a: GSA and Counties

GSA	Counties
North	Apache, Coconino, Mohave, Navajo, and Yavapai
Central	Gila, Maricopa, and Pinal (excluding zip codes 85542, 85192, and 85550)
South	Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma (including zip codes 85542, 85192, and 85550)

Table 1b: GSA and D-SNP Information by Contractor

Contractor	GSAs	D-SNP
Banner – University Family Care (Banner – UFC)	Central, South	Banner – University Care Advantage
Mercy Care	Central, South (Pima County Only)	Mercy Care
UnitedHealthcare Community Plan (UnitedHealthcare)	North, Central	Arizona Physicians IPA

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

This certification covers the ALTCS-EPD Program which provides Long-Term Services & Supports (LTSS), as well as physical and mental health services and case management services to eligible members who are elderly and/or have physical disabilities.

Additional information regarding covered services can be found in the Scope of Services section of the ALTCS-EPD contract.

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

The ALTCS-EPD Program operates on a statewide basis and, since the late 1980s, it has been the health plan for individuals who are elderly and/or have a physical disability.

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

The rate certification for the CYE 25 capitation rates for the ALTCS-EPD Program is effective for the 12-month time period from October 1, 2024, through September 30, 2025.

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

The populations covered under ALTCS-EPD Program are individuals who are elderly and/or have physical disabilities and have been deemed eligible to receive long-term care services through ALTCS.

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

The ALTCS-EPD Program has two risk groups: one group for members who are dually eligible for Medicare and Medicaid ("Duals") and another group for members who are not eligible for Medicare ("Non-Duals"). The capitation rates fund prospective and prior period coverage (PPC) of members for long-term, acute, mental health and case management services. The rates also include coverage of acute care only services for members that qualify for ALTCS but decline to receive long-term care services. Rates for the ALTCS-EPD population differ by GSA, risk group, and Contractor.

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

ALTCS determines eligibility for ALTCS-EPD services through eligibility offices located throughout the State. Further information is available in the Eligibility section of the ALTCS-EPD Contract.

Under the maintenance of effort (MOE) requirements included in the Families First Coronavirus Response Act (FFCRA), with a few exceptions as noted in the law, members who were eligible at the beginning of the COVID-19 public health emergency (PHE), or who became eligible during the PHE, remained treated as eligible for such benefits until March 31, 2023, or later, based on the Arizona renewal plan submitted to CMS. Under the Consolidated Appropriations Act, 2023 (CAA) which ended the Medicaid continuous coverage protection as of March 31, 2023, states were allowed to resume disenrollment of people who are no longer eligible for Medicaid eligibility after a complete redetermination of each person's eligibility for all categories of Medicaid.

In practice, enrollment in the ALTCS-EPD Program is predicated upon meeting the eligibility requirements for ALTCS, as defined in the contract and state statute, and being elderly and/or physically disabled; physical disabilities do not generally resolve, and health needs generally increase as members age, so it is unlikely a member would lose ALTCS eligibility on the basis of no longer needing the level of medical support required by the ALTCS eligibility statutes, but in that unlikely event, the member would transition to the ALTCS Transitional Program, for members who fail to be at "immediate risk of institutionalization", which provides the same level of care as ALTCS with the exception of limiting institutional services to 90 days per admission. There are three allowable income limit definitions for ALTCS financial eligibility under the Arizona 1115 Waiver. The first definition is income equal to or less than 300% of the Federal Benefit Rate (approximately 233% of the Federal Poverty Limit (FPL)), as used by the Social Security Administration (SSA) to determine eligibility for Supplemental Security Income (SSI); the second and third definitions cover the "Freedom to Work" groups (state optional TXIX coverage groups under the ALTCS program in the 1115 Waiver), which cover a) individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL and b) employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL. These higher allowable income limits for ALTCS also make it unlikely a member would lose financial

eligibility once determined eligible for ALTCS-EPD based on their age and/or physical disability. As such, neither the PHE nor the unwinding of the PHE should have had any impact on the ALTCS-EPD Program enrollment.

There are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the population to be covered under the ALTCS-EPD program during CYE 25.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6. The special contract provisions related to payment included in the CYE 25 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1))
- Reinsurance Arrangement (42 CFR § 438.6(b)(1))
- Alternative Payment Model (APM) Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Withhold Arrangement) (42 CFR § 438.6(b)(3))
- Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) (42 CFR § 438.6(c)(1)(iii)(A))
- Vaccines for Children (VFC) (42 CFR § 438.6(c)(1)(iii)(A))
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(D))
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(D))
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(D))
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(D))
- Safety Net Services Initiative (SNSI) (42 CFR § 438.6(c)(1)(iii)(D))
- Nursing Facility Supplemental Payments (NF-SP) (42 CFR § 438.6(c)(1)(iii)(D))

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

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

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

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

All proposed differences among the CYE 25 capitation rates for the ALTCS-EPD Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the ALTCS-EPD Program.

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

The CYE 25 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.vi. Effective Dates of Changes

The effective dates of changes to the ALTCS-EPD Program are consistent with the assumptions used to develop the CYE 25 capitation rates for the ALTCS-EPD Program.

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

The certified capitation rates were developed such that each ALTCS-EPD Program Contractor would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 25.

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

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

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

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

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

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

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

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

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 25 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 25 capitation rates for the ALTCS-EPD Program.

I.1.A.xii. Evaluation of COVID-19 PHE and Unwinding

This section of the 2025 Guide includes CMS recommendations for risk mitigation strategies for rating periods following the end of the PHE until enrollment is expected to stabilize. All risk mitigation strategies are addressed in the contract and below in Section I.4.C. and will be submitted to CMS prior to the start of the rating period in accordance with the specific documentation requirements under 42 CFR § 438.6(b)(1).

This section also requests description of evaluations conducted, and the rationale for any applicable assumptions included or not included in rate development related to the COVID-19 PHE and related

unwinding within the rate certification. Information on all assumptions included in the rate development, based on the available and applicable state specific, as well as nationally and regionally applicable, data (outlined below in Section I.1.B.xi.(a)), to address the direct and indirect impacts of the COVID-19 PHE and related unwinding are described in each of the sections below:

- I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria
- I.1.B.xi.(a) Available Applicable Data
- I.1.B.xi.(b) Accounting for Direct and Indirect Impacts
- I.1.B.xi.(d) Risk Mitigation Strategies
- I.2.B.iii.(d) Changes in the Program

Additional evaluation conducted related to the COVID-19 PHE and related unwinding which did not result in adjustments to the rate development for CYE 25 varies by program. The ALTCS-EPD Program was not impacted by the MOE requirements of the PHE in the same way that other AHCCCS programs were, as described above in Section I.1.A.iii.(c)(iv), which resulted in the evaluation of changes in acuity being negligible as stated below in I.1.B.xi.(b), and so while the population was evaluated for acuity changes, no adjustments to the rate were made as they were unnecessary. Changes in Arizona COVID-19 case rates were reviewed both in general and with respect to the different COVID-19 variants in the base data time period and more recently, but no adjustments for expected new variants were included in capitation rate development. In a change from previous years' rate development processes, the actuaries did not include specific assumptions about COVID-19 test utilization or unit costs, nor specific growth utilization rates for any COVID-19 treatments. Additionally, the previously included non-risk cost settlement of COVID-19 vaccines and administrations has been removed from the contract, so those costs have not been excluded from the base data this year, but no assumptions were made specific to these services.

I.1.A.xiii. Rate Certification Procedures

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

This section of the 2025 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

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

This is a new rate certification that documents that the ALTCS-EPD Program capitation rates are changing effective October 1, 2024.

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

Not applicable. This rate certification will prospectively change the ALTCS-EPD Program capitation rates effective October 1, 2024.

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

This section of the 2025 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 for certified

rates per rate cell, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.4(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

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

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

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

I.1.B. Appropriate Documentation

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

The actuaries are certifying capitation rates for each rate cell.

I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 25 capitation rates for the ALTCS-EPD Program.

I.1.B.iii. Medical Loss Ratio

The capitation rates were developed so each Contractor would reasonably achieve a medical loss ratio (MLR) standard of at least 85 percent as required per 42 CFR § 438.4(b)(9). The AHCCCS Division of Business and Finance (DBF) Actuarial Team calculates a modified MLR where the only inclusion in the numerator is the projected gross medical expense component of the capitation rates (discounts related to pharmacy rebates are included in this calculation) which does not include any projections of incentive payments for providers, ensuring the result of the calculation will be less than or equal to the actual MLR calculation because the modified MLR calculation does not include any considerations for the allowed additional expenses under 42 CFR § 438.8(e)(3)-(4) in the numerator. For CYE 25 capitation rates, the modified MLR for each ALTCS-EPD Contractor was greater than 85 percent. Per 42 CFR § 438.5(b)(5) the AHCCCS DBF Actuarial Team reviewed past MLR results focusing in on the MLR results that correspond to the base period and for any Contractors performing below 85 percent the actuaries would make adjustments to assumptions in capitation rate setting where appropriate, however this was not necessary because all Contractors for all programs were above 85 percent MLR for the base period.

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

This section of the 2025 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates vary 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.v. Capitation Rate Range Assumptions – Not Applicable

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

I.1.B.vi. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes relevant section numbers from the 2025 Guide. Sections of the 2025 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.vii. Assurance Rate Assumptions Do Not Differ by Federal Financial Participation

All proposed differences in the assumptions, methodologies, or factors used to develop the certified CYE 25 capitation rates for the covered populations under the ALTCS-EPD Program are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

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

All covered populations under the ALTCS-EPD Program receive the regular Federal Medical Assistance Percentage (FMAP).

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

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

The 2025 Guide requests a comparison to the final certified rates in the previous rate certification. Those comparisons are included in Appendix 3.

The 2025 Guide also requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. In past years, the AHCCCS DBF Actuarial Team has thus defined any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year as a negative change in the rate. There are no large changes in the CYE 25 capitation rates as compared to the most recent certified CYE 24 capitation rates. The CYE 25 capitation rates decreased for one Contractor in the Central GSA for both the Dual and Non-Dual risk groups, and

in the North GSA for the Dual risk group. The rate decreases are primarily attributable to decreases in the projected gross medical expense from CYE 24 to CYE 25, and a decrease to the underwriting gain percentage built into the capitation rates.

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

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

I.1.B.x. Future Rate Amendments

There are no known future amendments to the ALTCS-EPD Program capitation rates at this time.

I.1.B.xi. Addressing COVID-19 PHE and Unwinding Impacts

I.1.B.xi.(a) Available Applicable Data

The AHCCCS DBF Actuarial Team and AHCCCS DBF financial analysts have reviewed data, regulations, and information from a variety of applicable sources to address the COVID-19 PHE and related unwinding in rate setting. For CYE 25 rate development, the AHCCCS DBF Actuarial Team has used a base data time period with six months before and after the end date of the Medicaid continuous coverage protection, including the program's member disenrollments through the end of the contract year. The AHCCCS DBF Actuarial Team will continue to collaborate with the Division for Member and Provider Services (DMPS) to monitor and evaluate levels of churn in the AHCCCS population since all members' eligibility redeterminations have been completed at the time of this rate certification. Further details about state specific and national data sources used for rate development over the course of the PHE or during and after the unwinding are listed below.

- State Data Sources
    - AHCCCS historical and current encounter data including utilization and costs by category of service (COS), risk group, GSA, and program
    - AHCCCS telehealth utilization and cost data by risk group, GSA, and program
    - AHCCCS non-emergency transportation (NEMT) utilization and cost data by risk group, GSA, and program
    - AHCCCS historical and current enrollment by risk group, GSA, and program
    - Historical and ongoing COVID-19 case rates for Arizona (not restricted to Medicaid populations)
    - AHCCCS COVID-19 testing by risk group, GSA, and program
    - AHCCCS COVID-19 vaccination rates by risk group, GSA, and program
    - AHCCCS child and adolescent well-care visit rates
    - AHCCCS Home and Community-Based Services (HCBS) and Nursing Facility (NF) placement by risk group, GSA, and ALTCS-EPD Contractor

  - Arizona Medicaid eligibility information, provided by the AHCCCS DMPS, which identified members who, if not for the MOE, would have been determined ineligible and disenrolled; this information was used in previous years to evaluate potential changes in acuity of the population covered under the ALTCS-EPD Program population after March 31, 2023, when states could disenroll people no longer eligible for Medicaid
- National Data Sources
  - Daily case rate, death rate, and vaccination rate data for Arizona collated and cleaned by the Centers for Disease Control
  - Consumer and Producer price inflation data published by the Bureau of Labor Statistics
  - National webinars discussing various impacts of the response to the COVID-19 PHE and the end of continuous coverage protections
  - Policy memoranda and newsletters related to available PHE unwinding flexibilities and considerations published by various universities and government agencies (examples below):
    - State Health Official Letter 23-002
    - Princeton University State Health and Value Strategies (SHVS):
      - Planning for the end of the Continuous Coverage Requirement
      - Best Practices for Publicly Reporting State Unwinding Data
      - State Reporting to Monitor the Unwinding of the Medicaid Continuous Coverage Requirement
    - CMS Policy Guidance FAQ dated May 12, 2023, on unwinding the continuous enrollment requirement
    - State Medicaid Director Letter 23-004

I.1.B.xi.(b) Accounting for Direct and Indirect Impacts and Related Unwinding

The list above in I.1.A.xii. details the sections of the certification which describe assumptions included in the rate development to address the direct and indirect impacts of the COVID-19 PHE and related unwinding. A brief narrative summary of how the capitation rates account for the direct and indirect impacts of the COVID-19 PHE and related unwinding through the incorporation of the assumptions in the rate development, described in those sections of the certification, is provided below.

The CYE 25 capitation rates account for the direct and indirect impacts of the COVID-19 PHE and related unwinding by using a base data experience period that reflects changes in service delivery expected to continue beyond the pandemic, such as increased telehealth usage; and by setting HCBS/NF placement mix percentages for the CYE 25 contract year using the most recently available data to reflect the return to a new equilibrium, without forecasting improved mix percentages. The rate development also captures the impact of the ending of governmental purchase/subsidization of two COVID-19 treatments, Paxlovid and Lagevrio, as addressed in I.2.B.iii.(d).

As noted above in Section I.1.A.iii.(c)(iv), the MOE requirements under the FFCRA had little to no impact on the membership under the ALTCS-EPD Program as eligibility is predicated upon needing the level of medical support required by the ALTCS eligibility statutes, and the allowable income limits are significantly higher than other AHCCCS programs. Any member leaving the ALTCS-EPD Program due to

no longer meeting the ALTCS medical support requirements would have had their Medicaid eligibility continued under the ALTCS Transitional Program, and members are unlikely to exceed the allowable income limits. Because of these unique aspects of eligibility for the ALTCS-EPD Program, there were no measurable changes in the acuity of the membership due to the ending of the continuous coverage protections effective March 31, 2023, and no acuity adjustment was necessary.

I.1.B.xi.(c) COVID-19 Costs Paid Outside of Capitation Rates (Non-Risk) – Not Applicable

Not applicable. There are no COVID-19 costs covered on a non-risk basis outside of the CYE 25 capitation rates.

I.1.B.xi.(d) Risk Mitigation Strategies

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 25 contracts will continue AHCCCS' long-standing program policy and will include risk corridors. There are no risk mitigation strategies utilized specifically for COVID-19 costs for CYE 25. This is a change from previous contract years when COVID-19 vaccines and their administration costs were reimbursed through a cost settlement outside of the capitation rates on a non-risk basis.

I.2. Data

This section provides documentation for the Data section of the 2025 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 DBF Actuarial Team and the State. The AHCCCS DBF Actuarial Team worked with the appropriate teams at AHCCCS to obtain the primary sources of data in accordance with 42 CFR § 438.5(c).

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

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

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

The primary data sources used or reviewed for the development of the CYE 25 capitation rates for the ALTCS-EPD Program were:

- Adjudicated and approved encounter data submitted by the ALTCS-EPD Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2019 through February 2024
  - Adjudicated and approved through the second February 2024 encounter cycle
- Reinsurance payments made to the ALTCS-EPD Contractors for services
  - Incurred from December 2019 through September 2023 paid through April 2024
- Enrollment data for the ALTCS-EPD Contractors from the AHCCCS PMMIS mainframe
  - October 2019 through February 2024
- Annual and quarterly financial statements submitted by the ALTCS-EPD Contractors and reviewed by the AHCCCS DBF Finance & Reinsurance Team
  - October 2019 through December 2023
- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DBF Rates & Reimbursement Team
- Data from AHCCCS DBF Rates & Reimbursement Team related to DAP, see Section I.4.D.
- Data from AHCCCS DBF financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership provided by the Contractors, including additional detail on claims runout and prior period adjustments included in financial statements
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CYE 23
- Projected CYE 25 enrollment data provided by the AHCCCS DBF Budget Team
- NF and HCBS placement data for October 2019 through July 2024
- Member level share of cost data provided by AHCCCS for October 2019 through September 2023
- Any additional data used and not identified here will be identified in their applicable sections below

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

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

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

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

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

AHCCCS Contractors sometimes use sub-capitation/block purchasing arrangements for some services. The sub-capitation and block purchasing arrangements between the Contractors and their providers require that the providers submit claims for services provided, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated/block purchased. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated/block purchased encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there are repricing methodologies (i.e., formulas) for sub capitated/block purchased encounters to estimate a health plan valued amount in place of the health plan paid amount of zero. The units of service data from the encounters and the repriced amounts were used as the basis for calculating utilization per 1000 and unit cost values.

I.2.B.ii.(a)(v) Base Data Exception – Not Applicable

Not applicable. No exception to the base data requirements was necessary for capitation rate development.

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/block purchased encounters.

The AHCCCS DBF Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a PMPM basis looking for anomalous patterns in encounter, unit, or cost totals, such as incurred months where totals are unusually low or high. If any anomalies are found, the AHCCCS DBF Actuarial Team reports the findings to the AHCCCS Information Services Division (ISD) Data Management and Oversight (DMO) Team, who then works with the Contractors to identify causes. In addition, the AHCCCS ISD DMO Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

AHCCCS Contractors know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides the Contractors with the "Encounter Monthly Data File" (aka the "magic" file) which contains the previous 36 months of encounter data. Data fields contained in this file include, but are not limited to, adjudication status, AHCCCS ID, Claim Reference Number (CRN), Provider ID and various cost amounts. The adjudication status has five types: adjudicated/approved, adjudicated/plan denied, adjudicated/AHCCCS denied, pended, and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters but providing this file to the Contractors allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions.

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

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

The AHCCCS ISD DMO 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 COS used in the rate development process.

The AHCCCS DBF Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe and ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 25 capitation rates for the ALTCS-EPD Program. Additionally, the AHCCCS DBF 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 DBF Actuarial Team compared the CYE 23 encounter data for all services provided by ALTCS-EPD Contractors to the annual financial statement data for the same entities for CYE 23. The AHCCCS DBF Actuarial Team also compared the CYE 23 encounter data to the yearly supplemental data

request from the ALTCS-EPD Contractors. After adjustments were made to the encounter data for completion, the financial statements, the AHCCCS encounter data, and the ALTCS-EPD Contractors' encounter data were judged to be consistent for capitation rate setting.

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

As required by ASOP No. 23, the AHCCCS DBF Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the ALTCS-EPD Contractors and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the ALTCS-EPD Contractors and reviewed by the AHCCCS DBF Finance & Reinsurance Team. The AHCCCS DBF Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuaries note additional reliance on the following:

- data provided by the AHCCCS DBF Rates & Reimbursement Team with regard to DAP and fee schedule impacts,
- data provided by the AHCCCS DBF financial analysts with regard to some program changes,
- information and data provided by Milliman consultants with regard to the HEALTHII and SNSI State directed payments,
- data provided by ALTCS-EPD Contractors in the yearly supplemental data request with regards to administrative and case management components, and
- data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

The actuaries have found the encounter data in total, after adjustments for data concerns, to be appropriate for the purposes of developing the CYE 25 capitation rates for the ALTCS-EPD Program.

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

Concerns related to potential fraud, waste, and abuse being included within the encounter data were identified, and specific adjustments to address those concerns have been made within the rate development process. More detail on these concerns and adjustments are included below in Section I.2.B.iii.(d). There were no other material concerns identified with the availability or quality of the data.

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

The AHCCCS DBF Actuarial Team determined that the CYE 23 encounter data in total, after adjustments noted in Section I.2.B.ii.(b)(iii), was appropriate to use as the base data for developing the CYE 25 capitation rates for the ALTCS-EPD 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 25 capitation rates for the ALTCS-EPD 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 25 capitation rates for the ALTCS-EPD Program.

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

Not applicable. The AHCCCS DBF Actuarial Team did not rely on a data book to develop the CYE 25 capitation rates for the ALTCS-EPD Program.

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

This section describes adjustments made to the CYE 23 encounter data that was used as the base data for developing the CYE 25 capitation rates for the ALTCS-EPD Program.

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

Not applicable. No credibility adjustments were made to the CYE 23 encounter data.

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

The AHCCCS DBF Actuarial Team developed completion factors to apply to the encounter data. Completion factors were calculated using the development method with monthly encounter data incurred from October 2019 through February 2024 and adjudicated and approved through the second encounter cycle for February 2024. The completion factors were developed by Contractor, GSA, major COS, and month of service, combining the experience of Dual and Non-Dual members. The major COS used in ALTCS-EPD completion factor development are primarily based upon the AHCCCS form type, with form A (CMS-1500 professional form type) being further subdivided into HCBS and acute services. Distinct completion factors are therefore developed for the following COS: Nursing Facility (LTSS, form type L), HCBS (LTSS, form type A), Acute-Inpatient (non-LTSS, form type I), Acute-Outpatient (non-LTSS, form type O), Acute-Pharmacy (non-LTSS, form type C), and Acute-Other (non-LTSS, form types A and D). The monthly completion factors were applied to the encounter data on a monthly basis. Aggregate CYE 23 completion factors by Contractor, GSA, risk group, and COS can be found in Appendix 4. Table 2 below displays the aggregate impact of completion by GSA.

Table 2: Impact of Completion Factors

GSA	Before Completion	After Completion	Impact
North	$4,767.72	$4,888.27	2.53%
Central	$3,727.92	$3,816.60	2.38%
South	$4,684.16	$4,862.74	3.81%
Total	**$4,655.23**	**$4,786.79**	**2.83%**

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

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

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2022, through September 30, 2023) are described below, or in Section I.3.A.v. for base data adjustments required with respect to IMD in lieu of services. Adjustments to address the concerns noted by the actuaries in Section I.2.B.ii.(b)(iii) are also described in this section. All other program and fee schedule changes which occurred or are effective on or after October 1, 2023, are described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the rate for every individual risk group at the GSA level, that adjustment was deemed non-material and has been grouped in the other base data adjustment subset below.

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

Member Share of Cost Add-on

An adjustment was made to add CYE 23 NF and HCBS share of cost (SOC) payments to the base data. This adjustment grosses up the base encounter data to reflect both the provider and member liabilities prior to the application of trend and other prospective adjustments described in Section I.3.B. After application of those adjustments, the projected CYE 25 SOC payments were removed as described in Section I.3.B.ii.(a).

The overall impacts by GSA for the ALTCS-EPD Program are displayed below in Table 3. Totals may not add up due to rounding. Note that these impacts are after application of the percentages for members receiving LTSS and placement in the NF or HCBS settings.

Table 3: Member Share of Cost Add-on

GSA	Dollar Impact	PMPM Impact
North	$7,767,937	$265.60
Central	$33,776,341	$152.89
South	$16,177,657	$206.31
Total	**$57,721,935**	**$175.67**

Removal of Differential Adjusted Payments from Base Data

CYE 23 capitation rates funded DAP made from October 1, 2022, through September 30, 2023, 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, 2023, AHCCCS has removed the impact of CYE 23 DAP from the base period. To remove the impact, the AHCCCS DBF Actuarial Team requested provider IDs for the qualifying providers for the CYE 23 DAP by specific measure from the AHCCCS DBF Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 23 were then adjusted downward by the appropriate percentage bump specific to the DAP measure. The associated costs removed from the base data are displayed below in Table 4. Totals may not add up due to rounding.

See Section I.4.D. for information on adjustments included in CYE 25 capitation rates for DAP that are effective from October 1, 2024, through September 30, 2025.

Table 4: Removal of DAP from Base Data

GSA	Dollar Impact	PMPM Impact
North	($1,221,896)	($41.78)
Central	($13,260,001)	($60.02)
South	($5,015,119)	($63.96)
Total	**($19,497,017)**	**($59.34)**

Insulin Price Changes

The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. Since 2010, regardless of the calculated rebate amount under the rules of the MDRP, a cap of 100% of the average manufacturer price (AMP) had limited the total rebate amounts paid by the drug manufacturers. However, the American Rescue Plan Act (ARPA), enacted in March 2021, eliminated the 100% AMP cap on Medicaid drug rebates as of January 1, 2024. In response, rather than pay higher rebate amounts, many drug manufacturers have instead reduced the prices of their drugs. A very specific instance of this has been a drastic cost reduction for insulin products at the point of sale since the start of 2024. To account for this change, the AHCCCS DBF Actuarial Team calculated reduction factors at the program and risk group level by comparing the average unit cost observed between January 2024 and March 2024 to the average unit cost observed between January 2023 and March 2023. The reduction factors were then applied to the base period utilization to get the estimated savings associated with the reduced upfront pricing for these products.

The overall impact of Insulin repricing by GSA is displayed below in Table 5. Totals may not add up due to rounding.

Table 5: Insulin Price Changes

GSA	Dollar Impact	PMPM Impact
North	($104,921)	($3.59)
Central	($1,128,996)	($5.11)
South	($274,877)	($3.51)
Total	**($1,508,793)**	**($4.59)**

Other Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component of the rate for every individual risk group at the GSA level, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across risk groups within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 6. Totals

may not add up due to rounding. Brief descriptions of the individual program changes requiring base data adjustment are provided below.

- **Community Intervener Services**
  Effective January 1, 2023, AHCCCS established a policy for provision of community intervener services to ALTCS members with dual sensory loss (i.e., blind and hard of hearing). Community interveners intercede between the member and the environment, allowing access to information usually gained through vision and hearing.
- **Dental Cone Beam CT Capture ***
  AHCCCS began reimbursing for cone beam CT capture for dental imaging, effective January 1, 2023. Cone-beam CT capture emits an x-ray beam shaped like a cone as opposed to the conventional fan-shaped beam. This procedure is expected to be used for any tooth extraction as well as for endodontic procedures such as molar and premolar root canals. This type of imaging would be done in addition to current X-ray imaging. AHCCCS requires prior authorization for fee-for-service coverage of cone beam CT capture.
- **Sleep Study ***
  Effective January 1, 2023, AHCCCS added the WatchPAT system as a billable service, using CPT code 95800 (an unattended sleep study with analysis of airflow or peripheral arterial tone and recording of sleep time). The WatchPAT algorithm detects respiratory (apnea/hypopnea) events, sleep/wake status, and determines sleep stages.
- **Latuda to Lurasidone**
  In February 2023, a generic version of the drug Latuda, lurasidone, came to market from multiple manufacturers for use in the United States. AHCCCS, on the recommendation of the Pharmacy and Therapeutics (P&T) Committee, made policy changes to approve the generic drug lurasidone in place of the brand drug Latuda. The AHCCCS DBF Actuarial Team analyzed pharmacy encounter data for Latuda and lurasidone to estimate the impact to the capitation rates for this change.
- **Fraud, Waste, and Abuse Adjustment**
  In May 2023, a multi-agency review and investigation of potential fraud, waste, and abuse resulted in the suspension of dozens of providers of Medicaid services based on Credible Allegations of Fraud (CAF). Since that time, there have been additional CAF provider suspensions. The AHCCCS DBF Actuarial Team has reviewed Contractor encounters submitted by providers suspended and/or terminated as of May 2024, per the Provider Terminations & Active Suspensions list, for unit cost and quantity characteristics which are substantially different from the characteristics of encounters submitted by providers not identified on the publicly posted CAF list and adjusted the irregular encounters to bring them into alignment with reasonable utilization and cost patterns. In response to concerns about abusive billing practices using the H0015 procedure code, AHCCCS set a specific fee schedule rate for H0015 in May 2023. Additional information about the development of the impact of the H0015 fee schedule change for all programs is provided below in Section I.3.B.ii.(a). More information about the investigation of potential fraud, waste, and abuse can be found on the AHCCCS website at

https://azahcccs.gov/shared/News/PressRelease/PaymentSuspensions.html and at https://azahcccs.gov/Fraud/SoberLivingFraud.html.

- **Paxlovid and Lagevrio**
  Paxlovid and Lagevrio are two oral antiviral medications that are available for treating mild to moderate COVID-19. In November 2023, the transition from government-managed distribution to traditional commercial distribution of these medications began. This has resulted in increased ingredient costs to the Contractors for these treatments. To account for this change, the AHCCCS DBF Actuarial Team repriced the base data utilization to the average unit cost observed between March 2024 and May 2024 after the transition period was assumed to be complete.
- **Humira Biosimilars**
  In recent years, several biosimilar and interchangeable products have become available as a substitute for Humira. The interchangeable products are priced significantly lower than the Humira brand products. Effective August 1, 2024, AHCCCS will shift preferred status from Humira to the interchangeable biosimilar options. The impact of this was modeled as a unit cost change to the base period utilization data.

Table 6: Other Base Data Adjustments

GSA	Dollar Impact	PMPM Impact
North	$11,983	$0.41
Central	($740,394)	($3.35)
South	($91,773)	($1.17)
Total	**($820,184)**	**($2.50)**

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

The AHCCCS DBF Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 25 capitation rates.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2025 Guide.

I.3.A. Rate Development Standards

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

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

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

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

I.3.A.iii. In Lieu Of Services or Settings (ILOS)

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

I.3.A.iv. ILOS Cost Percentage – Not Applicable

Not applicable. There are no ILOS under the ALTCS-EPD Program, except for short term stays in an IMD which are addressed in Section I.3.A.v. below.

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 in a month in an IMD in accordance with 42 CFR § 438.6(e).

Costs Associated with an Institution for Mental Disease Stay

The AHCCCS DBF Actuarial Team adjusted the base data to remove the costs associated with stays in an IMD for enrollees aged 21-64 in accordance with 42 CFR § 438.6(e). The AHCCCS DBF 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 DBF 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 DBF 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 23 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 23 encounter data, the AHCCCS DBF 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 $869.45 and was derived from the CYE 23 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 AHCCCS DBF 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).

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 combined impacts of repricing all IMD stays to the cost of the same services through providers included under the State plan, removing IMD stays which exceeded 15 cumulative days in a month, and removing medical expenses related to problematic IMD stays by GSA for the ALTCS-EPD Program are displayed below in Table 7. Totals may not add up due to rounding.

Table 7: IMD Repricing and Removal of All Costs for Repriced Stays > 15 Cumulative Days in a Month

GSA	Dollar Impact	PMPM Impact
North	$205	$0.01
Central	($56,013)	($0.25)
South	($10,293)	($0.13)
Total	**($66,101)**	**($0.20)**

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

Appendix 7a contains the projected net medical expenses PMPM by rate cell.

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

This section provides information on the projected benefit costs included in the CYE 25 capitation rates for the ALTCS-EPD 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 Section I.3.A.v. The adjusted base data PMPMs were trended forward 24 months, from the midpoint of the CYE 23 base period to the midpoint of the CYE 25 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below.

Appendix 4 contains the base data and base data adjustments by COS and rate cell. Appendix 5 contains the projected benefit cost trends. Appendix 6 contains gross medical expenses by COS and rate cell after applying prospective program and reimbursement changes, and CYE 25 DAP. Appendix 7a contains projected percentages of members receiving LTSS and projected percentages of LTSS members placed in NF or HCBS settings at a rate cell level. Appendix 7b illustrates the capitation rate development, which includes the projected administrative expense, case management expense, underwriting (UW) gain, and premium tax by rate cell.

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

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

AHCCCS FFS Fee Schedule Updates

AHCCCS typically makes annual updates to provider fee schedules used for AHCCCS FFS programs. The AHCCCS DBF Rates & Reimbursement Team and the AHCCCS DBF 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 DBF Finance & Reinsurance Team regarding health plan fee schedules.

Additionally, the contract has requirements that the Contractors reimburse FQHCs/RHCs at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates include adjustments to bring the base FQHC/RHC encounter data up to the projected CYE 25 FQHC/RHC PPS rates.

Effective October 1, 2024, AHCCCS added clarifying language in contracts requiring that the Contractor shall reimburse providers at no less than the regional maximum allowable rate as set by the Centers for Medicare and Medicaid, which is the fee schedule in the State Plan, for vaccines administered for the VFC program.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative or regulatory mandates. Additionally, effective January 1, 2024, and July 1, 2024, AHCCCS implemented quarterly rate adjustments for physician administered drugs (PADs) in alignment with updates to the State Plan. The CYE 25 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DBF Rates & Reimbursement Team used the CYE 23 encounter data to develop the impacts of fee schedule changes between the base year and the rating period. The AHCCCS DBF Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to calculate the adjustment to the CYE 23 base data. The AHCCCS DBF Actuarial Team then reviewed the results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting COS.

AHCCCS also increases some fee schedule rates effective January 1 of each year to recognize the annual minimum wage increase resulting from the passing of Proposition 206. The increased costs for this change have been included with the fee schedule changes already discussed.

Effective May 1, 2023, AHCCCS set a fixed fee schedule rate for billing code H0015 of $157.86 for one unit of billable service, a change from the prior "by report" rate methodology which paid 58.66% of the billed amount. The AHCCCS DBF Actuarial Team reviewed the encounter data before and after May 2023 and assessed that the change in cost did not have a long phasing in period. With that information in mind, the AHCCCS DBF Actuarial Team re-priced H0015 encounter data incurred before May 2023 using the unit costs of the services after May 2023 and included the impact of the repricing with the other fee schedule adjustment changes.

The overall impact of the AHCCCS Fee-for-Service fee schedule updates by GSA is illustrated below in Table 8. Totals may not add up due to rounding.

Table 8: Aggregate Fee Schedule Changes

GSA	Dollar Impact	PMPM Impact
North	$1,934,286	$66.14
Central	$18,976,578	$85.90
South	$7,680,595	$97.95
Total	**$28,591,459**	**$87.02**

Diabetic Drug Class Utilization Changes

Glucagon-like peptide-1 (GLP-1) receptor agonists and sodium-glucose co-transporter-2 inhibitors (SGLT2) play a key role in the treatment of type 2 diabetes mellitus. These drugs may also lead to weight loss, and a reduced need for insulins. The AHCCCS DBF Actuarial Team viewed all historical adjudicated and approved encounters for these drug classes as well as the projected pharmacy trend assumptions to determine if the changing utilization patterns of these drug classes was appropriately accounted for by the trend assumptions, or if a specific adjustment would be more appropriate. After review, the AHCCCS actuaries judged a separate, specific adjustment to be appropriate, except for specific rate cells made up of only Dual eligible members.

The impacts to the ALTCS-EPD Program of the separate, specific adjustments, accounting for the changing utilization patterns of the three diabetic drug classes, are displayed below in Table 9. Totals may not add up due to rounding.

Table 9: Diabetic Drug Class Utilization Change

GSA	Dollar Impact	PMPM Impact
North	$20,366	$0.70
Central	$997,705	$4.52
South	$266,588	$3.40
Total	**$1,284,660**	**$3.91**

Mix Percentage Change Impacts

The ALTCS-EPD Program has a long-standing practice of using mix percentages to create a blended capitation rate. The two percentages that are used to get to a blended rate are the percentage of members receiving LTSS services (LTSS %) and the percentage of members utilizing HCBS rather than NF services, which we call the HCBS mix percentage (HCBS %). The LTSS % is used to project the number of members out of the total ALTCS-EPD population who receive LTSS through the program, with the remainder of the members being those who opt out of receiving LTSS and choose to only have their acute services covered under the program. The HCBS % is used to project the number of LTSS members that will be utilizing HCBS rather than NF services; the HCBS % is applied to the HCBS component of the capitation rates, and the complement (1 minus HCBS %) is applied to the NF component of the capitation rates. To estimate projected CYE 25 LTSS utilization and HCBS mix percentages, the AHCCCS DBF Actuarial Team analyzed the placement data from March 2023 through February 2024 to determine the GSA, Contractor, and risk group LTSS and HCBS mix percentages for that time frame and used those as the projections for CYE 25.

The impacts to the ALTCS-EPD Program accounting for the change in mix percentages from the base period to the rating period, are displayed below in Table 10. Totals may not add up due to rounding.

Table 10: Mix Percentage Change

GSA	Dollar Impact	PMPM Impact
North	$313,742	$10.73
Central	$1,836,463	$8.31
South	$578,733	$7.38
Total	**$2,728,938**	**$8.31**

Rezdiffra *

In March 2024, AHCCCS began coverage of Rezdiffra in accordance with requirements of participation in the Medicaid Drug Rebate Program (MDRP) after the FDA gave accelerated approval to Rezdiffra, along with a Breakthrough Therapy designation, for the treatment of adults with noncirrhotic non-alcoholic steatohepatitis (NASH) with moderate to advanced liver scarring (fibrosis, severity levels F2 or F3). The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers.

To estimate the prevalence of NASH in the AHCCCS membership, the AHCCCS DBF financial analysts first reviewed encounters including diagnosis codes for NASH for adults 18 years and older. The analysts consulted with the Chief of Hepatology with Arizona Liver Health to determine that approximately 39% of patients with NASH have fibrosis severity levels of F2 or F3. Due to potential questions of the drug's efficacy, it was assumed that only 25% of drug candidates would begin treatment in CYE 25. After forecasting the number of members that would use Rezdiffra, the AHCCCS DBF financial analysts estimated annual costs of the drug.

For CYE 25 rate development, the projected impact of AHCCCS coverage of Rezdiffra was allocated across risk groups and GSAs using base period distribution of members with a NASH diagnosis code. The overall impact of the changes by GSA is displayed below in Table 11. Totals may not add up due to rounding.

Table 11: Rezdiffra

GSA	Dollar Impact	PMPM Impact
North	$258,550	$8.84
Central	$1,029,756	$4.66
South	$737,801	$9.41
Total	**$2,026,108**	**$6.17**

Wegovy *

Wegovy, a semaglutide product FDA approved for weight loss, gained expanded approval by the FDA in March 2024 to reduce the risk of serious heart problems in obese or overweight adults. 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 Wegovy for members without diabetes meeting certain criteria related to age, history of cardiovascular problems, and body mass index (BMI) measurements.

AHCCCS clinical experts developed the specific criteria for coverage of Wegovy and the AHCCCS DBF financial analysts reviewed base year encounters to identify members who would be eligible for Wegovy based on the coverage criteria. GLP-1s, including Wegovy, have had unprecedented popularity across the country. However, the immense popularity has also led to severe supply shortages. Additionally, recent research published in the journal *Obesity* has shown that 40% of patients taking Wegovy are still persistent at 12 months, which is approximately three times more adherence than with other anti-obesity medications. The CYE 25 estimated impact was developed as a full year of utilization for all eligible individuals under the clinical criterion, and then a 50% reduction factor was applied in the analysis in recognition of both shortages and high expected adherence.

For CYE 25 rate development, the projected impact was allocated across risk groups and GSAs using base period distribution of members identified as meeting the criteria for coverage. The overall impact of the changes by GSA is displayed below in Table 12. Totals may not add up due to rounding.

Table 12: Wegovy

GSA	Dollar Impact	PMPM Impact
North	$249,469	$8.53
Central	$1,417,151	$6.41
South	$375,251	$4.79
Total	**$2,041,871**	**$6.21**

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 gross medical component of the rate for every individual risk group at the GSA level, that program or reimbursement change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across risk groups within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 13. Totals may not add up due to rounding. Brief descriptions of the individual program or reimbursement changes are provided below.

- **Pharmacy and Therapeutics Committee Recommendations – Post Base Year ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 25. 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.
- **Addition of ALTCS Children to Populations eligible for T1015 billing for Multi-Specialty Interdisciplinary Clinic (MSIC) Services ***
  Effective October 1, 2023, AHCCCS is expanding the population of children eligible for receiving T1015 (Clinic Visit/Encounter, All-Inclusive) for Multi-Specialty Independent Clinics (MSICs) beyond the current CRS children to include children in the two ALTCS programs. For MSICs, the expansion allows T1015 to be billed in addition to other codes for this expanded population of children.
- **Adolescent SUD Screening ***
  The American Academy of Pediatrics encourages primary care clinicians to follow the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and recommends universal screening for substance use disorder (SUD) for adolescents. Effective October 1, 2023, AHCCCS began covering SUD screening for all 12- to 20-year-olds during EPSDT well-child visits.
- **Corneal Cross-Linking ***
  Effective January 1, 2024, AHCCCS began coverage of two procedure codes (0402T and J2787) for corneal cross-linking treatment used to prevent the progression of corneal ectasia.

- **Annual Syphilis Testing ***
  In alignment with recommendations from The Centers for Disease Control and Prevention and the Arizona Department of Health Services, effective October 1, 2024, AHCCCS will begin requiring providers to offer annual Syphilis testing for members aged 15 years and older.
- **ASAM Continuum – U9 Modifier ***
  Effective October 1, 2024, AHCCCS will implement a provider initiative that will require the American Society of Addiction Medicine (ASAM) CONTINUUM™ assessment tool to be used in the public mental health system. In order to provide additional reimbursement to help offset the annual subscription fees for access to the assessment tool, providers may include the U9 modifier when billing for HCPCS codes H0018, limited to twice per member stay, and H0035, limited to twice per member per year.
- **Parents as Paid Caregivers Training Support ***
  Effective October 1, 2024, AHCCCS will expand the use of S5110, Home care training, family; per 15 minutes, for family support services as part of a waiver amendment to extend the parent as paid caregiver of minor children to permanent authority.

Table 13: Combined Miscellaneous Program Changes

GSA	Dollar Impact	PMPM Impact
North	$59,603	$2.04
Central	($1,059)	($0.00)
South	$151,847	$1.94
Total	**$210,392**	**$0.64**

Projected Member Share of Cost Removal

After application of trend and other prospective adjustments to the base period data described above, the actuaries removed projected CYE 25 member SOC payments from the NF and HCBS service categories to reflect only Contractor liability in the capitation rates. The CYE 25 projection for SOC payments was developed by reviewing historical SOC experience (CYE 19 through CYE 23) for consistency in year-over-year increases at the rate cell level, using CPI forecasts to trend the CYE 23 base amount PMPM for SOC forward to CYE 25, and adjusting for any outlier trends.

The overall impact by GSA for the ALTCS-EPD Program is displayed below in Table 14. Totals may not add up due to rounding. Note that these impacts are after application of the percentages for members receiving LTSS and placement in the NF or HCBS settings.

Table 14: Projected Member Share of Cost Removal

GSA	Dollar Impact	PMPM Impact
North	($8,476,542)	($289.83)
Central	($36,706,247)	($166.16)
South	($17,676,793)	($225.43)
Total	**($62,859,581)**	**($191.31)**

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

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

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

The ALTCS-EPD Program Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuaries to set the CYE 25 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2019 through early February 2024 and adjudicated and approved through the second February 2024 encounter cycle. The trend was developed primarily with actual experience from the Medicaid population.

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

Historical utilization, unit cost, and PMPM data from October 2019 through February 2024 were organized by incurred year and month, COS, and region (Central GSA or North/South GSAs). The historical experience was adjusted for completion and normalized for historical program and fee schedule changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 23 (April 1, 2023) to the midpoint of the rating period for CYE 25 (April 1, 2025). Projected benefit cost trends were based on actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. No simple formulaic solution exists to determine future trend; actuarial judgment is required. Each COS and region were analyzed in the same manner.

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

All COS PMPM trend assumptions were compared to similar assumptions made in prior years for ALTCS-EPD capitation rates and judged reasonable to assume for projection to CYE 25.

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

The 2025 Guide requires explanation of outlier or negative trends. As in past years, the AHCCCS DBF Actuarial Team has defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. There are no outlier or negative trends assumed in the CYE 25 ALTCS-EPD capitation rate development.

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

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

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

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

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

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

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

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

Projected benefit cost trends do not vary except by COS and region.

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 DMCS Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. As of September 13, 2024, no additional services have been identified as necessary services to comply with MHPAEA.

I.3.B.v. ILOS

There are no ILOS allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an IMD in lieu of services in an inpatient hospital. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the capitation rate development has complied with the requirements of 42 CFR § 438.6(e), 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 PPC for the period of time prior to the member's enrollment during which the member is eligible for covered services. PPC refers to the time frame from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with ALTCS-EPD. ALTCS-EPD Contractors receive notification from AHCCCS of the member's enrollment. ALTCS-EPD Contractors are responsible for payment of all claims for medically necessary services covered by ALTCS-EPD and provided to members during PPC.

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

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

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

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

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

No specific adjustments are made to the CYE 25 capitation rates for the ALTCS-EPD Program for the PPC time frame, given that the encounter and enrollment data are already included within the base data used for capitation rate development.

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

This section provides documentation 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 Contractors are required to adjust encounters for recovery of overpayments, per the following contract requirement:

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

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

Adjustments related to provider payment requirements under State directed payments, as defined in 42 CFR § 438.2, are discussed in Section I.4.D of this rate certification. Additionally, provider payment requirements related to FQHCs/RHCs and the VFC program 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

There were no material adjustments made related to litigation.

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

All material and non-material changes have been included in the capitation rate development process and all requirements in this section of the 2025 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

Alternative Payment Model Initiative – Performance Based Payments

The CYE 25 capitation rates for the ALTCS-EPD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2), called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractors that are aimed at quality improvement such as reducing costs, improving health outcomes, or improving access to care.

Alternative Payment Model Initiative – Quality Measure Performance

The incentive arrangement for the APM Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of performance measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement. The incentive arrangement uses a ranked score to distribute available incentive dollars by performance measure, but Contractors will not be ranked if they did not earn either a performance achievement score or a performance improvement score for a given measure. The maximum incentive pool possible is approximately $18 million, which is the amount that would be available if every Contractor earned exactly 0% of the withhold described below. This is not anticipated to happen; thus, the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

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

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

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

Alternative Payment Model Initiative – Performance Based Payments

All enrollees, children and adults, may be covered by this incentive arrangement. Likewise, all network providers have the opportunity to participate in the APM arrangements and all covered services are eligible for inclusion. The Contractors' provider contracts must include performance measures for quality and/or cost effectiveness. The Contractors are mandated to utilize the APM strategies in the

Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 as defined at https://hcp-lan.org/workproducts/apm-whitepaper.pdf.

Alternative Payment Model Initiative – Quality Measure Performance

The incentive arrangement includes performance measures that will be determined in late September 2024. All enrollees utilizing the services addressed in the performance measures, and providers of these services, are covered by the incentive arrangement, unless specifically stated otherwise in contract or policy.

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

Alternative Payment Model Initiative – Performance Based Payments

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

Alternative Payment Model Initiative – Quality Measure Performance

The purpose of the APM Initiative – Quality Measure Performance incentive arrangement is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through APM strategies.

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

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

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

Alternative Payment Model Initiative – Performance Based Payments

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 25 capitation rates and had no effect on the development of the capitation rates for the ALTCS-EPD Program. The incentive payments will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the CYE 25 contract year.

Alternative Payment Model Initiative – Quality Measure Performance

Incentive payments for the APM Initiative – Quality Measure Performance incentive arrangement are not included in the CYE 25 capitation rates and had no effect on the development of the capitation rates for the ALTCS-EPD Program. Incentive payments will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the contract year and the computation of the performance measures, and after the withhold payments are distributed and the value of the incentive pool determined.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2025 Guide provides information on the definition and requirements of a withhold arrangement.

I.4.B.ii. Appropriate Documentation

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

The ALTCS-EPD Program includes a percentage of capitation withhold arrangement which the Contractor may earn back. Each Contractor's earnings are based on their performance achievement score, using a threshold benchmark and a high-performance benchmark, and/or performance improvement score by measure.

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

The time period of the withhold arrangement described herein is twelve months.

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

All enrollees, services, and providers are covered by this withhold arrangement unless specifically stated otherwise in contract or policy.

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

The purpose of the ALTCS-EPD Program withhold is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings by aligning the incentives of the Contractor and provider through APM strategies.

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

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

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

It is unlikely that a Contractor will not receive some portion of the withhold back. However, the AHCCCS DBF Actuarial Team does not have the information needed to develop an estimate of the withheld amount that is not reasonably achievable, as a new policy governing the performance measure results became effective October 1, 2022, for CYE 23 and forward. The AHCCCS DBF Actuarial Team expects to have the first estimate of withhold not reasonably achievable under the new policy in the summer of 2025.

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

The actuaries relied upon the AHCCCS DBF Finance & Reinsurance Team's review. Their review indicated that the total withhold percentage of 1% of capitation revenue does not have a detrimental impact on the Contractors' financial operating needs and capital reserves. The AHCCCS DBF Finance & Reinsurance Team's interpretation of financial operating needs relates to cash flow needs for the Contractors to pay

claims and administer benefits for its covered populations. The AHCCCS DBF Finance & Reinsurance Team evaluated the reasonableness of the withhold within this context by reviewing the Contractors' cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by AHCCCS. To evaluate the reasonableness of the withhold in relation to capitalization levels, the AHCCCS DBF Finance & Reinsurance Team reviewed the surplus above the equity per member requirement, the performance bond amounts, and the financial stability of each Contractor to pay all obligations. The AHCCCS DBF Finance & Reinsurance Team reviewed cash and cash equivalent levels in relation to the withhold arrangement and has indicated the withhold arrangement is reasonable based on current cash levels.

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

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

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

The CYE 25 capitation rates documented in this rate certification are actuarially sound even if none of the withhold is earned back.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2025 Guide provides information on the requirements for risk-sharing mechanisms.

In accordance with 42 CFR § 438.6(b)(1), all risk-sharing mechanisms have been developed in accordance with 42 CFR § 438.4, the rate development standards in 42 CFR § 438.5, and generally accepted actuarial principles and practices. Additionally, all risk-sharing mechanisms are documented in the contracts and capitation rate certification for the rating period which will be submitted to CMS before the start of the rating period and will not be modified or added after the start of the rating period.

I.4.C.ii. Appropriate Documentation

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

The CYE 25 contract for the ALTCS-EPD Program will include risk corridors.

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

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 25 contract will continue AHCCCS' long-standing program policy and will include risk corridors. This rate certification will use the term risk corridor to be consistent with the 2025 Guide. The ALTCS-EPD 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-EPD Program. The first is a reconciliation of actual SOC payments to assumed SOC offsets in the capitation rates, and the second is a reconciliation of costs to reimbursement (tiered reconciliation).

The SOC risk corridor will reconcile the actual member SOC payments received by each Contractor during each contract year against the PMPM amounts assumed in the capitation rates for that year. The SOC payments are reconciled to zero; that is, payments to, or recoupments from, each Contractor are the arithmetic difference between the actual and assumed amounts, grossed up by 2% for premium tax.

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

Table 15: Tiered Risk Corridor Risk Bands

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

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

The risk corridors did not have any effect on the development of the CYE 25 capitation rates for the ALTCS-EPD Program.

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

Risk-sharing mechanisms are developed in accordance with generally accepted actuarial principles and practices. The threshold amounts for the risk corridors were set using actuarial judgment with consideration of conversations between the AHCCCS DBF Actuarial Team, the AHCCCS DBF Finance & Reinsurance Team, and the AHCCCS Office of the Director.

I.4.C.ii.(a)(v) Risk-Sharing Arrangements Consistent with Pricing Assumptions

The inclusion of risk corridors as part of the contract is independent of the pricing assumptions used in capitation rate development. If the contract did not include risk corridors, the pricing assumptions used in capitation rate development would be unchanged.

Please see Section I.4.C.ii.(c) for documentation of reinsurance risk-sharing arrangements and the resulting impacts on capitation rate development.

I.4.C.ii.(a)(vi) Expected Remittance/Payment from Risk-Sharing Arrangements

If experience in the rating period aligns with pricing assumptions used in capitation rate development, there will be no remittance/payment between AHCCCS and the Contractors associated with the risk corridors. The risk corridors protect the State against excessive Contractor profits and protect Contractors from excessive losses when experience in the rating period materially differs from the pricing assumptions. Additional information regarding the risk corridors can be found in the contract as well as in the AHCCCS Contractors Operations Manual (ACOM) 301.

See Section I.4.C.ii.(c) for reinsurance risk-sharing arrangements.

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

Not applicable. The ALTCS-EPD Program contract does not include a medical loss ratio remittance or payment requirement.

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

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

AHCCCS provides a reinsurance program to the AHCCCS Contractors 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 biologic drugs. Additionally, rather than the ALTCS-EPD Contractors 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 and reinsurance payments are used as the base for development of the reinsurance offset.

The AHCCCS reinsurance program has been in place since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the ALTCS-EPD Contractors for covered services incurred above the deductible. The deductible is the responsibility of the ALTCS-EPD Contractors. The deductible for CYE 25 Regular reinsurance cases is $150,000, which is unchanged from the CYE 24 deductible but represents an increase from the base year CYE 23 Regular reinsurance case deductible of $75,000. The

limit on High Dollar Catastrophic reinsurance is $1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

For additional information on the reinsurance program, refer to the Reinsurance section of the ALTCS-EPD 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 expense component of the capitation rates.

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

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

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

The methodology for setting the reinsurance offset has not changed from the CYE 24 capitation rates. The reinsurance offsets by risk group are developed from CYE 23 reinsurance payments to the ALTCS-EPD Contractors for Regular and Catastrophic reinsurance cases associated with services incurred during the base period. The data is "brought current" by way of completion factors specific to reinsurance payments, adjustments for historical and prospective program and reimbursement changes, and has the same trend factors applied as the gross medical expense for acute care services, since LTSS expenses are not eligible for consideration in reinsurance. The PMPM expense trend assumed for the Acute – Inpatient COS is applied to payments for Regular reinsurance cases; the Acute – Pharmacy PMPM expense trend is applied to payments for the biologic case type; and the aggregate PMPM expense trend for all Acute services is applied to payments for Catastrophic reinsurance cases.

Changes to the reinsurance program from the CYE 23 base period to the CYE 25 rating period include updated drug coverage under the biologic reinsurance case type and increasing the deductible for Regular reinsurance cases to $150,000 as noted above. The projected costs of the additional drugs covered by the reinsurance program were calculated by taking the projected costs for CYE 25 for those drugs and applying a zero-dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset. The adjustments needed to reflect the higher deductible level for the Regular reinsurance case type were developed by calculating the total encounter costs associated with each Regular reinsurance case for which payments were made during CYE 23; applying completion factors, trend, and fee schedule changes to bring the encounter costs forward to the CYE 25 rating year; and

calculating the reinsurance payments that would be made for each case when applying the new $150,000 deductible and the coinsurance limit of 75%.

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

This section of the 2025 Guide provides information on delivery system and provider payment initiatives (i.e., State directed payments) authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

The only State directed payments addressed in this certification are the ones related to the ALTCS-EPD Program. The contract requires the adoption of a minimum fee schedule for two sets of providers, FQHC/RHC and VFC providers, using State plan approved rates, as defined in 42 CFR § 438.6(a), as allowed under 42 CFR § 438.6(c)(1)(iii)(A). This State directed payment for FQHC/RHC and VFC providers do not require written approval prior to implementation per 42 CFR § 438.6(c)(2)(i). The State directed payments which require preprints for prior approval are DAP, APSI, PSI, HEALTHII, SNSI, and NF-SP. The 2025 Guide requires a specifically formatted Table in addition to the information provided here. This CMS prescribed Table can be found in Appendix 8a.

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

Federally Qualified Health Centers and Rural Health Clinics

Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Arizona Medicaid State plan as a minimum fee schedule for FQHC/RHC providers. The Arizona Medicaid State plan describes the methodology for the calculation of PPS rates in Attachment 4.19-B starting on Page 3a.

Vaccines for Children

Through the VFC program, the Federal and State governments purchase, and make available at no cost, vaccines for AHCCCS children under age 19. A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(20)(C)(ii) of the Act. Contractors are required to adopt the payment rates in the Arizona Medicaid State plan, as described on Page 66b, as a minimum fee schedule for VFC providers.

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. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP. The potential rate increases range from 0.5% to 20.0%, depending on the provider type.

Access to Professional Services Initiative

The APSI provides a uniform percentage increase of 75% to otherwise contracted rates for eligible practitioners, critical to professional training and education efforts, who deliver services to AHCCCS

members. The uniform percentage increase is applicable only to services covered under the AHCCCS APSI policy. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Pediatric Services Initiative

The PSI provides a uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 licensed beds. The PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

The SNSI directed payment provides a uniform percentage increase for inpatient and outpatient services provided by the eligible public safety net hospital. The SNSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. This increase is intended to supplement, not supplant, payments to the eligible public safety net hospital.

Nursing Facility Supplemental Payments

The NF-SP delivers a uniform dollar increase across all Contractors' reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund, plus FMAP, and is expected to fluctuate based on utilization and available funds for each quarter. The increase is intended to supplement, not supplant, payments to eligible providers.

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

The FQHC/RHC and VFC minimum fee schedule and the DAP initiative are the only directed payments incorporated in the capitation rates. The 2025 Guide requires a specifically formatted Table in addition to the information provided here. This CMS prescribed Table can be found in Appendix 8a.

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

The FQHC/RHC and VFC minimum fee schedule State directed payments impact all ALTCS-EPD rate cells. The DAP initiative impacts all ALTCS-EPD rate cells.

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

The FQHC/RHC and VFC minimum fee schedule impacts are included as part of the aggregate fee schedule changes shown in Appendix 6. For the total impact by rate cell for the FQHC/RHC and VFC minimum fee schedules see Appendix 8b. For DAP, see Appendix 6 for medical impact by risk group and Appendix 8b for total impact by rate cell.

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

Federally Qualified Health Centers and Rural Health Clinics

The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates, described above in Section I.3.B.ii.(a).

Vaccines for Children

The impact of the minimum fee schedule requirement for VFC providers is addressed as part of the fee schedule updates, described above in Section I.3.B.ii.(a).

Differential Adjusted Payments

The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 23 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DBF 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 25 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and risk group to the applicable COS to come to the final dollar impact for CYE 25 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and COS level which the AHCCCS DBF Actuarial Team then aggregated to the specific risk groups for each program).

I.4.D.ii.(a)(ii)(D) Preprint Acknowledgement

AHCCCS has submitted the DAP 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuaries received and reviewed each State directed payment preprint at the time the rates were certified. The DAP payment arrangement accounted for in the capitation rates, and described in the preceding sections, is included in the capitation rates in a manner consistent with the preprint under CMS review.

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

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

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

The APSI, PSI, HEALTHII, SNSI and NF-SP are not included in the ALTCS-EPD certified capitation rates and will be paid out via lump sum payments. The 2025 Guide requires a specifically formatted Table in addition to the information provided here. This CMS prescribed Table can be found in Appendix 8a.

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

Access to Professional Services Initiative

Anticipated payments, including premium tax, for APSI are approximately $6.6 million for the ALTCS-EPD Program. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Services Initiative

Anticipated payments, including premium tax, for PSI are approximately $1.4 million for the ALTCS-EPD Program. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 25 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments, including premium tax, for HEALTHII are approximately $81.9 million for the ALTCS-EPD Program. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 25 utilization will be used to redistribute the payments.

Safety Net Services Initiative

Anticipated payments, including premium tax, for SNSI are approximately $9.7 million for the ALTCS-EPD Program. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 25 utilization will be used to redistribute the payments.

Nursing Facility Supplemental Payments

The anticipated payments, including premium tax, for NF-SP are approximately $92.4 million for the ALTCS-EPD Program. AHCCCS will distribute the total payment via five payments, four of which will be quarterly lump sum payments totaling 85% of the total estimated amount to the Contractors. The final lump sum payment, made after the end of the contract year, will equal the difference between the quarterly payments and the per bed day enhanced support uniform dollar increase multiplied by total annual bed days calculated based on encounter data for the contract year.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

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

Nursing Facility Supplemental Payments

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

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

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

I.4.D.ii.(a)(iii)(D) Preprint Acknowledgement

Access to Professional Services Initiative

AHCCCS has submitted the APSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuaries received and reviewed each State directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Pediatric Services Initiative

AHCCCS has submitted the PSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuaries received and reviewed each State directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Hospital Enhanced Access Leading to Health Improvements Initiative

AHCCCS has submitted the HEALTHII 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuaries received and reviewed each State directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Safety Net Services Initiative

AHCCCS has submitted the HEALTHII 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuaries received and reviewed each State directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Nursing Facility Supplemental Payments

AHCCCS has submitted the NF-SP 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuaries received and reviewed each State directed payment preprint at the time the rates were

certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

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

Nursing Facility Supplemental Payments

After the rating period is complete and the final NF-SP payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NF-SP payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved State directed payment preprint, 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 rate certification, including minimum fee schedules using State plan approved rates or total published Medicare payment rates as defined in 42 CFR § 438.6(a).

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 State directed payment or authorized under applicable law, regulation, or waiver.

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

Not applicable. There are no pass-through payments for the ALTCS-EPD Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2025 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 primary data sources used to develop the administrative component of the CYE 25 capitation rates for the EPD program were the CYE 23 quarterly financial statements submitted by the Contractors, and historical and projected administrative expense data submitted by the Contractors per a supplemental data request. The ALTCS-EPD Contractors' supplemental data request included actual CYE 23 amounts, actual CYE 24 Q1-Q3 (through March 31, 2024) amounts, and actual/projected amounts for CYE 24. This data request included breakouts into different administrative categories for each time frame. The actuaries also reviewed Consumer Price Index (CPI) data from S&P Global Market Intelligence Healthcare Cost Review.

Administrative Expenses

The actuaries used CYE 23 administrative (Admin) expenses reported in the Contractors' quarterly financial statements as the base experience for projecting CYE 25 Admin expenses. The actuaries also evaluated each Contractor's supplemental data submission for reasonableness to make Contractor-specific adjustments in developing the final projected Admin expenses.

The wage-driven portion of the CYE 23 Admin expenses was trended forward from the base period to the rating period by the projected CPI for wage earners. The trend factor was based on data from an external firm, S&P Global Market Intelligence Healthcare Cost Review, which was reviewed and determined to be reasonable. A trend factor was not applied to the non-wage-driven portion of the CYE 23 Admin expenses. The CYE 25 projected wage-driven and non-wage-driven amounts were summed together to equal the projected CYE 25 Admin expenses. The administrative expenses are set as a percentage of statewide projected gross medical expenses by Contractor, and then the percentage by Contractor is applied to the projected gross medical expense by GSA and risk group (Dual or Non-Dual) to develop the projected CYE 25 Admin expense by rate cell.

Case Management Expenses

The actuaries used CYE 23 case management expenses by GSA and risk group, as reported in the Contractors' quarterly financial statements, as the base experience for projecting CYE 25 Case Management expenses. Adjustments were made for the change in HCBS mix percentage from the base experience period to the rating period, and to increase the wage-driven portion of the base case management expenses by the projected CPI for wage earners (as described in the Admin section above).

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

The data, assumptions, and methodology used to develop the CYE 25 projected administrative and case management costs are similar to the previous rating period and have been documented above.

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

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

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

The projected non-benefit costs for each of the listed categories of costs in the 2025 Guide are shown in Appendix 7b for the CYE 25 capitation rates.

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

The administrative component of the CYE 25 ALTCS-EPD capitation rates are described above in Section I.5.B.i.(a). The PMPM amounts by rate cell are provided in Appendix 7b.

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

The CYE 25 capitation rates for the ALTCS-EPD 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 25 capitation rates for the ALTCS-EPD Program include a decreased provision (denoted as UW gain and expressed as a percentage) for contributions to reserves, risk margin, and cost of capital, compared to the CYE 24 capitation rates UW gain assumption. The decrease is primarily attributable to the completion of the unwinding without significant impacts on the acuity of the population as projected last year. Cost of capital remains elevated compared to rating periods prior to CYE 24 given the current, higher than historical, interest rate environment. For CYE 25, the actuaries have built in a provision of 1.15% for the UW gain.

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

No other material or non-material non-benefit costs are reflected in the CYE 25 capitation rates for the ALTCS-EPD Program.

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

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

I.6. Risk Adjustment – Not Applicable

Not applicable. The CYE 25 capitation rates for the ALTCS-EPD Program do not include risk adjustment.

I.7. Acuity Adjustments – Not Applicable

Not applicable. The CYE 25 capitation rate for the ALTCS-EPD Program does not utilize acuity adjustments.

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

Section II of the 2025 Guide is applicable to the ALTCS-EPD Program because the CYE 25 capitation rates for the ALTCS-EPD Program are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 and the ALTCS-EPD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. Applicability of Section I for MLTSS

The rate development standards and appropriate documentation described in Section I of the 2025 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 2025 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 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, I.5, and I.6.

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

There are no other payment structures, incentives, or disincentives to pay ALTCS-EPD 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-EPD 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-EPD 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 2025 Guide is not applicable to the ALTCS-EPD Program. As noted in Section I.1.B.iii, all covered populations under the ALTCS-EPD Program receive the regular FMAP.

Appendix 1: Actuarial Certification

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

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

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 25 capitation rates for the ALTCS-EPD Program have been documented according to the guidelines established by CMS in the 2025 Guide. The CYE 25 capitation rates for the ALTCS-EPD Program are effective from October 1, 2024, through September 30, 2025.

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

SIGNATURE ON FILE	September 13, 2024
Matthew C. Varitek Fellow, Society of Actuaries Member, American Academy of Actuaries	Date

SIGNATURE ON FILE	September 13, 2024
Luna Zong Associate, Society of Actuaries Member, American Academy of Actuaries	Date

Appendix 2: Certified Capitation Rates

Appendix 2: Certified Capitation Rates

GSA	Contractor	Dual	Non-Dual
North	UnitedHealthcare Community Plan	$3,929.28	$7,887.39
Central	Banner – University Family Care	$5,054.36	$10,617.65
Central	Mercy Care	$5,232.04	$10,605.87
Central	UnitedHealthcare Community Plan	$3,761.56	$8,553.83
South	Banner – University Family Care	$5,094.75	$9,437.84
South	Mercy Care	$5,084.30	$8,787.27

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

GSA	Contractor	Risk Group	CYE 25 Projected MMs	CYE 24 Capitation Rate	CYE 25 Capitation Rate	Projected Expenditures CYE 24	Projected Expenditures CYE 25	Percentage Change
North	UnitedHealthcare Community Plan	Dual	25,090	$3,947.09	$3,929.28	$ 99,031,475	$ 98,584,653	(0.45%)
Central	Banner – University Family Care	Dual	26,382	$5,049.50	$5,054.36	$ 133,216,270	$ 133,344,477	0.10%
Central	Mercy Care	Dual	84,059	$5,069.23	$5,232.04	$ 426,113,363	$ 439,798,967	3.21%
Central	UnitedHealthcare Community Plan	Dual	67,893	$3,812.33	$3,761.56	$ 258,831,942	$ 255,384,986	(1.33%)
South	Banner – University Family Care	Dual	45,755	$4,944.20	$5,094.75	$ 226,222,201	$ 233,110,393	3.04%
South	Mercy Care	Dual	20,323	$4,866.12	$5,084.30	$ 98,893,227	$ 103,327,141	4.48%
North	UnitedHealthcare Community Plan	Non-Dual	4,157	$7,778.43	$7,887.39	$ 32,335,599	$ 32,788,533	1.40%
Central	Banner – University Family Care	Non-Dual	6,021	$10,512.84	$10,617.65	$ 63,297,235	$ 63,928,242	1.00%
Central	Mercy Care	Non-Dual	24,915	$10,339.34	$10,605.87	$ 257,605,419	$ 264,246,060	2.58%
Central	UnitedHealthcare Community Plan	Non-Dual	11,644	$8,565.72	$8,553.83	$ 99,737,833	$ 99,599,465	(0.14%)
South	Banner – University Family Care	Non-Dual	8,393	$9,341.25	$9,437.84	$ 78,398,234	$ 79,208,853	1.03%
South	Mercy Care	Non-Dual	3,945	$8,745.28	$8,787.27	$ 34,496,766	$ 34,662,413	0.48%
Composite		**Dual**	**269,502**	**$4,609.65**	**$4,688.47**	**$ 1,242,308,479**	**$ 1,263,550,616**	**1.71%**
Composite		**Non-Dual**	**59,074**	**$9,578.98**	**$9,723.92**	**$ 565,871,086**	**$ 574,433,566**	**1.51%**
Composite		**Total**	**328,576**	**$5,503.08**	**$5,593.79**	**$ 1,808,179,565**	**$ 1,837,984,182**	**1.65%**

Appendix 4: Base Data and Base Data Adjustments

Appendix 4: Base Data and Base Data Adjustments

Contractor | UnitedHealthcare Community Plan
GSA | North
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 24,145 | LTSS %: 97.62% | HCBS Mix %: 69.98%
Projection Period | Member Months: 25,090 | LTSS %: 97.97% | HCBS Mix %: 69.90%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	Insulin	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$6,038.55	0.97055	$6,221.78	$954.70	$7,176.47	0.00%	(1.21%)	0.00%	0.00%	$7,089.65
HCBS - Assisted Living	$1,015.87	0.98288	$1,033.56	$22.39	$1,055.95	0.00%	(0.46%)	0.00%	0.00%	$1,051.11
HCBS - Attendant Care	$689.39	0.98288	$701.40	$8.93	$710.32	0.00%	(1.37%)	0.00%	0.00%	$700.58
HCBS - Other	$114.41	0.98288	$116.40	$0.00	$116.40	0.00%	(0.87%)	0.00%	0.00%	$115.39
Acute - Inpatient	$9.87	0.96017	$10.28	$0.00	$10.28	0.00%	(2.75%)	0.00%	0.00%	$9.99
Acute - Other	$121.33	0.98340	$123.38	$0.00	$123.38	0.00%	(0.14%)	0.19%	0.00%	$123.44
Acute - Outpatient	$20.06	0.97121	$20.65	$0.00	$20.65	0.00%	(1.46%)	0.00%	0.00%	$20.35
Acute - Pharmacy	$5.78	0.99988	$5.78	$0.00	$5.78	(2.56%)	0.00%	0.00%	0.00%	$5.63
Acute - Physician	$26.60	0.98340	$27.05	$0.00	$27.05	0.00%	(0.00%)	0.00%	0.00%	$27.05
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$1,769.34	0.97055	$1,823.03	$279.73	$2,102.76	0.00%	(1.21%)	0.00%	0.00%	$2,077.32
HCBS Component PMPM[4]	$1,243.12	0.98288	$1,264.77	$21.40	$1,286.17	0.00%	(0.83%)	0.00%	0.00%	$1,275.51
Acute Component PMPM[5]	$183.63	0.98129	$187.13	$0.00	$187.13	(0.08%)	(0.40%)	0.12%	0.00%	$186.46
Total Medical PMPM	**$3,196.09**	**0.97593**	**$3,274.93**	**$301.13**	**$3,576.06**	**(0.00%)**	**(1.03%)**	**0.01%**	**0.00%**	**$3,539.29**

Percent Members Receiving LTSS	97.62%
HCBS Mix Percent	69.98%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | UnitedHealthcare Community Plan
GSA | North
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 4,001 | LTSS %: 94.65% | HCBS Mix %: 73.39%
Projection Period | Member Months: 4,157 | LTSS %: 94.81% | HCBS Mix %: 73.67%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	Insulin	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$9,197.31	0.97055	$9,476.38	$141.44	$9,617.83	0.00%	(1.51%)	0.00%	0.00%	$9,472.55
HCBS - Assisted Living	$517.91	0.98288	$526.93	$0.00	$526.93	0.00%	(0.31%)	0.00%	0.00%	$525.29
HCBS - Attendant Care	$1,157.35	0.98288	$1,177.51	$6.99	$1,184.50	0.00%	(1.34%)	0.00%	0.00%	$1,168.64
HCBS - Other	$313.45	0.98288	$318.91	$0.00	$318.91	0.00%	(0.75%)	0.00%	0.00%	$316.51
Acute - Inpatient	$620.84	0.96017	$646.59	$0.00	$646.59	0.00%	(2.27%)	0.00%	0.01%	$631.96
Acute - Other	$571.74	0.98340	$581.39	$0.00	$581.39	0.00%	(0.07%)	0.03%	0.00%	$581.18
Acute - Outpatient	$344.35	0.97121	$354.56	$0.00	$354.56	0.00%	(1.44%)	0.00%	0.00%	$349.44
Acute - Pharmacy	$1,233.73	0.99988	$1,233.88	$0.00	$1,233.88	(1.97%)	0.00%	0.10%	0.00%	$1,210.86
Acute - Physician	$469.12	0.98340	$477.04	$0.00	$477.04	0.00%	(0.00%)	0.00%	0.00%	$477.02
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$2,316.44	0.97055	$2,386.73	$35.62	$2,422.35	0.00%	(1.51%)	0.00%	0.00%	$2,385.76
HCBS Component PMPM[4]	$1,381.53	0.98288	$1,405.59	$4.86	$1,410.44	0.00%	(0.98%)	0.00%	0.00%	$1,396.62
Acute Component PMPM[5]	$3,239.79	0.98370	$3,293.47	$0.00	$3,293.47	(0.74%)	(0.61%)	0.04%	0.00%	$3,250.45
Total Medical PMPM	**$6,937.76**	**0.97911**	**$7,085.78**	**$40.48**	**$7,126.26**	**(0.34%)**	**(0.99%)**	**0.02%**	**0.00%**	**$7,032.84**

Percent Members Receiving LTSS	94.65%
HCBS Mix Percent	73.39%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Banner – University Family Care
GSA | Central
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 25,389 | LTSS %: 98.53% | HCBS Mix %: 77.11%
Projection Period | Member Months: 26,382 | LTSS %: 98.32% | HCBS Mix %: 77.42%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	**Base Medical**	**Completion Factors**	**Completed Base Medical**	**SOC Payments Added**	**Subtotal**	**Insulin**	**DAP Payments Removed**	**Other Base Data Adjustments**	**IMD**	**Adjusted Base Gross Medical**
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$6,970.11	0.94784	$7,353.65	$919.06	$8,272.70	0.00%	(1.38%)	0.00%	0.00%	$8,158.44
HCBS - Assisted Living	$1,641.62	0.96131	$1,707.69	$15.06	$1,722.75	0.00%	(0.47%)	0.00%	(0.00%)	$1,714.57
HCBS - Attendant Care	$986.09	0.96131	$1,025.77	$6.92	$1,032.69	0.00%	(2.23%)	0.00%	0.00%	$1,009.64
HCBS - Other	$99.35	0.96131	$103.34	$0.00	$103.34	0.00%	(1.62%)	0.00%	0.00%	$101.67
Acute - Inpatient	$32.48	0.95350	$34.06	$0.00	$34.06	0.00%	(2.71%)	0.00%	(0.17%)	$33.08
Acute - Other	$267.43	0.95832	$279.07	$0.00	$279.07	0.00%	(0.06%)	0.01%	(0.00%)	$278.93
Acute - Outpatient	$28.23	0.94630	$29.84	$0.00	$29.84	0.00%	(1.82%)	0.00%	0.00%	$29.29
Acute - Pharmacy	$2.59	0.99888	$2.60	$0.00	$2.60	(0.68%)	0.00%	0.06%	0.00%	$2.58
Acute - Physician	$55.97	0.95832	$58.40	$0.00	$58.40	0.00%	(0.32%)	0.00%	(0.02%)	$58.21
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$1,571.83	0.94784	$1,658.33	$207.26	$1,865.58	0.00%	(1.38%)	0.00%	0.00%	$1,839.82
HCBS Component PMPM[4]	$2,071.85	0.96131	$2,155.24	$16.70	$2,171.93	0.00%	(1.15%)	0.00%	(0.00%)	$2,146.93
Acute Component PMPM[5]	$386.71	0.95728	$403.96	$0.00	$403.96	(0.00%)	(0.45%)	0.01%	(0.02%)	$402.10
Total Medical PMPM	**$4,030.39**	**0.95563**	**$4,217.53**	**$223.95**	**$4,441.48**	**(0.00%)**	**(1.18%)**	**0.00%**	**(0.00%)**	**$4,388.84**

Percent Members Receiving LTSS	98.53%
HCBS Mix Percent	77.11%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Banner – University Family Care
GSA | Central
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 5,794 | LTSS %: 95.33% | HCBS Mix %: 65.73%
Projection Period | Member Months: 6,021 | LTSS %: 95.26% | HCBS Mix %: 65.49%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	**Base Medical**	**Completion Factors**	**Completed Base Medical**	**SOC Payments Added**	**Subtotal**	**Insulin**	**DAP Payments Removed**	**Other Base Data Adjustments**	**IMD**	**Adjusted Base Gross Medical**
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$10,349.94	0.94784	$10,919.46	$82.62	$11,002.08	0.00%	(1.54%)	0.00%	0.00%	$10,832.70
HCBS - Assisted Living	$1,100.36	0.96131	$1,144.65	$1.09	$1,145.74	0.00%	(0.55%)	0.00%	0.00%	$1,139.42
HCBS - Attendant Care	$1,168.39	0.96131	$1,215.41	$1.06	$1,216.47	0.00%	(2.20%)	0.00%	0.00%	$1,189.72
HCBS - Other	$342.21	0.96131	$355.99	$0.00	$355.99	0.00%	(0.92%)	0.00%	0.00%	$352.71
Acute - Inpatient	$1,076.53	0.95350	$1,129.03	$0.00	$1,129.03	0.00%	(1.89%)	0.00%	0.04%	$1,108.13
Acute - Other	$926.95	0.95832	$967.27	$0.00	$967.27	0.00%	(0.04%)	0.01%	0.00%	$966.94
Acute - Outpatient	$461.29	0.94630	$487.47	$0.00	$487.47	0.00%	(3.33%)	0.00%	0.00%	$471.22
Acute - Pharmacy	$1,021.55	0.99888	$1,022.70	$0.00	$1,022.70	(2.14%)	0.00%	(1.54%)	0.00%	$985.35
Acute - Physician	$534.19	0.95832	$557.42	$0.00	$557.42	0.00%	(0.33%)	0.00%	0.00%	$555.58
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$3,381.22	0.94784	$3,567.28	$26.99	$3,594.27	0.00%	(1.54%)	0.00%	0.00%	$3,538.94
HCBS Component PMPM[4]	$1,636.14	0.96131	$1,701.99	$1.35	$1,703.34	0.00%	(1.34%)	0.00%	0.00%	$1,680.57
Acute Component PMPM[5]	$4,020.51	0.96557	$4,163.88	$0.00	$4,163.88	(0.53%)	(0.96%)	(0.38%)	0.01%	$4,087.22
Total Medical PMPM	**$9,037.87**	**0.95810**	**$9,433.16**	**$28.34**	**$9,461.50**	**(0.23%)**	**(1.25%)**	**(0.17%)**	**0.01%**	**$9,306.72**

Percent Members Receiving LTSS	95.33%
HCBS Mix Percent	65.73%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Mercy Care
GSA | Central
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 80,895 | LTSS %: 97.90% | HCBS Mix %: 79.45%
Projection Period | Member Months: 84,059 | LTSS %: 97.88% | HCBS Mix %: 79.25%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	**Base Medical**	**Completion Factors**	**Completed Base Medical**	**SOC Payments Added**	**Subtotal**	**Insulin**	**DAP Payments Removed**	**Other Base Data Adjustments**	**IMD**	**Adjusted Base Gross Medical**
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$7,778.99	0.97815	$7,952.76	$809.53	$8,762.28	0.00%	(1.47%)	0.00%	0.00%	$8,633.33
HCBS - Assisted Living	$1,152.81	0.98465	$1,170.79	$20.10	$1,190.89	0.00%	(0.53%)	0.00%	0.00%	$1,184.52
HCBS - Attendant Care	$1,635.08	0.98465	$1,660.57	$6.60	$1,667.17	0.00%	(1.96%)	0.00%	0.00%	$1,634.48
HCBS - Other	$198.39	0.98465	$201.48	$0.00	$201.48	0.00%	(0.89%)	0.00%	0.00%	$199.69
Acute - Inpatient	$59.14	0.93057	$63.55	$0.00	$63.55	0.00%	(2.61%)	0.00%	0.08%	$61.94
Acute - Other	$251.99	0.96978	$259.84	$0.00	$259.84	0.00%	(0.07%)	0.09%	(0.00%)	$259.87
Acute - Outpatient	$49.33	0.97265	$50.71	$0.00	$50.71	0.00%	(0.93%)	0.00%	0.00%	$50.24
Acute - Pharmacy	$11.80	0.99927	$11.81	$0.00	$11.81	(0.68%)	0.00%	0.06%	(0.00%)	$11.74
Acute - Physician	$85.69	0.96978	$88.36	$0.00	$88.36	0.00%	(0.31%)	0.00%	(0.00%)	$88.09
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$1,565.31	0.97815	$1,600.28	$162.90	$1,763.18	0.00%	(1.47%)	0.00%	0.00%	$1,737.23
HCBS Component PMPM[4]	$2,322.56	0.98465	$2,358.77	$20.77	$2,379.54	0.00%	(1.33%)	0.00%	0.00%	$2,347.77
Acute Component PMPM[5]	$457.95	0.96557	$474.28	$0.00	$474.28	(0.02%)	(0.55%)	0.05%	0.01%	$471.88
Total Medical PMPM	**$4,345.82**	**0.98026**	**$4,433.33**	**$183.66**	**$4,616.99**	**(0.00%)**	**(1.31%)**	**0.01%**	**0.00%**	**$4,556.88**

Percent Members Receiving LTSS	97.90%
HCBS Mix Percent	79.45%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Mercy Care
GSA | Central
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 23,977 | LTSS %: 94.67% | HCBS Mix %: 72.00%
Projection Period | Member Months: 24,915 | LTSS %: 94.91% | HCBS Mix %: 71.61%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	Insulin	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$11,793.54	0.97815	$12,056.99	$93.51	$12,150.50	0.00%	(1.65%)	0.00%	0.00%	$11,949.78
HCBS - Assisted Living	$594.63	0.98465	$603.90	$2.94	$606.84	0.00%	(0.53%)	0.00%	0.00%	$603.63
HCBS - Attendant Care	$2,076.02	0.98465	$2,108.39	$3.70	$2,112.08	0.00%	(1.68%)	0.00%	0.00%	$2,076.67
HCBS - Other	$650.26	0.98465	$660.39	$0.00	$660.39	0.00%	(0.69%)	0.00%	0.00%	$655.81
Acute - Inpatient	$784.14	0.93057	$842.65	$0.00	$842.65	0.00%	(2.74%)	0.00%	0.01%	$819.64
Acute - Other	$937.87	0.96978	$967.10	$0.00	$967.10	0.00%	(0.08%)	0.00%	0.00%	$966.31
Acute - Outpatient	$308.21	0.97265	$316.88	$0.00	$316.88	0.00%	(1.63%)	0.00%	0.00%	$311.72
Acute - Pharmacy	$1,267.25	0.99927	$1,268.18	$0.00	$1,268.18	(2.14%)	0.00%	(1.54%)	0.00%	$1,221.87
Acute - Physician	$594.80	0.96978	$613.33	$0.00	$613.33	0.00%	(0.30%)	0.00%	0.00%	$611.46
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$3,125.61	0.97815	$3,195.43	$24.78	$3,220.21	0.00%	(1.65%)	0.00%	0.00%	$3,167.02
HCBS Component PMPM[4]	$2,263.70	0.98465	$2,298.99	$4.52	$2,303.52	0.00%	(1.28%)	0.00%	0.00%	$2,274.07
Acute Component PMPM[5]	$3,892.28	0.97109	$4,008.14	$0.00	$4,008.14	(0.68%)	(0.77%)	(0.49%)	0.00%	$3,931.00
Total Medical PMPM	**$9,281.59**	**0.97675**	**$9,502.56**	**$29.31**	**$9,531.87**	**(0.28%)**	**(1.19%)**	**(0.21%)**	**0.00%**	**$9,372.09**

Percent Members Receiving LTSS	94.67%
HCBS Mix Percent	72.00%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | UnitedHealthcare Community Plan
GSA | Central
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 65,338 | LTSS %: 97.16% | HCBS Mix %: 82.72%
Projection Period | Member Months: 67,893 | LTSS %: 97.22% | HCBS Mix %: 82.73%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	Insulin	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$6,576.25	0.97055	$6,775.79	$905.28	$7,681.07	0.00%	(1.33%)	0.00%	0.00%	$7,578.68
HCBS - Assisted Living	$1,260.51	0.98288	$1,282.46	$11.95	$1,294.41	0.00%	(0.38%)	0.00%	0.00%	$1,289.53
HCBS - Attendant Care	$749.85	0.98288	$762.91	$4.36	$767.27	0.00%	(1.66%)	0.00%	0.00%	$754.52
HCBS - Other	$144.60	0.98288	$147.11	$0.00	$147.11	0.00%	(1.22%)	0.00%	0.00%	$145.32
Acute - Inpatient	$21.14	0.96017	$22.01	$0.00	$22.01	0.00%	(2.92%)	0.00%	0.10%	$21.39
Acute - Other	$169.09	0.98340	$171.94	$0.00	$171.94	0.00%	(0.06%)	(0.03%)	(0.00%)	$171.79
Acute - Outpatient	$13.42	0.97121	$13.81	$0.00	$13.81	0.00%	(1.63%)	0.00%	0.00%	$13.59
Acute - Pharmacy	$13.61	0.99988	$13.61	$0.00	$13.61	(0.68%)	0.00%	0.06%	(0.00%)	$13.53
Acute - Physician	$36.15	0.98340	$36.76	$0.00	$36.76	0.00%	(0.00%)	0.00%	(0.00%)	$36.76
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$1,104.35	0.97055	$1,137.85	$152.02	$1,289.88	0.00%	(1.33%)	0.00%	0.00%	$1,272.68
HCBS Component PMPM[4]	$1,731.84	0.98288	$1,761.99	$13.11	$1,775.11	0.00%	(0.88%)	0.00%	0.00%	$1,759.49
Acute Component PMPM[5]	$253.40	0.98164	$258.14	$0.00	$258.14	(0.04%)	(0.38%)	(0.01%)	0.01%	$257.06
Total Medical PMPM	**$3,089.58**	**0.97834**	**$3,157.99**	**$165.14**	**$3,323.13**	**(0.00%)**	**(1.02%)**	**(0.00%)**	**0.00%**	**$3,289.23**

Percent Members Receiving LTSS	97.16%
HCBS Mix Percent	82.72%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | UnitedHealthcare Community Plan
GSA | Central
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 11,206 | LTSS %: 94.49% | HCBS Mix %: 75.44%
Projection Period | Member Months: 11,644 | LTSS %: 94.79% | HCBS Mix %: 75.15%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	Insulin	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$8,996.94	0.97055	$9,269.93	$90.59	$9,360.53	0.00%	(1.63%)	0.00%	(0.03%)	$9,204.65
HCBS - Assisted Living	$966.28	0.98288	$983.11	$0.50	$983.60	0.00%	(0.29%)	0.00%	0.00%	$980.77
HCBS - Attendant Care	$1,170.07	0.98288	$1,190.44	$1.90	$1,192.34	0.00%	(1.53%)	0.00%	0.00%	$1,174.08
HCBS - Other	$297.30	0.98288	$302.48	$0.00	$302.48	0.00%	(0.86%)	0.00%	0.00%	$299.89
Acute - Inpatient	$713.21	0.96017	$742.79	$0.00	$742.79	0.00%	(2.85%)	0.00%	(0.52%)	$717.87
Acute - Other	$697.91	0.98340	$709.69	$0.00	$709.69	0.00%	(0.07%)	0.01%	(0.05%)	$708.96
Acute - Outpatient	$329.78	0.97121	$339.55	$0.00	$339.55	0.00%	(1.97%)	0.00%	0.00%	$332.87
Acute - Pharmacy	$1,221.24	0.99988	$1,221.39	$0.00	$1,221.39	(2.14%)	0.00%	(1.54%)	(0.00%)	$1,176.75
Acute - Physician	$617.71	0.98340	$628.13	$0.00	$628.13	0.00%	(0.00%)	0.00%	(0.08%)	$627.62
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$2,087.77	0.97055	$2,151.12	$21.02	$2,172.15	0.00%	(1.63%)	0.00%	(0.03%)	$2,135.97
HCBS Component PMPM[4]	$1,734.74	0.98288	$1,764.94	$1.71	$1,766.65	0.00%	(0.96%)	0.00%	0.00%	$1,749.77
Acute Component PMPM[5]	$3,579.85	0.98305	$3,641.56	$0.00	$3,641.56	(0.72%)	(0.78%)	(0.52%)	(0.13%)	$3,564.08
Total Medical PMPM	**$7,402.36**	**0.97945**	**$7,557.63**	**$22.73**	**$7,580.36**	**(0.34%)**	**(1.06%)**	**(0.25%)**	**(0.07%)**	**$7,449.82**

Percent Members Receiving LTSS	94.49%
HCBS Mix Percent	75.44%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Banner – University Family Care
GSA | South
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 44,033 | LTSS %: 98.69% | HCBS Mix %: 73.23%
Projection Period | Member Months: 45,755 | LTSS %: 98.50% | HCBS Mix %: 73.02%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	Insulin	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$7,096.92	0.94784	$7,487.44	$835.30	$8,322.74	0.00%	(1.18%)	0.00%	0.00%	$8,224.55
HCBS - Assisted Living	$1,005.34	0.96131	$1,045.80	$11.07	$1,056.87	0.00%	(0.31%)	0.00%	0.00%	$1,053.60
HCBS - Attendant Care	$1,413.49	0.96131	$1,470.38	$6.78	$1,477.16	0.00%	(2.37%)	0.00%	0.00%	$1,442.10
HCBS - Other	$181.96	0.96131	$189.28	$0.00	$189.28	0.00%	(1.96%)	0.00%	0.00%	$185.56
Acute - Inpatient	$18.56	0.95350	$19.46	$0.00	$19.46	0.00%	(2.72%)	0.00%	0.32%	$18.99
Acute - Other	$128.84	0.95832	$134.44	$0.00	$134.44	0.00%	(0.11%)	0.19%	0.00%	$134.55
Acute - Outpatient	$45.67	0.94630	$48.27	$0.00	$48.27	0.00%	(1.58%)	0.00%	0.00%	$47.50
Acute - Pharmacy	$3.13	0.99888	$3.13	$0.00	$3.13	(0.14%)	0.00%	0.51%	0.00%	$3.14
Acute - Physician	$77.22	0.95832	$80.58	$0.00	$80.58	0.00%	(0.32%)	0.00%	0.00%	$80.32
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$1,874.87	0.94784	$1,978.03	$220.67	$2,198.70	0.00%	(1.18%)	0.00%	0.00%	$2,172.77
HCBS Component PMPM[4]	$1,879.64	0.96131	$1,955.29	$12.90	$1,968.19	0.00%	(1.54%)	0.00%	0.00%	$1,937.80
Acute Component PMPM[5]	$273.41	0.95640	$285.87	$0.00	$285.87	(0.00%)	(0.60%)	0.10%	0.02%	$284.51
Total Medical PMPM	**$4,027.92**	**0.95466**	**$4,219.20**	**$233.57**	**$4,452.77**	**(0.00%)**	**(1.30%)**	**0.01%**	**0.00%**	**$4,395.07**

Percent Members Receiving LTSS	98.69%
HCBS Mix Percent	73.23%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Banner – University Family Care
GSA | South
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 8,077 | LTSS %: 96.27% | HCBS Mix %: 71.03%
Projection Period | Member Months: 8,393 | LTSS %: 96.42% | HCBS Mix %: 70.37%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	**Base Medical**	**Completion Factors**	**Completed Base Medical**	**SOC Payments Added**	**Subtotal**	**Insulin**	**DAP Payments Removed**	**Other Base Data Adjustments**	**IMD**	**Adjusted Base Gross Medical**
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$9,434.33	0.94784	$9,953.46	$94.29	$10,047.76	0.00%	(1.35%)	0.00%	0.00%	$9,911.96
HCBS - Assisted Living	$531.60	0.96131	$553.00	$1.59	$554.58	0.00%	(0.37%)	0.00%	0.00%	$552.55
HCBS - Attendant Care	$1,568.80	0.96131	$1,631.94	$4.73	$1,636.67	0.00%	(2.36%)	0.00%	0.00%	$1,598.05
HCBS - Other	$341.64	0.96131	$355.39	$0.00	$355.39	0.00%	(1.26%)	0.00%	0.00%	$350.92
Acute - Inpatient	$996.44	0.95350	$1,045.03	$0.00	$1,045.03	0.00%	(1.81%)	0.00%	(0.15%)	$1,024.56
Acute - Other	$752.24	0.95832	$784.96	$0.00	$784.96	0.00%	(0.14%)	0.01%	(0.03%)	$783.70
Acute - Outpatient	$465.65	0.94630	$492.07	$0.00	$492.07	0.00%	(1.53%)	0.00%	(0.02%)	$484.46
Acute - Pharmacy	$1,119.32	0.99888	$1,120.58	$0.00	$1,120.58	(2.23%)	0.00%	(0.96%)	0.00%	$1,085.06
Acute - Physician	$552.17	0.95832	$576.18	$0.00	$576.18	0.00%	(0.41%)	0.00%	(0.03%)	$573.68
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$2,631.49	0.94784	$2,776.29	$26.30	$2,802.59	0.00%	(1.35%)	0.00%	0.00%	$2,764.71
HCBS Component PMPM[4]	$1,669.81	0.96131	$1,737.01	$4.32	$1,741.33	0.00%	(1.77%)	0.00%	0.00%	$1,710.48
Acute Component PMPM[5]	$3,885.81	0.96690	$4,018.82	$0.00	$4,018.82	(0.62%)	(0.74%)	(0.27%)	(0.05%)	$3,951.47
Total Medical PMPM	**$8,187.10**	**0.95956**	**$8,532.12**	**$30.62**	**$8,562.74**	**(0.29%)**	**(1.15%)**	**(0.12%)**	**(0.02%)**	**$8,426.65**

Percent Members Receiving LTSS	96.27%
HCBS Mix Percent	71.03%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Mercy Care
GSA | South
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 19,558 | LTSS %: 98.47% | HCBS Mix %: 72.02%
Projection Period | Member Months: 20,323 | LTSS %: 98.37% | HCBS Mix %: 71.77%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	Insulin	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$6,490.77	0.97815	$6,635.76	$793.50	$7,429.26	0.00%	(1.33%)	0.00%	0.00%	$7,330.41
HCBS - Assisted Living	$1,096.19	0.98465	$1,113.28	$23.68	$1,136.96	0.00%	(0.33%)	0.00%	0.00%	$1,133.20
HCBS - Attendant Care	$1,597.30	0.98465	$1,622.21	$7.73	$1,629.94	0.00%	(2.02%)	0.00%	0.00%	$1,597.02
HCBS - Other	$285.72	0.98465	$290.18	$0.00	$290.18	0.00%	(0.77%)	0.00%	0.00%	$287.94
Acute - Inpatient	$39.29	0.93057	$42.22	$0.00	$42.22	0.00%	(2.48%)	0.00%	0.43%	$41.35
Acute - Other	$103.19	0.96978	$106.40	$0.00	$106.40	0.00%	(0.10%)	0.24%	0.00%	$106.55
Acute - Outpatient	$35.10	0.97265	$36.09	$0.00	$36.09	0.00%	(0.54%)	0.00%	0.00%	$35.89
Acute - Pharmacy	$4.90	0.99927	$4.90	$0.00	$4.90	(0.14%)	0.00%	0.51%	0.00%	$4.92
Acute - Physician	$102.61	0.96978	$105.81	$0.00	$105.81	0.00%	(0.19%)	0.00%	0.00%	$105.61
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$1,788.57	0.97815	$1,828.52	$218.65	$2,047.17	0.00%	(1.33%)	0.00%	0.00%	$2,019.93
HCBS Component PMPM[4]	$2,112.77	0.98465	$2,145.72	$22.27	$2,167.99	0.00%	(1.27%)	0.00%	0.00%	$2,140.39
Acute Component PMPM[5]	$285.10	0.96502	$295.44	$0.00	$295.44	(0.00%)	(0.52%)	0.09%	0.06%	$294.34
Total Medical PMPM	**$4,186.44**	**0.98051**	**$4,269.67**	**$240.93**	**$4,510.60**	**(0.00%)**	**(1.25%)**	**0.01%**	**0.00%**	**$4,454.67**

Percent Members Receiving LTSS	98.47%
HCBS Mix Percent	72.02%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Mercy Care
GSA | South
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 3,796 | LTSS %: 95.87% | HCBS Mix %: 70.99%
Projection Period | Member Months: 3,945 | LTSS %: 95.95% | HCBS Mix %: 71.35%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	Insulin	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]										
Nursing Facility (NF)	$9,342.64	0.97815	$9,551.34	$189.28	$9,740.62	0.00%	(1.60%)	0.00%	0.00%	$9,584.78
HCBS - Assisted Living	$440.22	0.98465	$447.09	$5.75	$452.84	0.00%	(0.34%)	0.00%	0.00%	$451.32
HCBS - Attendant Care	$2,110.77	0.98465	$2,143.68	$8.44	$2,152.12	0.00%	(1.92%)	0.00%	0.00%	$2,110.73
HCBS - Other	$874.57	0.98465	$888.20	$0.00	$888.20	0.00%	(0.78%)	0.00%	0.00%	$881.26
Acute - Inpatient	$445.36	0.93057	$478.59	$0.00	$478.59	0.00%	(2.58%)	0.00%	0.02%	$466.34
Acute - Other	$599.79	0.96978	$618.48	$0.00	$618.48	0.00%	(0.13%)	0.01%	0.00%	$617.75
Acute - Outpatient	$215.48	0.97265	$221.54	$0.00	$221.54	0.00%	(1.91%)	0.00%	0.00%	$217.31
Acute - Pharmacy	$723.28	0.99927	$723.81	$0.00	$723.81	(2.23%)	0.00%	(0.96%)	0.00%	$700.88
Acute - Physician	$493.40	0.96978	$508.77	$0.00	$508.77	0.00%	(0.32%)	0.00%	0.00%	$507.15
PMPMs based on All Members in Risk Group[2]										
NF Component PMPM[3]	$2,598.86	0.97815	$2,656.91	$52.65	$2,709.56	0.00%	(1.60%)	0.00%	0.00%	$2,666.21
HCBS Component PMPM[4]	$2,331.34	0.98465	$2,367.69	$9.66	$2,377.35	0.00%	(1.43%)	0.00%	0.00%	$2,343.42
Acute Component PMPM[5]	$2,477.31	0.97104	$2,551.20	$0.00	$2,551.20	(0.63%)	(0.75%)	(0.27%)	0.00%	$2,509.43
Total Medical PMPM	**$7,407.51**	**0.97779**	**$7,575.80**	**$62.31**	**$7,638.11**	**(0.21%)**	**(1.26%)**	**(0.09%)**	**0.00%**	**$7,519.06**

Percent Members Receiving LTSS	95.87%
HCBS Mix Percent	70.99%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 5: Projected Benefit Cost Trends

Appendix 5: Projected Benefit Cost Trends

		I.3.B.iii.	I.3.B.iii.	
GSA	COS	Utilization per 1000	Unit Cost	PMPM
Central	NF	0.0%	2.0%	2.0%
Central	HCBS - Assisted Living	2.4%	0.5%	2.9%
Central	HCBS - Attendant Care	4.0%	0.0%	4.0%
Central	HCBS - Other	2.0%	0.0%	2.0%
Central	Acute - Inpatient	2.5%	0.0%	2.5%
Central	Acute - Other	0.0%	4.0%	4.0%
Central	Acute - Outpatient	2.5%	0.0%	2.5%
Central	Acute - Pharmacy	1.3%	5.3%	6.7%
Central	Acute - Physician	0.0%	4.0%	4.0%
North/South	NF	1.0%	1.2%	2.2%
North/South	HCBS - Assisted Living	1.7%	1.5%	3.2%
North/South	HCBS - Attendant Care	3.5%	0.5%	4.0%
North/South	HCBS - Other	1.7%	0.5%	2.2%
North/South	Acute - Inpatient	2.0%	0.5%	2.5%
North/South	Acute - Other	0.4%	3.0%	3.4%
North/South	Acute - Outpatient	2.0%	0.5%	2.5%
North/South	Acute - Pharmacy	1.0%	5.7%	6.8%
North/South	Acute - Physician	0.4%	3.0%	3.4%

Appendix 6: Development of Gross Medical Component

Appendix 6: Development of Gross Medical Component

Contractor | UnitedHealthcare Community Plan
GSA | North
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 24,145 | LTSS %: 97.62% | HCBS Mix %: 69.98%
Projection Period | Member Months: 25,090 | LTSS %: 97.97% | HCBS Mix %: 69.90%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$7,089.65	2.21%	1.11%	0.00%	0.00%	0.00%	0.00%	$7,489.35	$114.89	$7,604.24		$7,604.24
HCBS - Assisted Living	$1,051.11	3.17%	2.50%	0.00%	0.00%	0.00%	0.00%	$1,146.86	$5.01	$1,151.86		$1,151.86
HCBS - Attendant Care	$700.58	4.02%	2.85%	0.00%	0.00%	0.00%	0.00%	$779.63	$4.75	$784.39		$784.39
HCBS - Other	$115.39	2.21%	2.61%	0.00%	0.00%	0.00%	0.00%	$123.69	$0.52	$124.21		$124.21
Acute - Inpatient	$9.99	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	$10.50	$0.00	$10.50		$10.50
Acute - Other	$123.44	3.36%	0.05%	0.00%	0.00%	0.00%	0.01%	$131.96	$0.01	$131.97		$131.97
Acute - Outpatient	$20.35	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	$21.38	$0.00	$21.38		$21.38
Acute - Pharmacy	$5.63	6.76%	0.00%	55.60%	71.64%	0.00%	13.89%	$19.51	$0.00	$19.51		$19.51
Acute - Physician	$27.05	3.36%	0.00%	0.00%	0.00%	0.00%	0.00%	$28.90	$0.00	$28.90		$28.90
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$2,077.32	2.21%	1.11%	0.00%	0.00%	0.00%	0.00%	$2,194.43	$33.66	$2,228.10	0.63%	$2,242.13
HCBS Component PMPM[4]	$1,275.51	3.44%	2.64%	0.00%	0.00%	0.00%	0.00%	$1,400.60	$7.02	$1,407.62	0.25%	$1,411.17
Acute Component PMPM[5]	$186.46	3.54%	0.03%	5.11%	6.58%	0.00%	1.28%	$212.25	$0.01	$212.27	0.00%	$212.27
Total Medical PMPM	**$3,539.29**	**2.73%**	**1.61%**	**0.28%**	**0.36%**	**0.00%**	**0.07%**	**$3,807.28**	**$40.70**	**$3,847.98**	**0.46%**	**$3,865.56**

Percent Members Receiving LTSS	97.62%	0.37%	97.97%
HCBS Mix Percent	69.98%	-0.11%	69.90%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | UnitedHealthcare Community Plan
GSA | North
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 4,001 | LTSS %: 94.65% | HCBS Mix %: 73.39%
Projection Period | Member Months: 4,157 | LTSS %: 94.81% | HCBS Mix %: 73.67%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$9,472.55	2.21%	1.11%	0.00%	0.00%	0.00%	0.00%	$10,006.59	$160.20	$10,166.78		$10,166.78
HCBS - Assisted Living	$525.29	3.17%	2.51%	0.00%	0.00%	0.00%	0.02%	$573.33	$1.90	$575.23		$575.23
HCBS - Attendant Care	$1,168.64	4.02%	2.87%	0.00%	0.00%	0.00%	0.01%	$1,300.88	$7.29	$1,308.17		$1,308.17
HCBS - Other	$316.51	2.21%	1.18%	0.00%	0.00%	0.00%	0.10%	$334.88	$0.51	$335.39		$335.39
Acute - Inpatient	$631.96	2.51%	0.01%	0.00%	0.00%	0.00%	0.00%	$664.13	$16.26	$680.39		$680.39
Acute - Other	$581.18	3.36%	2.52%	0.00%	0.00%	0.00%	0.01%	$636.58	$0.56	$637.14		$637.14
Acute - Outpatient	$349.44	2.51%	1.20%	0.00%	0.00%	0.00%	0.00%	$371.62	$7.06	$378.68		$378.68
Acute - Pharmacy	$1,210.86	6.76%	0.00%	1.44%	2.34%	0.34%	0.30%	$1,441.84	$0.00	$1,441.84		$1,441.84
Acute - Physician	$477.02	3.36%	2.83%	0.00%	0.00%	0.00%	0.00%	$524.09	$3.89	$527.98		$527.98
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$2,385.76	2.21%	1.11%	0.00%	0.00%	0.00%	0.00%	$2,520.27	$40.35	$2,560.61	-0.87%	$2,538.39
HCBS Component PMPM[4]	$1,396.62	3.53%	2.52%	0.00%	0.00%	0.00%	0.03%	$1,534.62	$6.74	$1,541.36	0.55%	$1,549.76
Acute Component PMPM[5]	$3,250.45	4.45%	0.97%	0.57%	0.92%	0.13%	0.12%	$3,638.26	$27.77	$3,666.03	0.00%	$3,666.03
Total Medical PMPM	**$7,032.84**	**3.53%**	**1.33%**	**0.27%**	**0.43%**	**0.06%**	**0.06%**	**$7,693.15**	**$74.85**	**$7,768.00**	**-0.18%**	**$7,754.18**

Percent Members Receiving LTSS	94.65%	0.17%	94.81%
HCBS Mix Percent	73.39%	0.38%	73.67%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Banner – University Family Care
GSA | Central
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 25,389 | LTSS %: 98.53% | HCBS Mix %: 77.11%
Projection Period | Member Months: 26,382 | LTSS %: 98.32% | HCBS Mix %: 77.42%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$8,158.44	2.00%	1.12%	0.00%	0.00%	0.00%	0.00%	$8,583.27	$125.78	$8,709.05		$8,709.05
HCBS - Assisted Living	$1,714.57	2.93%	2.50%	0.00%	0.00%	0.00%	0.00%	$1,862.05	$7.67	$1,869.72		$1,869.72
HCBS - Attendant Care	$1,009.64	4.00%	2.77%	0.00%	0.00%	0.00%	0.00%	$1,122.25	$14.53	$1,136.78		$1,136.78
HCBS - Other	$101.67	2.00%	2.43%	0.00%	0.00%	0.00%	0.09%	$108.44	$0.99	$109.43		$109.43
Acute - Inpatient	$33.08	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	$34.76	$0.00	$34.76		$34.76
Acute - Other	$278.93	4.00%	0.00%	0.00%	0.00%	0.00%	0.03%	$301.79	$0.03	$301.83		$301.83
Acute - Outpatient	$29.29	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	$30.78	$0.00	$30.78		$30.78
Acute - Pharmacy	$2.58	6.67%	0.00%	8.85%	29.51%	0.00%	8.55%	$4.49	$0.00	$4.49		$4.49
Acute - Physician	$58.21	4.00%	0.00%	0.00%	0.00%	0.00%	0.11%	$63.03	$0.00	$63.03		$63.03
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$1,839.82	2.00%	1.12%	0.00%	0.00%	0.00%	0.00%	$1,935.62	$28.37	$1,963.98	-1.55%	$1,933.47
HCBS Component PMPM[4]	$2,146.93	3.29%	2.60%	0.00%	0.00%	0.00%	0.00%	$2,349.68	$17.62	$2,367.29	0.19%	$2,371.83
Acute Component PMPM[5]	$402.10	3.80%	0.00%	0.09%	0.30%	0.00%	0.13%	$434.85	$0.03	$434.88	0.00%	$434.88
Total Medical PMPM	**$4,388.84**	**2.81%**	**1.76%**	**0.01%**	**0.03%**	**0.00%**	**0.01%**	**$4,720.14**	**$46.02**	**$4,766.16**	**-0.55%**	**$4,740.18**

Percent Members Receiving LTSS	98.53%	-0.21%	98.32%
HCBS Mix Percent	77.11%	0.40%	77.42%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Banner – University Family Care
GSA | Central
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 5,794 | LTSS %: 95.33% | HCBS Mix %: 65.73%
Projection Period | Member Months: 6,021 | LTSS %: 95.26% | HCBS Mix %: 65.49%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$10,832.70	2.00%	1.12%	0.00%	0.00%	0.00%	0.00%	$11,397.07	$185.79	$11,582.86		$11,582.86
HCBS - Assisted Living	$1,139.42	2.93%	2.50%	0.00%	0.00%	0.00%	0.00%	$1,237.43	$5.63	$1,243.06		$1,243.06
HCBS - Attendant Care	$1,189.72	4.00%	2.74%	0.00%	0.00%	0.00%	0.00%	$1,322.03	$15.40	$1,337.43		$1,337.43
HCBS - Other	$352.71	2.00%	0.92%	0.00%	0.00%	0.00%	0.19%	$371.04	$1.38	$372.42		$372.42
Acute - Inpatient	$1,108.13	2.50%	0.01%	0.00%	0.00%	0.00%	0.00%	$1,164.38	$21.31	$1,185.70		$1,185.70
Acute - Other	$966.94	4.00%	1.49%	0.00%	0.00%	0.00%	0.01%	$1,061.53	$0.65	$1,062.18		$1,062.18
Acute - Outpatient	$471.22	2.50%	1.27%	0.00%	0.00%	0.00%	0.00%	$501.38	$16.54	$517.92		$517.92
Acute - Pharmacy	$985.35	6.67%	0.00%	1.30%	1.32%	1.72%	(0.57%)	$1,163.81	$0.00	$1,163.81		$1,163.81
Acute - Physician	$555.58	4.00%	3.22%	0.00%	0.00%	0.00%	0.00%	$620.29	$4.20	$624.49		$624.49
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$3,538.94	2.00%	1.12%	0.00%	0.00%	0.00%	0.00%	$3,723.31	$60.70	$3,784.01	0.63%	$3,807.74
HCBS Component PMPM[4]	$1,680.57	3.30%	2.41%	0.00%	0.00%	0.00%	0.02%	$1,836.39	$14.04	$1,850.43	-0.44%	$1,842.20
Acute Component PMPM[5]	$4,087.22	4.12%	0.94%	0.33%	0.34%	0.44%	(0.14%)	$4,511.39	$42.70	$4,554.10	0.00%	$4,554.10
Total Medical PMPM	**$9,306.72**	**3.18%**	**1.27%**	**0.15%**	**0.15%**	**0.20%**	**(0.06%)**	**$10,071.09**	**$117.44**	**$10,188.53**	**0.15%**	**$10,204.04**

Percent Members Receiving LTSS	95.33%	-0.08%	95.26%
HCBS Mix Percent	65.73%	-0.37%	65.49%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Mercy Care
GSA | Central
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 80,895 | LTSS %: 97.90% | HCBS Mix %: 79.45%
Projection Period | Member Months: 84,059 | LTSS %: 97.88% | HCBS Mix %: 79.25%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$8,633.33	2.00%	1.12%	0.00%	0.00%	0.00%	0.00%	$9,082.32	$147.07	$9,229.38		$9,229.38
HCBS - Assisted Living	$1,184.52	2.93%	2.50%	0.00%	0.00%	0.00%	0.00%	$1,286.33	$6.50	$1,292.83		$1,292.83
HCBS - Attendant Care	$1,634.48	4.00%	2.80%	0.00%	0.00%	0.00%	0.00%	$1,817.34	$19.43	$1,836.77		$1,836.77
HCBS - Other	$199.69	2.00%	1.75%	0.00%	0.00%	0.00%	0.09%	$211.58	$1.16	$212.74		$212.74
Acute - Inpatient	$61.94	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	$65.08	$0.00	$65.08		$65.08
Acute - Other	$259.87	4.00%	(0.01%)	0.00%	0.00%	0.00%	0.03%	$281.14	$0.05	$281.19		$281.19
Acute - Outpatient	$50.24	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	$52.79	$0.00	$52.79		$52.79
Acute - Pharmacy	$11.74	6.67%	0.00%	8.85%	29.51%	0.00%	8.55%	$20.43	$0.00	$20.43		$20.43
Acute - Physician	$88.09	4.00%	0.00%	0.00%	0.00%	0.00%	0.11%	$95.37	$0.00	$95.37		$95.37
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$1,737.23	2.00%	1.12%	0.00%	0.00%	0.00%	0.00%	$1,827.57	$29.59	$1,857.17	0.94%	$1,874.64
HCBS Component PMPM[4]	$2,347.77	3.46%	2.61%	0.00%	0.00%	0.00%	0.01%	$2,578.41	$21.07	$2,599.48	-0.27%	$2,592.50
Acute Component PMPM[5]	$471.88	3.76%	(0.01%)	0.35%	1.17%	0.00%	0.38%	$514.81	$0.05	$514.86	0.00%	$514.86
Total Medical PMPM	**$4,556.88**	**2.94%**	**1.78%**	**0.04%**	**0.12%**	**0.00%**	**0.04%**	**$4,920.79**	**$50.71**	**$4,971.50**	**0.21%**	**$4,982.00**

Percent Members Receiving LTSS	97.90%	-0.02%	97.88%
HCBS Mix Percent	79.45%	-0.25%	79.25%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Mercy Care
GSA | Central
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 23,977 | LTSS %: 94.67% | HCBS Mix %: 72.00%
Projection Period | Member Months: 24,915 | LTSS %: 94.91% | HCBS Mix %: 71.61%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$11,949.78	2.00%	1.12%	0.00%	0.00%	0.00%	0.00%	$12,571.28	$219.99	$12,791.27		$12,791.27
HCBS - Assisted Living	$603.63	2.93%	2.49%	0.00%	0.00%	0.00%	0.00%	$655.51	$3.02	$658.53		$658.53
HCBS - Attendant Care	$2,076.67	4.00%	2.80%	0.00%	0.00%	0.00%	0.00%	$2,308.95	$24.00	$2,332.95		$2,332.95
HCBS - Other	$655.81	2.00%	0.88%	0.00%	0.00%	0.00%	0.19%	$689.62	$2.75	$692.37		$692.37
Acute - Inpatient	$819.64	2.50%	0.02%	0.00%	0.00%	0.00%	0.00%	$861.30	$20.37	$881.67		$881.67
Acute - Other	$966.31	4.00%	0.51%	0.00%	0.00%	0.00%	0.01%	$1,050.61	$0.98	$1,051.59		$1,051.59
Acute - Outpatient	$311.72	2.50%	1.73%	0.00%	0.00%	0.00%	0.00%	$333.16	$4.65	$337.82		$337.82
Acute - Pharmacy	$1,221.87	6.67%	0.00%	1.30%	1.32%	1.72%	(0.57%)	$1,443.16	$0.00	$1,443.16		$1,443.16
Acute - Physician	$611.46	4.00%	4.10%	0.00%	0.00%	0.00%	0.00%	$688.51	$5.60	$694.10		$694.10
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$3,167.02	2.00%	1.12%	0.00%	0.00%	0.00%	0.00%	$3,331.73	$58.30	$3,390.03	1.66%	$3,446.27
HCBS Component PMPM[4]	$2,274.07	3.43%	2.38%	0.00%	0.00%	0.00%	0.04%	$2,490.81	$20.29	$2,511.10	-0.30%	$2,503.69
Acute Component PMPM[5]	$3,931.00	4.46%	0.90%	0.43%	0.43%	0.56%	(0.18%)	$4,376.74	$31.60	$4,408.34	0.00%	$4,408.34
Total Medical PMPM	**$9,372.09**	**3.39%**	**1.33%**	**0.18%**	**0.18%**	**0.24%**	**(0.07%)**	**$10,199.28**	**$110.19**	**$10,309.48**	**0.47%**	**$10,358.30**

Percent Members Receiving LTSS	94.67%	0.25%	94.91%
HCBS Mix Percent	72.00%	-0.55%	71.61%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | UnitedHealthcare Community Plan
GSA | Central
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 65,338 | LTSS %: 97.16% | HCBS Mix %: 82.72%
Projection Period | Member Months: 67,893 | LTSS %: 97.22% | HCBS Mix %: 82.73%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$7,578.68	2.00%	1.11%	0.00%	0.00%	0.00%	0.00%	$7,972.77	$119.19	$8,091.96		$8,091.96
HCBS - Assisted Living	$1,289.53	2.93%	2.49%	0.00%	0.00%	0.00%	0.00%	$1,400.34	$4.68	$1,405.03		$1,405.03
HCBS - Attendant Care	$754.52	4.00%	2.69%	0.00%	0.00%	0.00%	0.00%	$838.04	$7.78	$845.83		$845.83
HCBS - Other	$145.32	2.00%	2.45%	0.00%	0.00%	0.00%	0.09%	$155.04	$1.29	$156.33		$156.33
Acute - Inpatient	$21.39	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	$22.48	$0.00	$22.48		$22.48
Acute - Other	$171.79	4.00%	0.01%	0.00%	0.00%	0.00%	0.03%	$185.87	$0.02	$185.89		$185.89
Acute - Outpatient	$13.59	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.28	$0.00	$14.28		$14.28
Acute - Pharmacy	$13.53	6.67%	0.00%	8.85%	29.51%	0.00%	8.55%	$23.56	$0.00	$23.56		$23.56
Acute - Physician	$36.76	4.00%	0.00%	0.00%	0.00%	0.00%	0.11%	$39.80	$0.00	$39.80		$39.80
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$1,272.68	2.00%	1.11%	0.00%	0.00%	0.00%	0.00%	$1,338.86	$20.02	$1,358.88	-0.03%	$1,358.51
HCBS Component PMPM[4]	$1,759.49	3.25%	2.56%	0.00%	0.00%	0.00%	0.01%	$1,923.49	$11.06	$1,934.54	0.08%	$1,936.02
Acute Component PMPM[5]	$257.06	4.03%	0.00%	0.73%	2.43%	0.00%	0.74%	$285.98	$0.02	$286.00	0.00%	$286.00
Total Medical PMPM	**$3,289.23**	**2.84%**	**1.81%**	**0.06%**	**0.19%**	**0.00%**	**0.06%**	**$3,548.33**	**$31.09**	**$3,579.42**	**0.03%**	**$3,580.53**

Percent Members Receiving LTSS	97.16%	0.06%	97.22%
HCBS Mix Percent	82.72%	0.02%	82.73%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | UnitedHealthcare Community Plan
GSA | Central
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 11,206 | LTSS %: 94.49% | HCBS Mix %: 75.44%
Projection Period | Member Months: 11,644 | LTSS %: 94.79% | HCBS Mix %: 75.15%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$9,204.65	2.00%	1.11%	0.00%	0.00%	0.00%	0.00%	$9,683.29	$155.36	$9,838.65		$9,838.65
HCBS - Assisted Living	$980.77	2.93%	2.49%	0.00%	0.00%	0.00%	0.00%	$1,065.06	$2.97	$1,068.03		$1,068.03
HCBS - Attendant Care	$1,174.08	4.00%	2.69%	0.00%	0.00%	0.00%	0.00%	$1,304.03	$11.01	$1,315.04		$1,315.04
HCBS - Other	$299.89	2.00%	1.87%	0.00%	0.00%	0.00%	0.19%	$318.43	$1.77	$320.20		$320.20
Acute - Inpatient	$717.87	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	$754.24	$17.77	$772.01		$772.01
Acute - Other	$708.96	4.00%	0.90%	0.00%	0.00%	0.00%	0.01%	$773.81	$0.75	$774.56		$774.56
Acute - Outpatient	$332.87	2.50%	1.09%	0.00%	0.00%	0.00%	0.00%	$353.55	$6.25	$359.80		$359.80
Acute - Pharmacy	$1,176.75	6.67%	0.00%	1.30%	1.32%	1.72%	(0.57%)	$1,389.87	$0.00	$1,389.87		$1,389.87
Acute - Physician	$627.62	4.00%	4.11%	0.00%	0.00%	0.00%	0.00%	$706.77	$5.11	$711.88		$711.88
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$2,135.97	2.00%	1.11%	0.00%	0.00%	0.00%	0.00%	$2,247.04	$36.05	$2,283.10	1.49%	$2,317.20
HCBS Component PMPM[4]	$1,749.77	3.34%	2.51%	0.00%	0.00%	0.00%	0.02%	$1,915.70	$11.23	$1,926.93	-0.06%	$1,925.86
Acute Component PMPM[5]	$3,564.08	4.50%	1.00%	0.45%	0.46%	0.59%	(0.20%)	$3,978.23	$29.87	$4,008.10	0.00%	$4,008.10
Total Medical PMPM	**$7,449.82**	**3.53%**	**1.39%**	**0.22%**	**0.22%**	**0.29%**	**(0.09%)**	**$8,140.98**	**$77.15**	**$8,218.13**	**0.40%**	**$8,251.16**

Percent Members Receiving LTSS	94.49%	0.32%	94.79%
HCBS Mix Percent	75.44%	-0.38%	75.15%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Banner – University Family Care
GSA | South
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 44,033 | LTSS %: 98.69% | HCBS Mix %: 73.23%
Projection Period | Member Months: 45,755 | LTSS %: 98.50% | HCBS Mix %: 73.02%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$8,224.55	2.21%	1.26%	0.00%	0.00%	0.00%	0.00%	$8,701.10	$127.55	$8,828.65		$8,828.65
HCBS - Assisted Living	$1,053.60	3.17%	2.85%	0.00%	0.00%	0.00%	0.00%	$1,153.56	$3.85	$1,157.41		$1,157.41
HCBS - Attendant Care	$1,442.10	4.02%	2.93%	0.00%	0.00%	0.00%	0.00%	$1,605.95	$29.18	$1,635.13		$1,635.13
HCBS - Other	$185.56	2.21%	2.60%	0.00%	0.00%	0.00%	0.00%	$198.89	$2.78	$201.67		$201.67
Acute - Inpatient	$18.99	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	$19.96	$0.00	$19.96		$19.96
Acute - Other	$134.55	3.36%	0.03%	0.00%	0.00%	0.00%	0.03%	$143.83	$0.02	$143.85		$143.85
Acute - Outpatient	$47.50	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	$49.92	$0.00	$49.92		$49.92
Acute - Pharmacy	$3.14	6.76%	0.00%	131.71%	44.51%	0.00%	21.25%	$14.54	$0.00	$14.54		$14.54
Acute - Physician	$80.32	3.36%	0.00%	0.00%	0.00%	0.00%	0.02%	$85.83	$0.00	$85.83		$85.83
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$2,172.77	2.21%	1.26%	0.00%	0.00%	0.00%	0.00%	$2,298.66	$33.70	$2,332.35	0.59%	$2,346.00
HCBS Component PMPM[4]	$1,937.80	3.57%	2.88%	0.00%	0.00%	0.00%	0.00%	$2,138.09	$25.88	$2,163.97	-0.47%	$2,153.71
Acute Component PMPM[5]	$284.51	3.33%	0.02%	6.10%	2.06%	0.00%	1.00%	$314.08	$0.02	$314.09	0.00%	$314.09
Total Medical PMPM	**$4,395.07**	**2.89%**	**1.90%**	**0.40%**	**0.13%**	**0.00%**	**0.07%**	**$4,750.82**	**$59.59**	**$4,810.42**	**0.07%**	**$4,813.80**

Percent Members Receiving LTSS	98.69%	-0.19%	98.50%
HCBS Mix Percent	73.23%	-0.28%	73.02%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Banner – University Family Care
GSA | South
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 8,077 | LTSS %: 96.27% | HCBS Mix %: 71.03%
Projection Period | Member Months: 8,393 | LTSS %: 96.42% | HCBS Mix %: 70.37%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$9,911.96	2.21%	1.29%	0.00%	0.00%	0.00%	0.00%	$10,489.00	$158.86	$10,647.86		$10,647.86
HCBS - Assisted Living	$552.55	3.17%	2.77%	0.00%	0.00%	0.00%	0.14%	$605.31	$2.13	$607.44		$607.44
HCBS - Attendant Care	$1,598.05	4.02%	2.98%	0.00%	0.00%	0.00%	0.04%	$1,781.18	$31.05	$1,812.24		$1,812.24
HCBS - Other	$350.92	2.21%	1.85%	0.00%	0.00%	0.00%	0.08%	$373.69	$3.25	$376.93		$376.93
Acute - Inpatient	$1,024.56	2.51%	0.03%	0.00%	0.00%	0.00%	0.00%	$1,076.96	$19.23	$1,096.19		$1,096.19
Acute - Other	$783.70	3.36%	1.84%	0.00%	0.00%	0.00%	0.02%	$852.84	$1.50	$854.34		$854.34
Acute - Outpatient	$484.46	2.51%	1.74%	0.00%	0.00%	0.00%	0.00%	$517.96	$8.67	$526.63		$526.63
Acute - Pharmacy	$1,085.06	6.76%	0.00%	0.72%	1.86%	1.91%	0.29%	$1,296.79	$0.00	$1,296.79		$1,296.79
Acute - Physician	$573.68	3.36%	4.54%	0.00%	0.00%	0.00%	0.00%	$640.72	$4.54	$645.26		$645.26
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$2,764.71	2.21%	1.29%	0.00%	0.00%	0.00%	0.00%	$2,925.66	$44.31	$2,969.97	2.41%	$3,041.52
HCBS Component PMPM[4]	$1,710.48	3.59%	2.78%	0.00%	0.00%	0.00%	0.07%	$1,887.34	$24.91	$1,912.25	-0.77%	$1,897.56
Acute Component PMPM[5]	$3,951.47	4.04%	1.23%	0.21%	0.55%	0.56%	0.09%	$4,385.27	$33.93	$4,419.21	0.00%	$4,419.21
Total Medical PMPM	**$8,426.65**	**3.36%**	**1.57%**	**0.10%**	**0.26%**	**0.27%**	**0.06%**	**$9,198.28**	**$103.15**	**$9,301.43**	**0.61%**	**$9,358.29**

Percent Members Receiving LTSS	96.27%	0.15%	96.42%
HCBS Mix Percent	71.03%	-0.92%	70.37%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Mercy Care
GSA | South
Risk Group | Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 19,558 | LTSS %: 98.47% | HCBS Mix %: 72.02%
Projection Period | Member Months: 20,323 | LTSS %: 98.37% | HCBS Mix %: 71.77%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$7,330.41	2.21%	1.35%	0.00%	0.00%	0.00%	0.00%	$7,761.76	$101.64	$7,863.40		$7,863.40
HCBS - Assisted Living	$1,133.20	3.17%	2.91%	0.00%	0.00%	0.00%	0.00%	$1,241.41	$4.16	$1,245.57		$1,245.57
HCBS - Attendant Care	$1,597.02	4.02%	3.08%	0.00%	0.00%	0.00%	0.00%	$1,781.19	$23.49	$1,804.69		$1,804.69
HCBS - Other	$287.94	2.21%	1.87%	0.00%	0.00%	0.00%	0.00%	$306.42	$1.95	$308.37		$308.37
Acute - Inpatient	$41.35	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	$43.46	$0.00	$43.46		$43.46
Acute - Other	$106.55	3.36%	0.04%	0.00%	0.00%	0.00%	0.03%	$113.91	$0.01	$113.92		$113.92
Acute - Outpatient	$35.89	2.51%	0.00%	0.00%	0.00%	0.00%	0.00%	$37.72	$0.00	$37.72		$37.72
Acute - Pharmacy	$4.92	6.76%	0.00%	131.71%	44.51%	0.00%	21.25%	$22.78	$0.00	$22.78		$22.78
Acute - Physician	$105.61	3.36%	0.00%	0.00%	0.00%	0.00%	0.02%	$112.86	$0.00	$112.86		$112.86
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$2,019.93	2.21%	1.35%	0.00%	0.00%	0.00%	0.00%	$2,138.80	$28.01	$2,166.80	0.78%	$2,183.61
HCBS Component PMPM[4]	$2,140.39	3.54%	2.91%	0.00%	0.00%	0.00%	0.00%	$2,360.86	$20.99	$2,381.85	-0.45%	$2,371.13
Acute Component PMPM[5]	$294.34	3.39%	0.01%	9.07%	3.07%	0.00%	1.48%	$330.73	$0.01	$330.73	0.00%	$330.73
Total Medical PMPM	**$4,454.67**	**2.94%**	**2.02%**	**0.61%**	**0.21%**	**0.00%**	**0.10%**	**$4,830.38**	**$49.00**	**$4,879.38**	**0.12%**	**$4,885.48**

Percent Members Receiving LTSS	98.47%	-0.11%	98.37%
HCBS Mix Percent	72.02%	-0.34%	71.77%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Mercy Care
GSA | South
Risk Group | Non-Dual
Base Period | October 1, 2022 through September 30, 2023
Projection Period | October 1, 2024 through September 30, 2025
Base Period | Member Months: 3,796 | LTSS %: 95.87% | HCBS Mix %: 70.99%
Projection Period | Member Months: 3,945 | LTSS %: 95.95% | HCBS Mix %: 71.35%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	Rezdiffra	Wegovy	Diabetes Drug Class Changes	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]												
Nursing Facility (NF)	$9,584.78	2.21%	1.36%	0.00%	0.00%	0.00%	0.00%	$10,149.50	$135.32	$10,284.82		$10,284.82
HCBS - Assisted Living	$451.32	3.17%	2.81%	0.00%	0.00%	0.00%	0.14%	$494.60	$1.41	$496.01		$496.01
HCBS - Attendant Care	$2,110.73	4.02%	3.09%	0.00%	0.00%	0.00%	0.04%	$2,355.29	$33.83	$2,389.11		$2,389.11
HCBS - Other	$881.26	2.21%	0.97%	0.00%	0.00%	0.00%	0.08%	$930.30	$6.72	$937.02		$937.02
Acute - Inpatient	$466.34	2.51%	0.11%	0.00%	0.00%	0.00%	0.00%	$490.59	$11.88	$502.47		$502.47
Acute - Other	$617.75	3.36%	1.48%	0.00%	0.00%	0.00%	0.02%	$669.89	$1.38	$671.28		$671.28
Acute - Outpatient	$217.31	2.51%	1.21%	0.00%	0.00%	0.00%	0.00%	$231.13	$4.22	$235.34		$235.34
Acute - Pharmacy	$700.88	6.76%	0.00%	0.72%	1.86%	1.91%	0.29%	$837.63	$0.00	$837.63		$837.63
Acute - Physician	$507.15	3.36%	3.13%	0.00%	0.00%	0.00%	0.00%	$558.79	$4.14	$562.94		$562.94
PMPMs based on All Members in Risk Group[2]												
NF Component PMPM[3]	$2,666.21	2.21%	1.36%	0.00%	0.00%	0.00%	0.00%	$2,823.30	$37.64	$2,860.94	-1.17%	$2,827.54
HCBS Component PMPM[4]	$2,343.42	3.46%	2.54%	0.00%	0.00%	0.00%	0.06%	$2,572.69	$28.55	$2,601.25	0.58%	$2,616.39
Acute Component PMPM[5]	$2,509.43	4.15%	1.10%	0.21%	0.55%	0.57%	0.09%	$2,788.04	$21.62	$2,809.66	0.00%	$2,809.66
Total Medical PMPM	**$7,519.06**	**3.27%**	**1.64%**	**0.07%**	**0.19%**	**0.19%**	**0.05%**	**$8,184.03**	**$87.82**	**$8,271.85**	**-0.22%**	**$8,253.60**

Percent Members Receiving LTSS	95.87%	0.07%	95.95%
HCBS Mix Percent	70.99%	0.51%	71.35%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 7a: Capitation Rate Development - Medical Component

Appendix 7a: Dual Capitation Rate Development

				Appendix 6	I.3.B.ii.(a)	I.4.C.ii.(c)	Subtotal	I.3.B.ii.(a)	I.3.B.ii.(a)	Product	Total
GSA	Contractor	Risk Group	Category of Service	Projected Gross Medical	Projected SOC	RI Offset	Projected Net Medical	Projected Percent Members Receiving LTSS	Projected Mix	Net Medical After LTSS and HCBS Mix	Total Net Medical
North	UnitedHealthcare Community Plan	Dual	Nursing Facility	$7,604.24	($1,064.27)	$0.00	$6,539.97	97.97%	30.10%	$1,928.33	
			Home and Community Based Services	$2,060.46	($25.44)	$0.00	$2,035.01	97.97%	69.90%	$1,393.74	**$3,532.91**
			Acute	$212.27	$0.00	($1.42)	$210.84			$210.84	
Central	Banner – University Family Care	Dual	Nursing Facility	$8,709.05	($976.25)	$0.00	$7,732.80	98.32%	22.58%	$1,716.74	
			Home and Community Based Services	$3,115.93	($20.73)	$0.00	$3,095.19	98.32%	77.42%	$2,356.05	**$4,504.51**
			Acute	$434.88	$0.00	($3.15)	$431.73			$431.73	
Central	Mercy Care	Dual	Nursing Facility	$9,229.38	($888.42)	$0.00	$8,340.97	97.88%	20.75%	$1,694.19	
			Home and Community Based Services	$3,342.34	($27.10)	$0.00	$3,315.24	97.88%	79.25%	$2,571.48	**$4,758.81**
			Acute	$514.86	$0.00	($21.72)	$493.14			$493.14	
Central	UnitedHealthcare Community Plan	Dual	Nursing Facility	$8,091.96	($994.39)	$0.00	$7,097.56	97.22%	17.27%	$1,191.57	
			Home and Community Based Services	$2,407.19	($16.93)	$0.00	$2,390.26	97.22%	82.73%	$1,922.40	**$3,377.41**
			Acute	$286.00	$0.00	($22.57)	$263.43			$263.43	
South	Banner – University Family Care	Dual	Nursing Facility	$8,828.65	($914.39)	$0.00	$7,914.25	98.50%	26.98%	$2,103.03	
			Home and Community Based Services	$2,994.20	($18.19)	$0.00	$2,976.01	98.50%	73.02%	$2,140.62	**$4,553.41**
			Acute	$314.09	$0.00	($4.33)	$309.76			$309.76	
South	Mercy Care	Dual	Nursing Facility	$7,863.40	($865.37)	$0.00	$6,998.03	98.37%	28.23%	$1,943.30	
			Home and Community Based Services	$3,358.63	($34.61)	$0.00	$3,324.02	98.37%	71.77%	$2,346.70	**$4,621.80**
			Acute	$330.73	$0.00	$1.07	$331.80			$331.80	

Appendix 7a: Non-Dual Capitation Rate Development

				Appendix 6	I.3.B.ii.(a)	I.4.C.ii.(c)	Subtotal	I.3.B.ii.(a)	I.3.B.ii.(a)	Product	Total
GSA	Contractor	Risk Group	Category of Service	Projected Gross Medical	Projected SOC	RI Offset	Projected Net Medical	Projected Percent Members Receiving LTSS	Projected Mix	Net Medical After LTSS and HCBS Mix	Total Net Medical
North	UnitedHealthcare Community Plan	Non-Dual	Nursing Facility	$10,166.78	($130.13)	$0.00	$10,036.65	94.81%	26.33%	$2,505.90	
			Home and Community Based Services	$2,218.79	($10.70)	$0.00	$2,208.09	94.81%	73.67%	$1,542.29	**$7,035.82**
			Acute	$3,666.03	$0.00	($678.40)	$2,987.63			$2,987.63	
Central	Banner – University Family Care	Non-Dual	Nursing Facility	$11,582.86	($96.81)	$0.00	$11,486.05	95.26%	34.51%	$3,775.91	
			Home and Community Based Services	$2,952.91	($3.40)	$0.00	$2,949.51	95.26%	65.49%	$1,840.08	**$9,417.48**
			Acute	$4,554.10	$0.00	($752.61)	$3,801.48			$3,801.48	
Central	Mercy Care	Non-Dual	Nursing Facility	$12,791.27	($116.27)	$0.00	$12,674.99	94.91%	28.39%	$3,414.95	
			Home and Community Based Services	$3,683.86	($6.80)	$0.00	$3,677.06	94.91%	71.61%	$2,499.07	**$9,805.57**
			Acute	$4,408.34	$0.00	($516.78)	$3,891.56			$3,891.56	
Central	UnitedHealthcare Community Plan	Non-Dual	Nursing Facility	$9,838.65	($91.84)	$0.00	$9,746.81	94.79%	24.85%	$2,295.57	
			Home and Community Based Services	$2,703.27	($3.12)	$0.00	$2,700.15	94.79%	75.15%	$1,923.63	**$7,655.98**
			Acute	$4,008.10	$0.00	($571.33)	$3,436.78			$3,436.78	
South	Banner – University Family Care	Non-Dual	Nursing Facility	$10,647.86	($134.84)	$0.00	$10,513.02	96.42%	29.63%	$3,003.01	
			Home and Community Based Services	$2,796.61	($6.06)	$0.00	$2,790.55	96.42%	70.37%	$1,893.45	**$8,394.67**
			Acute	$4,419.21	$0.00	($920.99)	$3,498.21			$3,498.21	
South	Mercy Care	Non-Dual	Nursing Facility	$10,284.82	($184.54)	$0.00	$10,100.28	95.95%	28.65%	$2,776.81	
			Home and Community Based Services	$3,822.15	($8.33)	$0.00	$3,813.82	95.95%	71.35%	$2,610.69	**$8,104.27**
			Acute	$2,809.66	$0.00	($92.90)	$2,716.76			$2,716.76	

Appendix 7b: Capitation Rate Development – Final Capitation Rate

Appendix 7b: Capitation Rate Development

Dual								
		Appendix 7a	I.5.B.i.	I.5.B.i.	I.5.B.ii.(c)	Calculation	I.5.B.ii.(b)	Total
GSA	Contractor	Net Medical	Case Management	Admin	UW Gain Percent	UW Gain	Premium Tax	Capitation Rate
North	UnitedHealthcare Community Plan	$3,532.91	$169.89	$103.61	1.15%	$44.28	$78.59	$3,929.28
Central	Banner - University Family Care	$4,504.51	$145.66	$246.13	1.15%	$56.96	$101.09	$5,054.36
Central	Mercy Care	$4,758.81	$173.36	$136.27	1.15%	$58.97	$104.64	$5,232.04
Central	UnitedHealthcare Community Plan	$3,377.41	$166.76	$99.77	1.15%	$42.39	$75.23	$3,761.56
South	Banner - University Family Care	$4,553.41	$132.98	$249.05	1.15%	$57.42	$101.89	$5,094.75
South	Mercy Care	$4,621.80	$171.57	$131.94	1.15%	$57.30	$101.69	$5,084.30

Non-Dual								
		Appendix 7a	I.5.B.i.	I.5.B.i.	I.5.B.ii.(c)	Calculation	I.5.B.ii.(b)	Total
GSA	Contractor	Net Medical	Case Management	Admin	UW Gain Percent	UW Gain	Premium Tax	Capitation Rate
North	UnitedHealthcare Community Plan	$7,035.82	$378.13	$226.80	1.15%	$88.89	$157.75	$7,887.39
Central	Banner - University Family Care	$9,417.48	$310.09	$558.06	1.15%	$119.66	$212.35	$10,617.65
Central	Mercy Care	$9,805.57	$175.67	$292.98	1.15%	$119.53	$212.12	$10,605.87
Central	UnitedHealthcare Community Plan	$7,655.98	$388.83	$241.55	1.15%	$96.40	$171.08	$8,553.83
South	Banner - University Family Care	$8,394.67	$237.22	$510.83	1.15%	$106.36	$188.76	$9,437.84
South	Mercy Care	$8,104.27	$175.17	$233.05	1.15%	$99.03	$175.75	$8,787.27

Appendix 8a: State Directed Payments – CMS Prescribed Table

Appendix 8a: State Directed Payments – CMS Prescribed Tables

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

Control name of the State directed payment	Type of payment - Section I.4.D.ii.(a)(i)(A)	Brief description - Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.D.ii.(a)(iii)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	Minimum Fee Schedule	Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Arizona Medicaid State plan as a minimum fee schedule for FQHC/RHC providers.	Rate Adjustment
Vaccines for Children (VFC)	Minimum Fee Schedule	Contractors are required to adopt the payment rates in the Arizona Medicaid State plan as a minimum fee schedule for VFC providers.	Rate Adjustment
AZ_Fee_IPH.OPH.PC.SP.NF.HCBS.BHI.BHO.D_Renewal_20241001-20250930 (DAP)	Uniform Percentage Increase	Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.	Rate Adjustment
AZ_Fee_AMC_Renewal_20241001-20250930 (APSI)	Uniform Percentage Increase	75% increase to otherwise contracted rates for professional services provided by eligible practitioners, applicable only to services covered under the AHCCCS APSI policy.	Separate Payment Term
AZ_Fee_IPH.OPH1_Renewal_20241001-20250930 (PSI)	Uniform Percentage Increase	Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 beds. The uniform percentage increase is based on a fixed total payment amount, and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_IPH.OPH2_Renewal_20241001-20250930 (HEALTHII)	Uniform Percentage Increase	Uniform percentage increase for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class' aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term
AZ_Fee_IPH.OPH3_Renewal_20241001-20250930 (SNSI)	Uniform Percentage Increase	Uniform percentage increase to the Contractor’s rates for inpatient and outpatient services provided by the public safety net hospital. The uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_NF_Renewal_20241001-20250930 (NF-SP)	Uniform Dollar Amount	Uniform dollar increase across all Contractor's reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund, plus FMAP, and is expected to fluctuate based on utilization and available funds for each quarter.	Separate Payment Term

Appendix 8a: State Directed Payments – CMS Prescribed Tables

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

Control name of the State directed payment	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Impact - Section I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	All EPD rate cells are affected.	See Appendix 8b for total impact by rate cell.	The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates. The AHCCCS DBF Rates & Reimbursement Team developed the impacts of bringing the base FQHC/RHC encounter data up to the projected CYE 25 FQHC/RHC PPS rates, by applying the change in PPS rates as a unit cost change to the CYE 23 base data. The AHCCCS DBF Actuarial Team then reviewed the FQHC/RHC results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting category of service as part of the overall fee schedule update.	Not applicable.	Not applicable.
Vaccines for Children (VFC)	All EPD rate cells are affected.	See Appendix 8b for total impact by rate cell.	The impact of the minimum fee schedule requirement for VFC providers is addressed as part of the fee schedule updates. The AHCCCS DBF financial analyst developed the impacts of bringing vaccines administered for the VFC program to the minimum fee schedule using CYE 23 encounter data. The AHCCCS DBF Actuarial Team then reviewed these results and applied to the rate cell level as part of the overall fee schedule update.	Not applicable.	Not applicable.
AZ_Fee_IPH.OPH.PC.SP.NF.HCBS.BHI.BHO.D_Renewal_20241001-20250930 (DAP)	All EPD rate cells are affected.	See Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell.	The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 23 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DBF 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 25 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 25 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DBF Actuarial Team then aggregated to the specific rate cells for each program).	AHCCCS has submitted the DAP §438.6(c) preprint to CMS but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the preprint under CMS review.	Not applicable.

Appendix 8a: State Directed Payments – CMS Prescribed Tables

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

Control name of the State directed payment	Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20241001-20250930 (APSI)	$6,610,948	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Access to Professional Services Initiative (APSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved State directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH1_Renewal_20241001-20250930 (PSI)	$1,413,064	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Pediatric Service Initiative (PSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The PSI payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved State directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH2_Renewal_20241001-20250930 (HEALTHII)	$81,918,001	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The HEALTHII payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved State directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH3_Renewal_20241001-20250930 (SNSI)	$9,733,548	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Hospital Enhanced Access Leading to Safety Net Services Initiative (SNSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The SNSI payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final SNSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the SNSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved State directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_NF_Renewal_20241001-20250930 (NF-SP)	$92,378,352	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Nursing Facility Supplemental Payments (NF-SP) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The NF-SP payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final NF-SP is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NF-SP into the rate certification's rate cells, consistent with the distribution methodology included in the approved State directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Appendix 8b: State Directed Payments – Estimated PMPMs

Appendix 8b: State Directed Payments - Estimated PMPMs

Dual									
		I.3.B.ii.	I.3.B.ii.	I.4.D.	I.4.D.	I.4.D.	I.4.D.	I.4.D.	I.4.D.
GSA	Contractor	FQHC/RHC	VFC	DAP	APSI	PSI	HEALTHII	SNSI	NF-SP
North	UnitedHealthcare Community Plan	$0.06	$0.00	$40.93	$0.70	$0.00	$30.02	$0.33	$377.85
Central	Banner - University Family Care	$0.01	$0.00	$45.61	$1.29	$0.00	$58.15	$1.46	$271.79
Central	Mercy Care	$0.00	$0.00	$50.93	$4.95	$0.00	$93.86	$5.77	$235.65
Central	UnitedHealthcare Community Plan	$0.01	$0.00	$31.09	$1.23	$0.01	$28.72	$1.49	$201.06
South	Banner - University Family Care	$0.05	$0.00	$59.67	$2.40	$0.00	$51.62	$0.41	$325.84
South	Mercy Care	$0.04	$0.00	$49.13	$1.82	$0.00	$65.25	$0.01	$345.99

Non-Dual									
		I.3.B.ii.	I.3.B.ii.	I.4.D.	I.4.D.	I.4.D.	I.4.D.	I.4.D.	I.4.D.
GSA	Contractor	FQHC/RHC	VFC	DAP	APSI	PSI	HEALTHII	SNSI	NF-SP
North	UnitedHealthcare Community Plan	$4.06	$0.01	$74.53	$72.50	$31.99	$1,140.08	$1.50	$327.80
Central	Banner - University Family Care	$1.58	$0.00	$117.76	$96.66	$25.61	$1,242.46	$118.27	$420.98
Central	Mercy Care	$0.41	$0.00	$111.10	$104.88	$25.83	$1,108.78	$232.43	$341.74
Central	UnitedHealthcare Community Plan	$1.35	$0.00	$77.68	$84.96	$34.35	$1,003.38	$198.80	$289.75
South	Banner - University Family Care	$5.48	$0.00	$104.02	$128.24	$7.91	$1,334.31	$10.64	$365.72
South	Mercy Care	$5.23	$0.00	$87.53	$88.97	$3.84	$855.92	$42.70	$373.36