AHCCCS
Arizona Health Care Cost Containment System

Contract Year Ending 2020 Arizona Long Term Care System Department of Economic Security/Division of Developmental Disabilities Capitation Rate Certification

October 1, 2019 through September 30, 2020

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438 at 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies used in the development of the October 1, 2019 through September 30, 2020 (Contract Year Ending 2020 or CYE 20) actuarially sound capitation rates for the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Program. Due to one fee schedule change (Proposition 206 Minimum Wage Increase) that will be implemented with an effective date of January 1, 2020, this certification will cover two sets of capitation rates. One set will apply for the time frame from October 1, 2019 through December 31, 2019, and another set will apply from January 1, 2020 through September 30, 2020. The rate development process is the same for both sets of capitation rates except the latter set includes the impact of the Proposition 206 Minimum Wage Increase adjustment. 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 at 81 FR 27497 applicable to this rate certification, the 2019-2020 Medicaid Managed Care Rate Development Guide (2020 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2020 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 2020 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

> “Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and

other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

As stated on page 2 of the 2020 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 2020 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The CYE 20 capitation rates for the ALTCS DES/DDD Program are effective for the twelve month time period from October 1, 2019 through September 30, 2020.

I.1.A.ii. Required Elements

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

The actuarial certification letter for the CYE 20 capitation rates for the ALTCS DES/DDD Program, signed by Erica Johnson, ASA, MAAA, is in Appendix 1. Ms. Johnson meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854, provided below for reference.

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

Ms. Johnson certifies that the CYE 20 capitation rates for the ALTCS DES/DDD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 at 81 FR 27497.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ALTCS DES/DDD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856. The ALTCS DES/DDD contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 at 81 FR 27497 and the 2020 Guide.

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

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

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

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

ALTCS DES/DDD is the only managed care plan for this program. Effective October 1, 2019, ALTCS DES/DDD members will receive integrated physical and behavioral health care under the ALTCS DES/DDD Program in addition to receiving Long Term Services & Supports (LTSS) under the ALTCS DES/DDD Program, rather than receiving behavioral health services under the separate Regional Behavioral Health Authorities (RBHA) Program. Effective October 1, 2019, ALTCS DES/DDD will subcontract the integrated physical and behavioral services to two integrated subcontractors, and retain the LTSS responsibilities for the ALTCS/DES DDD members, with the exception of LTSS services provided

in a nursing facility which are also being subcontracted to the integrated subcontractors effective October 1, 2019.

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

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

Services covered by ALTCS DES/DDD have traditionally included long-term care services, acute services and limited behavioral health services (i.e. treatment for ADHD, anxiety and depression when provided by the member's primary care physician) for most members. Effective October 1, 2018, coverage of services expanded to include Children's Rehabilitative Services (CRS) specialty care and comprehensive behavioral health services for child members who have a CRS qualifying condition, as coverage of those services shifted from the CRS Program. Effective October 1, 2019, coverage of services is expanding again to integrate care for all ALTCS DES/DDD members including comprehensive behavioral health services for all members, not just those with a CRS qualifying condition, to be provided through the ALTCS DES/DDD Program as coverage of those services shifts from the RBHA Program. Targeted Case Management (TCM) services are covered for those members who do not meet the functional requirements for ALTCS services.

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

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

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

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

The CYE 20 capitation rates for the ALTCS DES/DDD Program are effective for, the three month time period from October 1, 2019 through December 31, 2019, and the nine month time period from January 1, 2020 through September 30, 2020.

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

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

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

The first rate cell (regular DDD capitation rate) includes the costs of providing covered long-term care, acute care, CRS specialty care for members with a CRS qualifying condition, and behavioral health services for all DD members. The capitation rate incorporates an additional increase effective January 1, 2020 for the impact of the minimum wage change.

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

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

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

There are 3 types of DDD eligibility.

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

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

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

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

There are no expected changes to the eligibility and enrollment criteria during CYE 20 that would impact the populations to be covered under the ALTCS DES/DDD program.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE 20 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

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

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

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

Proposed differences among the CYE 20 capitation rates for the ALTCS DES/DDD Program are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the ALTCS DES/DDD Program.

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

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

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

The effective dates of changes to the ALTCS DES/DDD Program are consistent with the assumptions used to develop the CYE 20 capitation rates for the ALTCS DES/DDD Program.

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

The capitation rates were developed such that ALTCS DES/DDD would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 20.

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

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

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

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

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 20 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the revised CYE 20 capitation rates for the ALTCS DES/DDD Program.

I.1.A.ix. Rate Certification Procedures

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

This is a new rate certification that documents that the ALTCS DES/DDD Program capitation rates are changing effective October 1, 2019, and January 1, 2020.

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

Not applicable. This rate certification will change the ALTCS DES/DDD Program capitation rates effective October 1, 2019, and January 1, 2020.

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

This section of the 2020 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell, in accordance with 42 CFR § 438.7(c)(3), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

CMS requires a contract amendment be submitted whenever capitation rates change for any reason other than application of an approved payment term (e.g. risk adjustment methodology) which was included in the initial managed are contract. The state will submit a contract amendment to CMS to reflect the ALTCS DES/DDD Program capitation rates changing effective October 1, 2019, and January 1, 2020.

I.1.B. Appropriate Documentation

I.1.B.i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 20 capitation rates for the ALTCS DES/DDD Program.

I.1.B.ii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2020 Guide. Sections of the 2020 Guide that do not apply will be marked as “Not Applicable”; any section wherein all subsections are not applicable will be collapsed to the section heading.

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

The covered populations under the ALTCS DES/DDD Program receive the regular FMAP. The ALTCS DES/DDD Program is eligible to receive Children’s Health Insurance Program (CHIP) funding for TCM for those acute enrolled members who are TXXI. There have not been any CHIP members provided TCM services under the contract since 2015.

I.1.B.iv. Comparison of Rates

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

The 2020 Guide requests a comparison to the final certified rates in the previous rate certification. As the services covered by the program are changing effective October 1, 2019, the comparison for the regular DD cell is not an "apples to apples" comparison and should not be treated as such. Comparisons between the most recently certified CYE 19 ALTCS DES/DDD Program capitation rates effective January 1, 2019, and the CYE 20 capitation rates being certified in this actuarial rate certification are available in Appendix 3.

I.1.B.iv.(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.2. Data

This section provides documentation for the Data section of the 2020 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 Division of Health Care Management (DHCM) Actuarial Team and the State. The AHCCCS DHCM Actuarial Team worked with the appropriate teams at AHCCCS and ALTCS DES/DDD to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) at 81 FR 27858.

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

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

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

The types of data that AHCCCS relied upon for developing the CYE 20 capitation rates for the ALTCS DES/DDD program were:

- Adjudicated and approved encounter data submitted by ALTCS DES/DDD, ALTCS DES/DDD subcontractors, the CRS Contractor, and the RBHAs, provided from the AHCCCS PMMIS mainframe;
  - Incurred from October 1, 2015 through March 31, 2019;
  - Adjudicated and approved through April 15, 2019;
- Reinsurance payments made to ALTCS DES/DDD for services;
  - Incurred from October 1, 2015 through March 31, 2019;
- Historical and projected enrollment data for ALTCS DES/DDD members and TCM members, provided by ALTCS DES/DDD;
- Supplemental intermediate care facility (ICF), nursing facility (NF), and home and community based services (HCBS) expenses provided by the ALTCS DES/DDD program;
  - October 1, 2015 through September 30, 2016 (CYE 16 or FFY 16);
  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17);
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18);
- Quarterly and annual financial statements submitted by ALTCS DES/DDD, ALTCS DES/DDD subcontractors, the CRS Contractor, and the RBHAs, and reviewed by the AHCCCS DHCM Finance & Reinsurance Team;
  - October 1, 2015 through September 30, 2016 (CYE 16 or FFY 16);
  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17);

  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18);
  - October 1, 2018 through March 31, 2019 (YTD CYE 19 or YTD FFY 19);
- AHCCCS Fee-for-Service fee schedules developed and maintained by the AHCCCS DHCM Rates & Reimbursement Team;
- Public Notice of proposed fee schedule changes for CYE 20 posted by ALTCS DES/DDD;
- Data from AHCCCS DHCM Rates & Reimbursement team related to DAP, see Section 1.4.D;
- Data from AHCCCS financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a);
- Historical and projected targeted case management expenses provided by ALTCS DES/DDD;
  - Historical from October 1, 2015 through March 31, 2019;
  - Projected for CYE 20
- Historical and projected administrative and case management expenses from ALTCS DES/DDD, including supplemental information related to an expanded quality management unit within ALTCS DES/DDD;
  - Historical from October 1, 2015 through March 31, 2019;
  - Projected for CYE 20
- Projected administrative expenses from a competitive bid process for ALTCS DES/DDD integrated subcontractors for CYE 20.

Additional sources of data used or reviewed were:

- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the IMD analysis, incurred in CYE 18;
- Projected CYE 20 enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team;
- Integrated subcontractors' membership, including member choices effective October 1, 2019, as of July 31, 2019 for determining administrative expense thresholds related to the bids;
- Any additional data used and not identified here will be identified in their applicable sections below.

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

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

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

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

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

For LTSS provided in either an ICF or HCBS setting, ALTCS DES/DDD does not use sub-capitated arrangements. The program utilizes staff models for some of these LTSS services. The program has staff models for State Operated Group Homes (SOGH) and State Operated Intermediate Care Facilities (SOICF) throughout the State and also for those located at the Arizona Training Program at Coolidge (ATPC) campus. Encounters are submitted for the LTSS services provided in staff models, with health plan paid amounts of zero. These encounters go through all of the same processes described below in Section I.2.B.ii.(b) and are available to the actuaries through the AHCCCS PMMIS mainframe. The units

from the encounters are then matched up with the cost of those services reflected in the supplemental expense information provided by ALTCS DES/DDD for purposes of rate development.

Non-LTSS services have historically been subcontracted by the ALTCS DES/DDD Program to subcontracted acute health plans. These health plans submit encounters in the same manner as other health plans, under the ALTCS DES/DDD health plan ID with a Transmission Submitter Number (TSN) to identify the payer as one of the subcontracted health plans. These encounters go through all of the same processes described below in Section I.2.B.ii.(b) and are available to the actuaries through the AHCCCS PMMIS mainframe.

Effective October 1, 2019, LTSS services provided in a nursing facility will be the responsibility of the integrated subcontractors, along with CRS specialty care for ALTCS DES/DDD members with a CRS qualifying condition, and acute and behavioral services for all ALTCS DES/DDD members, as described in Section I.1.A.ii.(c)(i)(A).

The acute subcontractors, the CRS contractor, and the RBHAs (all of which bore responsibility for some portion of care provided to ALTCS DES/DDD members in the base data year, FFY 18, and prior data years, FFY 16 and FFY 17) also use sub-capitated arrangements with some providers which still require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05 and health plan paid of zero (i.e. sub-capitated)) encounters to estimate a health plan valued amount for these encounters. The repricing methodology used in the rate development process for the acute and CRS components differs from the methodology used for the behavioral health component. For the acute and CRS components, the repricing methodology uses the minimum of AHCCCS fee schedule, the health plan billed amount and the health plan allowed amount, less any third party insurance amounts to estimate a health plan valued amount. For the behavioral health component, sub-capitated costs are set as the health plan allowed amount less any third party insurance amounts. These different repricing methodologies have been tested and found to be the most appropriate for capturing accurate costs by the different Contractors (aligning to reported financial statements detailing sub-capitated expenditures). The units of service data from the sub-capitated encounters and the repriced amounts were used for the basis of calculating utilization and unit cost for all components, in conjunction with the regular encounters.

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

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

Guidelines and formats for submitting individual encounters generally follow health insurance industry standards used by commercial insurance companies and Medicare; however some requirements are specific to the AHCCCS program. All encounter submissions are subject to translation and validation using standards and custom business rules (guidelines). Once translation has occurred and the encounters pass validation, they are passed to the AHCCCS PMMIS mainframe and are subject to

approximately 500 claims type edits resulting in the approval, denial or pend of each encounter. This process occurs for both regular and sub-capitated encounters.

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

ALTCS DES/DDD, and all other AHCCCS Contractors, know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides ALTCS DES/DDD with the "Encounter Monthly Data File" (aka the "magic" file) which contains the previous 36 months of encounter data. ALTCS DES/DDD is responsible for providing the "magic" file to the integrated subcontractors. Data fields contained in this file include, but are not limited to, adjudication status, AHCCCS ID, Claim Reference Number (CRN), Provider ID and various cost amounts. The adjudication status has five types: adjudicated/approved, adjudicated/plan denied, adjudicated/AHCCCS denied, pended and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters, but providing this file to ALTCS DES/DDD and, by extension, their subcontractors allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions. No pended data was used to develop the capitation rates.

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

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

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

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

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

Through the DHCM Actuarial Team review of the encounter data provided from the AHCCCS PMMIS mainframe, the team ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 20 capitation rates for the ALTCS DES/DDD program. Additionally, the team ensured that only services covered under the state plan were included.

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

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

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

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon encounter data submitted by ALTCS DES/DDD, ALTCS DES/DDD acute subcontractors, the CRS Contractor, and the RBHAs and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by ALTCS DES/DDD, ALTCS DES/DDD acute subcontractors, the CRS Contractor, and the RBHAs and reviewed by the AHCCCS Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP and fee schedule impacts, on the Public Notice of proposed fee schedule changes for CYE 20 posted by ALTCS DES/DDD to its website, on data provided by the AHCCCS financial analysts with regards to some program changes, on information and data provided by Mercer consultants with regards to mental health parity and pharmacy reimbursement savings, on data provided by the integrated subcontractors with regards to administrative components, on analysis provided by an actuarial student under direct supervision of the actuary, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

The AHCCCS DHCM Actuarial Team has found the FFY 18 encounter data and supplemental cost data for state operated facilities, with adjustments for the issues identified in Section I.2.B.ii.(b)(i)(C) above, to be appropriate for the purposes of developing the appropriate components for the CYE 20 capitation rates for the ALTCS DES/DDD program. The development of the encounter issue adjustments are described below in Section I.2.B.iii.(c).

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

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

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

The AHCCCS DHCM Actuarial Team determined that the FFY 18 encounter data for LTSS, acute, CRS, and behavioral services with inclusion of supplemental cost data related to staff models for LTSS provided in state operated facilities were appropriate to use as the base data for developing the CYE 20 capitation rates for the ALTCS DES/DDD program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 20 capitation rates for the ALTCS DES/DDD program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 20 capitation rates for the ALTCS DES/DDD program.

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

Not applicable. The AHCCCS DHCM Actuarial Team did not rely on a data book to develop the CYE 20 capitation rates.

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

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

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

No credibility adjustment was necessary.

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

An adjustment was made to the encounter data to reflect the level of completion. AHCCCS calculated completion factors using the development method with monthly encounter data from October 1, 2015 through March 31, 2019. The monthly completion factors were applied to the encounter data on a monthly basis. The aggregated FFY 18 completion factors are shown in Table 1 below.

Table 1: Completion Factors

Rate Component	Before Completion	After Completion	Impact
LTSS	$2,889.19	$2,901.60	0.43%
Integrated Care Services (ICS)	$735.27	$793.05	7.86%
Total	$3,624.46	$3,694.66	1.94%

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

During the rate development process, it was determined that one of the ALTCS DES/DDD subcontractors incorrectly submitted encounters for ADA – Dental Services (form type D) during the base data year (FFY 18). Encounters were submitted with consistent utilization information, but inconsistent cost information from December 2017 through November 2018. To correct for this issue, the actuary derived a quarterly unit cost assumption by dividing the Dental services cost reported in the subcontractor's financial reporting for the errant period by the utilization information present in encounters during the same period. Encounter costs were then replaced by multiplying the utilization amount in each errant quarter by the replacement unit cost. The effect of this adjustment is given in Table 2a below.

Table 2a: Subcontractor Dental Encounter Issue

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,901.60	$2,901.60	0.00%
Integrated Care Services (ICS)	$793.05	$796.53	0.44%
Total	$3,694.66	$3,698.14	0.09%

An additional error was uncovered related to the Pharmacy encounters submitted by ALTCS DES/DDD for fee-for-service claims incurred for American Indian members; beginning April 2018, there are no encounters submitted for Pharmacy claims. Because of the relatively small population in this program, costs are highly sensitive to small changes in utilization. Prior to April 2018, it was observed that there was a substantial increase in Pharmacy costs for this program related to two high cost members, whose utilization pattern is presumed to continue for the duration of the base data year. To correct for this data issue, the actuary averaged the last two months of observable encounter data (to incorporate the high cost members), and applied this average to all missing months of the base data year. The impact of this change to the base data encounters is given in Table 2b below.

Table 2b: AIHP Missing Pharmacy Encounters

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,901.60	$2,901.60	0.00%
Integrated Care Services (ICS)	$796.53	$798.85	0.29%
Total	$3,698.14	$3,700.46	0.06%

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, 2017 through September 30, 2018) are described below. Some adjustments after September 30, 2018 are also included, and were considered in order to normalize data for review and development of trend. In particular, an adjustment for the minimum wage increase effective on January 1, 2019 along with a similar change from January 1, 2018 is included, as well as provider fee schedule changes that took effect October 1, 2018. All other program and fee schedule changes which occurred or are effective on or after October 1, 2018 are described in Section I.3.B.ii.(a).

Adjustments to the base data as required with respect to IMD in-lieu-of services are described in Section I.3.A.v.

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

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

Proposition 206 Reimbursement Rate Changes through 1/1/2019

Effective January 1, 2018 and January 1, 2019, AHCCCS increased fee schedule rates for select Home and Community-Based Services (HCBS) procedure codes, all Nursing Facility (NF) revenue codes, and all Alternative Living Facility (ALF) procedure codes, to address the increased labor costs resulting from minimum wage increases approved on November 8, 2016 by the state's voters under Proposition 206 and by city of Flagstaff voters under Proposition 414. This assures that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. Through continued discussion with ALTCS DES/DDD, AHCCCS knows the increased rates are similarly adopted by ALTCS DES/DDD.

The AHCCCS DHCM Rates & Reimbursement team used historical encounter data for relevant HCBS procedure codes, NF revenue codes, and ALF procedure codes to develop adjustments for the minimum wage increases. The magnitude of each adjustment varied by the percentage of services for which reimbursement rates were adjusted and the amount by which each service was adjusted. The PMPM impacts, as provided in Table 3a below, were incorporated into base data adjustment and trend development as appropriate.

Table 3a: Proposition 206 Reimbursement Rate Changes through 1/1/2019

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,901.60	$2,943.70	1.45%
Integrated Care Services (ICS)	$798.85	$798.85	0.00%
Total	$3,700.46	$3,742.55	1.14%

Combined Miscellaneous Base Data Adjustments

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

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

- **Behavioral Health Non-emergency Transportation to CBSP***
  Policy guidance effective July 1, 2018, clarified that non-emergency medical transportation (NEMT) may be provided for transporting an individual to community-based support programs (CBSP), in addition to registered providers. The policy specifies select qualifying CBSP, such as Alcoholics Anonymous and National Alliance on Mental Illness Family Support.
- **Out-of-Network Inpatient Behavioral Health Services***
  As part of the 2018 Legislative session, the Arizona Legislature passed HB 2659 which limits AHCCCS reimbursement of inpatient behavioral health services provided at a facility that does not contract with the member's Contractor to 90% of AHCCCS fee schedule rates, beginning July 1, 2018. Prior to the law's implementation, AHCCCS reimbursed these non-contracted services at 100% of fee schedule rates.
- **Provider Fee Schedule Changes**
  AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding their fee schedules. Additionally, effective July 1, 2018, ALTCS DES/DDD negotiated an aggregate 13.22% decrease to the provider reimbursement rates for one specific ICF.
- **Pharmacy Reimbursement Savings**
  Analysis of pharmacy claims for all AHCCCS managed care programs and AHCCCS Fee-for-Service (FFS) program has identified significant variability across all Contractors, and analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to the lesser of Health Plan Paid amounts or AHCCCS FFS repriced amounts would result in an annual savings of $68.2 million or 5.6% of pharmacy spend for FFY 18 across all programs. AHCCCS Contractors should reasonably be able to achieve pharmacy pricing that is at or near that achieved by the AHCCCS FFS program. However, AHCCCS recognizes that the full savings amount may not be reasonably achievable in a single year, and is therefore adjusting the base pharmacy data of each program by 33% of the savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing. Based on continued analysis, further adjustments may be made to phase-in larger savings amounts in subsequent contract periods.
- **Removal of Crisis Services from Base Data**
  Beginning October 1, 2019, ALTCS DES/DDD will cover most behavioral health services of members, in addition to Long Term Services and Supports (LTSS), acute care services, and CRS.

However, the RBHA program will continue to cover crisis intervention services provided to all members during the first 24 hours following a crisis event. This includes coverage of crisis hotlines, mobile crisis teams, and stabilization services. The actuary removed the cost of these services from the relevant base data encounters.

- **Removal of Access to Professional Services Initiative (APSI)**
  CYE 18 capitation rates for the CRS Contractor (services integrated into ALTCS DES/DDD effective October 1, 2018) funded Access to Professional Services Initiative (APSI) fee schedule increases for claim payments made from October 1, 2017 through September 30, 2018. The enhanced fee schedule was used to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. As these enhanced fee schedule payments expired September 30, 2018, AHCCCS removed the impact of CYE 18 APSI from the base period.
- **Removal of Differential Adjusted Payments from Base Data**
  CYE 18 capitation rates for the ALTCS DES/DDD program and the various other programs being integrated into the ALTCS DES/DDD program funded Differential Adjusted Payments (DAP) made from October 1, 2017 through September 30, 2018 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, 2018, AHCCCS has removed the impact of CYE 18 DAP from the base period.

  See Section I.4.D. for information on adjustments included in CYE 20 capitation rates for DAP that are effective from October 1, 2019 through September 30, 2020.

Table 3b: Combined Miscellaneous Base Data Adjustments

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,943.70	$2,939.60	-0.14%
Integrated Care Services (ICS)	$798.85	$794.42	-0.55%
Total	$3,742.55	$3,734.02	-0.23%

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

The AHCCCS DHCM Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 20 capitation rates.

Additionally, as part of the AHCCCS DHCM Actuarial Team's analysis of reinsurance costs, it was determined that there were high cost outlier reinsurance cases in the base data year that needed to be adjusted for both projected medical expense and reinsurance offset development to ensure the projections would more reasonably reflect expected future experience. Outliers were assessed by comparing member-specific reinsurable costs to relevant historical averages, defined by all of the specific member's costs from October 2015 to March 2019 for the same encounter form type and reinsurance case type (inpatient only, hemophilia diagnosis, Von Willebrand's diagnosis, Gaucher's diagnosis, and approved high cost biologic drugs). Member-specific costs that were more than two

standard deviations above the historical average were set equal to two standard deviations above the relevant historical average computed without the outlier. As most members with a reinsurance case in any given year do not generally have a reinsurance case in other years, this approach only modifies very high reinsurance payment amounts among members with sufficient historical experience to have narrow enough confidence bands to identify outliers. This change resulted in a reduction of costs included in the base encounter data, which was used as the basis of the reinsurance offset development described below in Section I.4.C.ii.(c)(iv). The impact of this change on the medical component of the capitation rate is given in Table 4 below.

Table 4: Outlier Reduction

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,939.60	$2,939.58	0.00%
Integrated Care Services (ICS)	$794.42	$776.48	-2.26%
Total	$3,734.02	$3,716.06	-0.48%

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2020 Guide.

I.3.A. Rate Development Standards

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

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

I.3.A.ii. Variations in Assumptions

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

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

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

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

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

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

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

Costs Associated with an Institution for Mental Disease stay

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

The data used to determine the base data adjustment was the CYE 18 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 18 encounter data, the AHCCCS

DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID and Provider Name. The list of IMDs was updated during the CYE 20 rate development in a collaborative effort between the health plans and the AHCCCS DHCM Actuarial Team. 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 $864.51 and was derived from the CYE 18 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 fee-for-service 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 fee-for-service fee schedule per diem rate. The costs associated with institutional stays at an IMD that were repriced in the base data are displayed below in Table 5a. Totals may not add up due to rounding.

Table 5a: IMD Repricing Impact

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,939.58	$2,939.58	0.00%
Integrated Care Services (ICS)	$776.48	$776.65	0.02%
Total	$3,716.06	$3,716.24	0.00%

The AHCCCS DHCM Actuarial Team identified all members age 21 to 64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed below in Table 5b. Totals may not add up due to rounding.

Table 5b: Removal of repriced stays longer than 15 cumulative days in a month

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,939.58	$2,939.58	0.00%
Integrated Care Services (ICS)	$776.65	$776.40	-0.03%
Total	$3,716.24	$3,715.99	-0.01%

Once a member was identified as having an IMD stay(s) greater than 15 cumulative days in a month, all encounter data for the member was pulled for the timeframe(s) they were in the IMD in order to remove those additional medical service costs from rate development. The associated costs removed from the base data are displayed below in Table 5c. Totals may not add up due to rounding.

Table 5c: Removal of Other Costs Associated with Problematic IMD Stays

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$2,939.58	$2,939.58	0.00%
Integrated Care Services (ICS)	$776.40	$776.37	0.00%
Total	$3,715.99	$3,715.95	0.00%

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

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

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

This section provides information on the projected benefit costs included in the CYE 20 capitation rates for the ALTCS DES/DDD Program.

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

The base data described in Section I.2.B.ii. was adjusted to reflect completion and all base data adjustments described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in I.3.A.v. The adjusted base data per-member-per-month (PMPM) expenditures were trended forward 24 months from the midpoint of the CYE 18 time period to the midpoint of the CYE 20 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below. Appendix 4 contains the base data and base data adjustments, Appendix 5 contains the projected benefit cost trends, and Appendix 6 contains the prospective programmatic and fee schedule changes. Additionally, Appendix 6 illustrates the capitation rate development, including DAP, reinsurance offset, administrative expense, underwriting (UW) gain, and premium tax.

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

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

Legislatively Funded Provider Fee Schedule Changes

In the 2019 legislative session, the legislature passed a general appropriations bill which outlined funding for ALTCS DES/DDD to implement provider fee schedule increases. The AHCCCS DHCM Rates & Reimbursement Team spread the legislative funding across HCBS and NF provider reimbursement rates, and the impacts have been included by category of service based on utilization of the specific services in the base year. ALTCS DES/DDD has indicated via a recent Public Notice that the funding will instead be targeted to specific rate codes to address member and provider concerns. The actuary is certifying to the overall impact of the legislative funding, not the spread by category of service, and ALTCS DES/DDD is aware of this limitation. The impact to the capitation rate is given in Table 6a below.

Table 6a: Legislatively Funded Provider Fee Schedule Changes

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,084.32	$3,305.56	7.17%
Integrated Care Services (ICS)	$823.43	$824.38	0.11%
Total	$3,907.75	$4,129.94	5.69%

Proposition 206 Reimbursement Rate Changes

Effective January 1, 2020, AHCCCS is increasing fee schedule rates for select Home and Community-Based Services (HCBS) procedure codes, all Nursing Facility (NF) revenue codes, and all Alternative Living Facility (ALF) procedure codes, to address the increased labor costs resulting from minimum wage increases approved on November 8, 2016 by the state's voters under Proposition 206 and by city of Flagstaff voters under Proposition 414. This assures that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. Through continued discussion with ALTCS DES/DDD, AHCCCS knows the increased rates are similarly adopted by ALTCS DES/DDD.

The data used by the AHCCCS DHCM Rates & Reimbursement team to develop an adjustment for the minimum wage increase was the CYE 18 encounter data for the HCBS procedure codes, NF revenue codes, and the ALF procedure codes. For HCBS, a 2.0% increase was applied to the encounter data to reflect a January 1, 2020 minimum wage adjustment. For NF and ALF, a 1.0% increase was applied to the encounter data to reflect a January 1, 2020 minimum wage adjustment. The PMPM impacts to Institutional and HCBS services, as provided in Table 6b, were incorporated into expense projections for the rating period.

Table 6b: Proposition 206 Reimbursement Rate Changes

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,305.56	$3,390.51	2.57%
Integrated Care Services (ICS)	$824.38	$824.50	0.01%
Total	$4,129.94	$4,215.01	2.06%

Adjustment for Unassigned Authorized Services

During the CYE 19 rating period, the AHCCCS DHCM Actuarial Team was made aware of an operational issue with the ALTCS DES/DDD program where a substantial quantity of LTSS services were being authorized by ALTCS DES/DDD case managers but were not being assigned to providers in a timely fashion, artificially suppressing utilization in the base period encounter data. While steps were taken to work through the unassigned services backlog during CYE 19, a key limiting factor has been identified to be the reimbursement rates paid by the program to providers, and the backlog remains an issue going into the CYE 20 rating period. Due to the legislative funding for provider rate increases described above, and the recent Public Notice detailing the proposed fee schedule changes posted by ALTCS DES/DDD on its website, it is expected that this processing backlog will be mitigated during the CYE 20 rating period by targeted fee schedule increases. The current backlog of authorized services is expected to be reduced

by 90% or more. Using the proposed ALTCS DES/DDD fee schedules and the information provided by ALTCS DES/DDD on the backlog including units per member by category of service, the actuary developed an estimate of increased costs associated with the backlog reduction. The approximate amount of the increase in utilization and thus LTSS expenditures for CYE 20 is shown below in Table 6c.

Table 6c: Correction for Unassigned Authorized Services

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,390.51	$3,440.80	1.48%
Integrated Care Services (ICS)	$824.50	$824.50	0.00%
Total	$4,215.01	$4,265.29	1.19%

Combined Miscellaneous Program Changes

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 rate cell capitation rate, that program change was deemed non-material for the purpose of the actuarial rate certification. The aggregated impacts of all non-material changes are shown below in Table 6d. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Substance Use Disorder Assessment***
  Effective October 1, 2018, AHCCCS updated provider fee schedules to include a targeted increase to providers who conduct a computer-guided, structured interview utilizing American Society of Addiction Medicine (ASAM) software. The service enables providers to determine the appropriate level of treatment based upon a set of medically accepted criteria.
- **Social Determinants of Health***
  The Targeted Investments Program has benchmarks for screening members for the presence of social determinants of health (SDOH). These benchmarks are expected to result in increased use of the covered screening services in CYE 19 and CYE 20.
- **SSI/SSDI Outreach, Access and Recovery (SOAR)***
  Effective October 1, 2018, AHCCCS began recognizing SOAR as a distinct reimbursable case management service. Through SOAR, providers assist individuals who are homeless or at risk of becoming homeless and who have a serious mental illness in applying for federal SSI/SSDI benefits.
- **Behavioral Health Services in Schools***
  The Arizona Legislature passed SB 1520 during the 2018 Legislative session which included an appropriation to fund increased behavioral health services in schools. The targeted services are in addition to any existing behavioral health services provided, including those provided to students with disabilities under the State's School Based Services program. HB 2747 passed during the 2019 Legislative session continues to fund behavioral health services in schools.
- **Universal Blood Lead Screening***
  Effective October 1, 2018, AHCCCS policy guidance required that all enrolled children receive blood lead screenings at 12 and 24 months of age, or at least once before the age of 6 years if a

child did not receive the scheduled screenings. With CMS approval, AHCCCS issued requirements in April 205 that only children residing in certain zip codes must receive scheduled blood screenings. The October 1, 2018 policy change effectively restored universal blood lead screens for all children, regardless of location of residence in the state.

- **Naturopathic Physicians Providing EPSDT***
  In CYE 19, AHCCCS began accepting applications for Doctors of Naturopathic Medicine (ND) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children under 21 years of age. The AHCCCS Office of Administrative and Legal Services (OALS) has interpreted federal and state laws to require the State to cover "medical care, or any other type of remedial care recognized under State law" provided by an ND as EPSDT services to "correct or ameliorate" any physical or mental conditions of the member. Use of services provided by NDs to members will largely replace existing use of services provided by other registered physician provider types. State law, however, places some limitations on the medications NDs may prescribe while many of the practitioners use pharmacological interventions sparingly. As a result, a number of ND office visits will require additional follow-up visits to a prescribing provider, which will increase use of services.
- **LISAC Mental Health Assessments**
  Effective November 1, 2018, AHCCCS included Licensed Independent Substance Abuse Counselors (LISAC) among qualifying providers that will be reimbursed for non-physician mental health assessments. The scope of practice for LISAC includes evaluation and treatment of substance abuse disorders, which can require use of mental health assessments. After unintendedly removing the permission for LISAC to bill for these services during the period from July 1, 2017 to October 31, 2018, the change restored that billing authority.
- **Prenatal Syphilis Screening***
  In September 2018, the Arizona Department of Health Services (ADHS) declared a syphilis outbreak for women and babies in Arizona. In response to the outbreak, AHCCCS issued a joint position statement with ADHS on February 28, 2019 to clarify that AHCCCS covers 3 prenatal syphilis screens during a member's pregnancy. The statement aligns with screening recommendations from the Centers for Disease Control and Prevention (CDC) that all pregnant women receive a screen during their first prenatal visit, and again early in the third trimester and at the time of delivery if they are at high risk of syphilis.
- **Bilateral Cochlear Implants***
  Effective March 1, 2019, AHCCCS revised policy to specify coverage of bilateral cochlear impacts for children 20 years of age or younger. The change recognizes the latest standard of care and a CMS decision memo regarding the appropriateness of bilateral cochlear implants. Prior to the change, policy specified coverage of unilateral cochlear implants for children.
- **Transportation Network Companies for NEMT***
  Beginning May 1, 2019, AHCCCS established a Transportation Network Company (TNC) provider type that delivers non-emergency medical transportation (NEMT) services through a ride-sharing model. The TNC-specific fee schedule is lower than ordinary NEMT base rates. The expansion of providers that can deliver NEMT services to members is also expected to reduce

missed medical appointments and thus increase medical utilization. The estimated cost reduction associated with lower priced NEMT services provided by TNCs exceeds the estimated cost increase of additional office visits and NEMT rides associated with additional office visits.

- **3D Mammography***

  Effective June 1, 2019, upon recommendation of the AHCCCS Quality Management Team, AHCCS began covering digital breast tomosynthesis (3D mammograms) for preventive screening and diagnosis of adults 21 years of age and older. The AHCCCS Quality Management Team made the recommendation in recognition of studies that find use of 3D mammograms in addition to or in place of 2D services has, at times, improved detection of breast cancer in some populations. Contractors are permitted to use prior authorization criteria in evaluating medical necessity of 3D services for members.

- **Pharmacy & Therapeutics Committee Decisions***

  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 19 that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 20. 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.

- **Advanced Practice Nurse MAT***

  The Federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) permits Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists to administer Buprenorphine for medication assisted treatment (MAT). The federal law is expected to increase use of MAT and costs to the program.

- **Telehealth for Rural and Urban Access to Care***

  Effective October 1, 2019, AHCCCS policy is revised to improve access to telehealth services. The revision to policy eliminates restrictions on service categories for which telehealth can be used, removes place of service requirements for the distant site provider, and clarifies that telehealth services may be used in urban and rural settings.

- **Rx Rebates Adjustment**

  An adjustment was made to the base data to reflect the impact of Rx Rebates because the base data does not include any adjustments for Rx Rebates reported within the Contractors' financial statements. The data that the AHCCCS DHCM Actuarial Team reviewed was the CYE 16, CYE 17, and CYE 18 annual financial statement reports and the CYE 19 Q1 and Q2 financial statement reports. From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment. Using the data mentioned, the actuary determined the percent of pharmacy costs represented by reported rebates for CYE 18, for each contractor, then applied those percentages to the corresponding CYE 18 Pharmacy (form type C) encounter data.

- **Behavioral Health Residential Facilities***
  Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team will establish a differentiated Fee For Service rate for Behavioral Health Residential Facilities (BHRF) that are licensed by ADHS to provide personal care services.
- **Provider Fee Schedule Changes***
  AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. In addition to the annual updates to provider fee schedules, effective January 1, 2020, the DRG adjustor for burns is increasing. Although it is not mandated through the health plan contracts, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding their fee schedules.

  The ALTCS DES/DDD contract has requirements that ALTCS DES/DDD reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. This contract requirement was effective April 1, 2015. The AHCCCS Fee-for-Service Fee Schedule Updates program change includes a fee schedule adjustment to bring the encounter base data from CYE 18 up to projected CYE 20 FQHC PPS rates.

Table 6d: Combined Miscellaneous Program Changes

Rate Component	Before Adjustment	After Adjustment	Impact
LTSS	$3,440.80	$3,440.66	0.00%
Integrated Care Services (ICS)	$824.50	$823.52	-0.12%
Total	$4,265.29	$4,264.18	-0.03%

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

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

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

ALTCS DES/DDD, its subcontractors, the CRS Contractor, and the RBHAs are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuary to set the CYE 20 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 1, 2015 through March 31, 2019 and adjudicated and approved through April 15, 2019, as well as supplemental cost data provided by ALTCS DES/DDD as described in Section I.2.B.ii.(a) for the staff model as noted in Section I.2.B.ii.(a)(iv).

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

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

The encounter and supplemental data was summarized by month and major category of service, and by utilization per 1000, unit costs, and PMPM values. The encounter data was adjusted for completion and the encounter data issues described in Section I.2.B.iii.(c). Additionally, the encounter data was adjusted to normalize for previous program and reimbursement changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 18 (April 1, 2018) to the midpoint of the rating period for CYE 20 (April 1, 2020). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. Projected benefit cost trends were based on actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. Each category of service was analyzed in the same manner.

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

All PMPM trend assumptions were compared to similar assumptions made in CYE 19 for ALTCS DES/DDD capitation rates and judged reasonable to assume for projection to CYE 20, considering the change in the base data time period as well as changes to covered services.

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

The 2020 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuary defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%.

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

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

The only outlier trend is for HCBS Attendant Care services, which has a PMPM trend above 7%. The utilization of the HCBS Attendant Care COS has been increasing steadily since October 2015. The assumed utilization trend of 7% was based upon actuarial judgement with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. Given the long-term consistency of the growth in the HCBS Attendant Care services COS over time, the actuary judged that the assumed utilization and unit cost trends for this COS are the most appropriate assumptions to reflect expected costs in CYE 20, and the resulting PMPM trend assumption is in line with the most recent twelve months of experience.

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

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

The projected benefit cost trends by major category of service for utilization per 1000, unit cost, and PMPM values are included in Appendix 5. The aggregate projected benefit cost trend impact for the two years of change for the ALTCS DES/DDD Program for utilization per 1000, unit cost and PMPM values are included below in Table 7.

Table 7: Changes in Price and Utilization

Rate Component	Utilization per 1000	Unit Cost	PMPM
LTSS	1.77%	3.10%	4.92%
Integrated Care Services (ICS)	1.37%	4.63%	6.06%
Total	1.68%	3.42%	5.16%

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

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

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

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

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

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

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

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

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

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

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

The AHCCCS DHCM Medical Management Team, the AHCCCS Office of Administrative Legal Services (OALS) Team, and the AHCCCS Office of the Director, in coordination with AHCCCS managed care contractors and Mercer consultants, have completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA. Updates to program analysis will be reviewed throughout the year for continued compliance.

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

The following types of services can be provided as in-lieu-of services per the ALTCS DES/DDD contract: services in alternative inpatient settings licensed by ADHS/DLS in lieu of services in an inpatient hospital (distinct and disparate from in-lieu-of-services provided in an IMD). These services are then included in the ALTCS DES/DDD Program's capitation rate development categories of service. Encounters which are in-lieu-of services are not identified separately in the data. Thus, the actuary cannot define the percentage of cost that in-lieu-of services represent in the capitation rates. However, the in-lieu-of services are treated exactly the same as all other State Plan approved services in rate development. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.3(e), and this is described above in Section I.3.A.v.

I.3.B.vi. Retrospective Eligibility Periods

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

AHCCCS provides prior period coverage for the period of time prior to the member's enrollment during which the member is eligible for covered services. Prior period coverage refers to the time frame from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with ALTCS DES/DDD. ALTCS DES/DDD receives notification from AHCCCS of the member's enrollment. ALTCS DES/DDD is responsible for payment of all claims for medically necessary services covered by ALTCS DES/DDD and provided to members during prior period coverage.

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

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

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

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

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

No specific adjustments are made to the CYE 20 capitation rates for the ALTCS DES/DDD Program for the prior period time frame, given that the encounter and enrollment data are already included within the base data used for rate development.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

All material and non-material changes have been included in the rate development process and all requirements in this section of the 2020 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangement Standards

Not applicable. There are no incentive arrangements in the CYE 20 capitation rates for the ALTCS DES/DDD program.

I.4.B. Withhold Arrangements

Not applicable. There are no withhold arrangements in the CYE 20 capitation rates for the ALTCS DES/DDD program.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2020 Guide provides information on the requirements for risk-sharing mechanisms.

I.4.C.ii. Appropriate Documentation

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

The CYE 20 capitation rates for the ALTCS DES/DDD Program will include a risk corridor for the regular DDD rate cell.

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

AHCCCS has a long-standing program policy of including risk corridors within many of the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 20 capitation rates are consistent with AHCCCS' long-standing program policy and will include a risk corridor for all regular DDD services under the ALTCS DES/DDD Program. This rate certification will use the term risk corridor to be consistent with the 2020 Guide. The DES/DDD Contract refers to the risk corridor as a reconciliation.

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

The risk corridor will reconcile ALTCS DES/DDD's medical cost expenses to the net capitation paid to ALTCS DES/DDD. Net capitation is equal to the capitation rates paid less the administrative component, the case management component, the health insurance provider fee (if applicable), and the premium tax plus any reinsurance payments. ALTCS DES/DDD's medical cost expenses are equal to the fully adjudicated encounters, sub-cap/block payment expenses, and staff model expenses for LTSS services as reported by ALTCS DES/DDD 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. The risk corridor will limit ALTCS DES/DDD profits to 6% and losses to 2%.

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

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

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

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

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

I.4.C.ii.(b) Remittance/Payment Requirements for Specified Medical Loss Ratio

Not applicable. The ALTCS DES/DDD Program contract does not include an MLR remittance or payment requirement.

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

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

AHCCCS provides a reinsurance program to ALTCS DES/DDD for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than ALTCS DES/DDD paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical. One could view the reinsurance offset as a premium. Historical encounter data which would trigger a reinsurance case based on the applicable reinsurance rules and service responsibility of ALTCS DES/DDD in CYE 20 is the basis of the reinsurance offset.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses ALTCS DES/DDD for covered services incurred above the deductible. The deductible is the responsibility of ALTCS DES/DDD. There has been no change to the deductible or coinsurance factors applicable to the regular reinsurance or catastrophic reinsurance program since the last rate setting period.

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

This component of the rate cell is updated to incorporate costs of integrating physical and behavioral health services for all DD members under the ALTCS DES/DDD Program responsibility.

For additional information, including all deductibles and coinsurance amounts, on the reinsurance program refer to the Reinsurance section of the ALTCS DES/DDD Program contract.

I.4.C.ii.(c)(ii) Effect on Development of Capitation Rates

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical PMPM calculated for the rate setting period. It is a separate calculation, and does not affect the methodologies for development of the gross medical capitation PMPM rate.

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

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

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

The capitation rates are adjusted by subtracting the reinsurance offset amounts from the gross medical expenses since ALTCS DES/DDD will receive payment from AHCCCS for reinsurance cases. The data used to develop the reinsurance offset amounts are historical encounters incurred during FFY 18. Encounter data were adjusted in line with the changes outlined in sections I.2.B.iii, I.3.B.ii, and I.3.B.iii. Additionally, these data were adjusted for a contractor reporting factor, representing the rate at which the contractor does not report reinsurance cases that would otherwise merit reimbursement. The contractor reporting factor was developed from historical reinsurance payments as compared to the aggregated encounters for individual members which would have triggered reinsurance payments in each contract year. The historical average for this discrepancy is approximately 99% of “eligible reinsurance cases based on encounters” become “actual reinsurance cases submitted by the contractor”. Costs from the adjusted and trended encounter data were then evaluated for each member individually, repricing the total, by reinsurance case type, to a “reinsurance case value”, using the deductibles and coinsurance percentages specific to each case type as outlined in the contract for CYE 20. The reinsurance offset was derived by taking the sum of the reinsurance case values and dividing by the CYE 20 projected member months.

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

I.4.D.i. Rate Development Standards

This section of the 2020 Guide provides information on delivery system and provider payment initiatives authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

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

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

Differential Adjusted Payments

The Differential Adjusted Payment (DAP) initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 28.5%, depending on the provider type.

Access to Professional Services Initiative

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

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

The APSI provides a uniform percentage increase of 85% to otherwise contracted rates for qualified practitioners–for all claims for which AHCCCS is the primary payer. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Pediatric Services Initiative

The Pediatric Services Initiative (PSI) seeks to provide enhanced support to ensure financial viability of the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. In 2014, as the Arizona legislature expanded coverage for adults, it authorized AHCCCS to make uncompensated care payments to the state's freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. CMS approved an extension of the Safety Net Care Pool (SNCP) for freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds, only, "in light of their critical role in Medicaid delivery and as a transition to reforming the current payment system." (CMS demonstration approval letter, Dec. 26, 2013) Independent evaluations of the SNCP confirmed the need for enhanced funding for freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds and recommended that

AHCCCS "consider additional policy changes to direct funding to Phoenix Children's Hospital (PCH) and the recipients it serves" should PCH continue to experience uncompensated costs. (Evaluation of Safety Net Care Pool Payments for Phoenix Children's Hospital, Navigant, March 29, 2018) The PSI is consistent with AHCCCS' and CMS' shared goals of ensuring financial support through payment rates rather than separate funding pools.

The PSI provides a uniform percentage increase of 36% to otherwise contracted rates for qualified practitioners. The rate increase is intended to supplement, not supplant, payments to eligible providers.

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

Differential Adjusted Payments are the only directed payments incorporated in the capitation rates.

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

Only the regular DDD rate cell is impacted. There is no impact to the Targeted Case Management rate cell. See Appendix 6 for the gross medical impact to the regular DDD rate cell. See Appendix 7 for the total impact including underwriting gain and premium tax.

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

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 4.0% increase), Critical Access Hospitals (eligible for up to 28.5% increase), other hospitals and inpatient facilities (eligible for up to 4.0% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral health outpatient clinics and integrated clinics (eligible for up to 7.0% increase on all services provided), physicians, physician assistants, registered nurse practitioners, dental providers (eligible for a 1.0% increase), home and community based services providers (eligible for a 1.0% increase on specified services at specified places of service) and Federally Qualified Health Centers (FQHCs) (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 18 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 20 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

The amount of medical payments for the DAP included in the CYE 20 capitation rates for the ALTCS DES/DDD Program are displayed below in Table 8. These projected medical payments do not include underwriting gain or premium tax. Totals may not add up due to rounding.

Table 8: DAP CYE 20

Rate Component	Non-FQHC Dollar Impact	FQHC Dollar Impact	Total Dollar Impact
LTSS	$5,613,149	$0	$5,613,149
Integrated Care Services (ICS)	$3,162,732	$22,626	$3,185,358
Total	$8,775,881	$22,626	$8,798,507

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

AHCCCS has submitted the Differential Adjusted Payments § 438.6(c) pre-prints to CMS, but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described in the preceding sections, is included in the capitation rates in a manner consistent with the pre-prints under CMS review.

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

The Access to Professional Services Initiative, and the Pediatric Services Initiative are not included in the ALTCS DES/DDD certified capitation rates and will be paid out via lump sum payments.

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $13.9 million. AHCCS will distribute the total payment via three quarterly lump sum payments to ALTCS DES/DDD, and a final lump sum payment after the completion of the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Pediatric Services Initiative

Anticipated payments including premium tax for PSI are approximately $17.6 million. AHCCS will distribute the total payment via three quarterly lump sum payments to ALTCS DES/DDD, and a final lump sum payment after the completion of the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

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

Access to Professional Services Initiative

The distribution methodology for the CYE 20 APSI payments will be based on members' utilization of services from APSI qualified providers. The 85 percent uniform percentage increase will be applied to eligible services performed by APSI qualified providers. Eligible services are those submitted on Form CMS-1500s and dental encounters, excluding any subcapitated/block purchase arrangements (identified by CN1 Code 05 on the encounter), and excluding services where AHCCCS is not the primary payer. The estimated amount for CYE 20 APSI was developed by applying the 85 percent uniform increase to CYE 18 utilization of eligible services based on encounters for the CYE 18 APSI qualified providers. The same definition of eligible services was applied for the estimated amount. The APSI qualified providers were identified by Billing Provider Tax IDs in AHCCCS encounter system. The encounter data used to distribute the final payment amounts will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells. The CYE 18 utilization is used as the basis for where to distribute the first three quarterly lump sum payments. The final quarterly lump sum payment will use CYE 20 encounter data for APSI qualified providers. The CYE 20 encounter data used to distribute the final lump sum payment amount will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 18, and thus distribution used to make the three initial quarterly lump sum payments.

Pediatric Service Initiative

The distribution methodology for the CYE 20 PSI will be based on members' utilization of inpatient and outpatient services at freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The 36 percent uniform percentage increase will be applied to eligible services performed by providers eligible for the Pediatric Service Initiative. Eligible services are those submitted on UB-04 Inpatient Hospital and UB-04 Outpatient Hospital. The estimated amount for CYE 20 PSI was developed by applying the 36 percent uniform increase to CYE 18 utilization of eligible services based on encounters for the providers eligible for the Pediatric Services Initiative. The same definition of eligible services was applied for the estimated amount. The providers were identified by Servicing Provider Tax IDs in AHCCCS encounter system. The encounter data used to distribute the final payment amounts will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells. The CYE 18 utilization is used as the basis for where to distribute the first three quarterly lump sum payments. The final quarterly lump sum payments will use CYE 20 encounter data for eligible providers. The CYE 20 encounter data used to distribute the final lump sum payment amount will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 18, and thus distribution used to make the three initial quarterly lump sum payments.

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

Appendix 7 contains estimated PMPMs including premium tax.

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

Access to Professional Services Initiative

AHCCCS has submitted the APSI § 438.6(c) pre-print to CMS, but has not yet received approval. The pre-print will be amended and re-submitted to CMS to include the definition of eligible services listed above in the distribution methodology. The payment arrangement is accounted for in a manner consistent with the amended pre-print.

Pediatric Services Initiative

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

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

I.4.E. Pass-Through Payments

Not applicable. There are no pass-through payments in the CYE 20 capitation rates for the ALTCS DES/DDD Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2020 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

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

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

The projected ALTCS case management expense PMPM within the regular DDD capitation rate was informed by ALTCS DES/DDD's funding request for CYE 20. The projected PMPMs are derived from a case management expense model utilized by the AHCCCS DHCM Actuarial Team incorporating membership projections from AHCCCS DBF Budget Team, and salary information for case managers, case manager supervisors, and support staff provided by ALTCS DES/DDD along with the contractual and legislative requirements for case management ratios. The CYE 20 projection fully funds the required case management ratios in the contract. The projected PMPM associated with case management expenses for CYE 20 is denoted as Case Management in Appendix 6.

The projected administrative expense PMPMs for LTSS were informed by ALTCS DES/DDD's funding request for CYE 20, actual expenses reported by ALTCS DES/DDD for FFY 17 and FFY 18, and inflation forecasts provided in the IHS Markit First Quarter 2019 Healthcare Cost Report. The base data used for the administrative expense projection for LTSS was ALTCS DES/DDD administrative expenses reported during FFY 18. The actuary applied an adjustment to the reported expenses to reflect additional staffing required for a reorganization of the quality management unit. After adjustment for the additional staffing, the actuary developed a fixed and variable assumption related to the administrative expenses reported over time, and adjusted the variable portion of the administrative expenses with respect to membership growth. The actuary then inflated wage-related expenses by the CPI-W from the IHS Markit Healthcare Cost Report to come up with a projected administrative expense amount for CYE 20. This projection was then compared to the CYE 20 funding request from ALTCS DES/DDD. The actuary's estimated projection of administrative expenses for CYE 20 was similar to the forecast provided by ALTCS DES/DDD for CYE 20. The actuary's CYE 20 projection of administrative expenses for LTSS is denoted as Administration for LTSS in Appendix 6.

The administrative expense PMPM for CYE 20 for the integrated subcontractors are awarded administrative bid amounts from a Request for Proposal (RFP) competitive bid process which ALTCS DES/DDD engaged in to subcontract the Integrated Care Services (ICS) portion of their overall medical services responsibilities. One of the requirements of the RFP was to submit administrative bid amounts based on membership thresholds for the integrated contract. The administrative expense PMPM associated with the integrated care component of the capitation rate is thus a blended PMPM based on the membership for each integrated subcontractor as of October 1, 2019, as defined by current membership enrollment as of July 31, 2019 with adjustments for member choice submitted as of July

31, 2019. The CYE 20 blended administrative expense projection for the integrated subcontractors is denoted as Administration for Integrated Care Services in Appendix 6.

The Targeted Case Management (TCM) capitation rate is updated in this certification and will be effective for the entire twelve-month time period from October 1, 2019 through September 30, 2020. Similar to ALTCS case management, TCM expenses were determined by incorporating case manager, case manager supervisor, and support staff salary information as well as supplemental staff model expenses provided by ALTCS DES/DDD. However, unlike the ALTCS case management costs, TCM used membership projections from ALTCS DES/DDD. The CYE 20 TCM projection fully funds the required case management ratios in the contract.

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

There were no other material changes not addressed elsewhere to the data, assumptions, or methodologies for projected non-benefit costs since the last rate certification.

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

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

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

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

The administrative component of the CYE 20 capitation rates for the ALTCS DES/DDD Program is described above in Section I.5.B.i.(a).

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

The CYE 20 capitation rates for the ALTCS DES/DDD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 20 capitation rate for the regular DDD rate cell includes a provision of 1% for underwriting gain. There is no provision for underwriting gain in the Targeted Case Management rate cell.

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

There are no other material or non-material non-benefit costs added to the non-benefit component for the certified capitation rates for the ALTCS DES/DDD Program.

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

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

The capitation rates for the ALTCS DES/DDD Program reflected in this rate certification do not incorporate the Health Insurance Providers Fee (HIPF). AHCCCS will follow previous capitation rate methodologies for the HIPF in which capitation rates are amended to reflect the calculated HIPF and related tax impacts, except in years for which there is a federally mandated moratorium on the fee and

no capitation rate adjustment happens. AHCCCS intends to submit a new actuarial certification due to this update, except in years where there is a moratorium and no capitation rate adjustment happens.

I.5.B.iii.(b) Data Year or Fee Year

Not applicable. The HIPF is not incorporated into the CYE 20 capitation rates for the ALTCS DES/DDD Program.

I.5.B.iii.(c) Description of how Fee was Determined

Not applicable. The HIPF is not incorporated into the CYE 20 capitation rates for the ALTCS DES/DDD Program.

I.5.B.iii.(d) Address if not in Rates

The capitation rates in this certification do not include the fee because the rates will be adjusted to account for the fee at a later date, except in years where there is a moratorium and no capitation rate adjustment happens. If there is no moratorium, a new certification will be submitted with the rate impacts to CMS once the fees are known.

The PMPM capitation adjustments will be developed based on the HIPF liability reported to AHCCCS. The Contractors are notified of the HIPF liability for the entire corporate entity by the Treasury Department. The Contractors who receive multiple streams of revenue applicable to the HIPF calculation will be responsible for allocating an appropriate portion of their HIPF liability to AHCCCS, which will be verified by the AHCCCS DHCM Actuarial Team for reasonableness and appropriateness. To determine if the reported revenue and the HIPF liability allocations to AHCCCS from the Contractors is reasonable and appropriate, the AHCCCS DHCM Actuarial Team will review for each Contractor the HIPF liability allocated to AHCCCS as a percentage of the total HIPF liability from the IRS, and the revenue allocated to AHCCCS as a percentage of the total revenue reported to the IRS. Additionally, the AHCCCS DHCM Actuarial Team will compare the revenue allocated to each AHCCCS program from each Contractor against paid capitation data and determine if the revenue allocated by Contractor to each AHCCCS program is reasonable and appropriate.

As in previous years, the PMPM adjustments will be developed based on each corporate entity's actual member months within each applicable rate cell. The HIPF adjustment to the capitation rates is expected to be calculated late in the fee year.

I.5.B.iii.(e) Summary of Benefits Under 26 CFR §57.2(h)(2)(ix)

The per member per month cost included in the CYE 20 capitation rates for the ALTCS DES/DDD Program attributable to long-term care, nursing home care, home health care, or community-based care are located in Tables 9a and 9b below.

Table 9a: Effective October 1, 2019 to December 31, 2019

Setting	Gross Medical	Underwriting Gain	Premium Tax
HCBS	$3,250.43	$32.50	$67.00
NF	$118.75	$1.19	$2.45
Total	$3,369.19	$33.69	$69.45

Table 9b: Effective January 1, 2020 to September 30, 2020

Setting	Gross Medical	Underwriting Gain	Premium Tax
HCBS	$3,335.15	$33.35	$68.74
NF	$118.99	$1.19	$2.45
Total	$3,454.14	$34.54	$71.20

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

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

I.6. Risk Adjustment and Acuity Adjustments

This section of the 2020 Guide is not applicable to the ALTCS DES/DDD Program. The certified capitation rates paid to the ALTCS DES/DDD Program capitation rates are not risk or acuity adjusted.

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

Section II of the 2020 Guide is applicable to the ALTCS DES/DDD Program because the CYE 20 capitation rates for ALTCS DES/DDD are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 at 81 FR 27858 and the ALTCS DES/DDD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. CMS Expectations

The rate development standards and appropriate documentation described in Section I of the 2020 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 2020 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. A member's individual long-term care setting does not determine the capitation paid for that member.

II.1.C. Appropriate Documentation

II.1.C.i. Considerations

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

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

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

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

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

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

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

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

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

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

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

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

II.1.C.iii. Additional Information

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

Section III New Adult Group Capitation Rates

Section III of the 2020 Guide is not applicable to the ALTCS DES/DDD Program.

Appendix 1: Actuarial Certification

I, Erica Johnson, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and an Associate of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 20 capitation rates for the ALTCS DES/DDD Program have been documented according to the guidelines established by CMS in the 2020 Guide. The CYE 20 capitation rates for the ALTCS DES/DDD Program are effective for the three month time period from October 1, 2019 through December 31, 2019, and the nine month period from January 1, 2020 through September 30, 2020.

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

SIGNATURE ON FILE	August 16, 2019
Erica Johnson	Date

Associate, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

DDD Capitation Rates Effective October 1, 2019 through December 31, 2019	
Regular DDD	$4,752.63
Targeted Case Management	$172.92

DDD Capitation Rates Effective January 1, 2020 through September 30, 2020	
Regular DDD	$4,840.31
Targeted Case Management	$172.92

Appendix 3: Comparisons and Fiscal Impact Summary

DDD Capitation Rates Effective October 1, 2019 through December 31, 2019						
Rate Cell	Rate Effective 1/1/2019	Rate Effective 10/1/2019	% Change		CYE 20 Projected MMs	CYE 20 Projected Expenses
ALTCS DDD	$4,194.32	$4,752.63	13.31%		102,637	$487,795,700
TCM	$154.28	$172.92	12.08%		15,127	$2,615,851

DDD Capitation Rates Effective January 1, 2020 through September 30, 2020						
Rate Cell	Rate Effective 10/1/2019	Rate Effective 1/1/2020	% Change		CYE 20 Projected MMs	CYE 20 Projected Expenses
ALTCS DDD	$4,752.63	$4,840.31	1.84%		313,828	$1,519,026,128
TCM	$172.92	$172.92	0.00%		45,336	$7,839,726

DDD Capitation Rates CYE 20 Weighted Average						
Rate Cell	Rate Effective 1/1/2019	CYE 20 Average Rate	% Change		CYE 20 Projected MMs	CYE 20 Projected Expenses
ALTCS DDD	$4,194.32	$4,818.70	14.89%		416,465	$2,006,821,828
TCM	$154.28	$172.92	12.08%		60,463	$10,455,577

Appendix 4: Base Data and Base Data Adjustments

Category of Service	Base PMPM	Completion	Completed Base PMPM	Subcontractor Form D Issue	AIHP Form C Issue	Adjusted PMPM	Prop 206 Normalization	Comb. Misc. Adjustment	Outlier Removal	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
ATPC_ICF	$37.23	100.00%	$37.23	0.00%	0.00%	$37.23	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$37.23
ATPC_SOGH	$13.14	100.00%	$13.14	0.00%	0.00%	$13.14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$13.14
Attendant Care	$307.46	99.58%	$308.74	0.00%	0.00%	$308.74	1.74%	0.00%	0.00%	0.00%	0.00%	0.00%	$314.11
Day Treatment	$340.63	99.59%	$342.03	0.00%	0.00%	$342.03	1.73%	0.00%	0.00%	0.00%	0.00%	0.00%	$347.96
Employment	$83.67	99.59%	$84.01	0.00%	0.00%	$84.01	1.74%	0.00%	0.00%	0.00%	0.00%	0.00%	$85.47
Hab - Per 15 Min	$332.69	99.59%	$334.06	0.00%	0.00%	$334.06	1.74%	0.00%	0.00%	0.00%	0.00%	0.00%	$339.86
Hab - Per Diem	$1,048.73	99.59%	$1,053.05	0.00%	0.00%	$1,053.05	1.74%	0.00%	0.00%	0.00%	0.00%	0.00%	$1,071.41
InstEnc_ICF	$37.81	97.96%	$38.60	0.00%	0.00%	$38.60	0.00%	-10.23%	0.00%	0.00%	0.00%	0.00%	$34.65
InstEnc_SNF[1]	$13.85	98.10%	$14.12	0.00%	0.00%	$14.12	0.88%	-1.07%	0.00%	0.00%	0.00%	0.00%	$14.09
Misc	$16.19	99.62%	$16.25	0.00%	0.00%	$16.25	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	$16.25
Nursing	$142.30	99.59%	$142.88	0.00%	0.00%	$142.88	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$142.88
Respite	$285.78	99.60%	$286.92	0.00%	0.00%	$286.92	1.76%	0.00%	0.00%	0.00%	0.00%	0.00%	$291.98
SelfCare Home Management	$5.99	99.59%	$6.01	0.00%	0.00%	$6.01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$6.01
SO_ICF	$14.03	100.00%	$14.03	0.00%	0.00%	$14.03	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$14.03
SOGH	$12.54	100.00%	$12.54	0.00%	0.00%	$12.54	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$12.54
Therapies and Evaluations	$145.69	99.59%	$146.28	0.00%	0.00%	$146.28	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$146.28
Transportation	$51.48	99.59%	$51.70	0.00%	0.00%	$51.70	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	$51.69
Integrated Care Services (ICS)	$735.27	92.71%	$793.05	0.44%	0.29%	$798.85	0.00%	-0.55%	-2.26%	0.02%	-0.03%	0.00%	$776.37
Gross Medical	**$3,624.46**		**$3,694.66**			**$3,700.46**							**$3,715.95**

1) Costs for Skilled Nursing Facilities will become the responsibility of the subcontractors beginning 10/1/2019.

Appendix 5: Projected Benefit Cost Trends

Statewide				
Rate Cell	Trend COS	Utilization Per 1000	Unit Cost	PMPM
DES/DDD	ATPC_ICF	-1.00%	1.60%	0.58%
DES/DDD	ATPC_SOGH	-1.00%	3.20%	2.17%
DES/DDD	Attendant Care	7.00%	0.40%	7.43%
DES/DDD	Day Treatment	0.00%	0.80%	0.80%
DES/DDD	Employment	-1.00%	3.00%	1.97%
DES/DDD	Hab - Per 15 Min	0.80%	0.90%	1.71%
DES/DDD	Hab - Per Diem	0.00%	3.00%	3.00%
DES/DDD	InstEnc_ICF	1.00%	0.00%	1.00%
DES/DDD	InstEnc_SNF*	0.20%	1.20%	1.40%
DES/DDD	Misc	-1.00%	-0.50%	-1.50%
DES/DDD	Nursing	0.50%	0.30%	0.80%
DES/DDD	Respite	0.30%	0.60%	0.90%
DES/DDD	SelfCare Home Management	-1.00%	1.20%	0.19%
DES/DDD	SO_ICF	-1.00%	1.10%	0.09%
DES/DDD	SOGH	0.10%	0.10%	0.20%
DES/DDD	Therapies and Evaluations	0.10%	0.20%	0.30%
DES/DDD	Transportation	0.10%	0.10%	0.20%
DES/DDD	Integrated Care Services (ICS)	0.68%	2.29%	2.99%

* These trends were developed in combination with subcontractor Form Types I, L, and O experience, as costs for Skilled Nursing Facilities will become the responsibility of the subcontractors beginning 10/1/2019.

Appendix 6: CYE 20 Capitation Rate Development

Category of Service	Adjusted Base PMPM	Trend	Provider Fee Schedule Changes	Unassigned Authorized Services	Combined Miscellaneous Changes	Gross Medical (10/1/19 - 12/31/19)	Proposition 206 Reimb. Change	Gross Medical (1/1/20 - 9/30/20)
ATPC_ICF	$37.23	0.58%	0.00%	0.00%	0.00%	$37.67	0.00%	$37.67
ATPC_SOGH	$13.14	2.17%	0.00%	0.00%	0.00%	$13.71	0.00%	$13.71
Attendant Care	$314.11	7.43%	7.04%	0.59%	0.00%	$390.32	2.62%	$400.53
Day Treatment	$347.96	0.80%	7.47%	0.70%	0.00%	$382.61	2.62%	$392.62
Employment	$85.47	1.97%	7.39%	1.00%	0.00%	$96.39	2.62%	$98.92
Hab - Per 15 Min	$339.86	1.71%	7.40%	2.10%	0.00%	$385.52	2.62%	$395.61
Hab - Per Diem	$1,071.41	3.00%	7.32%	1.38%	0.00%	$1,236.71	2.62%	$1,269.07
InstEnc_ICF	$34.65	1.00%	0.00%	0.00%	0.00%	$35.35	0.00%	$35.35
InstEnc_SNF	$14.09	1.40%	20.62%	0.00%	0.00%	$17.48	1.33%	$17.71
Misc	$16.25	-1.50%	7.64%	1.34%	0.00%	$17.20	2.62%	$17.65
Nursing	$142.88	0.80%	7.47%	3.81%	0.00%	$161.96	2.62%	$166.20
Respite	$291.98	0.90%	7.46%	1.34%	0.00%	$323.74	2.62%	$332.21
SelfCare Home Mgmt	$6.01	0.19%	7.51%	0.00%	0.00%	$6.49	2.62%	$6.66
SO_ICF	$14.03	0.09%	0.00%	0.00%	0.00%	$14.05	0.00%	$14.05
SOGH	$12.54	0.20%	7.51%	0.00%	0.00%	$13.54	2.62%	$13.89
Therapies and Evaluations	$146.28	0.30%	7.50%	5.43%	0.00%	$166.79	2.62%	$171.15
Transportation	$51.69	0.20%	7.51%	0.95%	-0.25%	$56.19	2.62%	$57.66
Integrated Care Services (ICS)	$776.37	2.99%	0.11%	0.00%	-0.12%	$823.40	0.01%	$823.52
Gross Medical	**$3,715.95**					**$4,179.11**		**$4,264.18**

Differential Adjusted Payments (DAP)	
Non-FQHC	$21.07
FQHC	$0.05
Total DAP	**$21.13**

Total DAP	**$21.13**	**$21.13**
Total Gross Medical PMPM	**$4,200.23**	**$4,285.31**
Reinsurance Offset	**-$55.35**	**-$55.35**
Total Net Medical PMPM	**$4,144.89**	**$4,229.96**

Non-benefit Expenses	PMPM	PMPM
Case Management	$188.70	$188.70
Administration for LTSS	$230.38	$230.38
Administration for Integrated Care Services	$53.73	$53.73
Total Medical with Admin and CM	$4,617.69	$4,702.76
Share of Cost	-$4.00	-$4.00
UW Gain	$43.89	$44.74
Pre-tax Capitation PMPM	$4,657.58	$4,743.50
Premium Tax	$95.05	$96.81
Capitation PMPM	**$4,752.63**	**$4,840.31**

Appendix 7: Delivery System and Provider Payment Initiatives

CYE 20 Estimated PMPM				
Directed Payment	**Medical**	**Underwriting Gain**	**Premium Tax**	**Total**
DAP FQHC	$21.07	$0.21	$0.43	$21.72
DAP Non-FQHC	$0.05	$0.00	$0.00	$0.06
APSI	$32.68	$0.00	$0.67	$33.35
PSI	$41.34	$0.00	$0.84	$42.18