



**Contract Year Ending 2022  
Arizona Long Term Care System  
Department of Economic Security/  
Division of Developmental Disabilities  
Capitation Rate Certification**

**October 1, 2021 through  
September 30, 2022**

**Prepared for:  
The Centers for Medicare & Medicaid  
Services**

**Prepared by:  
AHCCCS Division of Health Care  
Management**

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## Table of Contents

Introduction and Limitations .....	1
Section I Medicaid Managed Care Rates .....	2
I.1. General Information .....	4
I.1.A. Rate Development Standards.....	4
I.1.A.i. Standards and Documentation for Rate Ranges .....	4
I.1.A.ii. Rating Period.....	4
I.1.A.iii. Required Elements.....	4
I.1.A.iii.(a) Letter from Certifying Actuary.....	4
I.1.A.iii.(b) Final and Certified Capitation Rates .....	4
I.1.A.iii.(c) Program Information .....	4
I.1.A.iii.(c)(i) Summary of Program.....	5
I.1.A.iii.(c)(i)(A) Type and Number of Managed Care Plans .....	5
I.1.A.iii.(c)(i)(B) General Description of Benefits.....	5
I.1.A.iii.(c)(i)(C) Area of State Covered and Length of Time Program in Operation.....	6
I.1.A.iii.(c)(ii) Rating Period Covered.....	6
I.1.A.iii.(c)(iii) Covered Populations.....	6
I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria Impacts.....	6
I.1.A.iii.(c)(v) Summary of Special Contract Provisions Related to Payment .....	7
I.1.A.iii.(c)(vi) Retroactive Capitation Rate Adjustments – Not Applicable.....	8
I.1.A.iv. Rate Development Standards and Federal Financial Participation (FFP) .....	8
I.1.A.v. Rate Cell Cross-Subsidization.....	8
I.1.A.vi. Effective Dates of Changes .....	8
I.1.A.vii. Minimum Medical Loss Ratio.....	8
I.1.A.viii. Conditions for Certifying Capitation Rate Range – Not Applicable.....	8
I.1.A.ix. Certifying Actuarially Sound Capitation Rate Range – Not Applicable .....	8
I.1.A.x. Generally Accepted Actuarial Principles and Practices.....	8
I.1.A.x.(a) Reasonable, Appropriate, and Attainable Costs.....	8
I.1.A.x.(b) Rate Setting Process .....	8
I.1.A.x.(c) Contracted Rates .....	8
I.1.A.xi. Rates from Previous Rating Periods – Not Applicable .....	9

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

I.2.B.ii.(a) Description of Data.....	13
I.2.B.ii.(a)(i) Types of Data Used.....	13
I.2.B.ii.(a)(ii) Age of Data .....	14
I.2.B.ii.(a)(iii) Sources of Data.....	15
I.2.B.ii.(a)(iv) Sub-capitated Arrangements.....	15
I.2.B.ii.(b) Availability and Quality of the Data.....	16
I.2.B.ii.(b)(i) Data Validation Steps .....	16
I.2.B.ii.(b)(i)(A) Completeness of the Data .....	16
I.2.B.ii.(b)(i)(B) Accuracy of the Data .....	16
I.2.B.ii.(b)(i)(C) Consistency of the Data .....	17
I.2.B.ii.(b)(ii) Actuary’s Assessment of the Data.....	17
I.2.B.ii.(b)(iii) Data Concerns .....	18
I.2.B.ii.(c) Appropriate Data for Rate Development.....	18
I.2.B.ii.(c)(i) Not Using Encounter or Fee-for-Service Data – Not Applicable.....	18
I.2.B.ii.(c)(ii) Not Using Managed Care Encounter Data – Not Applicable .....	18
I.2.B.ii.(d) Use of a Data Book – Not Applicable.....	18
I.2.B.iii. Adjustments to the Data .....	18
I.2.B.iii.(a) Credibility of the Data – Not Applicable .....	18
I.2.B.iii.(b) Completion Factors .....	18
I.2.B.iii.(c) Errors Found in the Data.....	19
I.2.B.iii.(d) Changes in the Program .....	19
I.2.B.iii.(e) Exclusions of Payments or Services .....	22
I.3. Projected Benefit Costs and Trends.....	23
I.3.A. Rate Development Standards.....	23
I.3.A.i. Compliance with 42 CFR § 438.3(c)(1)(ii) and § 438.3(e) .....	23
I.3.A.ii. Projected Benefit Cost Trend Assumptions .....	23
I.3.A.iii. In-Lieu-Of Services .....	23
I.3.A.iv. Institution for Mental Disease .....	23
I.3.B. Appropriate Documentation.....	24
I.3.B.i. Projected Benefit Costs.....	24
I.3.B.ii. Projected Benefit Cost Development .....	25

I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies.....	25
I.3.B.ii.(b) Material Changes to the Data, Assumptions, and Methodologies .....	35
I.3.B.ii.(c) Recoveries of Overpayments to Providers .....	36
I.3.B.iii. Projected Benefit Cost Trends .....	36
I.3.B.iii.(a) Requirements .....	36
I.3.B.iii.(a)(i) Projected Benefit Cost Trends Data .....	36
I.3.B.iii.(a)(ii) Projected Benefit Cost Trends Methodologies .....	36
I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons .....	36
I.3.B.iii.(a)(iv) Supporting Documentation for Trends.....	37
I.3.B.iii.(b) Projected Benefit Cost Trends by Component .....	37
I.3.B.iii.(b)(i) Changes in Price and Utilization .....	37
I.3.B.iii.(b)(ii) Alternative Methods – Not Applicable.....	37
I.3.B.iii.(b)(iii) Other Components – Not Applicable .....	38
I.3.B.iii.(c) Variation in Trend .....	38
I.3.B.iii.(d) Any Other Material Adjustments .....	38
I.3.B.iii.(e) Any Other Adjustments .....	38
I.3.B.iv. Mental Health Parity and Addiction Equity Act Compliance .....	38
I.3.B.v. In-Lieu-Of Services .....	38
I.3.B.vi. Retrospective Eligibility Periods.....	38
I.3.B.vi.(a) Managed Care Plan Responsibility .....	38
I.3.B.vi.(b) Claims Data Included in Base Data .....	38
I.3.B.vi.(c) Enrollment Data Included in Base Data .....	38
I.3.B.vi.(d) Adjustments, Assumptions, and Methodology .....	39
I.3.B.vii. Impact of All Material Changes to Covered Benefits or Services.....	39
I.3.B.vii.(a) Covered Benefits.....	39
I.3.B.vii.(b) Recoveries of Overpayments.....	39
I.3.B.vii.(c) Provider Payment Requirements.....	39
I.3.B.vii.(d) Applicable Waivers .....	39
I.3.B.vii.(e) Applicable Litigation .....	39
I.3.B.viii. Impact of All Material and Non-Material Changes .....	39
I.4. Special Contract Provisions Related to Payment.....	40

I.4.A. Incentive Arrangement Standards.....	40
I.4.A.i. Rate Development Standards.....	40
I.4.A.ii. Appropriate Documentation.....	40
I.4.A.ii.(a) Description of Any Incentive Arrangements .....	40
I.4.A.ii.(a)(i) Time Period .....	40
I.4.A.ii.(a)(ii) Enrollees, Services, and Providers Covered .....	40
I.4.A.ii.(a)(iii) Purpose.....	40
I.4.A.ii.(a)(iv) Attestation to Limit on Incentive Payments.....	40
I.4.A.ii.(a)(v) Effect on Capitation Rate Development.....	40
I.4.B. Withhold Arrangements – Not Applicable.....	40
I.4.C. Risk-Sharing Mechanisms .....	40
I.4.C.i. Rate Development Standards .....	40
I.4.C.ii. Appropriate Documentation.....	41
I.4.C.ii.(a) Description of Risk-Sharing Mechanisms.....	41
I.4.C.ii.(a)(i) Rationale for Risk-Sharing Mechanisms .....	41
I.4.C.ii.(a)(ii) Description of Risk-Sharing Mechanism Implementation.....	41
I.4.C.ii.(a)(iii) Effect of Risk-Sharing Mechanisms on Capitation Rates.....	42
I.4.C.ii.(a)(iv) Risk-Sharing Mechanisms Documentation.....	42
I.4.C.ii.(b) Remittance/Payment Requirements for Specified Medical Loss Ratio – Not Applicable .....	42
I.4.C.ii.(c) Reinsurance Requirements.....	42
I.4.C.ii.(c)(i) Description of Reinsurance Requirements.....	42
I.4.C.ii.(c)(ii) Effect on Development of Capitation Rates .....	43
I.4.C.ii.(c)(iii) Development in Accordance with Generally Accepted Actuarial Principles and Practices...	43
I.4.C.ii.(c)(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset.....	43
I.4.D. State Directed Payments .....	43
I.4.D.i. Rate Development Standards.....	43
I.4.D.ii. Appropriate Documentation .....	44
I.4.D.ii.(a) Description of State Directed Payments .....	44
I.4.D.ii.(a)(i) Type and Description of Directed Payment Arrangements .....	44
I.4.D.ii.(a)(ii) Directed Payments Incorporated in Capitation Rates .....	45
I.4.D.ii.(a)(ii)(A) Rate Cells Affected .....	45

I.4.D.ii.(a)(ii)(B) Impact on the Rate Cells Affected .....	45
I.4.D.ii.(a)(ii)(C) Data, Assumptions, Methodology to Develop Directed Payment Adjustment.....	45
I.4.D.ii.(a)(ii)(D) Pre-print Acknowledgement .....	46
I.4.D.ii.(a)(ii)(E) Maximum Fee Schedule – Not Applicable .....	46
I.4.D.ii.(a)(iii) Directed Payments Under Separate Payment Arrangement .....	46
I.4.D.ii.(a)(iii)(A) Aggregate Amount .....	46
I.4.D.ii.(a)(iii)(B) Actuarial Certification of the Amount of the Separate Payment Term.....	46
I.4.D.ii.(a)(iii)(C) Estimated Impact by Rate Cell .....	47
I.4.D.ii.(a)(iii)(D) Pre-print Acknowledgement .....	47
I.4.D.ii.(a)(iii)(E) Future Documentation Requirements.....	47
I.4.D.ii.(b) Confirmation of No Other Directed Payments.....	48
I.4.D.ii.(c) Confirmation Regarding Required Reimbursement Rates .....	48
I.4.E. Pass-Through Payments – Not Applicable .....	48
I.5. Projected Non-Benefit Costs.....	49
I.5.A. Rate Development Standards.....	49
I.5.B. Appropriate Documentation.....	49
I.5.B.i. Description of the Development of Projected Non-Benefit Costs.....	49
I.5.B.i.(a) Data, Assumptions, Methodology .....	49
I.5.B.i.(b) Changes Since the Previous Rate Certification.....	50
I.5.B.i.(c) Any Other Material Changes.....	50
I.5.B.ii. Projected Non-Benefit Costs by Category.....	50
I.5.B.ii.(a) Administrative Costs.....	50
I.5.B.ii.(b) Taxes and Other Fees .....	50
I.5.B.ii.(c) Contribution to Reserves, Risk Margin, and Cost of Capital .....	50
I.5.B.ii.(d) Other Material Non-Benefit Costs.....	50
I.5.B.iii. Historical Non-Benefit Costs .....	51
I.6. Risk Adjustment and Acuity Adjustments – Not Applicable .....	52
Section II Medicaid Managed Care Rates with Long-Term Services and Supports .....	53
II.1. Managed Long-Term Services and Supports .....	53
II.1.A. CMS Expectations .....	53
II.1.B. Rate Development Standards .....	53

II.1.B.i. Rate Cell Structure .....	53
II.1.B.i.(a) Blended Capitation Rate .....	53
II.1.B.i.(b) Non-Blended Capitation Rate – Not Applicable .....	53
II.1.C. Appropriate Documentation.....	53
II.1.C.i. Considerations .....	53
II.1.C.i.(a) Rate Cell Structure .....	53
II.1.C.i.(b) Data, Assumptions, Methodologies .....	53
II.1.C.i.(c) Other Payment Structures, Incentives, or Disincentives .....	53
II.1.C.i.(d) Effect of MLTSS on Utilization and Unit Cost .....	53
II.1.C.i.(e) Effect of MLTSS on Setting of Care .....	54
II.1.C.ii. Projected Non-benefit Costs .....	54
II.1.C.iii. Additional Information.....	54
Section III New Adult Group Capitation Rates – Not Applicable .....	55
Appendix 1: Actuarial Certification .....	56
Appendix 2: Certified Capitation Rates.....	59
Appendix 3: Comparisons and Fiscal Impact Summary .....	61
Appendix 4: Base Data and Base Data Adjustments.....	63
Appendix 5: Projected Benefit Cost Trends .....	65
Appendix 6: CYE 22 Capitation Rate Development.....	67
Appendix 7: State Directed Payments .....	69
Appendix 7a: CMS Prescribed Tables.....	70
Appendix 7b: State Directed Payments Estimated PMPMs.....	74



## Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the October 1, 2021 through September 30, 2022 (Contract Year Ending 2022 (CYE 22), or alternatively, Federal Fiscal Year 2022 (FFY 22)) actuarially sound capitation rates for the Arizona 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) effective January 1, 2022, this certification will cover two sets of capitation rates. One set will apply for the time frame from October 1, 2021 through December 31, 2021 and another set will apply from January 1, 2022 through September 30, 2022. 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 AHCCCS website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2021-2022 Medicaid Managed Care Rate Development Guide (2022 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2022 Guide describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2022 Guide to help facilitate the review of this rate certification by CMS.

## Section I Medicaid Managed Care Rates

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

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

- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
- § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

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

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

As stated on pages 2 and 3 of the 2022 Guide, CMS will also use these three principles in applying the regulation standards:

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

## **I.1. General Information**

This section provides documentation for the General Information section of the 2022 Guide.

### **I.1.A. Rate Development Standards**

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

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

#### **I.1.A.ii. Rating Period**

The CYE 22 capitation rates for the ALTCS DES/DDD Program are effective for the 12-month time period from October 1, 2021 through September 30, 2022, with one set of capitation rates being effective for the 3-month time period from October 1, 2021 through December 31, 2021 and the second set of capitation rates being effective for the 9-month time period from January 1, 2022 through September 30, 2022.

#### **I.1.A.iii. Required Elements**

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

The actuarial certification letter for the CYE 22 capitation rates for the 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, 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 22 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.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the 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). 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 and the 2022 Guide.

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

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

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

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

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

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

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

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

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

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

### **I.1.A.iii.(c)(i)(C) 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.iii.(c)(ii) Rating Period Covered**

The CYE 22 capitation rates for the ALTCS DES/DDD Program are effective for the 3-month time period from October 1, 2021 through December 31, 2021 and the 9-month time period from January 1, 2022 through September 30, 2022.

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

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

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

The first rate cell (regular DDD capitation rate) includes the costs of providing covered long-term care, acute care, CRS specialty care for members with a CRS qualifying condition, and behavioral health services for all DD members.

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

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

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

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

There are three types of DDD eligibility:

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

Due to the above referenced Court Opinion, ALTCS DES/DDD estimates that 25% of previously ineligible applicants would be deemed eligible for DDD State Only, Targeted Case Management, or ALTCS based on the new eligibility criteria. The capitation rate development assumes that there will be no difference in the projected costs on average for members deemed eligible under the revised eligibility criteria from those deemed eligible under the previous eligibility criteria.

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

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

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6. The special contract provisions related to payment included in the CYE 22 capitation rates are:

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

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



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

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

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

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

### **I.1.A.v. 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.vi. 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 22 capitation rates for the ALTCS DES/DDD Program.

### **I.1.A.vii. 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 22.

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

Not applicable. The actuary is not certifying capitation rate ranges.

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

Not applicable. The actuary is not certifying capitation rate ranges.

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

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

In the 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.x.(b) Rate Setting Process**

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 22 capitation rates certified in this report represent the contracted rates by rate cell.



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

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

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

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

### **I.1.A.xiii. Rate Certification Procedures**

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

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

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

This is a new rate certification that documents that the ALTCS DES/DDD Program capitation rates are changing effective October 1, 2021 and January 1, 2022.

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

Not applicable. This rate certification will change the ALTCS DES/DDD Program capitation rates effective October 1, 2021 and January 1, 2022.

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

This section of the 2022 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell for certified rates per rate cell, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.7(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

CMS requires a contract amendment be submitted whenever capitation rates change for any reason other than application of an approved payment term (e.g., risk adjustment methodology) which was included in the initial managed care contract. The state will submit a contract amendment to CMS to reflect the ALTCS DES/DDD Program capitation rates changing effective October 1, 2021 and January 1, 2022.

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

CMS requires a contract amendment and capitation rate amendment in the event that any State Medicaid program feature is invalidated by a court of law, or a change in federal statute, regulation, or

approval. The rate amendment adjusting the capitation rates must remove costs specific to any program or activity no longer authorized by law, taking into account the effective date of the loss of program authority.

## **I.1.B. Appropriate Documentation**

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

The actuary is certifying capitation rates for each rate cell.

### **I.1.B.ii. Elements**

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

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

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

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

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

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

### **I.1.B.v. Rate Certification Index**

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2022 Guide. Sections of the 2022 Guide that do not apply will be marked as “Not Applicable”; any section wherein all subsections are not applicable will be collapsed to the section heading.

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

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

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

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

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

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

The 2022 Guide requests a comparison to the final certified rates in the previous rate certification. Comparisons between the most recently certified CYE 21 ALTCS DES/DDD Program capitation rates effective January 1, 2021 and the CYE 22 capitation rates being certified in this actuarial rate certification are available in Appendix 3.

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

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

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

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

### **I.1.B.ix. Future Rate Amendments**

The list of possible amendments which would impact capitation rates in the future are shown in Table 1 below, along with the potential submission date, and the reason why the current certification cannot account for the changes anticipated to be made to the rates.

Table 1: Possible Future Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
American Rescue Plan Act (ARPA) proposals	February 2022	AHCCCS has submitted ARPA proposals to CMS for review and approval. AHCCCS also needs approval from the Arizona State Legislature for implementation of any approved ARPA items.

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

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

The AHCCCS DHCM Actuarial Team has read and discussed numerous articles (Health Affairs, Health Watch, KFF, Harvard, Science Alert, CMS FAQs, JAMA, etc.), attended several webinars discussing various aspects of the impacts of COVID-19 (enrollment mix changes, deferred versus foregone care, pandemic progression timelines, hospital utilization patterns, etc.), and monitored national trends and information such as unemployment reports published by the Bureau of Labor Statistics, emerging

COVID-19 case rates, and projections of vaccine utilization. The AHCCCS DHCM Actuarial Team continues to monitor national legislation and federal guidance on the public health emergency (PHE) end date and plans to analyze changes in acuity of members due to maintenance of effort eligibility requirements in the FFCRA.

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

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

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

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

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

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

## **I.2. Data**

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

### **I.2.A. Rate Development Standards**

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

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

### **I.2.B. Appropriate Documentation**

#### **I.2.B.i. Data Request**

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

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

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

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

The types of data that AHCCCS relied upon for developing the CYE 22 capitation rates for the ALTCS DES/DDD Program were:

- Adjudicated and approved encounter data submitted by ALTCS DES/DDD, ALTCS DES/DDD subcontractors, the CRS Contractor, and the RBHAs and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2016 through early March 2021
  - Adjudicated and approved through the first encounter cycle in March 2021
- Reinsurance payments made to ALTCS DES/DDD for services
  - Incurred from October 2016 through May 2021 paid through May 2021
- Historical and projected enrollment data for ALTCS DES/DDD members and Targeted Case Management members, provided by ALTCS DES/DDD
- Supplemental intermediate care facility (ICF), nursing facility (NF), and home and community based services (HCBS) expenses provided by the ALTCS DES/DDD Program
  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17)
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
  - October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19)
  - October 1, 2019 through September 30, 2020 (CYE 20 or FFY 20)

- Quarterly and annual financial statements submitted by ALTCS DES/DDD, prior acute subcontractors, the prior CRS subcontractor, the RBHAs, and the integrated subcontractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17)
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
  - October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19)
  - October 1, 2019 through September 30, 2020 (CYE 20 or FFY 20)
  - October 1, 2020 through March 31, 2021 (year-to-date (YTD) CYE 21 or YTD FFY 21);
- AHCCCS FFS fee schedules developed and maintained by the AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement team related to DAP, see Section I.4.D;
- Data from AHCCCS DHCM financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)
- Historical and projected Targeted Case Management expenses provided by ALTCS DES/DDD
  - Historical from October 1, 2016 through March 31, 2021
  - Projected for CYE 22
- Historical and projected administrative and case management expenses from ALTCS DES/DDD, including supplemental information related to salary increases for a subset of staff within ALTCS DES/DDD
  - Historical from October 1, 2016 through March 31, 2021
  - Projected for CYE 22
- Projected administrative expenses from a competitive bid process for ALTCS DES/DDD integrated subcontractors for CYE 22.

Additional sources of data used or reviewed were:

- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in Calendar Year 2019 (CalYr19)
- Historical and projected enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
  - Projections for CYE 22
  - Historical enrollment from mid CYE 21 and earlier
- Integrated subcontractors' membership for determining administrative expense thresholds related to the bids
- Any additional data used and not identified here will be identified in their applicable sections below

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

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

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

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

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

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

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

The previous acute subcontractors, the CRS subcontractor, the RBHAs, and the integrated subcontractors (all of which bore responsibility for some portion of care provided to ALTCS DES/DDD members in the base data year, CalYr19, and prior data years) 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, CRS, and integrated care components differs from the methodology used for the behavioral health components from the RBHAs. For the acute, CRS, and integrated care 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 from the RBHAs, 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 DHCM Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a per member per month (PMPM) basis looking for anomalous patterns in encounter, unit, or cost totals, such as incurred months where totals are unusually low or high. If any anomalies are found, the AHCCCS DHCM Actuarial Team reports the findings to the AHCCCS Office of Data Analytics (ODA) Team, which then works with the health plan to determine causal factors. In addition, the AHCCCS ODA Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

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

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

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

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

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

AHCCCS has an additional encounter process which ensures that each adjudicated and approved encounter contains a valid AHCCCS member ID for an individual who was enrolled on the date that the service was provided. The process also checks to ensure that each adjudicated and approved encounter



is for a covered service under the state plan and contains the codes necessary to map it into one of the categories of service used in the rate development process.

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

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

The AHCCCS DHCM Actuarial Team reviewed encounter data from all relevant Contractors providing services to ALTCS DES/DDD members over the October 1, 2016 through March 31, 2021 time frame, along with supplemental cost data from ALTCS DES/DDD for state operated facilities, for consistency by viewing month over month, and year over year changes. The AHCCCS DHCM Actuarial Team also compared the aggregated encounter and supplemental cost data to financial statements for all relevant Contractors. This and subsequent reviews led to adjustments to the encounter data for the subcontractors due to some encounter submission issues and an encounter extract error. These adjustments are described below in Section I.2.B.iii.(c). After adjustments, the data was judged to be consistent across data sources.

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

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon encounter data submitted by ALTCS DES/DDD, ALTCS DES/DDD acute subcontractors, the prior CRS subcontractor, and the RBHAs and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by ALTCS DES/DDD, ALTCS DES/DDD prior acute subcontractors, the prior CRS subcontractor, the RBHAs, and the integrated subcontractors and reviewed by the AHCCCS Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regard to DAP and fee schedule impacts, on the Public Notice of proposed fee schedule changes for CYE 22 posted by ALTCS DES/DDD to its website, on data provided by the AHCCCS DHCM financial analysts with regard to some program changes, on information and data provided by Mercer consultants with regard to pharmacy reimbursement savings, on information and data provided by Milliman consultants with regard to the HEALTHII program, on data provided by the integrated subcontractors with regard to administrative components, on analysis provided by an actuarial student under direct supervision of the actuary, and on data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

The AHCCCS DHCM Actuarial Team has found the CalYr19 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 22 capitation

rates for the ALTCS DES/DDD Program. The development of the encounter issue adjustments are described below in Section I.2.B.iii.(c).

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

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

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

The AHCCCS DHCM Actuarial Team determined that the CalYr19 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 22 capitation rates for the ALTCS DES/DDD Program.

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

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

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

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

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

Not applicable. The AHCCCS DHCM Actuarial Team did not rely on a data book to develop the CYE 22 capitation rates.

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

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

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

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

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

An adjustment was made to the encounter data to reflect the level of completion. AHCCCS calculated completion factors using the development method with monthly encounter data from October 2016 through early March 2021. The monthly completion factors were applied to the encounter data on a monthly basis. The aggregated CalYr19 completion factor impacts are shown in Table 2 below.

Table 2: Completion Factor Impacts

Rate Component	Before Completion	After Completion	Impact
LTSS	\$3,035.68	\$3,036.28	0.02%
Integrated Care Services	\$812.29	\$822.26	1.23%
Total	\$3,847.97	\$3,858.54	0.27%

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

During the rate development process, it was determined that there were some dental and pharmacy encounters that had incorrect amounts or dates. Smoothing was applied to correct for date errors, and replacement with corrected costs for the amount errors. Additionally, an issue with the data extract for pharmacy data was discovered during a later review, and an adjustment to revert to a prior correct data extract was applied. These adjustments account for a decrease of about 0.37% to the overall data used for capitation rate development.

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

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

If a base data adjustment change had an impact of 0.2% or less for the regular DDD rate cell (base data adjustments do not impact the Targeted Case Management rate cell), that adjustment was deemed non-material and has been grouped in the combined miscellaneous base data adjustment subset below along with a brief description of each adjustment. Some of the impacts for base data adjustment changes described below (indicated by an asterisk \*) were developed by AHCCCS DHCM financial analysts with oversight from the AHCCCS DHCM Clinical Quality Management (CQM) Team and the Office of the Director's Chief Medical Officer. As noted above in Section I.2.B.ii.(b)(ii), the actuary relied upon the professional judgment of the AHCCCS DHCM financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuary met with the AHCCCS DHCM financial analysts to understand at a high level how the estimated amounts were derived and the data used for the amounts. The actuary was unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

#### ***Provider Fee Schedule Changes***

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

included by category of service based on utilization of the specific services in the base year. The impact of both the legislatively mandated provider fee schedule increases and the annual AHCCCS fee schedule updates through December 31, 2019 is given in Table 3a below.

Table 3a: Provider Fee Schedule Changes

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$106.50	\$48,354,075
Integrated Care Services	\$0.93	\$421,627
Total	\$107.42	\$48,775,703

**Pharmacy Reimbursement Savings**

Analysis of pharmacy claims for all AHCCCS managed care programs and the AHCCCS FFS program identified significant variability across all Contractors, and analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to AHCCCS FFS repriced amounts would result in an annual savings of \$71.5 million or 4.8% of pharmacy spend for CalYr19 across all programs. In past years, AHCCCS recognized that the full savings amount identified in similar analyses may not be reasonably achievable in a single year. As a result, the base pharmacy data of each program was adjusted by 33% in CYE 20 and 66% in CYE 21 of the amount identified in the original CYE 18 analysis as savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing. Based on the updated analysis of CalYr19 which only considers savings based on AHCCCS FFS pricing and does not include savings base on a lesser of calculation, for CYE 22, AHCCCS is adjusting the base pharmacy data of each program by 90% of the savings identified in the analysis of CalYr19 pharmacy data for valuing claims data to AHCCCS FFS prices. The impact of this change is shown in Table 3b below.

Table 3b: Pharmacy Reimbursement Savings

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$0.00	\$0
Integrated Care Services	(\$12.69)	(\$5,760,614)
Total	(\$12.69)	(\$5,760,614)

**Combined Miscellaneous Base Data Adjustments**

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

- Substance Use Disorder Assessment \***

Effective October 1, 2018, AHCCCS updated provider fee schedules to include a targeted increase to providers who conduct a computer-guided, structured interview utilizing American

Society of Addiction Medicine (ASAM) software. The service enables providers to determine the appropriate level of treatment based upon a set of medically accepted criteria. Slower-than-anticipated adoption of the ASAM software caused by compatibility issues with provider electronic health record (EHR) systems limited use of ASAM in the base period. To raise adoption of the software during CYE 22, AHCCCS is providing a differential adjusted payment for providers that submit a letter of intent to complete integration of ASAM with their EHR system. For CYE 22 rate development, additional impacts for the fee schedule change and incentivized adoption of ASAM are included above any base period encounters.

- **Pharmacy & Therapeutics Committee Decisions – Base Year \***

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy and drug coverage changes during CalYr19 that impacted utilization and unit costs of Contractors' pharmacy costs in the base period. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness, and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

- **Transportation Network Companies for NEMT \***

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

- **3D Mammography \***

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

- **Behavioral Health Residential Facilities Personal Care Differential \***

Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team established a differentiated FFS rate for Behavioral Health Residential Facilities that are licensed by ADHS to provide personal care services.

- **Pay and Chase Guidance \***

Federal regulation 42 CFR 433.139, Payment of Claims, requires agencies and their Contractors to pay and chase claims for preventive pediatric care services, including EPSDT services, regardless of the existence of third-party liability at the time the claim is filed. Preventive pediatric care refers to screening and diagnostic services to identify congenital, physical, mental health routine examinations performed in the absence of complaints and screening or treatment designed to avert various infectious and communicable diseases from occurring in children under 21 years of age. As a result of questions to AHCCCS regarding coordination of benefits for members with Autism Spectrum Disorder, the agency provided additional clarification to Contractors in CalYr19 on preventive services that must be reimbursed on a pay

and chase basis. This clarification is anticipated to increase costs of Contractors in situations in which they are unable to successfully recover funding from liable third parties.

- **Removal of Crisis Services from Base Data**

Effective October 1, 2019, ALTCS DES/DDD began covering most behavioral health services of members, in addition to LTSS, acute care services, and CRS services. However, the RBHA Program continues to cover crisis intervention services provided to all members during the first 24 hours following a crisis event. This includes coverage of crisis hotlines, mobile crisis teams, and stabilization services. The actuary removed the cost of these services from the relevant base data encounters.

- **Removal of Access to Professional Services Initiative**

CYE 19 capitation rates for the prior CRS subcontractor (services integrated into ALTCS DES/DDD effective October 1, 2018) funded APSI fee schedule increases for claim payments made from October 1, 2018 through September 30, 2019. The enhanced fee schedule was used to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. As these enhanced fee schedule payments expired September 30, 2019, AHCCCS removed the impact of CYE 19 APSI from the base period CalYr19.

- **Removal of Differential Adjusted Payments from Base Data**

CYE 19 and CYE 20 capitation rates for the ALTCS DES/DDD Program and the various other programs integrated into the ALTCS DES/DDD Program funded DAP made from October 1, 2018 through September 30, 2019 and from October 1, 2019 through September 30, 2020 to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health, and reduce cost of care growth. As these payments expired September 30, 2019 and September 30, 2020, AHCCCS has removed the impact of DAP from the base period CalYr19.

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

Table 3c: Combined Miscellaneous Base Data Adjustments

Rate Component	PMPM Impact	Dollar Impact
LTSS	(\$4.01)	(\$1,822,674)
Integrated Care Services	(\$1.16)	(\$526,452)
Total	(\$5.17)	(\$2,349,126)

### 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 22 capitation rates.

## I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2022 Guide.

### I.3.A. Rate Development Standards

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

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

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

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

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

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

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

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

##### ***Costs Associated with an Institution for Mental Disease stay***

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

The data used to determine the base data adjustment was the CYE 19 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 19 encounter data, the AHCCCS DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the Non-IMD price-per-day. The Non-IMD price-per-day used in the analysis was \$890.14 and was derived from the CalYr19 encounter data for similar IMD services that occurred within a Non-IMD setting. The encounter data was



used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a Non-IMD setting which may not be fully captured within the AHCCCS FFS fee schedule per diem rate. The costs associated with institutional stays at an IMD that were repriced in the base data are displayed below in Table 4a. Totals may not add up due to rounding.

Table 4a: IMD Repricing Impact

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$0.00	\$0
Integrated Care Services	\$1.35	\$614,267
Total	\$1.35	\$614,267

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

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

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$0.00	\$0
Integrated Care Services	(\$2.26)	(\$1,026,587)
Total	(\$2.26)	(\$1,026,587)

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

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

Rate Component	PMPM Impact	Dollar Impact
LTSS	(\$0.04)	(\$20,139)
Integrated Care Services	(\$0.38)	(\$174,264)
Total	(\$0.43)	(\$194,404)

### 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 22 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.iv. The adjusted base data PMPM expenditures were trended forward 33 months from the midpoint of the CalYr19 time period to the midpoint of the CYE 22 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below.

The CYE 22 capitation rates also include an offset to account for ALTCS DES/DDD members' projected SOC in CYE 22. Each member's SOC is determined based on their monthly income less certain allowable deductions based on the member's placement in either an Institutional or HCBS setting; the personal allowances for HCBS placements tend to exceed member income, so it is rare for SOC to be nonzero in these circumstances. Contrarily, personal allowance for members in Institutional settings is limited to 15% of the Federal Benefits Rate, so members in these settings often have a positive SOC amount. The SOC offset was developed based on base period (CalYr19) ALTCS DES/DDD member share of cost data. The share of cost data was evaluated for trend over the period from October 1, 2016 through December 31, 2019, but the effect was not statistically different from zero, so no trend was applied. The SOC offset ensures that capitation rates only reflect ALTCS DES/DDD's responsibility for costs, and not those of its members.

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, SOC offset, administrative expense, underwriting (UW) gain, and premium tax.

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

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

Following national and state emergency declarations in March 2020, AHCCCS has sought authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. As of this writing, Appendix K authorities are projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end, while other select 1115 waiver changes are approved from March 1, 2020 until 60 days after the end of the federal emergency declaration. For CYE 21 rate development, the actuaries have incorporated projected impacts of these authorities and other AHCCCS responses to the COVID-19 outbreak for portions of the contract period, these are indicated by a † symbol.

### ***AHCCCS FFS Fee Schedule Updates***

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

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

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 22 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DHCM Rates & Reimbursement Team used both the CYE 19 and CYE 20 encounter data to develop the impacts of the fee schedule changes at October 1, 2020 and October 1, 2021. The October 1, 2020 fee schedule changes also incorporated increased base reimbursement rates for services reimbursed under the dental fee schedule and physician fee schedule, not including the physician drug fee schedule, to restore provider rates to those in existence prior to reductions implemented in state fiscal year 2009, per Arizona State HB 2668 (Laws 2020, Chapter 46). The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for each time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the cumulative impacts to CalYr19 by program.

For the duration of the COVID-19 PHE, CMS expanded the range of Medicare codes that may be billed for services provided by a resident without the direct supervision of a primary care physician, using the GE modifier. AHCCCS has aligned with CMS by expanding the set of codes for which resident-provided services can be billed using the GE modifier. The AHCCCS DHCM Actuarial Team applied the impacts by

program as part of the fee schedule changes as the change is non-material for each program and rate cell when considered alone.

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

In the 2021 legislative session, the legislature passed a general appropriations bill which included funding for the ALTCS DES/DDD Program to implement provider fee schedule increases for HCBS and NF services. The AHCCCS DHCM Actuarial Team adjusted CYE 22 capitation rates to reflect the level of additional appropriated funding for the ALTCS DES/DDD Program. AHCCCS' expectation is that the funded rate increases will be adopted by the ALTCS DES/DDD. The changes are expected to increase statewide costs under the ALTCS DES/DDD Program by \$113.1M, or \$249.02 PMPM.

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

“Rebasing calculations included updated base rates (both standardized amounts and wage indices), relative weights, and change of policy adjusters. Outlier identification and payment methodology has not changed nor has any other underlying claim pricing calculation (notwithstanding the above noted changes to factors, indices, and statewide standardized base rate).”

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

AHCCCS also increases some fee schedule rates effective January 1 of each year to recognize the annual minimum wage increase resulting from the passing of Proposition 206. The increased costs for the 2020 and 2021 minimum wage changes are included here; the impacts of the 2022 minimum wage change are shown separately below. The overall impact of the AHCCCS FFS fee schedule updates is illustrated below in Table 5a. Totals may not add up due to rounding.

Table 5a: Provider Fee Schedule Changes

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$379.61	\$172,359,550
Integrated Care Services	\$56.16	\$25,498,539
Total	\$435.77	\$197,858,089

**COVID-19 LTSS Utilization Mix Adjustment †**

The COVID-19 PHE has had a large impact on the mix of services being utilized by members in the ALTCS DES/DDD Program. During the COVID-19 PHE, LTSS utilization has shifted from less expensive services like day programs (and associated transportation costs) to more cost-intensive services like attendant care and habilitation services. The CYE 22 capitation rate development recognizes that this COVID-19 PHE service mix should revert closer to the mix of services observed pre-pandemic over the course of the rating period, and that the base data time frame does not include this utilization mix change. To account for this difference, an analyst on the AHCCCS DHCM Actuarial Team, under the supervision of the actuary, examined COVID-19 PHE data trended to the expected end of the COVID-19 PHE, and the base period data trended to the end of the rating period. The analyst developed a linear interpolation to derive values between the expected end of the COVID-19 PHE and the end of the CYE 22 rating period, tapering each category of service impacted back towards the base period amounts after trend. To develop a projection for the additional expected costs over the rating period, the analyst compared this estimated total for the rating period to a counterfactual estimate for the rating period where no COVID-19 service mix shift had occurred. The overall impact is illustrated below in Table 5b. Totals may not add up due to rounding.

Table 5b: COVID-19 LTSS Utilization Mix Adjustment

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$184.37	\$83,710,210
Integrated Care Services	\$0.00	\$0
Total	\$184.37	\$83,710,210

**Applied Behavior Analysis**

Consistent with the Medical Policy update on November 1, 2019 stipulating coverage of Applied Behavior Analysis (ABA) services, AHCCCS has been working with ALTCS DES/DDD to phase out an earlier version of the service (called ‘ECM’ by ALTCS DES/DDD) that no longer complies with the guidance and create a new service, delivered through the ALTCS DES/DDD’s subcontractors. As part of the phase out, new authorizations for the earlier service ceased effective October 1, 2020, while authorizations for that service still in place at that time have been allowed to expire naturally. Utilization for the new ABA service increased throughout CYE 20 and into CYE 21, while utilization for the ECM service has diminished and is expected to end completely by September 30, 2021.

To estimate the impact in the contract period, the AHCCCS DHCM Actuarial Team reviewed utilization and unit cost data for the ECM service, as well as the new ABA service. The team reviewed data on a per-member basis and generated an “active case” count for each service type. For ECM, “active cases”

were defined as continuous use of the service by an individual member until either a gap of two months or greater or 12 months from the earliest use date; this definition is an artifact of ALTCS DES/DDD’s case management authorization process, whereby members are assigned ECM services for a limited duration of time, usually up to 12 months. For the new ABA service, “active cases” were defined as continuous use of the service until a gap of two months or greater. The “active case” definitions produced counts of active cases in each month during the data review period (October 1, 2016 to December 31, 2019), which gave the team an understanding of how many new cases arrive in each month and how many attrition out in each month. Using this information, the team developed a forecast of active cases through the end of the contract period, keeping in mind the freeze on new cases for the ECM service beginning October 1, 2020. Active cases for ECM are expected to diminish to zero by September 30, 2021, while cases for the new ABA services will gradually increase from about 120 at the end of CalYr2019 to over 600 at the end of FFY2021, and then stabilize. The team then used ordinary least squares regression to estimate the total utilization based on the active case count. The team determined that the results of the regression were reasonable, strongly predictive, and consistent with the assumptions for linear models. Total cost was determined by multiplying the utilization forecast by the average unit price for these services in the CalYr2019 base data year, and applying growth factors for completion, normalization, trend, and relevant program changes. The net impact of the ECM phase-out and ABA phase-in is displayed below in Table 5c. Totals may not add up due to rounding.

**Table 5c: Applied Behavior Analysis Transition**

Rate Component	PMPM Impact	Dollar Impact
LTSS	(\$39.18)	(\$17,790,516)
Integrated Care Services	\$81.68	\$37,084,137
Total	\$42.49	\$19,293,621

***Reimbursement for HCBS Delivered by Parents \* ‡***

CMS approved AHCCCS’ requested 1115 Waiver Appendix K authority to reimburse parents or legally responsible individuals for HCBS provided to a child under the age of 18 years. The authority is projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end. To estimate the impact, the AHCCCS DHCM financial analysts reviewed encounters for the period March 1, 2020 to December 31, 2020. The analysts projected that monthly service use from October 1, 2021 to March 31, 2022 of the rating period would be similar to the level of monthly use in the encounters reviewed. The overall impact of the change is displayed below in Table 5d. Totals may not add up due to rounding.

**Table 5d: COVID-19 Appendix K: Parent Caregiver**

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$15.47	\$7,025,162
Integrated Care Services	\$0.00	\$0
Total	\$15.47	\$7,025,162

***Transition of Augmentative and Alternative Communication Device Services***

Effective January 1, 2021, responsibility for providing AAC transitioned from ALTCS DES/DDD to its subcontracted health plans. Responsibility for providing AAC devices and services for American Indians opting out of the subcontracted managed care program members remains with ALTCS DES/DDD, accounting for about 1.5% of observed utilization during the base year (CaYr19). As a result of the transition, it is expected that both utilization and unit cost are expected to increase beyond trend assumptions. To estimate the impact of this transition in CYE22, an analyst on the AHCCCS DHCM Actuarial Team examined unit price differences between ALTCS DES/DDD and its subcontracted health plans for AAC devices and services and examined historical utilization patterns for this service and developed adjustments for both the expected increase in costs and utilization levels. The overall impact of the change is displayed below in Table 5e. Totals may not add up due to rounding.

Table 5e: Augmentative and Alternative Communication Transition

Rate Component	PMPM Impact	Dollar Impact
LTSS	(\$13.40)	(\$6,085,318)
Integrated Care Services	\$34.97	\$15,875,720
Total	\$21.56	\$9,790,402

***Proposition 206 Reimbursement Rate Changes***

As noted previously in describing the AHCCCS FFS Fee Schedule Updates, effective January of each year, AHCCCS increases fee schedule rates for select HCBS procedure codes, all NF revenue codes, and all ALF procedure codes, to address the increased labor costs resulting from minimum wage increases approved on November 8, 2016 by the state’s voters under Proposition 206 and by city of Flagstaff voters under Proposition 414.

The impact of the projected January 1, 2022 minimum wage update is included in Table 5f. The dollars and PMPMs shown here are specific to the nine-month period from January 1, 2022 through September 30, 2022. This impact changes the capitation rate for the regular DDD rate cell effective January 1, 2022, as shown in Appendix 6. Totals may not add up due to rounding.

Table 5f: January 2022 Proposition 206 Reimbursement Rate Change

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$45.58	\$15,580,519
Integrated Care Services	\$0.13	\$44,792
Total	\$45.71	\$15,625,311

***Combined Miscellaneous Program Changes***

The rate development process includes every individual program and reimbursement change as a separate adjustment. However, as noted earlier in this section, if an individual program or reimbursement change had an impact of 0.2% or less on the rate cell capitation rate, that program change was deemed non-material for the purpose of the actuarial rate certification. The aggregated



impacts of all non-material changes are shown below in Table 5g. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Pharmacy & Therapeutics Committee Decisions \***

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

- **ALTCS Home Delivered Meals \* ‡**

CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to expand the provision of home delivered meals to members enrolled in the ALTCS DES/DDD Program. The authority is projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end.

- **Peanut Allergy Drug Approval \***

On January 31, 2020, the FDA approved the immunotherapy drug Palforzia for treatment of peanut allergy in children 4 to 17 years of age. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in MDRP, AHCCCS began coverage of Palforzia on January 31, 2020.

- **Spinal Muscular Atrophy Drug Approval \***

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

- **Opioid Treatment Program Reimbursement \***

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

- **Off Campus Hospital Outpatient Department Reimbursement \***

Effective October 1, 2020, AHCCCS is reimbursing services billed at off campus hospital outpatient departments on a UB-04 form with PO or PN modifiers according to the physician or ambulatory surgical center fee schedules. The change will represent a decrease in reimbursement relative to outpatient hospital fee schedule rates that providers billed before the change.

- **Outpatient Psychiatric Hospital Reimbursement \***

Beginning October 1, 2020, AHCCCS is implementing an outpatient hospital fee schedule reimbursement methodology for outpatient services provided by psychiatric hospitals. Prior to this change, AHCCCS manually approved Contractor payments to psychiatric hospitals for outpatient services, which were not subject to a specific reimbursement methodology. To estimate the impact, the AHCCCS DHCM financial analysts repriced base period encounters at outpatient hospital fee schedule rates.
- **Adult Hepatitis C Screening Recommendation \***

On March 2, 2020, the U.S. Preventive Services Task Force (USPSTF) published a final recommendation that all adults 19 to 79 years of age be screened for hepatitis C (HCV). This represents an expansion of recommended screening from the previous guidance that adults born between 1945 and 1965 be screened. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the USPSTF final recommendation on hepatitis screenings for adults.
- **Adult Human Papillomavirus Immunization Guidance \***

On August 16, 2019, the CDC Advisory Committee on Immunizations (ACIP) released a recommendation that adults 27 to 45 years of age at risk of contracting human papillomavirus immunization (HPV) are vaccinated. This represents an expansion to previous guidance, which recommended HPV immunizations for adults 19 to 26 years of age. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the ACIP recommendation on HPV immunizations for adults.
- **Increased Frequency of Dental Fluoride Visits \***

Beginning February 1, 2020, AHCCCS increased the maximum number of dental fluoride varnish applications that members may receive, from 2 to 4 applications a year.
- **Inpatient Dental Hygienist Teeth Cleanings \***

As part of the 2019 Legislative session, the Arizona Legislature passed HB 2058 which permits dental hygienists to provide services in an inpatient hospital setting under supervision of a physician. The legislation is expected to increase provision of inpatient teeth cleanings for prevention of ventilator associated pneumonia.
- **COVID-19 Tests \* ‡**

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

CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to eliminate the 40 hour limit on reimbursable caregiver services provided by a member's spouse during a 7-day period. The authority is projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end.
- **Personal Care Services in Short-Term Acute Care Settings \* ‡**

CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to reimburse for personal care services delivered to an ALTCS member during an acute care hospital or short-term



institutional stay. The authority is projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end.

- **Depression and Anxiety Screening Codes \***

Effective August 1, 2020, AHCCCS began coverage of procedure code 96127 for brief emotional or behavioral assessments.

- **Child Flu Shots at Pharmacies Flu Vaccine Initiative \***

Effective September 1, 2020, AHCCCS modified policy guidance to permit pharmacists to administer influenza vaccinations to children ages 3 - 18 years old. Prior to the change, policy limited pharmacist-administered influenza vaccines to adults 19 years and older.

- **Generic Drug for Treatment of PKU \***

On October 1, 2020, AHCCCS began covering generic version of the Kuvan drug for treatment of Phenylketonuria (PKU). The AHCCCS DHCM financial analysts project that all base period use of the Kuvan brand drug will transition to the lower priced generic drugs in CYE 22. Like Kuvan, the generic drug is eligible for reinsurance. The impacts of adding reinsurance eligibility are discussed in section I.4.C.ii.(c)(iv).

- **Dental Counseling Services \***

On the recommendation of the Office of the Director's Chief Medical Officer, AHCCCS began covering dental services for tobacco counseling effective October 1, 2020 and high-risk substance use counseling effective January 1, 2021.

- **Genetic Testing for Cardiovascular Disorders \***

AHCCCS began covering genetic tests for rare inherited cardiovascular disorders effective October 23, 2020. The tests are primarily recommended for identification of Long QT syndrome (LQTS) in first degree relatives of individuals with the disorder.

- **Expanded Telehealth Use \* ‡**

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

- **Rx Rebates Adjustment**

An adjustment was made to reflect the impact of Rx Rebates reported within the Contractors' financial statements, as pharmacy encounter data does not include these adjustments. The data that the AHCCCS DHCM Actuarial Team reviewed was the CYE 17, CYE 18, CYE 19 and CYE 20 annual financial statement reports and the CYE 21 Q1 financial statement reports. From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment to the projected CYE 22 Pharmacy (form type C) category of service.

- **Vaxelis Immunizations \***

Effective January 1, 2021, AHCCCS began covering Vaxelis as a combination immunization for children ages 6 weeks through 4 years against diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B, and disease due to haemophiles influenzae type b. The vaccination is administered in a series of three shots and is anticipated to substitute for anywhere from 7 to 16 shots of the previously available vaccinations for the diseases above. The federal Vaccines for Children program funds costs of the vaccines while AHCCCS and its contractors reimburse for administration of the vaccines. The CYE 22 rates include a reduction for the projected decrease in vaccine shots that will be administered to children.

- **Administration of CAR-T Cell Therapy \***

Effective May 3, 2021, AHCCCS began covering service codes for the administration of chimeric antigen receptor T cell therapy (0537T – 0540T).

- **Alzheimer’s Drug Approval \***

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

- **Cancer Profiling Tests \***

Effective July 1, 2021, AHCCCS began covering two medically necessary cancer profiling tests. The tests can assist providers in determining the most appropriate course of treatment for a patient’s cancer.

- **Bus Passes \***

Effective October 1, 2021, AHCCCS is revising policy to clarify that Contractors may reimburse public transport passes as non-emergency medical transport (NEMT). Passes would generally be billed with procedure code A0110. When offering a public transport pass, contractors should consider such things as location of the member, location of the member’s provider, public transportation schedules, and member ability to travel alone. CYE 22 adjustments to rates include projected costs of bus passes and increased use of medical services due to greater members options for transport, partly offset by savings from reduced use of more expensive alternative forms of NEMT.

- **Community Intervener Services \***

Effective October 1, 2021, AHCCCS is establishing policy for provision of community intervener services to ALTCS members with dual sensory loss (i.e., blind and hard of hearing). Community interveners intercede between the member and the environment, allowing access to information usually gained through vision and hearing. A reimbursement rate will be established for the community intervener services to be billed under procedure code S5135 and modifier CG.

- **Emergency Triage, Treat, and Transport \***  
Effective October 1, 2021, AHCCCS will implement an Emergency Triage, Treat, and Transport (ET3) model that is similar to the ET3 program that Medicare began in FFY 21. Under the state’s program, emergency service providers may begin billing for trips that result in delivery of on-site or telehealth services by a partner health professional or for trips to an outpatient non-emergency department provider. The AHCCCS DHCM financial analysts project that cost savings of diverting unnecessary emergency department visits to lower acuity settings under the ET3 model will be offset by additional costs of reimbursing emergency service providers for trips in which no or limited reimbursement was previously paid.
- **EPSDT Visits and Developmental Screens \***  
Effective October 1, 2021, AHCCCS is revising policy to better align Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits and developmental screening requirements with CMS Core Measures and recommendations from the American Academy of Pediatrics. The policy revisions require an additional EPSDT visit for child members at 30 months of age and two specialized developmental screens at the child member’s 18-month and 24-month EPSDT visits.
- **Hepatitis C Treatment Policy \***  
Numerous studies have found direct acting antiviral (DAA) medications are over 90% effective in curing HCV in an individual. On recommendation of the Office of the Director’s Chief Medical Officer, AHCCCS will revise policy to remove substance use remission requirements for receiving HCV DAA medications, effective October 1, 2021. Prior to the change, AHCCCS required members to be in remission for three or more months from the request date for treatment to be eligible for prior authorization approval of the drugs.
- **High Needs Therapeutic Foster Care Rates \***  
Effective October 1, 2021, AHCCCS is establishing increased Fee for Services (FFS) rates for Therapeutic Foster Care (TFC) services provided in a licensed family setting to higher needs foster children under 18 years of age.
- **Rate Increase for Vaccines for Children \***  
Effective October 1, 2021, AHCCCS is increasing reimbursement for administration of Vaccine for Children program vaccines to the maximum fee permitted to be reimbursed by the state under federal rule 77 FR 66669.

Table 5g: Combined Miscellaneous Program Changes

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$2.86	\$1,300,154
Integrated Care Services	\$7.81	\$3,544,029
Total	\$10.67	\$4,844,182

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

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

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

ALTCS DES/DDD, its subcontractors, and the RBHAs are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuary to set the CYE 22 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2016 through December 2019 and adjudicated and approved through the first encounter cycle in March 2021, 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). The data was truncated to avoid including any COVID-19 time period which had large and varied impacts on most categories of service, most of which are not anticipated to be continued through the entirety of the rating period, making the COVID-19 time period data inappropriate for use in developing trend projections. In particular, the expected partial regression to a pre-pandemic level during the rating period with respect to the LTSS utilization mix is addressed in Section I.3.B.ii.(a), and is not addressed as part of trend development.

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 33 months, from the midpoint of CalYr19 (July 1, 2019) to the midpoint of the rating period for CYE 22 (April 1, 2022). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. Projected benefit cost trends were based 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 21 for ALTCS DES/DDD capitation rates and judged reasonable to assume for projection to CYE 22, considering the change in the base data time period, the rating period, the intervening COVID-19 pandemic, as well as changes to covered services.

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

The 2022 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuary defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%.

The actuary assumed negative utilization trends in the following LTSS categories of service: State Operated ICF, State Operated Group Homes, State Operated ICF at ATPC, State Operated Group Homes at ATPC, Private ICF. These LTSS categories of service were analyzed separately and together, and the assumptions assumed for the CYE 22 capitation rate development are based on the combined experience of these categories of service as the separate experience for each was highly correlated with the others. The negative utilization 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 of the regression lines for the utilization data are negatively sloped. This is consistent with the declining population in these settings.

The only outlier trend is for HCBS Attendant Care services, which has a PMPM trend above 7%. The utilization of the HCBS Attendant Care category of service has been increasing steadily since October 2016. The assumed utilization trend of 8.1% was based upon actuarial judgement with consideration of 3-month, 6-month, and 12-month moving averages and with 12-month, 24-month, and 36-month linear regression results. Given the long-term consistency of the growth in the HCBS Attendant Care services category of service over time, the actuary judged that the assumed utilization and unit cost trends for this category of service are the most appropriate assumptions to reflect expected costs in CYE 22 (in the absence of the COVID-19 PHE). Additional adjustments related to LTSS utilization mix are addressed above in Section I.3.B.ii(a).

**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 between the base period and the rating period for the ALTCS DES/DDD Program for utilization per 1000, unit cost, and PMPMs are included below in Table 6.

Table 6: Changes in Price and Utilization

Rate Component	Utilization per 1000	Unit Cost	PMPM
LTSS	2.83%	1.19%	4.05%
Integrated Care Services	0.00%	2.71%	2.71%
Total	2.26%	1.49%	3.78%

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

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

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

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

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

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

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

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

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

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

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS DHCM Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. As of August 11, 2021, no additional services have been identified as necessary services to comply with MHPAEA.

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

There are no in-lieu-of services allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an Institution for Mental Disease (IMD) in lieu of services in an inpatient hospital. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.3(e) and this is described above in Section I.3.A.iv.

## **I.3.B.vi. Retrospective Eligibility Periods**

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

AHCCCS provides 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 22 capitation rates for the ALTCS DES/DDD Program for the prior period time frame, given that the encounter and enrollment data are already included within the base data used for rate development.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



## **I.4. Special Contract Provisions Related to Payment**

### **I.4.A. Incentive Arrangement Standards**

#### **I.4.A.i. Rate Development Standards**

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

#### **I.4.A.ii. Appropriate Documentation**

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

The CYE 22 contract for the ALTCS DES/DDD Program includes an incentive arrangement, as described under 42 CFR § 438.6(b)(2), called the APM Initiative – Performance Based Payments.

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

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

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

All enrollees, children and adults may be covered by this incentive arrangement. Network HCBS agencies exceeding ALTCS DES/DDD specified thresholds have the opportunity to participate in the APM arrangements; covered HCBS are eligible for inclusion.

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

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

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

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

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

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 22 capitation rates and had no effect on the development of the capitation rates for the ALTCS DES/DDD Program.

### **I.4.B. Withhold Arrangements – Not Applicable**

Not applicable. There are no withhold arrangements in the CYE 22 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 2022 Guide provides information on the requirements for risk-sharing mechanisms.



## **I.4.C.ii. Appropriate Documentation**

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

The CYE 22 capitation rates for the ALTCS DES/DDD Program will include risk corridors for the regular DDD rate cell. There is also a cost-settlement type arrangement for the administration of COVID-19 vaccines for the CYE 22 rating period.

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

AHCCCS has a long-standing program policy of including risk corridors within 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 22 capitation rates are consistent with AHCCCS' long-standing program policy and include risk corridors for services under the ALTCS DES/DDD Program. This rate certification will use the term risk corridor to be consistent with the 2022 Guide. The DES/DDD Contract refers to the risk corridor as a reconciliation.

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

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

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

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

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

The cost-settlement will reimburse ALTCS DES/DDD, and through ALTCS DES/DDD the integrated subcontractors, for the administration of COVID-19 vaccines via a periodic cost-settlement based upon adjudicated/approved encounter data subject to the two-year claiming rule.

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

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

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

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

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

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

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

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

##### **I.4.C.ii.(c)(i) Description of 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 22 is the basis of the reinsurance offset.

The AHCCCS reinsurance program has been in place since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses ALTCS DES/DDD for covered services incurred above the deductible. The deductible is the responsibility of ALTCS DES/DDD. There has been no change to the deductible or coinsurance factors applicable to the regular reinsurance or catastrophic reinsurance program since the last rate setting period.

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

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

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

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

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

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

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

The capitation rates are adjusted by subtracting the reinsurance offset amounts from the gross medical expenses since ALTCS DES/DDD will receive payment from AHCCCS for reinsurance cases. The data used to develop the reinsurance offset amounts are historical encounters incurred during CalYr19. Encounter data were adjusted in line with the changes outlined in sections I.2.B.iii., I.3.B.ii., and I.3.B.iii.; changes to the eligible drugs for the biotech reinsurance case type from the base period were adjusted based on the analysis prepared by AHCCCS DHCM financial analysts as described in sections I.2.B.iii.(d) and I.3.B.ii.(a), with an aggregate impact of approximately \$340,000. Additionally, these data were adjusted for a contractor reporting factor, representing the rate at which the contractor does not report reinsurance cases that would otherwise merit reimbursement. The contractor reporting factor was developed from historical reinsurance payments as compared to the aggregated encounters for individual members which would have triggered reinsurance payments in each contract year. The historical average for this discrepancy is approximately 98% of “eligible reinsurance cases based on encounters” become “actual reinsurance cases submitted by the contractor”. Costs from the adjusted and trended encounter data were then evaluated for each member individually, repricing the total, by reinsurance case type, to a “reinsurance case value”, using the deductibles and coinsurance percentages specific to each case type as outlined in the contract for CYE 22. The reinsurance offset was derived by taking the sum of the reinsurance case values and dividing by the CYE 22 projected member months.

### **I.4.D. State Directed Payments**

#### **I.4.D.i. Rate Development Standards**

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

## I.4.D.ii. Appropriate Documentation

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

The only pre-prints addressed in this certification are the ones related to ALTCS DES/DDD. Those pre-prints are DAP, APSI, PSI, and HEALTHII. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 7a.

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

##### ***Differential Adjusted Payments***

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

##### ***Access to Professional Services Initiative***

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

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

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

##### ***Pediatric Services Initiative***

The PSI seeks to provide enhanced support to ensure financial viability of the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The PSI provides a uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The PSI uniform percentage increase is

based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

#### ***Hospital Enhanced Access Leading to Health Improvements Initiative***

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

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

DAP are the only directed payments incorporated in the capitation rates. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 7a.

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

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

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

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

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

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.0% increase), Critical Access Hospitals (eligible for up to 10.5% increase), other hospitals and inpatient facilities (eligible for up to 5.0% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 8.5% increase on all services provided), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), and HCBS providers (eligible for up to 1.0% increase on specified services for some provider types, and all services for other provider types). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 20 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 22 time period. The

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

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

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

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

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

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

The APSI, PSI, and HEALTHII are not included in the ALTCS DES/DDD certified capitation rates and will be paid out via lump sum payments. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 7a.

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

##### ***Access to Professional Services Initiative***

Anticipated payments including premium tax for APSI are approximately \$8.8 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

##### ***Pediatric Services Initiative***

Anticipated payments including premium tax for PSI are approximately \$10.9 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 22 utilization will be used to redistribute the payments.

##### ***Hospital Enhanced Access Leading to Health Improvements Initiative***

Anticipated payments including premium tax for HEALTHII are approximately \$30.9 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 22 utilization will be used to redistribute the payments.

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

##### ***Access to Professional Services Initiative***

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

***Pediatric Services Initiative***

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

***Hospital Enhanced Access Leading to Health Improvements Initiative***

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

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

Appendix 7b contains estimated PMPMs including premium tax by rate cell for informational purposes only; these payments are not made on a PMPM basis.

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

***Access to Professional Services Initiative***

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

***Pediatric Services Initiative***

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

***Hospital Enhanced Access Leading to Health Improvements Initiative***

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

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

***Access to Professional Services Initiative***

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

***Pediatric Services Initiative***

After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate



certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

***Hospital Enhanced Access Leading to Health Improvements Initiative***

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

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

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

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

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

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

Not applicable. There are no pass-through payments for the ALTCS DES/DDD Program.



## **I.5. Projected Non-Benefit Costs**

### **I.5.A. Rate Development Standards**

This section of the 2022 Guide provides information on the non-benefit component of the capitation rates.

### **I.5.B. Appropriate Documentation**

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

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

The projected ALTCS case management expense PMPM within the regular DDD capitation rate was informed by ALTCS DES/DDD's expense projections for CYE 22. 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 22 projection fully funds the required case management ratios in the contract. The projected PMPM associated with case management expenses for CYE 22 is denoted as Case Management in Appendix 6.

The projected administrative expense PMPMs for LTSS were informed by ALTCS DES/DDD's expense projections for CYE 22, actual expenses reported by ALTCS DES/DDD for FFY 19 and FFY 20, and inflation forecasts provided in the IHS Markit First Quarter 2021 Healthcare Cost Report. The base data used for the administrative expense projection for LTSS was ALTCS DES/DDD administrative expenses reported during FFY 20. The actuary used fixed and variable percentages reported by ALTCS DES/DDD related to the administrative expenses reported over time and adjusted the variable portion of the administrative expenses with respect to membership growth. The actuary then inflated wage-related expenses by the CPI-W from the IHS Markit Healthcare Cost Report, modified by specific estimates of known salary increases for a subset of employees, and incorporated estimates for additional administrative requirements in the upcoming contract year to come up with a projected administrative expense amount for CYE 22. This projection was then compared to the CYE 22 expense projection from ALTCS DES/DDD. The actuary's estimated projection of administrative expenses for CYE 22 was similar to the forecast provided by ALTCS DES/DDD for CYE 22. The actuary's CYE 22 projection of administrative expenses for LTSS is denoted as Administration for LTSS in Appendix 6.

The administrative expense PMPM for CYE 22 for the integrated subcontractors are awarded administrative bid amounts from a Request for Proposal (RFP) competitive bid process which ALTCS DES/DDD engaged in to subcontract the Integrated Care Services portion of their overall medical services responsibilities. One of the requirements of the RFP was to submit administrative bid amounts based on membership thresholds for the integrated contract. To produce an estimate of the integrated subcontractor administrative cost, the actuary estimated the projected membership for each integrated subcontractor for CYE 22 to determine the appropriate bid threshold, based on reported integrated subcontractor enrollment as of February 2021. The actuary added administrative cost projections

associated with the AAC transition to the bid threshold amounts. The CYE 22 administrative expense projection for the integrated subcontractors is denoted as Administration for Integrated Care Services in Appendix 6.

The Targeted Case Management capitation rate is updated in this certification and will be effective for the entire 12-month time period from October 1, 2021 through September 30, 2022. Similar to ALTCS case management, Targeted Case Management expenses were determined by incorporating case manager, case manager supervisor, and support staff salary information as well as supplemental staff model expenses, inclusive of known salary adjustments for a subset of the employees, provided by ALTCS DES/DDD. However, unlike the ALTCS case management costs, Targeted Case Management used membership projections from ALTCS DES/DDD. The CYE 22 Targeted Case Management projection fully funds the required case management ratios in the contract.

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

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

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

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

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

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

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

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

The CYE 22 capitation rate for the regular DDD rate cell includes a provision of 1.0% for underwriting gain. There is no provision for underwriting gain in the Targeted Case Management rate cell.

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

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

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

Historical non-benefit cost data is provided by the plans via financial statements and additional data requests. The audited financial statements can be found on the AHCCCS website at:

<https://www.azahcccs.gov/Resources/OversightOfHealthPlans/contractedhealthplan.html>. Historical

non-benefit cost data was considered and used in the non-benefit cost assumptions as described in section I.5.B.i.(a) above.

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

This section of the 2022 Guide is not applicable to the ALTCS DES/DDD Program. The certified capitation rates paid to the ALTCS DES/DDD Program capitation rates do not include risk adjustment or acuity adjustment.

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

Section II of the 2022 Guide is applicable to the ALTCS DES/DDD Program because the CYE 22 capitation rates for ALTCS DES/DDD are subject to the applicable “actuarial soundness” provisions from 42 CFR § 438.4 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 2022 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 2022 Guide provides the two most common approaches to structuring the rate cells.

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

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

##### **II.1.B.i.(b) Non-Blended Capitation Rate – Not Applicable**

Not applicable. A member’s individual long-term care setting does not determine the capitation paid for that member.

#### **II.1.C. Appropriate Documentation**

##### **II.1.C.i. Considerations**

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

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

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

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

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

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

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

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

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

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

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

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

### **II.1.C.iii. Additional Information**

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

## **Section III New Adult Group Capitation Rates – Not Applicable**

Section III of the 2022 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(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 22 capitation rates for the ALTCS DES/DDD Program have been documented according to the guidelines established by CMS in the 2022 Guide. The CYE 22 capitation rates for the ALTCS DES/DDD Program are effective for the 3-month time period from October 1, 2021 through December 31, 2021 and the 9-month period from January 1, 2022 through September 30, 2022.

The actuarially sound capitation rates are based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rates, 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 11, 2021

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Erica Johnson

Date

Associate, Society of Actuaries

Member, American Academy of Actuaries

## **Appendix 2: Certified Capitation Rates**

<b>ALCS DES/DDD Capitation Rates</b>	
<b>Effective October 1, 2021 through December 31, 2021</b>	
Regular DDD	\$5,370.51
Targeted Case Management	\$181.02

<b>ALCS DES/DDD Capitation Rates</b>	
<b>Effective January 1, 2022 through September 30, 2022</b>	
Regular DDD	\$5,417.63
Targeted Case Management	\$181.02

## **Appendix 3: Comparisons and Fiscal Impact Summary**

ALTCS DES/DDD Capitation Rates						
Effective October 1, 2021 through December 31, 2021						
Rate Cell	Rate Effective 1/1/2021	Rate Effective 10/1/2021	% Change		CYE 22 Projected MMs	CYE 22 Projected Expenses
ALTCS DDD	\$5,309.41	\$5,370.51	1.15%		112,202	\$602,584,235
Targeted Case Management	\$176.08	\$181.02	2.81%		16,318	\$2,954,012

ALTCS DES/DDD Capitation Rates						
Effective January 1, 2022 through September 30, 2022						
Rate Cell	Rate Effective 10/1/2021	Rate Effective 1/1/2022	% Change		CYE 22 Projected MMs	CYE 22 Projected Expenses
ALTCS DDD	\$5,370.51	\$5,417.63	0.88%		341,842	\$1,851,973,899
Targeted Case Management	\$181.02	\$181.02	0.00%		51,346	\$9,294,703

ALTCS DES/DDD Capitation Rates						
CYE 22 Weighted Average						
Rate Cell	Rate Effective 1/1/2021	CYE 22 Average Rate	% Change		CYE 22 Projected MMs	CYE 22 Projected Expenses
ALTCS DDD	\$5,309.41	\$5,405.99	1.82%		454,045	\$2,454,558,134
Targeted Case Management	\$176.08	\$181.02	2.81%		67,664	\$12,248,715

## **Appendix 4: Base Data and Base Data Adjustments**

Category of Service	Base PMPM	Completion	Completed Base PMPM	Encounter Issues	Adjusted PMPM	Provider Fee Schedule Changes	Pharmacy Reimbursement Savings	Comb. Misc. Adjustment	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
ATPC ICF	\$31.14	100.00%	\$31.14	0.00%	\$31.14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$31.14
ATPC SOGH	\$14.96	100.00%	\$14.96	0.00%	\$14.96	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$14.96
Attendant Care	\$362.35	99.98%	\$362.43	0.00%	\$362.43	2.88%	0.00%	-0.14%	0.00%	0.00%	0.00%	\$372.33
Day Treatment	\$355.74	99.98%	\$355.81	0.00%	\$355.81	2.80%	0.00%	-0.13%	0.00%	0.00%	0.00%	\$365.30
Employment	\$81.81	99.98%	\$81.82	0.00%	\$81.82	2.40%	0.00%	-0.12%	0.00%	0.00%	0.00%	\$83.69
Hab - Per 15 Min	\$355.20	99.98%	\$355.27	0.00%	\$355.27	1.85%	0.00%	-0.13%	0.00%	0.00%	0.00%	\$361.36
Hab - Per Diem	\$1,113.92	99.98%	\$1,114.14	0.00%	\$1,114.14	3.69%	0.00%	-0.13%	0.00%	0.00%	0.00%	\$1,153.66
Misc - In Home Care	\$1.17	99.98%	\$1.17	0.00%	\$1.17	0.00%	0.00%	-0.13%	0.00%	0.00%	0.00%	\$1.17
Misc - DME	\$13.59	99.99%	\$13.59	0.00%	\$13.59	0.00%	0.00%	-0.06%	0.00%	0.00%	0.00%	\$13.58
Nursing	\$135.75	99.98%	\$135.78	0.00%	\$135.78	5.27%	0.00%	-0.13%	0.00%	0.00%	0.00%	\$142.74
Private ICF	\$27.68	99.94%	\$27.69	0.00%	\$27.69	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$27.69
Respite	\$289.40	99.98%	\$289.46	0.00%	\$289.46	2.74%	0.00%	-0.14%	0.00%	0.00%	0.00%	\$296.99
SelfCare Home Management	\$6.64	99.98%	\$6.64	0.00%	\$6.64	0.00%	0.00%	-0.14%	0.00%	0.00%	0.00%	\$6.63
SOGH	\$12.35	100.00%	\$12.35	0.00%	\$12.35	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$12.35
SOICF	\$13.75	100.00%	\$13.75	0.00%	\$13.75	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$13.75
Therapies and Evaluations	\$165.94	99.98%	\$165.97	0.00%	\$165.97	10.95%	0.00%	-0.13%	0.00%	0.00%	0.00%	\$183.92
Transportation	\$54.30	99.98%	\$54.31	0.00%	\$54.31	5.94%	0.00%	-0.13%	0.00%	0.00%	0.00%	\$57.46
Integrated Care Services	\$812.29	98.79%	\$822.26	-1.71%	\$808.16	0.11%	-1.57%	-0.15%	0.17%	-0.28%	-0.05%	\$793.95
<b>Gross Medical</b>	<b>\$3,847.97</b>		<b>\$3,858.54</b>		<b>\$3,844.44</b>							<b>\$3,932.67</b>



## **Appendix 5: Projected Benefit Cost Trends**

Statewide					
Rate Cell	Trend COS	Utilization Per 1000	Unit Cost	PMPM	
DES/DDD	ATPC ICF	-1.0%	0.0%	-1.0%	
DES/DDD	ATPC SOGH	-1.0%	0.0%	-1.0%	
DES/DDD	Attendant Care	8.1%	0.0%	8.1%	
DES/DDD	Day Treatment	0.0%	0.0%	0.0%	
DES/DDD	Employment	0.0%	0.0%	0.0%	
DES/DDD	Hab - Per 15 Min	0.0%	2.6%	2.6%	
DES/DDD	Hab - Per Diem	0.0%	0.2%	0.2%	
DES/DDD	Misc - In Home Care	0.0%	0.4%	0.4%	
DES/DDD	Misc - DME	0.0%	0.1%	0.1%	
DES/DDD	Nursing	0.0%	0.4%	0.4%	
DES/DDD	Private ICF	-1.0%	0.0%	-1.0%	
DES/DDD	Respite	0.0%	0.4%	0.4%	
DES/DDD	SelfCare Home Management	0.0%	0.4%	0.4%	
DES/DDD	SOGH	-1.0%	0.0%	-1.0%	
DES/DDD	SOICF	-1.0%	0.0%	-1.0%	
DES/DDD	Therapies and Evaluations	0.5%	0.1%	0.6%	
DES/DDD	Transportation	0.0%	0.0%	0.0%	
DES/DDD	Integrated Care Services	0.0%	1.0%	1.0%	

## **Appendix 6: CYE 22 Capitation Rate Development**

Category of Service	Adjusted Base PMPM	Trend Rates	Trended PMPM	Provider Fee Schedule Changes	COVID-19 LTSS Utilization Mix Adjustment	ABA Transition	AAC Transition	Parent Caregiver	Combined Miscellaneous Changes	Gross Medical (10/1/21 - 12/31/21)	Proposition 206 Reimb. Change	Gross Medical (1/1/22 - 9/30/22)
ATPC ICF	\$31.14	-1.0%	\$30.29	1.43%	0.00%	0.00%	0.00%	0.00%	2.40%	\$31.46	0.69%	\$31.68
ATPC SOGH	\$14.96	-1.0%	\$14.55	3.75%	0.00%	0.00%	0.00%	0.00%	2.40%	\$15.46	1.31%	\$15.66
Attendant Care	\$372.33	8.1%	\$461.27	12.06%	18.23%	0.00%	0.00%	0.00%	0.11%	\$611.80	1.21%	\$619.20
Day Treatment	\$365.30	0.0%	\$365.30	12.01%	-19.07%	0.00%	0.00%	0.00%	0.00%	\$331.14	1.23%	\$335.20
Employment	\$83.69	0.0%	\$83.69	11.85%	-12.08%	0.00%	0.00%	0.00%	0.00%	\$82.30	1.27%	\$83.34
Hab - Per 15 Min	\$361.36	2.6%	\$387.79	11.11%	9.85%	-8.28%	0.00%	0.85%	0.11%	\$438.30	1.17%	\$443.41
Hab - Per Diem	\$1,153.66	0.2%	\$1,160.01	12.03%	8.91%	0.00%	0.00%	0.83%	0.00%	\$1,427.11	1.25%	\$1,444.91
Misc - In Home Care	\$1.17	0.4%	\$1.18	11.61%	0.00%	0.00%	0.00%	0.00%	0.00%	\$1.32	1.32%	\$1.34
Misc - DME	\$13.58	0.1%	\$13.62	0.08%	0.00%	0.00%	-98.31%	0.00%	0.00%	\$0.23	1.14%	\$0.23
Nursing	\$142.74	0.4%	\$144.32	12.30%	1.56%	0.00%	0.00%	0.00%	0.00%	\$164.60	1.15%	\$166.49
Private ICF	\$27.69	-1.0%	\$26.94	1.45%	0.00%	0.00%	0.00%	0.00%	0.00%	\$27.33	0.70%	\$27.52
Respite	\$296.99	0.4%	\$300.27	12.26%	5.67%	0.00%	0.00%	0.00%	0.00%	\$356.20	1.16%	\$360.32
SelfCare Home Management	\$6.63	0.4%	\$6.71	12.17%	-16.38%	0.00%	0.00%	0.00%	0.00%	\$6.29	1.19%	\$6.37
SOGH	\$12.35	-1.0%	\$12.01	3.77%	0.00%	0.00%	0.00%	0.00%	2.40%	\$12.77	1.31%	\$12.93
SOICF	\$13.75	-1.0%	\$13.37	1.44%	0.00%	0.00%	0.00%	0.00%	2.40%	\$13.89	0.70%	\$13.99
Therapies and Evaluations	\$183.92	0.6%	\$186.97	12.35%	7.13%	0.00%	0.00%	0.00%	0.00%	\$225.04	1.14%	\$227.59
Transportation	\$57.46	0.0%	\$57.46	12.07%	-21.98%	0.00%	0.00%	0.00%	0.00%	\$50.24	1.21%	\$50.85
Integrated Care Services	\$793.95	1.0%	\$815.46	6.89%	0.00%	9.37%	3.67%	0.00%	0.79%	\$996.07	0.01%	\$996.20
<b>Gross Medical</b>	<b>\$3,932.67</b>		<b>\$4,081.21</b>							<b>\$4,791.54</b>		<b>\$4,837.25</b>

<b>Total DAP</b>	<b>\$21.41</b>	<b>\$21.41</b>
<b>Total Gross Medical PMPM</b>	<b>\$4,812.95</b>	<b>\$4,858.66</b>
<b>Reinsurance Offset</b>	<b>(\$77.77)</b>	<b>(\$77.77)</b>
<b>Total Net Medical PMPM</b>	<b>\$4,735.18</b>	<b>\$4,780.89</b>

Non-benefit Expenses	PMPM	PMPM
Case Management	\$194.75	\$194.75
Administration for LTSS	\$229.79	\$229.79
Administration for Integrated Care Services	\$54.43	\$54.43
Total Medical with Admin and CM	\$5,214.15	\$5,259.86
Share of Cost	(\$3.71)	(\$3.71)
UW Gain	\$52.67	\$53.13
Pre-tax Capitation PMPM	\$5,263.10	\$5,309.28
Premium Tax	\$107.41	\$108.35
<b>Capitation PMPM</b>	<b>\$5,370.51</b>	<b>\$5,417.63</b>

## Appendix 7: State Directed Payments

## Appendix 7a: CMS Prescribed Tables

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

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

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

Control name of the state directed payment	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Impact - Section I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
AZ_Fee_IP.OP.P C_Renewal_202 11001-20220931 (a.k.a. DAP)	Regular DDD	See Appendix 6 for medical impact by rate cell and Appendix 7b for total impact by rate cell. (Appendices 6 and 8b for ACC)	<p>The qualifying providers receiving the payments include: Hospitals subject to APR-DRG reimbursement (eligible for up to 3.0% increase), Critical Access Hospitals (eligible for up to 10.5% increase), Other Hospitals and Inpatient Facilities (eligible for up to 5.0% increase), Nursing Facilities (eligible for up to 2.0% increase), Integrated Clinics (eligible for a 10.0% increase on a limited set of codes), Behavioral Health Outpatient Clinics (eligible for a 1.0% increase), Behavioral Health Outpatient Clinics and Integrated Clinics (eligible for up to 8.5% increase on all services provided), Physicians, Physician Assistants, and Registered Nurse Practitioners (eligible for up to 3.5% increase), Behavioral Health Providers (eligible for up to 1.0% increase), Dental Providers (eligible for up to 2.0% increase), and HCBS Providers (eligible for up to 1.0% increase on specified services for some provider types, and all services for other provider types).</p> <p>The AHCCCS DHCM Rates &amp; Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates &amp; Reimbursement Team to develop the DAP impacts was the CYE 20 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates &amp; Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 22 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 22 (the data provided by the AHCCCS DHCM Rates &amp; Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).</p>	AHCCCS has submitted the Differential Adjusted Payments (DAP) §438.6(c) preprint to CMS, but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the pre-print under CMS review.	Not applicable.



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

Control name of the state directed payment	Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20211001-20220930 (a.k.a. APSI)	\$8,812,378	The actuary certifies to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 7b	AHCCCS has submitted the Access to Professional Services Initiative (APSI) §438.6(c) pre-print to CMS, but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IP.OP1_Renewal_20211001-20220930 (a.k.a. PSI)	\$10,940,386	The actuary certifies to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 7b	AHCCCS has submitted the Pediatric Service Initiative (PSI) §438.6(c) pre-print to CMS, but has not yet received approval. The PSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IP.OP2_Renewal_20211001-20220930 (a.k.a. HEALTHII)	\$30,933,180	The actuary certifies to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 7b	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) §438.6(c) pre-print to CMS, but has not yet received approval. The HEALTHII payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

## **Appendix 7b: State Directed Payments Estimated PMPMs**

CYE 22 Estimated PMPM				
Directed Payment	Medical	Underwriting Gain	Premium Tax	Total
DAP	\$21.41	\$0.22	\$0.44	\$22.07
APSI	\$19.41	\$0.00	\$0.40	\$19.80
PSI	\$24.10	\$0.00	\$0.49	\$24.59
HEALTHII	\$68.13	\$0.00	\$1.39	\$69.52