



**Contract Year Ending 2023  
Capitation Rate Certification  
Arizona Long Term Care System  
Department of Economic Security/ Division of  
Developmental Disabilities Program**

**October 1, 2022 through September 30, 2023**

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

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

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### Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the October 1, 2022 through September 30, 2023 (Contract Year Ending 2023 (CYE 23), or alternatively, Federal Fiscal Year 2023 (FFY 23)) actuarially sound capitation rates for the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Program.

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 2022-2023 Medicaid Managed Care Rate Development Guide (2023 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2023 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 2023 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.

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

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

- Actuarial Standards of Practice (ASOPs) applicable to Medicaid managed care rate setting which were effective before the start date of the rating period:
  - ASOP No. 1 - Introductory Actuarial Standard of Practice,
  - ASOP No. 5 - Incurred Health and Disability Claims,
  - ASOP No. 12 - Risk Classification (for All Practice Areas),
  - ASOP No. 23 - Data Quality,
  - ASOP No. 25 - Credibility Procedures,
  - ASOP No. 41 - Actuarial Communications,
  - ASOP No. 45 - The Use of Health Status Based Risk Adjustment Methodologies,
  - ASOP No. 49 - Medicaid Managed Care Capitation Rate Development and Certification, and
  - ASOP No. 56 - Modeling.
- The 2016 and 2020 Medicaid and CHIP Managed Care Final Rules (CMS-2390-F and CMS-2408-F)
- FAQs related to payments to MCOs and PIHPs for IMD stays
- The 2022-2023 Medicaid Managed Care Rate Development Guide (2023 Guide) published by CMS

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

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

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As stated on pages 2 and 3 of the 2023 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 2023 Guide.

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

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

This section of the 2023 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 23 capitation rates for the ALTCS DES/DDD Program are effective for the 12-month time period from October 1, 2022 through September 30, 2023.

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

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

The actuarial certification letter for the CYE 23 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 23 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 2023 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 organization for this program. ALTCS DES/DDD subcontracts some services to integrated subcontractors.

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

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

This certification covers the ALTCS DES/DDD Program which provides Long Term Services & Supports (LTSS) and physical and behavioral health services to its members. Additional information regarding covered services can be found in the ALTCS DES/DDD contract.

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 Regional Behavioral Health Authorities (RBHA) Program. Effective October 1, 2019, ALTCS DES/DDD subcontracted the integrated physical and behavioral health services to two integrated subcontractors as well as LTSS services provided in a nursing facility. 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.

Targeted Case Management services are covered for those members who do not meet the functional requirements for ALTCS services.

American Indians and Alaska Natives (AI/AN) enrolled in ALTCS DES/DDD can choose to receive their integrated physical and behavioral health services through managed care with one of the integrated subcontractors or on a fee-for-service (FFS) basis through the DDD Tribal Health Plan (DDD THP). Expenses for all services for all ALTCS DES/DDD members are included in the capitation rates for the ALTCS DES/DDD Program, including those AI/AN members who opt to receive services through the DDD-THP.

For the CYE 23 rating period, the projected expenses associated with the administration of COVID-19 vaccines are not included in the capitation rates; all COVID-19 vaccine costs in the base data period were removed as part of rate development, described below in Section I.2.B.iii.(d). ALTCS DES/DDD, along with its integrated subcontractors, is responsible for these expenses and will be reimbursed for these expenses on a non-risk basis 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 rate certification for the CYE 23 capitation rates for the ALTCS DES/DDD Program is effective for the 12-month time period from October 1, 2022 through September 30, 2023.

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

### 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

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

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

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 eligibility and enrollment criteria 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.

In practice, enrollment in the ALTCS DES/DDD program is predicated upon meeting the eligibility requirements for ALTCS, as defined in the contract and state statute, and also having one of the listed diagnoses from above; these diagnoses do not generally resolve, so it is unlikely a member would lose DES/DDD eligibility on the basis of no longer needing the level of medical support required by the ALTCS eligibility statutes, but in that unlikely event, the member would transition to a non-ALTCS AHCCCS program, i.e. the AHCCCS Complete Care program. There are two separate allowable income limit definitions for ALTCS financial eligibility under the Arizona 1115 Waiver. The first definition is income equal to or less than 300 percent of the Federal Benefit Rate (approximately 222 percent of the Federal Poverty Limit (FPL)), as used by the Social Security Administration (SSA) to determine eligibility for Supplemental Security Income (SSI); the second definition covers the “Freedom to Work” group (a state optional TXIX coverage group under the ALTCS program in the 1115 Waiver), which covers individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL. These higher allowable income limits for ALTCS also make it unlikely a member would lose financial eligibility once determined eligible for ALTCS DES/DDD based on the listed diagnoses above, but in that unlikely event, the member would transition to DDD State Only eligibility. The MOE requirements in place until the end of the month in which the PHE ends would continue the member’s eligibility under ALTCS in that case.

### **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 23 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))



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- Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) (42 CFR § 438.6(c)(1)(iii)(A))
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(C))
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(C))
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(C))
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(C))

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 23 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 CYE 23 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 23 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 23.

### **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.

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### 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 23 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 23 capitation rates for the ALTCS DES/DDD Program.

### I.1.A.xii. COVID-19 PHE Assumption, Impacts, and Risk Mitigation

This section of the 2023 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.

This section also requests description of evaluations conducted, and the rationale for any applicable assumptions included or not included in rate development related to the COVID-19 PHE within the rate certification. Information on all assumptions included in the rate development, based on the available and applicable state specific, as well as nationally and regionally applicable, data (outlined below in Section I.1.B.x.(a)), to address the direct and indirect impacts of the COVID-19 PHE are described in each of the sections below:

- I.1.A.iii.(c)(i)(B) General Description of Benefits
- I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria
- I.1.B.x.(a) Available Applicable Data to Address COVID-19 PHE in Capitation Rate Setting
- I.1.B.x.(b) How Capitation Rates Account for COVID-19 PHE Impacts
- I.1.B.x.(c) COVID-19 Costs Not at Risk – Outside Capitation Rates
- I.1.B.x.(d) Risk Mitigation Strategies Utilized for COVID-19 PHE
- I.2.B.iii.(d) Changes in the Program
- I.2.B.iii.(e) Exclusions of Payments or Services
- I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies
- I.3.B.iii.(a)(i) Projected Benefit Cost Trends Data
- I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons

Additional evaluation conducted related to the COVID-19 PHE which did not result in adjustments to the rate development for CYE 23 vary by program. The ALTCS DES/DDD Program is not impacted by the MOE requirements of the PHE in the same way that other AHCCCS programs are, as described above in Section I.1.A.iii.(c)(iv), which resulted in the evaluation of changes in acuity being negligible as stated

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below in I.1.B.x.(b), and so while the population was evaluated for acuity changes, no adjustments to the rate were made as they were unnecessary. Additionally, while there are data adjustments included in the rate development for some categories of service based on changes in utilization associated with the PHE, not all categories of service were impacted to the point of being unreasonable for use as the base data without adjustment. For example, pharmacy data was not adjusted, because this category of service was not disrupted in a material way. The level of COVID-19 vaccinations within the AHCCCS membership was evaluated and, though it contributed to the development of utilization adjustments as described in section I.2.B.iii.(d), no specific adjustment was applied due to current or projected vaccination rates because the observed utilization impacts related to the PHE were largely limited in scope to a few key LTSS categories. Changes in Arizona COVID-19 case rates were reviewed both in general and with respect to the different COVID-19 variants in the base data time period and more recently, but no adjustments for expected new variants were included in capitation rate development.

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

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

This section of the 2023 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, 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, 2022.

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

This section of the 2023 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell for certified rates per rate cell, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.4(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

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

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### **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 23 capitation rates for the ALTCS DES/DDD Program.

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

This section of the 2023 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 2023 Guide. Sections of the 2023 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 23 capitation rates for the covered populations under the ALTCS DES/DDD Program are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

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### 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 2023 Guide requests a comparison to the final certified rates in the previous rate certification. Comparisons between the most recently certified CYE 23 ALTCS DES/DDD Program capitation rates effective January 1, 2022 and the CYE 23 capitation rates being certified in this actuarial rate certification are available in Appendix 3. The 2023 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. For the purposes of the CYE 23 certified capitation rates, the actuary defined any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year as a negative change in the rate.

Both rate cells for the CYE 23 have large changes over the most recently certified capitation rates. For the regular DDD rate cell, this is primarily due to legislatively mandated provider rate increases as described in section I.3.B.ii.(a). For the Targeted Case Management rate cell, the primary driver is increased staffing costs.

#### 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	Early 2023	AHCCCS has received approval of various ARPA proposals from CMS and the Arizona State Legislature. However, the June 3, 2022 announcement of the extension of the timeline within which states can use ARPA funding means the spending plan is being revised and has not yet been finalized.

### 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

Arizona specific data and information available to the AHCCCS Division of Health Care Management (DHCM) Actuarial Team and the AHCCCS DHCM financial analysts and applicable for determining how to address the COVID-19 PHE in rate setting is listed below:

- AHCCCS historical and current encounter data including utilization and costs by category of service, risk group, GSA, and program
- AHCCCS telehealth utilization and cost data by risk group, GSA, and program
- AHCCCS non-emergency transportation (NEMT) utilization and cost data by risk group, GSA, and program
- AHCCCS historical and current enrollment by risk group, GSA, and program
- AHCCCS COVID-19 testing by risk group, GSA, and program
- AHCCCS COVID-19 vaccination rates by risk group, GSA, and program
- AHCCCS child and adolescent well-care visit rates
- Arizona Medicaid eligibility information, provided by the AHCCCS Division of Member and Provider Services (DMPS), which identified members who, if not for the MOE, would be ineligible, which was used in evaluating expected differences in acuity of the ALTCS DES/DDD Program population after the end of the COVID-19 PHE declaration
- Historical and ongoing COVID-19 case rates for Arizona (not just Medicaid population)

Since the beginning of the COVID-19 pandemic, 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 data and trends with regard to unemployment and inflation reports published by the Bureau of Labor Statistics, as well as state and national COVID-19 case rates published by a variety of sources. The AHCCCS DHCM Actuarial Team continues to monitor national legislation which impacts Medicaid, as well as monitoring federal guidance on the PHE end date and, as mentioned in the bullets above, has analyzed changes in acuity of members due to MOE eligibility requirements in the FFCRA.

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

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

The CYE 23 capitation rates account for the direct and indirect impacts of the COVID-19 PHE by adjusting the base data to revise the impacts of depressed utilization which show reversion towards a more pre-pandemic level within the base data period, by removing COVID-19 vaccine costs from the base data

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since AHCCCS has a non-risk based cost settlement with the Contractors for COVID-19 vaccines, by removing COVID-19 test experience from the base data period and modeling projected COVID-19 testing costs for the rating period. The CYE 23 capitation rates also account for the impacts of the COVID-19 PHE by using a base data experience period which includes changes in service delivery that are expected to continue beyond the pandemic, including increased telehealth usage.

As noted above in Section I.1.A.iii.(c)(iv), the MOE requirements under the PHE are unlikely to impact the membership under the ALTCS DES/DDD Program, as eligibility is predicated upon needing the level of medical support required by the ALTCS eligibility statutes, and the allowable income limits are significantly higher than other AHCCCS programs. Any member leaving the ALTCS DES/DDD Program due to no longer meeting the ALTCS medical support requirements will have their Medicaid eligibility continued under another non-ALTCS AHCCCS program, and members are unlikely to exceed the allowable income limits but would still receive supports through DDD State Only funding if they did. Because of these unique aspects of eligibility for the ALTCS DES/DDD program, there are not measurable changes in the acuity of the membership due to the PHE and MOE requirement, so no acuity adjustment was necessary.

### **I.1.B.x.(c) COVID-19 Costs Not at Risk – Outside Capitation Rates**

Costs for COVID-19 vaccines and administration of COVID-19 vaccines are covered on a non-risk basis outside of the capitation rates. Covering these COVID-19 costs on a non-risk basis outside of the capitation rates required removing related costs from the base data period, as described in Section I.2.B.iii.(d).

### **I.1.B.x.(d) 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 23 capitation rates will continue AHCCCS' long-standing program policy and will include risk corridors. For the CYE 23 rating period, AHCCCS is continuing the cost-settlement for administration of COVID-19 vaccines and carving these costs out of the capitation rates. This is the only risk mitigation strategy utilized specifically for COVID-19.

## I.2. Data

This section provides documentation for the Data section of the 2023 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 23 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 2017 through February 2022
  - Adjudicated and approved through the second February 2022 encounter cycle
- Reinsurance payments made to ALTCS DES/DDD for services
  - Incurred from October 2017 through May 2022 paid through May 2022
- 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, 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 September 30, 2021 (CYE 21 or FFY 21)
  - October 1, 2021 through February 28, 2022 (year-to-date (YTD) CYE 22 or YTD FFY 22)
- Quarterly and annual financial statements submitted by ALTCS DES/DDD, and the integrated subcontractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
  - October 1, 2019 through September 30, 2020 (CYE 20 or FFY 20)
  - October 1, 2020 through September 30, 2021 (CYE 21 or FFY 21)
  - October 1, 2021 through March 31, 2022 (YTD CYE 22 or YTD FFY 22)



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- 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, 2018 through March 31, 2022
  - Projected for CYE 23
- Historical and projected administrative and case management expenses from ALTCS DES/DDD
  - Historical from October 1, 2018 through March 31, 2022
  - Projected for CYE 23
- Bid administrative expenses from a competitive bid process for ALTCS DES/DDD integrated subcontractors updated for forecasted inflation.

Additional sources of data used or reviewed were:

- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CYE 2021
- Historical and projected enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
  - Projections for CYE 23
  - Historical enrollment from mid CYE 22 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. ALTCS DES/DDD utilizes staff models for some of these LTSS services. ALTCS DES/DDD 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

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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, CYE 21, or prior data years) also use sub-capitated arrangements with some providers which 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 sub-capitated encounters to estimate a health plan valued amount in place of the health plan paid amount of zero. 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 DHCM Data management and Oversight (DMO) Team, who then works with the health plan to identify causes. In

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

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

AHCCCS has an additional encounter process which ensures that each adjudicated and approved encounter contains a valid AHCCCS member ID for an individual who was enrolled on the date that the service was provided. The process also checks to ensure that each adjudicated and approved encounter is for a covered service under the state plan and contains the codes necessary to map it into one of the 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 23 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 2017 through February 2022 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. The data was judged to be consistent across data sources.

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

As required by ASOP No. 23, the AHCCCS DHCM Actuarial Team 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 the same entities 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 23 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 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 encounter data and supplemental cost data for state operated facilities to be appropriate for the purposes of developing the appropriate components for the CYE 23 capitation rates for the ALTCS DES/DDD Program.

### **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.

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

The AHCCCS DHCM Actuarial Team determined that the CYE 21 encounter data was appropriate to use as the base data for developing the CYE 23 capitation rates for the ALTCS DES/DDD Program with the inclusion of supplemental cost data related to staff models for LTSS provided in state operated facilities previously noted.

### **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 23 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 are used in the development of the CYE 23 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 23 capitation rates.

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

This section describes adjustments made to the CYE 21 encounter data that was used as the base data for developing the CYE 23 capitation rates for the ALTCS DES/DDD Program.

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

Not applicable. No credibility adjustments were made to the CYE 21 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 2017 through February 2022. The monthly completion factors were applied to the encounter data on a monthly basis. Aggregate completion factors by category of service for the regular DDD rate cell can be found in Appendix 4. The aggregated CYE 21 completion factor impacts are shown in Table 2 below.

**Table 2: Completion Factor Impacts**

Rate Component	Before Completion	After Completion	Impact
LTSS	\$3,417.87	\$3,456.80	1.14%
Integrated Care Services	\$843.98	\$889.99	5.45%
Total	\$4,261.86	\$4,346.79	1.99%

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

During the rate development process, no errors in the base year (CYE 21) encounter data were discovered.

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2020 through September 30, 2021) are described below, or in Section I.3.A.iv. for base data adjustments required with respect to IMD in-lieu-of services. Additional adjustments to address specific impacts of COVID-19 in the base period and utilization shifts associated with ABA services are also described in this section. All other program and fee schedule changes which occurred or are effective on or after October 1, 2021 are described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the rate for 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.

Some of the impacts for base data adjustment changes described below (indicated by an asterisk \*) were developed by AHCCCS DHCM financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS DHCM Clinical Quality Management (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

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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.

### **General Utilization Adjustments**

Significant shifts in utilization patterns were observed throughout CYE 21. Most of the observed change was related to the COVID-19 PHE, which saw, at first, greatly reduced utilization in LTSS day programs. As vaccination rates climbed throughout CYE 21, day program utilization partially recovered and stabilized at a level below the pre-pandemic average. The actuary also observed that the Omicron variant (December 2021 through early February 2022) displayed a much smaller impact on day programs as compared to the initial COVID outbreak, indicating that future movement in day programs is likely to remain stable pending future economic conditions or specific action by the ALTCS DES/DDD Program to encourage day program utilization.

In addition to COVID-19-related effects, the actuary observed utilization shifts consistent with the transition of ABA services from DES/DDD to its subcontractors, which started January 1, 2021 and appear to have stabilized and fully transitioned by January 1, 2022. To account for this dramatic shift in utilization, the actuary applied an increase to integrated subcontractor experience for CYE 2021 and an offsetting decrease to DES/DDD experience over the same period.

**Table 3a: General Utilization Adjustments**

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$84.70	\$39,953,801
Integrated Care Services	\$26.75	\$12,617,740
Total	\$111.46	\$52,571,541

### **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. During CYE 2020 and partially through CYE 2021, the ALTCS DES/DDD program provided enhanced provider payment rates to safeguard the provider network during the COVID-19 PHE; these enhanced rates expired partway through CYE 2021 and were replaced by permanent provider rate increases beginning in CYE 2022 (outlined in section I.3.B.ii.(a) below covering program changes on or after October 1, 2021). The impact of removing the enhanced provider payments partway through CYE 2021 and including the annual AHCCCS fee schedule updates through September 30, 2021 is given in Table 3b below.

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**Table 3b: Provider Fee Schedule Changes**

Rate Component	PMPM Impact	Dollar Impact
LTSS	(\$48.36)	(\$22,808,460)
Integrated Care Services	\$0.00	\$0
<b>Total</b>	<b>(\$48.36)</b>	<b>(\$22,808,460)</b>

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

CYE 21 capitation rates funded DAP made from October 1, 2020 through September 30, 2021 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, 2021, AHCCCS has removed the impact of DAP from the base period CYE 21. To remove the impact, the AHCCCS DHCM Actuarial Team requested provider IDs for the qualifying providers for the CYE 21 DAP by specific measure from the AHCCCS DHCM Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 21 were then adjusted downward by the appropriate percentage bump specific to the DAP measure. The impact of this adjustment is given in Table 3c below.

See Section I.4.D. for information on adjustments included in CYE 23 capitation rates for DAP that are effective from October 1, 2022 through September 30, 2023.

**Table 3c: CYE 21 DAP Removal**

Rate Component	PMPM Impact	Dollar Impact
LTSS	(\$9.86)	(\$4,652,941)
Integrated Care Services	(\$8.25)	(\$3,892,480)
<b>Total</b>	<b>(\$18.12)</b>	<b>(\$8,545,421)</b>

### ***Combined Miscellaneous Base Data Adjustments***

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component of the rate for the regular DDD rate cell, that program change was deemed non-material for the purpose of the actuarial rate certification. The impacts have been aggregated and are provided in Table 3d below. Brief descriptions of the individual program changes requiring base data adjustment are provided below.

- **Pharmacy and Therapeutics Committee Recommendations \***  
 On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE21 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.
- **Removal of Covid-19 Vaccine Costs from Base Data**  
 As noted above in Section I.1.B.x.(c), there is a separate mechanism to reimburse the Contractor

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for COVID-19 vaccines on a non-risk basis, so associated costs have been removed from the base encounter data.

- **Removal of COVID-19 Tests from Base Data**

As part of the monitoring of experience for the PHE, the DHCM Actuarial Team has reviewed utilization associated with COVID-19 testing each month. This review led the actuaries to the decision that it would be more appropriate to model these specific services as a COVID-19 specific adjustment than including the utilization and costs in the base data and proceeding as if no further adjustment would be needed to accurately project costs in the rating period. To that end, as part of the rate development process, all utilization and expenses associated with COVID-19 tests were removed from the base data, as well as from the data used to develop trends, and analyzed separately. The impact of the specific adjustment for including COVID-19 tests in the rating period is addressed below in Section I.3.B.ii.(a).

**Table 3d: Combined Miscellaneous Base Data Adjustments**

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$0.00	\$0
Integrated Care Services	(\$2.84)	(\$1,341,635)
Total	(\$2.84)	(\$1,341,635)

### 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 23 capitation rates. Other base data adjustments which excluded services from the data (i.e., COVID-19 vaccine removal) are described above in Section I.2.B.iii.(d).



### I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2023 Guide.

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

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

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

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

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

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

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 21 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 21 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 \$895.28 and was derived from the CYE 21 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

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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	\$0.39	\$185,065
Total	\$0.39	\$185,065

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	(\$0.78)	(\$365,992)
Total	(\$0.78)	(\$365,992)

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)	(\$17,638)
Integrated Care Services	(\$0.13)	(\$60,092)
Total	(\$0.16)	(\$77,730)

### I.3.B. Appropriate Documentation

#### I.3.B.i. Projected Benefit Costs

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

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

This section provides information on the projected benefit costs included in the CYE 23 capitation rates for the ALTCS DES/DDD Program.

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### 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 24 months from the midpoint of the CYE 21 time period to the midpoint of the CYE 23 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below.

The CYE 23 capitation rates include an offset to account for ALTCS DES/DDD members' projected share of cost (SOC) in CYE 23. 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 (CYE 21) ALTCS DES/DDD member SOC data. The SOC data was evaluated for trend over the period from October 1, 2017 through February 2022 and showed a consistent, annualized decline of 4%. 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, and Appendix 5 contains the projected benefit cost trends. Appendix 6 contains the development of the gross medical expense from the adjusted base data, including all prospective programmatic and fee schedule changes and the impact of the DAP, and Appendix 7 contains the development of the certified capitation rates from the projected gross medical expense, including 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 on the gross medical component of the regular DDD rate cell 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.

### ***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

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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 FQHCs/RHCs at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates include adjustments to bring the base FQHC/RHC encounter data up to the projected CYE 23 FQHC/RHC 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 23 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DHCM Rates & Reimbursement Team used the CYE 21 encounter data to develop the impacts of fee schedule changes between the base year and the rating period. The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to calculate the adjustment to the CYE 21 base data. The actuary then reviewed the results and applied aggregated percentage impacts by program, rate cell, and category of service.

Effective October 1, 2021, AHCCCS increased reimbursement for administration of Vaccine for Children (VFC) program vaccines to the maximum fee permitted to be reimbursed by the state under federal rule 77 FR 66669.

In the 2022 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 services. The AHCCCS DHCM Actuarial Team adjusted CYE 23 capitation rates to reflect the level of additional appropriated funding for the ALTCS DES/DDD program. The AHCCCS DHCM Actuarial team also adjusted CYE 23 capitation rates to reflect the legislative provider fee schedule increases in the general appropriations bill for NF services across all AHCCCS programs. AHCCCS' expectation is that the funded rate increases will be adopted by ALTCS DES/DDD for HCBS and by the ALTCS DES/DDD integrated subcontractors for NF services. The changes are expected to increase statewide costs under the ALTCS DES/DDD program by \$199.1M, or \$422.19 PMPM. The HCBS and NF fee schedule increases from the 2022 legislative session are in addition to the fee schedule increases for the same services from the 2021 legislative session which were described in the CYE 22 ALTCS DES/DDD capitation rate certification. The combined impacts of both years of legislatively mandated increases for HCBS and NF services are included in the table below which shows the overall impact of all provider fee schedule changes from October 1, 2021 and forward.

The general appropriations bill passed by the legislature in the 2022 session also included funding to increase the four global OBGYN codes (59400, 59510, 59610, 59618) effective October 1, 2022.

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Effective October 1, 2022, AHCCCS is increasing the All Patients Refined Diagnosis Related Group (APR-DRG) base rate for rural hospitals.

AHCCCS also increases some fee schedule rates effective January 1 of each year to recognize the annual minimum wage increase resulting from the passing of Proposition 206. The increased costs for this change have been included with the fee schedule changes already discussed. The overall impact of the AHCCCS Fee-for-Service fee schedule updates for all updates from October 1, 2021 through the end of CYE 23 are 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	\$786.41	\$370,938,973
Integrated Care Services	\$16.68	\$7,867,044
<b>Total</b>	<b>\$803.09</b>	<b>\$378,806,017</b>

### ***Combined Miscellaneous Program Changes***

The rate development process includes every individual program and reimbursement change as a separate adjustment. However, as noted earlier in this section, if an individual program or reimbursement change had an impact of 0.2% or less on the gross medical component of the regular DDD 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 5b. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Vaxelis Immunizations \***

AHCCCS began covering Vaxelis, 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, effective January 1, 2021, but a review of the encounter data shows that adoption of the combination immunization did not begin in earnest until October 2021, after the end of the base data time period. 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 23 rates include a reduction for the projected decrease in vaccine shots that will be administered to children.
- **Bus Passes \***

Effective October 1, 2021, AHCCCS revised AMPM 310-BB to clarify that Contractors may reimburse public transport passes as non-emergency medical transport (NEMT). Passes are generally 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 23 adjustments to rates

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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.

- **Emergency Triage, Treat, and Transport \***

Effective October 1, 2021, AHCCCS implemented 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 bill 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 revised 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.

- **High Needs Therapeutic Foster Care Rates \***

Effective October 1, 2021, AHCCCS established 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.

- **Reimbursement for Discarded Drugs \***

Effective January 1, 2022, AHCCCS began requiring Contractors to reimburse discarded amounts of medication products that can only be used once, also known as single use vials.

- **N95 Masks \***

In March 2022, AHCCCS advised Contractors that providers could bill and receive reimbursement for N95 masks issued to members with immunocompromised conditions.

- **Adult Chiropractic Services \***

Pursuant to HB2863, AHCCCS is adding chiropractic services ordered by a primary care physician as a covered service for adult members, effective October 1, 2022. Prior to the law, coverage of chiropractic services was limited to children under the age of 21 years.

- **Child Depression Screening \***

Effective October 1, 2022, the agency is revising the AHCCCS Medical Policy Manual (AMPM) 430 to recommend depression and suicide risk screens be provided to children ages 12 to 20 years during EPSDT visits. The change aligns with screening recommendations from the American Academy of Pediatrics. To estimate the impact, DHCM financial analysts reviewed EPSDT visit and depression screening utilization for the CYE 2021 base period. It was assumed that all members ages 12 to 20 years that had not received a depression screen during their EPSDT visits would receive 1 screen during CYE 2023. The analysts then assumed that the difference in the rate of depression diagnosis between screened and previously unscreened

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individuals in the base period would be reduced by 20% in CYE 2023. Costs of the additional screens and subsequent mental health services were priced using per user service costs observed during the base period.

- **COVID-19 Tests**

As noted above in Section I.2.B.iii.(d), the AHCCCS DHCM Actuarial Team has reviewed utilization associated with COVID-19 testing each month. As part of the rate development process, the AHCCCS DHCM Actuarial Team modeled projected utilization and costs for COVID-19 tests for the rating period. The projected utilization per 1000 was developed by averaging the utilization from the base period with more recent utilization from June 2021 through May 2022. The unit cost for different types of COVID-19 tests (lab/physician testing versus at-home test kits) was calculated with data specific to each type, and the distribution of tests by type provided the blend for an overall projected unit cost in the rating period. The actuary then combined projected utilization and unit cost into an overall PMPM for the Regular DDD rate cell. This modeling specifically incorporates more recent data than the base period in order to recognize that new variants and reduced public mitigation efforts have impacted the need for COVID-19 testing differently by population. No assumptions regarding vaccination rates were incorporated into the projections for use of tests.

- **Diabetes Self-Management Training \***

Pursuant to HB2083, AHCCCS is adding 10 hours per year of diabetes self-management training as a covered service for diabetic members, effective October 1, 2022. To estimate the impact, DHCM financial analysts first reviewed data of diabetes prevalence among members. Based on findings from a literature review of studies on diabetes self-management training programs, it was assumed that 6% of diabetic members would utilize the covered service. It was assumed that each utilizing member would receive 5 hours of services a year. The total cost of the visits was then estimated using the AHCCCS fee for service rate schedule for outpatient diabetes self-management training. The resulting cost impact was allocated across rate cells using member prevalence of diabetes diagnoses during FFY 2021.

- **Infant Dental Visits \***

Effective October 1, 2022, AHCCCS is revising AMPM 431 to expand coverage of preventive dental services to infants 6 – 12 months of age. The change is consistent with recommendations from Bright Futures and the American Academy of Pediatrics.

- **Maternal Postpartum Depression Screening \***

Effective October 1, 2022, the agency is revising AMPM 430 to recommend postpartum depression screens be provided to caretakers during a child's EPSDT for 6 months following birth. The change aligns with screening recommendations from Bright Futures.

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

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 23. The P&T Committee evaluates scientific evidence on the

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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.

- **Community Intervener Services \***

Effective January 1, 2023, 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. Adjustments for this item were included in the CYE 22 capitation rates, with the expectation that the service would be effective October 1, 2021. As described above, this change is now expected to be effective starting January 1, 2023.

- **Dental Cone Beam CT Capture \***

AHCCCS will reimburse for cone beam CT capture for dental imaging, beginning January 1, 2023. Cone-beam CT capture emits an x-ray beam shaped like a cone as opposed to the conventional fan-shaped beam. This procedure is expected to be used for any tooth extraction as well as for endodontic procedures such as molar and premolar root canals. This type of imaging would be done in addition to current X-ray imaging. AHCCCS estimates that 85-90% of conventional X-rays prior to extractions and 80% of root canals would be augmented by cone beam imaging to confirm results. AHCCCS will require prior authorization for fee-for-service coverage of cone beam CT capture.

- **Back to School Initiative \* -**

AHCCCS child and adolescent well-care visit rates have historically been lower than the CMS Medicaid median and these rates have declined as a result of the COVID-19 PHE. To address this issue, AHCCCS will implement a Back-to-School campaign beginning July 2023 to encourage child and adolescent well-care visit rates.

- **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 18, CYE 19, CYE 20 and CYE 21 annual financial statement reports and the CYE 22 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 23 Pharmacy (form type C) category of service.

**Table 5b: Combined Miscellaneous Program Changes**

Rate Component	PMPM Impact	Dollar Impact
LTSS	\$0.00	\$0
Integrated Care Services	\$3.71	\$1,750,652
<b>Total</b>	<b>\$3.71</b>	<b>\$1,750,652</b>



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### **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 and its subcontractors 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 23 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 2017 through December 2021 and adjudicated and approved through the second February 2022 encounter cycle, 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 adjusted to account for any COVID-19 time period which had large and varied impacts on categories of service which are not anticipated to be continued into the rating period

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 were summarized by month and category of service, and by utilization per 1000, unit costs, and PMPM values. The encounter data was adjusted for completion and to normalize for previous program and reimbursement changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 21 (April 1, 2021) to the midpoint of the rating period for CYE 23 (April 1, 2023). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. Projected benefit cost trends were based upon actuarial judgment after reviewing multiple moving averages and several linear regression lines for each of the utilization per 1000, unit cost and resulting PMPM trend assumptions. 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 22 for ALTCS DES/DDD capitation rates and judged reasonable to assume for projection to CYE 23, considering the change in the base data time period, the rating period, the intervening COVID-19 pandemic, as well as changes to covered services.

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

The 2023 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 23 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 for these categories of service was based upon actuarial judgment after reviewing multiple moving averages and several linear regression lines; all linear regression lines for the utilization data for these categories of service are negatively sloped. This is consistent with the declining population in these settings.

### 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 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	2.96%	0.71%	3.70%
Integrated Care Services	1.99%	2.49%	4.53%
Total	2.76%	1.08%	3.87%

#### 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 12, 2022, 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 capitation rate development has complied with the requirements of 42 CFR § 438.3(e) 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 23 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.

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### **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 and the ALTCS DES/DDD subcontractors 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/RHCs 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 2023 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 23 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 23 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 23 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 2023 Guide provides information on the requirements for risk-sharing mechanisms. For information on the COVID-19 costs covered on a non-risk basis, see Section I.1.B.x.(c).

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

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

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

The CYE 23 contract for the ALTCS DES/DDD Program will include risk corridors for the regular DDD rate cell.

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

AHCCCS has a long-standing program policy of including risk corridors within many of the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 23 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 2023 Guide. The ALTCS 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 ALTCS DES/DDD reconciling its Subcontractor costs to reimbursement and the second is the LTSS and DDD-THP 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 DDD-THP costs risk corridor will reconcile ALTCS DES/DDD's LTSS and DDD-THP 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 DDD-THP 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%.

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

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

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

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

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

Risk-sharing mechanisms are developed in accordance with generally accepted actuarial principles and practices. The threshold amounts for the risk corridors were set using actuarial 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.(a)(v) Risk-Sharing Arrangements Consistent with Pricing Assumptions**

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

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

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

If experience in the rating period aligns with pricing assumptions used in capitation rate development, there will be no remittance/payment between AHCCCS and the Contractors associated with the risk corridors. The risk corridors protect the State against excessive Contractor profits and protect Contractors from excessive losses when experience in the rating period materially differs from the pricing assumptions.

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

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

Not applicable. The ALTCS 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 AHCCCS Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the

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majority of the reinsurance cases falling into the Regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under Catastrophic, including reinsurance for biologic drugs. Additionally, rather than the ALTCS DES/DDD Contractor 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 23 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. The deductible for CYE 23 Regular reinsurance cases is \$75,000, an increase from the CYE 22 Regular reinsurance case deductible. The limit on High Dollar Catastrophic reinsurance is \$1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

The actual reinsurance case amounts are paid to 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 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 expense PMPM calculated for the rate setting period. It is a separate calculation and does not affect the methodologies for development of the gross medical expense component of the capitation 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 CYE 21. 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.



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The projected costs of drugs added to the biologic reinsurance case type after the base period was calculated by taking the projected costs for CYE 23 for those drugs and applying a zero dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset. The combined dollar impact to the reinsurance offset for the ALTCS DES/DDD Program is \$3,030,000.

Additionally, these data were adjusted for an expected 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 90% 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 23. The reinsurance offset was derived by taking the sum of the reinsurance case values and dividing by the CYE 23 projected member months.

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

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

This section of the 2023 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. The contract requires the adoption of a minimum fee schedule for FQHC/RHC providers using State plan approved rates, as defined in 42 CFR § 438.6(a), as allowed under 42 CFR § 438.6(c)(1)(iii)(A). This state directed payment for FQHC/RHC providers does not require written approval prior to implementation per 42 CFR § 438.6(c)(2)(ii). The state directed payments which require pre-prints for prior approval are DAP, APSI, PSI, and HEALTHII. The 2023 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

###### ***Federally Qualified Health Centers and Rural Health Clinics***

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

###### ***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

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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 0.25% to 20.0%, depending on the provider type.

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

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

- 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 25 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 70% 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 with more than 100 licensed beds. The PSI provides a uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, with more than 100 licensed beds. The PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

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

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

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

The FQHC/RHC minimum fee schedule and the DAP initiative are the only directed payments incorporated in the capitation rates. The 2023 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

### **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**

The FQHC/RHC minimum fee schedule impact is included as part of the aggregate fee schedule changes shown in Appendix 6. For the total impact to the regular DDD rate cell for the FQHC/RHC minimum fee schedule see Appendix 8b. For DAP see Appendix 6 for the medical impact and Appendix 8b for the total impact to the regular DDD rate cell.

### **I.4.D.ii.(a)(ii)(C) Data, Assumptions, Methodology to Develop Directed Payment Adjustment Federally Qualified Health Centers and Rural Health Clinics**

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

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

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.25% increase), Critical Access Hospitals (eligible for up to 10.75% increase), other hospitals and inpatient facilities (eligible for up to 5.0% increase), rehabilitation and long term acute care hospitals (eligible for a 0.25% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for up to a 1.0% increase), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 8.5% increase), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), physicians, physician assistants, and registered nurse practitioners specialty types (obstetrics and gynecology, pediatrics, cardiology and nephrology) (eligible for a 1.0% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), HCBS providers (eligible for up to 3.0% increase), therapeutic foster homes (eligible for up to 20.0% increase), specific provider types that have or plan to have a workforce development plan (eligible for a 1.0% increase), specific provider types that meet employment staff training requirements (eligible for a 2.0% increase), and crisis providers (eligible for a 3.0% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 21 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 23 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 23 (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).

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

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

AHCCCS has submitted the DAP 42 CFR § 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 2023 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

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

Anticipated payments including premium tax for APSI are approximately \$11.4 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 \$13.2 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 23 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 \$32.1 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 23 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.

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

### ***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 8b contains estimated PMPMs including premium tax for the regular DDD 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 42 CFR § 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 42 CFR § 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 42 CFR § 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

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

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 rate certification, including minimum fee schedules using State plan approved rates as defined in 42 CFR § 438.6(a).

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

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

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

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

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

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

This section of the 2023 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 23. 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 23 projection funds 85% of the required case management ratios in the contract. The projected PMPM associated with case management expenses for CYE 23 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 23, actual expenses reported by ALTCS DES/DDD for FFY 19, FFY 20, and FFY 21, and inflation forecasts provided in the IHS Markit First Quarter 2022 Healthcare Cost Report. The base data used for the administrative expense projection for LTSS was ALTCS DES/DDD administrative expenses reported during FFY 21. 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 specific estimates of known salary increases, and incorporated estimates for additional administrative requirements in the upcoming contract year to come up with a projected administrative expense amount for CYE 23. This projection was then compared to the CYE 23 expense projection from ALTCS DES/DDD. The actuary's estimated projection of administrative expenses for CYE 23 was similar to the forecast provided by ALTCS DES/DDD for CYE 23. The actuary's CYE 23 projection of administrative expenses for LTSS is denoted as Administration for LTSS in Appendix 6.

The administrative expense PMPM for CYE 23 for the integrated subcontractors reflects inflation-adjusted 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. The original bid amounts took effect October 2019; to produce an estimate of the integrated subcontractor administrative cost, the actuary estimated the projected membership for each integrated subcontractor for CYE 23 to determine the appropriate bid threshold, based on reported integrated subcontractor enrollment as of February 2022. The actuary adjusted compensation-related components of the bid amounts using projected CPI-W inflation from the IHS Markit Healthcare Cost Report and added administrative cost projections

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

associated with the AAC transition to the bid threshold amounts. The CYE 23 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, 2022 through September 30, 2023. 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, provided by ALTCS DES/DDD. However, unlike the ALTCS case management costs, Targeted Case Management used membership projections from ALTCS DES/DDD. The CYE 23 Targeted Case Management projection funds 85% of 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 23 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 23 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 23 capitation rate for the regular DDD rate cell includes a provision for margin (i.e., underwriting (UW) gain) of 1.0%. 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 23 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 AHCCCS Contractors via financial statements and additional data requests. The audited financial statements can be found on the AHCCCS website at:



## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

<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 2023 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 2023 Guide is applicable to the ALTCS DES/DDD Program because the CYE 23 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 2023 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 2023 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.

## **CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program**

### **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 2023 Guide is not applicable to the ALTCS DES/DDD Program.

### Appendix 1: Actuarial Certification

I, Erica Johnson, am an employee of 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 generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries, the Actuarial Standards Board, CMS, and federal regulations.

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

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

## CYE 23 Capitation Rate Certification – ALTCS DES/DDD Program

- § 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 23 capitation rates for the ALTCS DES/DDD Program have been documented according to the guidelines established by CMS in the 2023 Guide. The CYE 23 capitation rates for the ALTCS DES/DDD Program are effective for the 12-month time period from October 1, 2022 through September 30, 2023.

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 12, 2022

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Erica Johnson

Date

Associate, Society of Actuaries

Member, American Academy of Actuaries

## Appendix 2: Certified Capitation Rates

ALTCS DES/DDD Capitation Rates Effective October 1, 2022 through September 30, 2023	
Regular DDD	\$6,039.85
Targeted Case Management	\$216.33

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

ALTCS DES/DDD Capitation Rates						
Effective October 1, 2022 through September 30, 2023						
Rate Cell	Rate Effective 1/1/2022	Rate Effective 10/1/2022	% Change		CYE 23 Projected MMs	CYE 23 Projected Expenses
ALTCS DDD	\$5,435.55	\$6,039.85	11.12%		471,684	\$2,848,896,568
Targeted Case Management	\$181.02	\$216.33	19.51%		68,534	\$14,825,972

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



## CYE23 Capitation Rate Certification - DDD Program

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

Category of Service	I.2.B.iii.(b)	I.2.B.iii.(b)	I.2.B.iii.(b)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.iv	I.3.A.iv	I.3.A.iv	Subtotal
	Unadjusted Base PMPM	Completion Factors	Completed Base PMPM	General Utilization Adjustments	Provider Fee Schedule Changes	Removal of DAP	Comb. Misc. Adjustment	IMD (Reprice Stays of all Lengths)	IMD (Remove Stays > 15)	IMD (Remove Related Expenses > 15)	Adjusted Base PMPM
ATPC	\$49.73	1.0000	\$49.73	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$49.73
Attendant Care	\$594.59	0.9885	\$601.53	0.00%	(0.51%)	(0.30%)	0.00%	0.00%	0.00%	0.00%	\$596.71
Day Treatment	\$228.98	0.9863	\$232.16	28.27%	(1.97%)	(0.23%)	0.00%	0.00%	0.00%	0.00%	\$291.23
Employment	\$66.56	0.9871	\$67.43	30.35%	(3.47%)	(0.23%)	0.00%	0.00%	0.00%	(0.00%)	\$84.65
Hab - Per 15 Min	\$422.78	0.9885	\$427.69	(2.49%)	(0.98%)	(0.31%)	0.00%	0.00%	0.00%	0.00%	\$411.69
Hab - Per Diem	\$1,323.87	0.9887	\$1,339.07	0.00%	(1.94%)	(0.30%)	0.00%	0.00%	0.00%	(0.00%)	\$1,309.14
Misc. In Home Care	\$1.53	0.9874	\$1.55	0.00%	0.00%	(0.29%)	0.00%	0.00%	0.00%	0.00%	\$1.54
Nursing	\$131.21	0.9887	\$132.71	0.00%	(3.12%)	(0.30%)	0.00%	0.00%	0.00%	0.00%	\$128.18
Private ICF	\$23.16	0.9935	\$23.31	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$23.31
Respite	\$296.72	0.9889	\$300.04	0.00%	0.58%	(0.29%)	0.00%	0.00%	0.00%	0.00%	\$300.89
SelfCare Home Management	\$4.84	0.9894	\$4.90	0.00%	0.00%	(0.29%)	0.00%	0.00%	0.00%	0.00%	\$4.88
SOGH	\$16.59	1.0000	\$16.59	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$16.59
SOICF	\$19.85	1.0000	\$19.85	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	\$19.85
Therapies and Evaluations	\$205.90	0.9887	\$208.25	0.00%	(1.91%)	(0.30%)	0.00%	0.00%	0.00%	0.00%	\$203.65
Transportation	\$31.58	0.9866	\$32.01	28.99%	0.00%	(0.23%)	0.00%	0.00%	0.00%	0.00%	\$41.19
Integrated Care Services	\$843.98	0.9483	\$889.99	3.01%	0.00%	(0.90%)	(0.31%)	0.04%	(0.09%)	(0.01%)	\$905.13
<b>Gross Medical</b>	<b>\$4,261.86</b>		<b>\$4,346.79</b>								<b>\$4,388.38</b>

Appendix 5: Projected Benefit Cost Trends

Statewide				
Rate Cell	Trend COS	Utilization Per 1000	Unit Cost	PMPM
DES/DDD	ATPC	(2.5%)	1.8%	(0.7%)
DES/DDD	Attendant Care	5.9%	0.1%	6.0%
DES/DDD	Day Treatment	(0.2%)	0.3%	0.1%
DES/DDD	Employment	(0.2%)	0.3%	0.1%
DES/DDD	Hab - Per 15 Min	3.9%	0.1%	4.0%
DES/DDD	Hab - Per Diem	0.1%	0.3%	0.4%
DES/DDD	Misc. In Home Care	0.1%	1.0%	1.1%
DES/DDD	Nursing	0.1%	1.0%	1.1%
DES/DDD	Private ICF	(2.5%)	1.8%	(0.7%)
DES/DDD	Respite	0.1%	1.0%	1.1%
DES/DDD	SelfCare Home Management	0.1%	1.0%	1.1%
DES/DDD	SOGH	(2.5%)	1.8%	(0.7%)
DES/DDD	SOICF	(2.5%)	1.8%	(0.7%)
DES/DDD	Therapies and Evaluations	0.4%	0.1%	0.5%
DES/DDD	Transportation	(0.2%)	0.3%	0.1%
DES/DDD	Integrated Care Services	1.0%	1.2%	2.2%

**Appendix 6: Development of Gross Medical Component**

## CYE23 Capitation Rate Certification - DDD Program

### Appendix 6: Development of Gross Medical Component

Category of Service	Subtotal Adjusted Base PMPM	I.3.B.iii.(b)(i) Trend	Product Trended PMPM	I.3.B.ii.(a) Aggregate Fee Schedule Updates	I.3.B.ii.(a) Comb. Misc. Adjustment	Subtotal Gross Medical PMPM
ATPC	\$49.73	(0.74%)	\$48.99	0.00%	0.00%	\$48.99
Attendant Care	\$596.71	6.01%	\$670.54	22.25%	0.00%	\$819.75
Day Treatment	\$291.23	0.10%	\$291.81	22.38%	0.00%	\$357.11
Employment	\$84.65	0.10%	\$84.82	22.60%	0.00%	\$103.99
Hab - Per 15 Min	\$411.69	4.00%	\$445.32	22.09%	0.00%	\$543.67
Hab - Per Diem	\$1,309.14	0.40%	\$1,319.65	22.50%	0.00%	\$1,616.53
Misc. In Home Care	\$1.54	1.10%	\$1.58	22.82%	0.00%	\$1.94
Nursing	\$128.18	1.10%	\$131.02	22.06%	0.00%	\$159.93
Private ICF	\$23.31	(0.74%)	\$22.96	21.02%	0.00%	\$27.79
Respite	\$300.89	1.10%	\$307.55	22.07%	0.00%	\$375.42
SelfCare Home Management	\$4.88	1.10%	\$4.99	22.22%	0.00%	\$6.10
SOGH	\$16.59	(0.74%)	\$16.34	0.00%	0.00%	\$16.34
SOICF	\$19.85	(0.74%)	\$19.56	0.00%	0.00%	\$19.56
Therapies and Evaluations	\$203.65	0.50%	\$205.70	21.97%	0.00%	\$250.89
Transportation	\$41.19	0.10%	\$41.27	22.35%	0.00%	\$50.50
Integrated Care Services	\$905.13	2.24%	\$946.15	1.76%	0.39%	\$966.54
<b>Gross Medical</b>	<b>\$4,388.38</b>		<b>\$4,558.25</b>			<b>\$5,365.05</b>

DAP PMPM	\$48.01
<b>Gross Medical Plus DAP PMPM</b>	<b>\$5,413.06</b>

**Appendix 7: Capitation Rate Development**

## CYE23 Capitation Rate Certification - DDD Program

**Appendix 7: Capitation Rate Development**

Rate Cell	Gross Medical Plus DAP	RI Offset	Net Medical	Case Management	Admin - LTSS	Admin - ICS	UW Gain	Share of Cost Offset	Premium Tax	Certified Capitation Rate
ALTCS DES/DDD	\$5,413.06	(\$66.33)	\$5,346.73	\$206.46	\$251.60	\$58.26	\$59.22	(\$3.23)	\$120.80	\$6,039.85
Targeted Case Management	\$0.00	\$0.00	\$0.00	\$209.88	\$0.00	\$0.00	\$2.12	\$0.00	\$4.33	\$216.33

**Appendix 8a: State Directed Payments – CMS Prescribed Tables**

## CYE23 Capitation Rate Certification - DDD Program

### Appendix 8a: State Directed Payments – CMS Prescribed Tables

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

Control name of the state directed payment	Type of payment Section I.4.D.ii.(a)(i)(A)	Brief description Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.D.ii.(a)(iii)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	Minimum Fee Schedule	Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Medicaid State plan as a minimum fee schedule for FQHC/RHC providers.	Rate Adjustment
AZ_Fee_IP.OP.PC.SP.NF.HCBS.BHI.BHO.D_Renewal_20221001-20230930 (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_20221001-20230930 (APSI)	Uniform Percentage Increase	70% increase to otherwise contracted rates for professional services provided by qualified practitioners affiliated with designated hospitals.	Separate Payment Term
AZ_Fee_IP.OP1_Renewal_20221001-20230930 (PSI)	Uniform Percentage Increase	Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 beds. The uniform percentage increase is based on a fixed total payment amount, and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_IP.OP2_Renewal_20221001-20230930 (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's aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term



## CYE23 Capitation Rate Certification - DDD Program

### Appendix 8a: State Directed Payments – CMS Prescribed Tables

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

Control name of the state directed payment	Rate cells affected Section I.4.D.ii.(a)(ii)(A)	Impact Section I.4.D.ii.(a)(ii)(B)	Description of the adjustment Section I.4.D.ii.(a)(ii)(C)	Confirmation the rates are consistent with the preprint Section I.4.D.ii.(a)(ii)(D)	For maximum fee schedules, requested information Section I.4.D.ii.(a)(ii)(E)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	Regular DDD	See Appendix 8b for total impact by rate cell.	<p>The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates, described in Section I.3.B.ii.(a).</p> <p>The AHCCCS DHCM Rates &amp; Reimbursement Team developed the impacts of bringing the base FQHC/RHC encounter data up to the projected CYE 23 FQHC/RHC PPS rates, by applying the change in PPS rates as a unit cost change to the CYE 21 base data. The AHCCCS DHCM Actuarial Team then reviewed the FQHC/RHC results and applied aggregated percentage impacts by program, risk group, and category of service as part of the overall fee schedule update.</p>	Not applicable.	Not applicable.
AZ_Fee_IP.OP.PC.SP.NF.HCBS.BHI.BHO.D_Renewal_20221001-20230930 (DAP)	Regular DDD	See Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell.	<p>The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.25% increase), Critical Access Hospitals (eligible for up to 10.75 % increase), other hospitals and inpatient facilities (eligible for up to 5.0% increase), rehabilitation and long term acute care hospitals (eligible for a 0.25% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for up to a 1.0% increase), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 8.5% increase), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), physicians, physician assistants, and registered nurse practitioners specialty types (obstetrics and gynecology, pediatrics, cardiology and nephrology) (eligible for a 1.0% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), HCBS providers (eligible for up to 3.0% increase), therapeutic foster homes (eligible for up to 20.0% increase), specific provider types that have or plan to have a workforce development plan (eligible for a 1.0% increase), specific provider types that meet employment staff training requirements (eligible for a 2.0% increase), and crisis providers (eligible for a 3.0% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.</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 21 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 23 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 23 (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 DAP 42 CFR § 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 here, is included in the capitation rates in a manner consistent with the pre-print under CMS review.	Not applicable.

## CYE23 Capitation Rate Certification - DDD Program

### Appendix 8a: State Directed Payments – CMS Prescribed Tables

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

Control name of the state directed payment	Aggregate amount included in the certification Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20221001-20230930 (APSI)	\$11,381,228	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Access to Professional Services Initiative (APSI) 42 CFR § 438.6(c) 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_20221001-20230930 (PSI)	\$13,151,980	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Pediatric Service Initiative (PSI) 42 CFR § 438.6(c) 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_20221001-20230930 (HEALTHII)	\$32,084,151	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) 42 CFR § 438.6(c) 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	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 8b: State Directed Payments – Estimated PMPMs**

CYE 23 Estimated PMPM				
Directed Payment	Medical	Underwriting Gain	Premium Tax	Total
FQHC/RHC	\$1.18	\$0.01	\$0.02	\$1.22
DAP	\$48.01	\$0.48	\$0.99	\$49.49
APSI	\$24.13	\$0.00	\$0.49	\$24.62
PSI	\$27.88	\$0.00	\$0.57	\$28.45
HEALTHII	\$68.02	\$0.00	\$1.39	\$69.41