Contract Year Ending 2025
Capitation Rate Certification
Arizona Long Term Care System
Developmental Disabilities Program

October 1, 2024 through September 30, 2025

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Business and Finance

August 2, 2024

Table of Contents

Introduction and Limitations

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

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

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

The 2025 Guide describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2025 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

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

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

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

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

As stated on page 4 of the 2025 Guide, CMS will also use these three principles in applying the regulation standards:

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

I.1. General Information

This section provides documentation for the General Information section of the 2025 Guide.

I.1.A. Rate Development Standards

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

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

I.1.A.ii. Rating Period

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

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 25 capitation rates for the ALTCS-DD Program, signed by Ethan Sheffield, ASA, MAAA and Erica Johnson, ASA, MAAA, is in Appendix 1. Mr. Sheffield and Ms. Johnson meet 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.

Mr. Sheffield and Ms. Johnson certify that the CYE 25 capitation rates for the ALTCS-DD 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-DD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ALTCS-DD Program contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell when identifying a population at the certified capitation rate level (as shown in Appendix 2, Appendix 7, and Appendix 8b) to be consistent with the applicable provisions of 42 CFR Part 438 and the 2025 Guide and will use the term risk group when identifying a population not at the certified capitation rate level, such as when discussing the development of impacts where modeling was done for multiple programs.

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

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

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

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

DES/DDD is the only managed care organization for this program. AHCCCS requires DES/DDD to offer a Dual Eligible Special Needs Plan (D-SNP). DES/DDD subcontracts with integrated subcontractors who operate D-SNPs contracted with AHCCCS to provide some of the services (as outlined in I.1.A.iii.(c)(i)(B) below) for the members enrolled in the ALTCS-DD Program. Mercy Care operates the Mercy Care D-SNP, and UnitedHealthcare Community Plan operates the Arizona Physicians IPA D-SNP.

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

This certification covers the ALTCS-DD Program which provides Long Term Services & Supports (LTSS) and physical and mental health services to its members, as well as Targeted Case Management (TCM) services -- a benefit provided by DES/DDD to AHCCCS members with qualifying intellectual and developmental disabilities who exceed the functional limitations necessary for eligibility under an ALTCS program and are therefore not eligible for ALTCS-DD. Additional information regarding covered services can be found in the ALTCS-DD Program contract.

Although most LTSS are covered directly by DES/DDD, the Division maintains contracts with two integrated subcontractors to cover the following services for the ALTCS-DD Program:

- LTSS provided in a nursing facility, and
- all integrated physical and mental health services, including but not limited to:
    - Children's Rehabilitative Services (CRS) specialty care,
    - Applied behavior analysis (ABA) services, and
    - Augmentative and alternative communication (AAC) services.

American Indians and Alaska Natives (AI/AN) enrolled in the ALTCS-DD Program can choose to receive their integrated physical and mental 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).

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

The ALTCS-DD Program operates on a statewide basis and has been the health plan for individuals with developmental disabilities since the late 1980s.

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

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

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

The populations covered under the ALTCS-DD Program are individuals with a qualifying developmental disability.

ALTCS-DD Program 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 mental 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.

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

DES/DDD determines eligibility primarily by diagnosis of a cognitive disability: cerebral palsy, epilepsy, Down syndrome, or autism. Cognitive disability, defined in statute, A.R.S. § 36-551(14), as "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", is a covered diagnosis regardless of the origin of impairment. 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 mental health services including EPSDT. Members eligible for ALTCS under DES/DDD have choice with regard to which DES/DDD sub-contracted integrated health plan they wish to enroll in.

Additional information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the ALTCS-DD Program contract.

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

In practice, enrollment in the ALTCS-DD 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 ALTCS-DD eligibility on the basis of no longer needing the level of medical support required by the ALTCS eligibility statutes. Additionally, 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-DD Program based on the listed diagnoses above. As such, neither the PHE nor the unwinding of the PHE should have had any impact on the ALTCS-DD Program enrollment.

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

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

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

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)

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

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

The CYE 25 capitation rates were developed at the rate cell level. Payments from rate cells do not cross-subsidize payments of other rate cells.

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

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

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

The capitation rates were developed such that DES/DDD would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 25.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria
- I.1.B.xi.(a) Available Applicable Data
- I.1.B.xi.(b) Accounting for Direct and Indirect Impacts
- I.1.B.xi.(d) Risk Mitigation Strategies
- I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies
- I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons

Additional evaluation conducted related to the COVID-19 PHE and related unwinding which did not result in adjustments to the rate development for CYE 25 varies by program. The ALTCS-DD Program was not impacted by the MOE requirements of the PHE in the same way that other AHCCCS programs were, as described above in Section I.1.A.iii.(c)(iv), which resulted in the evaluation of changes in acuity being negligible as stated below in I.1.B.xi.(b), and so while the population was evaluated for acuity changes, no adjustments to the rate were made as they were unnecessary. In evaluating the impact of the PHE on the base data year, no categories of service (COS) were materially impacted in the base data year by the winter 2022 COVID-19 surge. The level of COVID-19 vaccinations within the ALTCS-DD membership was reviewed and no specific adjustment was applied due to current or projected vaccination rates within the rate development. Changes in Arizona COVID-19 case rates were reviewed both in general and with respect to the different COVID-19 variants in the base data time period and more recently, but no adjustments for expected new variants were included in capitation rate development. In a change from previous years' rate development processes, the actuaries did not include specific assumptions about COVID-19 test utilization or unit costs, nor specific growth utilization rates for any COVID-19 treatments. Additionally, the previously included non-risk cost settlement of COVID-19 vaccines and administrations has been removed from the contract, so those costs have not been excluded from the base data this year, but no assumptions were made specific to these services. The prior years' adjustments were judged to be unnecessary for CYE 25 given the distance between the base period from the onset of the pandemic as well as the relatively stable utilization patterns that have emerged for these services since the last rate development cycle.

I.1.A.xiii. Rate Certification Procedures

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

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

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

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

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

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

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

This section of the 2025 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell for certified rates per rate cell, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.4(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

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

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

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

I.1.B. Appropriate Documentation

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

The actuaries are certifying capitation rates for each rate cell.

I.1.B.ii. Elements

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

I.1.B.iii. Medical Loss Ratio

The capitation rates were developed so each Contractor would reasonably achieve a medical loss ratio (MLR) standard of at least 85 percent as required per 42 CFR § 438.4(b)(9). The AHCCCS Division of Business and Finance (DBF) Actuarial Team calculates a modified MLR where the only inclusion in the numerator is the projected gross medical expense component of the capitation rates (discounts related to pharmacy rebates are included in this calculation), ensuring the result of the calculation will be less than or equal to the actual MLR calculation because the modified MLR calculation does not include any considerations for the allowed additional expenses under 42 CFR § 438.8(e)(3)-(4) in the numerator. For CYE 25 capitation rates, the modified MLR for DES/DDD was greater than 85 percent. Per 42 CFR § 438.5(b)(5) the AHCCCS DBF Actuarial Team reviewed past MLR results focusing in on the MLR results

that correspond to the base period and for any Contractors performing below 85 percent the actuaries would make adjustments to assumptions in capitation rate setting where appropriate, however this was not necessary because all Contractors for all programs were above 85 percent MLR for the base period.

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

This section of the 2025 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell.

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

I.1.B.v. Capitation Rate Range Assumptions – Not Applicable

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

I.1.B.vi. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes relevant section numbers from the 2025 Guide. Sections of the 2025 Guide that do not apply will be marked as "Not Applicable"; any section wherein all subsections are not applicable will be collapsed to the section heading.

I.1.B.vii. Assurance Rate Assumptions Do Not Differ by Federal Financial Participation

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

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

The covered populations under the ALTCS-DD Program receive the regular Federal Medical Assistance Percentage. The ALTCS-DD 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.ix. Comparison to Prior Rates

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

The 2025 Guide requests a comparison to the final certified rates in the previous rate certification. Comparisons between the most recently certified CYE 24 ALTCS-DD Program capitation rates effective October 1, 2023, and the CYE 25 capitation rates being certified in this actuarial rate certification are available in Appendix 3. The 2025 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. As in past years, the AHCCCS DBF Actuarial Team has

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. Neither of the capitation rates certified in this rate certification meet those criteria.

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

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

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

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

I.1.B.x. Future Rate Amendments

There are no known, or expected, future amendments to the ALTCS-DD Program capitation rates.

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

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

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

- State Data Sources
    - AHCCCS historical and current encounter data including utilization and costs by COS, risk group, GSA, and program
    - AHCCCS telehealth utilization and cost data by risk group, GSA, and program
    - AHCCCS non-emergency transportation (NEMT) utilization and cost data by risk group, GSA, and program
    - AHCCCS historical and current enrollment by risk group, GSA, and program
    - Historical and ongoing COVID-19 case rates for Arizona (not restricted to Medicaid populations)
    - AHCCCS COVID-19 testing by risk group, GSA, and program
    - AHCCCS COVID-19 vaccination rates by risk group, GSA, and program
    - AHCCCS child and adolescent well-care visit rates
    - 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 have been determined ineligible and disenrolled

- National Data Sources
    - Daily case rate, death rate, and vaccination rate data for Arizona collated and cleaned by the Centers for Disease Control
    - Consumer and Producer price inflation data published by the Bureau of Labor Statistics
    - National webinars discussing various impacts of the response to the COVID-19 PHE and the end of continuous coverage protections
    - Policy memoranda and newsletters related to available PHE unwinding flexibilities and considerations published by various universities and government agencies (examples below):
        - State Health Official Letter 23-002
        - Princeton University State Health and Value Strategies (SHVS):
            - Planning for the end of the Continuous Coverage Requirement
            - Best Practices for Publicly Reporting State Unwinding Data
            - State Reporting to Monitor the Unwinding of the Medicaid Continuous Coverage Requirement
        - CMS Policy Guidance FAQ dated May 12, 2023, on unwinding the continuous enrollment requirement
        - State Medicaid Director Letter 23-004

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

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

The CYE 25 capitation rates account for the direct and indirect impacts of the COVID-19 PHE and related unwinding by using a base data experience period that includes changes in service delivery expected to continue beyond the unwinding of the pandemic, including increased telehealth usage, increased attendant care, and decreased employment, day treatment, and transportation services. The rate development also captures the impact of the ending of governmental purchase/subsidization of two COVID-19 treatments, Paxlovid and Lagevrio, as addressed in I.3.B.ii.(a).

As noted above in Section I.1.A.iii.(c)(iv), the MOE requirements under the FFCRA had little to no impact on the membership under the ALTCS-DD 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-DD Program due to no longer meeting the ALTCS medical support requirements would have had their Medicaid eligibility continued under another non-ALTCS AHCCCS program and had their eligibility redetermined there during the unwinding period, and ALTCS-DD members are also unlikely to have exceeded the allowable income limits for eligibility but would be eligible to receive supports through DDD State Only funding if

they did. Because of these unique aspects of eligibility for the ALTCS-DD Program, there were no measurable changes in the acuity of the membership due to the ending of the continuous coverage protections effective March 31, 2023, and no acuity adjustment was necessary.

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

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

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

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

I.2. Data

This section provides documentation for the Data section of the 2025 Guide.

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

Since AHCCCS employs their own actuaries, a formal data request was not needed between the AHCCCS DBF Actuarial Team and the State. The AHCCCS DBF Actuarial Team worked with the appropriate teams at AHCCCS and 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 primary data sources used or reviewed for the development of the CYE 25 capitation rates for the ALTCS-DD Program were:

- Adjudicated and approved encounter data submitted by all health plans with responsibility for services provided to ALTCS-DD members and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2018 through February 2024
  - Adjudicated and approved through the second February 2024 encounter cycle
  - Pended for DES/DDD from October 2022 through September 2023
- Reinsurance payments made to DES/DDD for services
  - Incurred from October 2018 through April 2024 paid through April 2024
- Historical and projected enrollment data for ALTCS-DD Program members and Targeted Case Management members, provided by DES/DDD
- Supplemental intermediate care facility (ICF), nursing facility (NF), and home and community based services (HCBS) expenses provided by DES/DDD for dates of service between October 2021 and February 2024
- Quarterly and annual financial statements submitted by DES/DDD, and other health plans with responsibility for services provided to ALTCS-DD members between October 2018 and the present, and reviewed by the AHCCCS DBF Finance & Reinsurance Team
- AHCCCS FFS fee schedules developed and maintained by the AHCCCS DBF Rates & Reimbursement Team
- Data from the AHCCCS DBF Rates & Reimbursement team related to DAP, see Section I.4.D.
- Data from AHCCCS DBF financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)

- Historical and projected Targeted Case Management expenses provided by DES/DDD
  - Historical expenses through February 2024
  - Projected expenses for March 2024 through September 2025
- Historical and projected administrative and case management expenses from DES/DDD
  - Historical expenses through February 2024
  - Projected expenses for March 2024 through September 2025
- Bid administrative expenses from a competitive bid process for ALTCS-DD Program 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 23
- Historical and projected enrollment data provided by the AHCCCS DBF Budget Team
  - Historical enrollment from mid CYE 24 and earlier
  - Projected enrollment through CYE 25
- 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, DES/DDD does not use sub-capitated arrangements. DES/DDD utilizes staff models for some of these LTSS services. 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 DES/DDD for purposes of rate development.

All services under the responsibility of DES/DDD's historically subcontracted health plans, and the current subcontracted integrated health plans are also submitted in the same manner as encounters from other health plans, under the 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.

In addition to the staff model addressed above, AHCCCS Contractors, including DES/DDD's integrated subcontractors, sometimes use sub-capitation/block purchasing arrangements for some services. The sub-capitation and block purchasing arrangements between the Contractors and their providers require that the providers submit claims for services provided, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated/block purchased encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there are repricing methodologies (i.e., formulas) for sub-capitated/block purchased encounters to estimate a health plan valued amount in place of the health plan paid amount of zero. The units of service data from the 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.(a)(v) Base Data Exception – Not Applicable

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

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

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

Guidelines and formats for submitting individual encounters generally follow health insurance industry standards used by commercial insurance companies and Medicare; however, some requirements are specific to the AHCCCS program. All encounter submissions are subject to translation and validation using standards and custom business rules (guidelines). Once translation has occurred and the encounters pass validation, they are passed to the AHCCCS PMMIS mainframe and are subject to approximately 500 claims type edits resulting in the approval, denial, or pend of each encounter. This process occurs for both regular and sub-capitated/block purchased encounters.

The AHCCCS DBF Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a 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 DBF Actuarial Team reports the findings to the AHCCCS Information Services Division (ISD) Data Management and Oversight (DMO) Team, who then works with the health plan to identify causes. In addition, the AHCCCS ISD DMO Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

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 DES/DDD with the "Encounter Monthly Data File" (aka the "magic" file) which contains the previous 36 months of encounter data. DES/DDD is responsible for providing the "magic" file to the integrated subcontractors. Data fields contained in this file include, but are not limited to, adjudication status, AHCCCS ID, Claim Reference Number (CRN), Provider ID, and various cost amounts. The adjudication status has five types: adjudicated/approved, adjudicated/plan denied, adjudicated/AHCCCS denied, pended, and adjudicated/void. This file, with its

expanded view of encounter statuses, allows DES/DDD and its subcontractors to compare the data to their claim payments to identify discrepancies and evaluate the need for new or revised submissions. For purposes of CYE 25 rate development, AHCCCS relied primarily on adjudicated/approved encounters, but also included some pended encounters related to services paid for by DES/DDD but which were held in an unadjudicated status due to missing Electronic Visit Verification (EVV) information. The actuaries determined that these costs were not reflected anywhere else in the adjudicated/approved encounter data, and that the EVV issue that generated the mass of pended encounters has since been resolved on a prospective basis. Since these pended encounters were not replaced in time to be adjudicated and represent service costs that DES/DDD will be at risk for in CYE 25, the actuaries determined that these costs should be included for purposes of rate development as they are representative of reasonable, appropriate, and attainable costs for the program.

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

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

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

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

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

The AHCCCS DBF Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe and ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 25 capitation rates for the ALTCS-DD Program. Additionally, the AHCCCS DBF Actuarial Team ensured that only services covered under the state plan were included.

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

The AHCCCS DBF Actuarial Team reviewed encounter data from all relevant Contractors providing services to ALTCS-DD Program members over the October 2018 through February 2024 time frame, along with supplemental cost data from DES/DDD for state operated facilities, for consistency by viewing month over month, and year over year changes. The AHCCCS DBF 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.

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

As required by ASOP No. 23, the AHCCCS DBF Actuarial Team discloses that the rate development process has relied upon encounter data submitted by DES/DDD, DES/DDD acute subcontractors, the prior CRS subcontractor, and the RBHAs retrieved 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 DBF Finance & Reinsurance Team. The AHCCCS DBF Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuaries note additional reliance on the following:

- data provided by the AHCCCS DBF Rates & Reimbursement Team with regard to DAP and fee schedule impacts,
- the Public Notice of proposed fee schedule changes for CYE 25 posted by DES/DDD to its website,
- data provided by the AHCCCS DBF financial analysts with regard to some program changes,
- information and data provided by Milliman consultants with regard to the HEALTHII and SNSI State directed payments,
- data provided by the integrated subcontractors with regard to administrative components, and
- data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

The actuaries have found the encounter data in total, after adjustments for data concerns, along with the supplemental cost data for state operated facilities to be appropriate for the purposes of developing the CYE 25 capitation rates for the ALTCS-DD Program.

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

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

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

The AHCCCS DBF Actuarial Team determined that the CYE 23 encounter data in total, after adjustments noted in I.2.B.ii.(b)(iii), was appropriate to use as the base data for developing the CYE 25 capitation rates for the ALTCS-DD Program with the inclusion of supplemental cost data related to staff models for LTSS provided in state operated facilities, and pended encounters for services affected by EVV implementation that are representative of services that will be delivered and allowed in the rating period, as 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 25 capitation rates for the ALTCS-DD 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 25 capitation rates for the ALTCS-DD Program.

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

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

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

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

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

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

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

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 2018 through February 2024. The monthly completion factors were applied to the encounter data on a monthly basis. Aggregated CYE 23 completion factors by COS for the regular DDD rate cell can be found in Appendix 4. The aggregated CYE 23 completion factor impacts are shown in Table 1 below.

Table 1: Completion Factor Impacts

Rate Component	Before Completion	After Completion	Impact
LTSS	$4,144.94	$4,154.41	0.23%
Integrated Care Services	$975.83	$1,005.48	3.04%
Total	**$5,120.76**	**$5,159.89**	**0.76%**

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

During the rate development process, it was determined that there were some missing pharmacy and private intermediate care facility (ICF) encounters, related to encounter processing system changes in that year. Corrections were made by applying interpolation to the affected data. The impact of these corrections accounts for approximately 0.11% of the gross medical component of the capitation rate.

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

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

If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the rate for 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 DBF financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS Division of Managed Care Services (DMCS) Clinical Quality Management (CQM) Team and the Office of the Director's Chief Medical Officer. The actuaries relied upon the

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

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS FFS programs. The AHCCCS DBF Rates & Reimbursement Team and the AHCCCS DBF Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts except where authorized under applicable law, regulation or waiver, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DBF Finance & Reinsurance Team regarding health plan fee schedules. The observed impacts of provider rate increases prior to October 1, 2023 are given below in Table 2a.

Table 2a: Provider Fee Schedule Changes

Rate Component	PMPM Impact	Dollar Impact
LTSS	$55.08	$29,528,879
Integrated Care Services	$0.00	$0
Total	**$55.08**	**$29,528,879**

Removal of Differential Adjusted Payments from Base Data

CYE 23 capitation rates funded DAP made from October 1, 2022, through September 30, 2023, to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health, and reduce cost of care growth. As these payments expired September 30, 2023, AHCCCS has removed the impact of DAP from the base period CYE 23. To remove the impact, the AHCCCS DBF Actuarial Team requested provider IDs for the qualifying providers for the CYE 23 DAP by specific measure from the AHCCCS DBF Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 23 were then adjusted downward by the appropriate percentage bump specific to the DAP measure. The impact of this adjustment is given in Table 2b below. See Section I.4.D. for information on adjustments included in CYE 25 capitation rates for DAP that are effective from October 1, 2024, through September 30, 2025.

Table 2b: CYE 23 DAP Removal

Rate Component	PMPM Impact	Dollar Impact
LTSS	($32.84)	($17,606,855)
Integrated Care Services	($8.87)	($4,755,405)
Total	**($41.71)**	**($22,362,259)**

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 2c below. Brief descriptions of the individual program changes requiring base data adjustment are provided below.

- **Community Intervener Services ***
  Effective January 1, 2023, AHCCCS established a policy for provision of community intervener services to ALTCS members with dual sensory loss (i.e., blind and hard of hearing). Community interveners intercede between the member and the environment, allowing access to information usually gained through vision and hearing.
- **Dental Cone Beam CT Capture ***
  AHCCCS began reimbursing for cone beam CT capture for dental imaging, effective January 1, 2023. Cone-beam CT capture emits an x-ray beam shaped like a cone as opposed to the conventional fan-shaped beam. This procedure is expected to be used for any tooth extraction as well as for endodontic procedures such as molar and premolar root canals. This type of imaging would be done in addition to current X-ray imaging. AHCCCS requires prior authorization for fee-for-service coverage of cone beam CT capture.
- **Sleep Study ***
  Effective January 1, 2023, AHCCCS added the WatchPAT system as a billable service, using CPT code 95800 (an unattended sleep study with analysis of airflow or peripheral arterial tone and recording of sleep time). The WatchPAT algorithm detects respiratory (apnea/hypopnea) events, sleep/wake status, and determines sleep stages.
- **Long-Acting Reversible Contraception ***
  Effective February 1, 2023, AHCCCS revised reimbursement rates for LARCs to equal the Wholesale Acquisition Cost (WAC) which reflects the costs providers pay for these medications.
- **Latuda to Lurasidone ***
  In February 2023, a generic version of the drug Latuda, lurasidone, came to market from multiple manufacturers for use in the United States. AHCCCS, on the recommendation of the Pharmacy and Therapeutics (P&T) Committee, made policy changes to approve the generic drug lurasidone in place of the brand drug Latuda. The AHCCCS DBF Actuarial Team analyzed pharmacy encounter data for Latuda and lurasidone to estimate the impact to the capitation rates for this change.
- **Fraud, Waste, and Abuse (FWA) Adjustment**
  In May 2023, a multi-agency review and investigation of potential fraud, waste, and abuse resulted in the suspension of dozens of providers of Medicaid services based on Credible Allegations of Fraud (CAF). Since that time, there have been additional CAF provider suspensions. The AHCCCS DBF Actuarial Team has reviewed Contractor encounters submitted by providers suspended and/or terminated as of May 2024, per the Provider Terminations & Active Suspensions list, for unit cost and quantity characteristics which are substantially different from

the characteristics of encounters submitted by providers not identified on the publicly posted CAF list and adjusted the irregular encounters to bring them into alignment with reasonable utilization and cost patterns. In response to concerns about abusive billing practices using the H0015 procedure code, AHCCCS set a specific fee schedule rate for H0015 in May 2023. Additional information about the development of the impact of the H0015 fee schedule change for all programs is provided below in Section I.3.B.ii.(a). More information about the investigation of potential fraud, waste, and abuse can be found on the AHCCCS website at https://azahcccs.gov/shared/News/PressRelease/PaymentSuspensions.html and at https://azahcccs.gov/Fraud/SoberLivingFraud.html.

Table 2c: Combined Miscellaneous Base Data Adjustments

Rate Component	PMPM Impact	Dollar Impact
LTSS	($3.40)	($1,825,086)
Integrated Care Services	($2.78)	($1,488,907)
Total	**($6.18)**	**($3,313,993)**

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

The AHCCCS DBF Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 25 capitation rates. Other base data adjustments which excluded services from the data 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 2025 Guide.

I.3.A. Rate Development Standards

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

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

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

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

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

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

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

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

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

The projected benefit costs include costs for members aged 21-64 that have a stay of no more than 15 cumulative days 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 DBF 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 DBF Actuarial Team repriced all utilization of an IMD at the cost of the same services through providers included under the State plan, regardless of length of stay. The AHCCCS DBF Actuarial Team then removed costs for members aged 21-64 for stays in an IMD exceeding 15 cumulative days in a month, whether through a single stay or multiple within the month. Additionally, the AHCCCS DBF Actuarial Team removed all associated medical costs that were provided to the member during the IMD stay(s) that exceeded 15 cumulative days in a month.

The data used to determine the base data adjustment was the CYE 23 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 23 encounter data, the AHCCCS DBF Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The

costs associated with an institutional stay at an IMD were repriced to the non-IMD price-per-day. The non-IMD price-per-day used in the analysis was $869.45 and was derived from the CYE 23 encounter data for similar IMD services that occurred within a non-IMD setting. The encounter data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a non-IMD setting which may not be fully captured within the AHCCCS FFS fee schedule per diem rate. The costs associated with institutional stays at an IMD that were repriced in the base data are displayed below in Table 3a. Totals may not add up due to rounding.

Table 3a: IMD Repricing Impact

Rate Component	PMPM Impact	Dollar Impact
LTSS	$0.00	$0
Integrated Care Services	$0.52	$276,956
Total	**$0.52**	**$276,956**

The AHCCCS DBF Actuarial Team identified all members aged 21-64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed below in Table 3b. Totals may not add up due to rounding.

Table 3b: 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	($0.54)	($289,971)
Total	**($0.54)**	**($289,971)**

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 3c. Totals may not add up due to rounding.

Table 3c: Removal of Other Costs Associated with Problematic IMD Stays

Rate Component	PMPM Impact	Dollar Impact
LTSS	($0.05)	($28,778)
Integrated Care Services	($0.09)	($48,343)
Total	**($0.14)**	**($77,121)**

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 25 capitation rates for the ALTCS-DD Program.

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

The base data described in Section I.2.B.ii. was adjusted to reflect completion and all base data adjustments described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in I.3.A.v. The adjusted base data PMPM expenditures were trended forward 24 months from the midpoint of the CYE 23 time period to the midpoint of the CYE 25 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below.

The CYE 25 capitation rates include an offset to account for ALTCS-DD Program members' projected share of cost (SOC) in CYE 25. 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 23) ALTCS-DD Program member SOC data. The SOC data was evaluated for trend over the period from October 1, 2018, through February 2024 and showed a consistent, annualized increase of 1%. The SOC offset ensures that capitation rates only reflect 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 DBF financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS DMCS CQM Team and the Office of the Director's Chief Medical Officer. The actuaries relied upon the professional judgment of the AHCCCS DBF financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuaries met with the AHCCCS DBF financial analysts to understand at a high level how the estimated amounts were derived, and the data used for the amounts. The actuaries were unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

AHCCCS FFS Fee Schedule Updates

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

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

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

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

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

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

The overall impact of the AHCCCS Fee-for-Service fee schedule updates for all updates from October 1, 2023, through the end of CYE 25 are illustrated below in Table 4a. Totals may not add up due to rounding.

Table 4a: Provider Fee Schedule Changes

Rate Component	PMPM Impact	Dollar Impact
LTSS	$100.37	$53,806,633
Integrated Care Services	($1.18)	($631,574)
Total	**$99.19**	**$53,175,059**

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 4b. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- **Adolescent SUD Screening ***
  The American Academy of Pediatrics encourages primary care clinicians to follow the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and recommends universal screening for substance use disorder (SUD) for adolescents. Effective October 1, 2023, AHCCCS began covering SUD screening for all 12- to 20-year-olds during EPSDT well-child visits.
- **Dental Varnish ***
  Previously, AHCCCS covered fluoride varnish up to 4 times per year in Primary Care Physician (PCP) offices for children up to age 2. Effective October 1, 2023, AHCCCS expanded the use of fluoride varnishes in primary care offices beyond the currently eligible 0–2-year-olds to include 3-, 4- and 5-year-old children in compliance with recommendations from the U.S. Preventive Services Task Force and the American Academy of Pediatrics.
- **Diabetic Drug Class Utilization Changes ***
  The AHCCCS DBF Actuarial Team reviewed all historical adjudicated and approved encounters for glucagon-like peptide-1 (GLP-1) receptor agonists, sodium-glucose co-transporter-2 inhibitors (SGLT2), and insulins, and determined that the changing utilization patterns of these drug classes was not fully accounted for by the projected trend assumptions, and have included a separate, specific adjustment to these drug classes as part of the capitation rate development.
- **Pharmacy and Therapeutics Committee Recommendations – Post Base Year ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 25. The P&T Committee evaluates scientific evidence on the

relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

- **T1015 Billing for Multi-Specialty Interdisciplinary Clinic (MSIC) Services ***
  Effective October 1, 2023, AHCCCS is expanding the population of children eligible for receiving T1015 (Clinic Visit/Encounter, All-Inclusive) for Multi-Specialty Interdisciplinary Clinics (MSICs) beyond the current CRS children to include children in the two ALTCS programs. For MSICs, the expansion allows T1015 to be billed in addition to other codes for this expanded population of children.
- **Paxlovid and Lagevrio ***
  Paxlovid and Lagevrio are two oral antiviral medications that are available for treating mild to moderate COVID-19. In November 2023, the transition from government-managed distribution to traditional commercial distribution of these medications began. This has resulted in increased ingredient costs to the Contractors for these treatments. To account for this change, the AHCCCS DBF Actuarial Team repriced the base data utilization to the average unit cost observed between March 2024 and May 2024 after the transition period was assumed to be complete.
- **Corneal Cross-Linking ***
  Effective January 1, 2024, AHCCCS began coverage of two procedure codes (0402T and J2787) for corneal cross-linking treatment used to prevent the progression of corneal ectasia.
- **Donor Milk ***
  Effective January 1, 2024, AHCCCS began coverage of procedure code T2101, human breast milk processing, storage, and distribution only, for cases where it is medically necessary where the infant is at high risk and where the mother's own milk is absent or insufficient in quantity.
- **Insulin Price Changes ***
  The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. Effective January 1, 2024, a provision in the American Rescue Plan Act (ARPA), enacted in March 2021, removed a cap on Medicaid drug rebates that had been in place since 2010. In response, rather than pay higher rebate amounts, many drug manufacturers have instead reduced the prices of their drugs. A very specific instance of this has been a drastic cost reduction for insulin products at the point of sale since the start of 2024. To account for this change, the AHCCCS DBF Actuarial Team calculated reduction factors at the program and risk group level by comparing the average unit cost observed between January 2024 and March 2024 to the average unit cost observed between January 2023 and March 2023. The reduction factors were then applied to the base period utilization to get the estimated savings associated with the reduced upfront pricing for these products.
- **Rezdiffra ***
  AHCCCS began coverage of Rezdiffra after it was approved by the FDA in March 2024. Rezdiffra is used to treat adults with noncirrhotic non-alcoholic steatohepatitis (NASH) with moderate to advanced liver scarring (fibrosis, severity levels F2 or F3).

- **Wegovy ***
  Wegovy, a semaglutide product FDA approved for weight loss, gained expanded approval by the FDA in March 2024 to reduce the risk of serious heart problems in obese or overweight adults. AHCCCS began coverage of Wegovy for members without diabetes meeting certain criteria related to age, history of cardiovascular problems, and body mass index (BMI) measurements.
- **Humira Biosimilars ***
  In recent years several biosimilar and interchangeable products have become available as a substitute for Humira. The interchangeable products are priced significantly lower than the Humira brand products. Effective August 2, 2024, AHCCCS will shift preferred status from Humira to the interchangeable biosimilar options.
- **Annual Syphilis Testing ***
  In alignment with recommendations from The Centers for Disease Control and Prevention and the Arizona Department of Health Services, effective October 1, 2024, AHCCCS will begin requiring providers to offer annual Syphilis testing for members aged 15 years and older.
- **ASAM Continuum – U9 Modifier ***
  Effective October 1, 2024, AHCCCS will implement a provider initiative that will require the American Society of Addiction Medicine (ASAM) CONTINUUM™ assessment tool to be used in the public mental health system. In order to provide additional reimbursement to help offset the annual subscription fees for access to the assessment tool, providers may include the U9 modifier when billing for HCPCS codes H0018, limited to twice per member stay, and H0035, limited to twice per member per year.
- **Parents as Paid Caregivers Training Support ***
  Effective October 1, 2024, AHCCCS will expand the use of S5110, Home care training, family; per 15 minutes, for family support services as part of a waiver amendment to extend the parent as paid caregiver of minor children to permanent authority.

Table 4b: Combined Miscellaneous Program Changes

Rate Component	PMPM Impact	Dollar Impact
LTSS	$0.85	$456,712
Integrated Care Services	($3.29)	($1,761,861)
Total	**($2.43)**	**($1,305,149)**

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

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 actuaries to set the CYE 25 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2018 through December 2023 and adjudicated and approved through the second February 2024 encounter cycle, as well as supplemental cost data provided by DES/DDD as described in Section I.2.B.ii.(a) for the staff model as noted in Section I.2.B.ii.(a)(iv).

All encounter and supplemental data used was specific to the ALTCS-DD Program population.

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

The encounter and supplemental data were summarized by month and COS, 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 23 (April 1, 2023) to the midpoint of the rating period for CYE 25 (April 1, 2025). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. Projected benefit cost trends were estimated 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 time series. Each COS was analyzed in the same manner.

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

All PMPM trend estimates were compared to similar estimates made in CYE 24 for ALTCS-DD Program capitation rates and judged reasonable to assume for projection to CYE 25, considering the change in the base data time period, the rating period, and the unwinding of the MOE, as well as changes to covered services.

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

The 2025 Guide requires explanation of outlier or negative trends. As in past years, the AHCCCS DBF Actuarial Team has defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%.

The actuaries assumed negative utilization trends in the following LTSS COS: Habilitation Per Diem, and Therapies. The negative utilization assumption for these COS 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 COS are negatively sloped. For Habilitation Per Diem services, this negative trend is consistent with declining population in group and developmental home settings; for Therapies, this is consistent with slight but continued increases in the volume of unassigned therapy services during CYE 23 and into CYE 24.

The actuaries assumed greater than 7% PMPM trend for Attendant Care and Habilitation Per 15 Minute services. Both COS have exhibited significant utilization growth, primarily among members 18 and younger, since April 2022, with substantial acceleration in growth since January 2023. This acceleration in growth lines up with diminished service delivery from school-based settings (beginning during the PHE), the deadline for mandatory EVV reporting, and the parents as paid caregivers (PPCG) initiative for minor children (beginning during the PHE). Additional detail about each of these factors is given below.

School-based Services

Day programs have been shown throughout the pandemic to have an inverse relationship with personal care services like Attendant Care and Habilitation Per 15 Minutes, indicating that service utilization in one (either day programs or personal care services) comes partially at the expense of the other; school-based services, which function as a day program during the schoolyear for members 18 and younger, diminished significantly during the PHE and did not recover to pre-pandemic levels. Additionally, since 2022, school-based services, on a per-member basis, have been experiencing renewed decline, and it is not expected that school-based services will reverse course by the end of the CYE 25 rating period. This decline and non-recovery pattern has set up a service supply shortage that is likely being covered by expanded availability of personal care services through the PPCG.

EVV Hard Edit

The January 1, 2023, mandatory implementation for the EVV system required that claims for EVV-mandated services be accompanied by valid EVV records in order to be eligible for reimbursement. The observed utilization growth that followed is broad-based, affecting service utilization for members of all ages, irrespective of whether the service is provided by a Direct Care Worker (DCW) or PPCG, but is most evident for services provided through PPCG to minors. It is believed that the electronic tracking for these services is capturing additional time spent providing these services to ALTCS members which was possibly underreported previously based on DCWs and PPCGs reporting scheduled time to the agency rather than exact times spent with the member. The “increased reporting due to mandatory EVV” effect is seen to be more prevalent with PPCG over DCW, and this is likely due to a larger percentage of DCWs being transitioned to using EVV by their agencies before January 2023. It is also likely that a parent’s transition from non-paid to paid caregiving tasks would be less clearly defined than for DCWs in the absence of the exact recordkeeping made possible by EVV, which accounts for another potential source for the “increased reporting due to mandatory EVV” within the PPCG.

PPCG

The PPCG initiative was one of the original Appendix K flexibilities requested by Arizona and approved by CMS and was continued as part of AHCCCS’ approved spending plan related to the ARPA. The initiative is intended to strengthen and enhance HCBS in Arizona, and allows parents to be paid, through a DCW agency, for providing some services to their minor children. The number of minors receiving services in these two COS as a percentage of the total population has significantly increased, with the growth primarily coming through services provided by parental caregivers. As mentioned in the paragraph above on school-based services, the service supply shortage caused by the lack of recovery in

school-based services is being backfilled by the expansion of DCW services provided primarily by parental caregivers, and it is expected that, so long as school-based services are not made more widely available, PPCG will continue to stand in the gap to ensure their children have the services they need.

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 COS for utilization per 1000, unit cost, and PMPM values are included in Appendix 5. The aggregate projected benefit cost trends for the ALTCS-DD Program for utilization per 1000, unit cost, and PMPMs are included below in Table 5.

Table 5: CYE 25 Trend Assumptions

Rate Component	Utilization per 1000	Unit Cost	PMPM
LTSS	5.31%	0.59%	5.93%
Integrated Care Services	4.54%	1.92%	6.55%
Total	**5.16%**	**0.84%**	**6.05%**

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 COS.

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

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

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

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

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS DMCS Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. As of August 2, 2024, no additional services have been identified as necessary services to comply with MHPAEA.

I.3.B.v. ILOS

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

I.3.B.vi. Retrospective Eligibility Periods

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

AHCCCS provides prior period coverage for the period of time prior to the member's enrollment during which the member is eligible for covered services. Prior period coverage refers to the time frame from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with DES/DDD. DES/DDD receives notification from AHCCCS of the member's enrollment. DES/DDD is responsible for payment of all claims for medically necessary services covered by 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 25 capitation rates for the ALTCS-DD Program for the prior period time frame, given that the encounter and enrollment data are already included within the base data used for rate development.

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

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

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

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

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

As noted in Section I.3.B.ii.(c), base period data was not adjusted to reflect recoveries of overpayments made to providers because DES/DDD and the integrated 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

Adjustments related to provider payment requirements under State directed payments, as defined in 42 CFR § 438.2, are discussed in Section I.4.D. of this rate certification. Additionally, provider payment requirements related to FQHCs/RHCs and the VFC program are described in Section I.3.B.ii.

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

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

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

There 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 2025 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

The CYE 25 contract for the ALTCS-DD 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 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 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 25 capitation rates and had no effect on the development of the capitation rates for the ALTCS-DD Program.

I.4.B. Withhold Arrangements – Not Applicable

Not applicable. There are no withhold arrangements in the CYE 25 capitation rates for the ALTCS-DD Program.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2025 Guide provides information on the requirements for risk-sharing mechanisms. For information on the COVID-19 costs covered on a non-risk basis, see Section I.1.B.xi.(c).

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 25 contract for the ALTCS-DD 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 25 contract will continue AHCCCS' long-standing program policy and will include risk corridors. This rate certification will use the term risk corridor to be consistent with the 2025 Guide. The ALTCS-DD Program 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-DD Program. The first is 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 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. DES/DDD will submit the reconciliation for AHCCCS approval and AHCCCS will reconcile with 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 DES/DDD's LTSS and DDD-THP medical cost expenses to the net retained capitation paid to 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. DES/DDD's medical cost expenses are equal to the fully adjudicated encounters, sub-cap/block payment medical expenses, and staff model expenses for LTSS and DDD-THP services as reported by DES/DDD with dates of service during the contract year. The risk corridor will limit DES/DDD profits to 6% and losses to 1%.

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

Additional information regarding the risk corridors can be found in the Compensation section of the ALTCS-DD Program 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 CYE 25 capitation rates for the ALTCS-DD 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 DBF Actuarial Team, the AHCCCS DBF Finance & Reinsurance Team, the AHCCCS Office of the Director, and the ALTCS-DD 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-DD 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 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 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 DES/DDD in CYE 25 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 DES/DDD for covered services incurred above the deductible. The deductible is the responsibility of DES/DDD. The deductible for CYE 25 Regular reinsurance cases is $150,000. The limit on High Dollar Catastrophic reinsurance is $1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

The actual reinsurance case amounts are paid to 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 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-DD 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 methodology for setting the reinsurance offset has not changed from the CYE 24 capitation rates. The capitation rates are adjusted by subtracting the reinsurance offset amounts from the gross medical expenses since 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 23. 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.

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 25 for those drugs and applying a zero dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset.

Additionally, these data were adjusted for an expected contractor reporting factor, representing the rate at which the contractor reports reinsurance cases that 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 95% 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 25. The reinsurance offset was derived by taking the sum of the reinsurance case values and dividing by the CYE 25 projected member months.

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

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

I.4.D.ii. Appropriate Documentation

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

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

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

Federally Qualified Health Centers and Rural Health Clinics

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

Vaccines for Children

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

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP. The potential rate increases range from 0.5% to 20.0%, depending on the provider type.

Access to Professional Services Initiative

The APSI provides a uniform percentage increase of 75% to otherwise contracted rates for eligible practitioners, critical to professional training and education efforts, who deliver services to AHCCCS members. The uniform percentage increase is applicable only to services covered under the AHCCCS APSI policy. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

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

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

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

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

Only the regular DDD rate cell is impacted by the FQHC/RHC and VFC minimum fee schedule State directed payments and the DAP initiative. There is no impact to the Targeted Case Management rate cell.

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

The FQHC/RHC and VFC minimum fee schedule impacts are included as part of the aggregate fee schedule changes shown in Appendix 6. See Appendix 8b for the total impact to the regular DDD rate cell for the FQHC/RHC and VFC minimum fee schedules. 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).

Vaccines for Children

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

Differential Adjusted Payments

The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 23 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DBF Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 25 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and risk group to the applicable COS to come to the final dollar impact for CYE 25 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and COS level which the AHCCCS DBF Actuarial Team then aggregated to the specific risk groups for each program).

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

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

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

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

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

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

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

Access to Professional Services Initiative

Anticipated payments, including premium tax, for APSI are approximately $16.00 million for the ALTCS-DD Program. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Services Initiative

Anticipated payments, including premium tax, for PSI are approximately $9.73 million for the ALTCS-DD Program. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 25 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments, including premium tax, for HEALTHII are approximately $67.49 million for the ALTCS-DD Program. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 25 utilization will be used to redistribute the payments.

Safety Net Services Initiative

Anticipated payments, including premium tax, for SNSI are approximately $4.81 million for the ALTCS-DD Program. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 25 utilization will be used to redistribute the payments.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

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

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) Preprint Acknowledgement

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

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

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

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

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

There are not any additional directed payments in the program that are not addressed in the rate certification, including minimum fee schedules using State plan approved rates or total published Medicare payment rates as defined in 42 CFR § 438.6(a).

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

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

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

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

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2025 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

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

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

The projected ALTCS case management expense PMPM within the regular DDD capitation rate was informed by DES/DDD's expense projections for CYE 25. The projected PMPMs are derived from a case management expense model utilized by the AHCCCS DBF Actuarial Team incorporating membership projections from the AHCCCS DBF Budget Team, and salary information for case managers, case manager supervisors, and support staff provided by DES/DDD along with the contractual and legislative requirements for case management ratios. The projected PMPM associated with case management expenses for CYE 25 is denoted as 'Case Management' in Appendix 7.

The projected administrative expense PMPMs for LTSS were informed by DES/DDD's expense projections for CYE 25, actual expenses reported by DES/DDD for CYE 21, CYE 22, and CYE 23, and inflation forecasts provided in the S&P Global Market Intelligence Healthcare Cost Review First Quarter 2024 Healthcare Cost Report. The base data used for the administrative expense projection for LTSS was DES/DDD administrative expenses reported during CYE 23. The actuaries used fixed and variable percentages reported by 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 actuaries incorporated estimates for additional administrative requirements in the upcoming contract year to come up with a projected administrative expense amount for CYE 25. This projection was then compared to the CYE 25 expense projection from DES/DDD. The actuaries' estimated projection of administrative expenses for CYE 25 was similar to the forecast provided by DES/DDD for CYE 25. The actuaries' CYE 25 projection of administrative expenses for LTSS is denoted as 'Admin - LTSS' in Appendix 7.

The administrative expense PMPM for CYE 25 for the integrated subcontractors reflects inflation-adjusted administrative bid amounts from a Request for Proposal (RFP) competitive bid process which 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 actuaries estimated the projected membership for each integrated subcontractor for CYE 25 to determine the appropriate bid threshold, based on reported integrated subcontractor enrollment as of February 2024. The actuaries adjusted compensation-related components of the bid amounts using projected CPI-W inflation from the S&P Global Market Intelligence Healthcare Cost Review Healthcare Cost Report and added administrative cost projections associated with the AAC transition to the bid threshold amounts.

Additionally, as discussed in I.2.B.iii.(d), portions of sub-capitated/block payments determined to be administrative were removed from medical encounter data and added to the administrative PMPM for each integrated subcontractor. The CYE 25 administrative expense projection for the integrated subcontractors is denoted as 'Admin - ICS' in Appendix 7.

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, 2024, through September 30, 2025. Similar to ALTCS case management, Targeted Case Management expenses were determined by incorporating case manager, case manager supervisor, and support staff salary information as well as supplemental staff model expenses provided by DES/DDD.

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 25 capitation rates for the ALTCS-DD Program is described above in Section I.5.B.i.(a).

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

The CYE 25 capitation rates for the ALTCS-DD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 25 capitation rates for the ALTCS-DD Program include a provision (denoted as underwriting (UW) gain and expressed as a percentage) for contributions to reserves, risk margin, and cost of capital. The CYE 25 UW gain of 1.0% is unchanged from the CYE 24 capitation rates based on the expectation that the unwinding of the PHE is not going to impact the ALTCS-DD Program to a measurable degree.

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 25 capitation rates for the ALTCS-DD 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

https://www.azahcccs.gov/Resources/OversightOfHealthPlans/contractedhealthplan.html. Historical non-benefit cost data was considered and used in the non-benefit cost assumptions as described in section I.5.B.i.(a) above.

I.6. Risk Adjustment – Not Applicable

This section of the 2025 Guide is not applicable to the ALTCS-DD Program. The certified capitation rates paid to the ALTCS-DD Program do not include risk adjustment.

I.7. Acuity Adjustments – Not Applicable

This section of the 2025 Guide is not applicable to the ALTCS-DD Program. The certified capitation rates paid to the ALTCS-DD Program do not utilize acuity adjustments.

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

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

II.1. Managed Long-Term Services and Supports

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

The rate development standards and appropriate documentation described in Section I of the 2025 Guide are applicable to the MLTSS rate development process.

II.1.B. Rate Development Standards

II.1.B.i. Rate Cell Structure

This section of the 2025 Guide provides the two most common approaches to structuring the rate cells.

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

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

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

Not applicable. A member's 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-DD Program 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-DD Program operates as managed care. No data is available that would quantify the impacts of care management on utilization or unit costs.

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

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

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

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

II.1.C.iii. Additional Information

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

Section III New Adult Group Capitation Rates – Not Applicable

Section III of the 2025 Guide is not applicable to the ALTCS-DD Program.

Appendix 1: Actuarial Certification

We, Ethan Sheffield and Erica Johnson, are employees of AHCCCS. We are Members of the American Academy of Actuaries and are Associates of the Society of Actuaries. We meet the qualification standards established by the American Academy of Actuaries and have followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries, the Actuarial Standards Board, CMS, and federal regulations.

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

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 25 capitation rates for the ALTCS-DD Program have been documented according to the guidelines established by CMS in the 2025 Guide. The CYE 25 capitation rates for the ALTCS-DD Program are effective for the 12-month time period from October 1, 2024, through September 30, 2025.

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

SIGNATURE ON FILE	August 2, 2024
Ethan Sheffield	Date
Associate, Society of Actuaries	
Member, American Academy of Actuaries	

SIGNATURE ON FILE	August 2, 2024
Erica Johnson	Date
Associate, Society of Actuaries	
Member, American Academy of Actuaries	

Appendix 2: Certified Capitation Rates

ALTCS-DD Capitation Rates Effective October 1, 2024, through September 30, 2025	
Regular DDD	$6,661.80
Targeted Case Management	$231.13

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

ALTCS-DD Capitation Rates Effective October 1, 2024, through September 30, 2025						
Rate Cell	Rate Effective 10/1/2023	Rate Effective 10/1/2024	% Change		CYE 25 Projected MMs	CYE 25 Projected Expenses
Regular DDD	$6,253.99	$6,661.80	6.52%		536,106	$3,571,430,650
Targeted Case Management	$222.25	$231.13	4.00%		90,497	$ 20,916,894

Appendix 4: Base Data and Base Data Adjustments

Appendix 5: Projected Benefit Cost Trends

Statewide				
Rate Cell	Trend COS	Utilization Per 1000	Unit Cost	PMPM
Regular DDD	ATPC	0.0%	0.0%	0.0%
Regular DDD	Attendant Care	11.0%	0.0%	11.0%
Regular DDD	Day Treatment	0.5%	0.0%	0.5%
Regular DDD	Employment	0.5%	0.0%	0.5%
Regular DDD	Hab - Per 15 Min	19.0%	0.0%	19.0%
Regular DDD	Hab - Per Diem	(0.2%)	1.8%	1.6%
Regular DDD	Misc. In Home Care	3.8%	0.0%	3.8%
Regular DDD	Nursing	3.8%	0.0%	3.8%
Regular DDD	Private ICF	0.0%	0.0%	0.0%
Regular DDD	Respite	3.8%	0.0%	3.8%
Regular DDD	SelfCare Home Management	3.8%	0.0%	3.8%
Regular DDD	SOGH	0.0%	0.0%	0.0%
Regular DDD	SOICF	0.0%	0.0%	0.0%
Regular DDD	Therapies and Evaluations	(0.1%)	0.0%	(0.1%)
Regular DDD	Transportation	0.5%	0.0%	0.5%
Regular DDD	Integrated Care Services	4.5%	1.9%	6.6%

Appendix 6: Development of Gross Medical Component

Appendix 7: Capitation Rate Development

Appendix 8a: State Directed Payments – CMS Prescribed Tables

Appendix 8b: State Directed Payments – Estimated PMPMs

CYE 25 Estimated PMPM				
Directed Payment	Medical	Underwriting Gain	Premium Tax	Total
DAP	$28.59	$0.29	$0.59	$29.47
FQHC/RHC	$1.41	$0.01	$0.03	$1.45
VFC	$0.01	$0.00	$0.00	$0.01
APSI	$29.26	$0.00	$0.60	$29.85
PSI	$17.79	$0.00	$0.36	$18.16
HEALTHII	$123.37	$0.00	$2.52	$125.89
SNSI	$8.79	$0.00	$0.18	$8.97