MILLIMAN CLIENT REPORT

Contract Year Ending 2021 Arizona Long Term Care System / Elderly and Physical Disability Capitation Rate Certification

October 1, 2020 through September 30, 2021

Arizona Health Care Cost Containment System

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Introduction and Limitations

INTRODUCTION

Milliman, Inc. (Milliman) has been retained by the Arizona Health Care Cost Containment System (AHCCCS) to provide actuarial and consulting services related to the development of contract year ending 2021 capitation rates for the Arizona Long-Term Care System / Elderly and Physical Disability program.

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for Contract Year Ending 2021 (CYE 21) effective October 1, 2020 through September 30, 2021, for the Arizona Long Term Care System/Elderly and Physical Disability (ALTCS/EPD) Program. All comparisons to prior rates in this certification refer to the capitation rates effective January 1, 2020, previously submitted within the actuarial memorandum as signed by Matthew C. Varitek dated August 15, 2019. This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

This rate certification may also be made available publicly on the AHCCCS website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 of 81 FR 27497 applicable to this rate certification, the 2020-2021 Medicaid Managed Care Rate Development Guide (2021 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2021 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 2021 Guide to help facilitate the review of this rate certification by CMS.

LIMITATIONS

The services for this project were performed under the terms of the September 30, 2019 Master Services Agreement for State of Arizona between GuideSoft, Inc. (dba Knowledge Services) and Milliman, Inc. and AHCCCS Task Order YH20-0084 approved March 23, 2020.

The information contained in this report has been prepared for AHCCCS to provide documentation of the development of the CYE 21 actuarially sound capitation rates for the population served under the ALTCS/EPD program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be shared with CMS and utilized in a public document. Any distribution of the information should be in its entirety. Any user of the information must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for AHCCCS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has relied upon certain data and information provided by AHCCCS and the participating Medicaid Contractors in the development of the CYE 21 capitation rates. The information may not be appropriate for any other purpose. Milliman has relied upon AHCCCS and the Contractors for the accuracy of the data and accepted it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information. Milliman’s data reliance includes eligibility and encounter data, Contractor-reported financial experience, AHCCCS provided adjustments for program changes, provider reimbursement changes, and other inputs, as well as information related to eligibility system and assignment of enrollees to rate cells.

Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual Medicaid Contractor. Results will differ if actual experience is different from the assumptions contained in the capitation rate setting documentation. AHCCCS and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

At the time of this rate certification, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on setting capitation rates, including whether the pandemic will increase or decrease costs in CYE 21. Given the lack of reliable and historical information for this unprecedented public health emergency, we did not adjust the capitation rates for foregone care, deferred care, and pent-up demand. However, it is known that the COVID-19 pandemic could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this rate certification. 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. In times such as these, the risk-sharing arrangements are even more important to the stability of the system.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Section I Medicaid Managed Care Rates

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

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

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), CMS, and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice (ASOPs) applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for all Practice Areas)); ASOP 23 (Data Quality); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2021 managed care program rating period.
- The 2021 Guide published by CMS.

Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

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

As stated on page 2 of the 2021 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 2021 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The CYE 21 capitation rates for the ALTCS/EPD Program are effective for the twelve month time period from October 1, 2020 through September 30, 2021.

I.1.A.ii. Required Elements

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

The actuarial certification letter for the CYE 21 capitation rates for the ALTCS/EPD Program, signed by Jill S. Herbold, FSA, MAAA, is in Appendix 1. Ms. Herbold meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854 provided below for reference.

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

Ms. Herbold certifies that the CYE 21 capitation rates for the ALTCS/EPD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 of 81 FR 27497.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ALTCS/EPD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856. The ALTCS/EPD contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 and the 2021 Guide.

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

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

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

The ALTCS/EPD Program contracts with three managed care plans. The number of managed care plans contracted with the Program varies by Geographical Service Area (GSA). The three GSAs, along with the managed care plans within the GSAs are listed in Table 1 below.

Table 1: Managed Care Plan(s) by GSA

GSA	Managed Care Plan(s)
Central	Banner – University Family Care (Banner – UFC) Mercy Care Plan (Mercy Care) United Health Care – Long Term Care (UHC – LTC)
North	UHC – LTC
South	Banner – UFC Mercy Care (Pima County Only)

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

This certification covers the ALTCS/EPD Program. This program delivers long-term, acute, behavioral health and case management services to eligible members who are elderly and/or have physical disabilities.

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

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

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

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

The CYE 21 capitation rates for ALTCS/EPD are effective for the twelve month time period from October 1, 2020 through September 30, 2021.

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

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

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

Ideally, the experience data would be analyzed by rate cells which are comprised of members with similar risk characteristics. However, segregating the ALTCS/EPD population into risk-based rate cells would lead to a statistical credibility problem due to the statewide dispersion of the relatively small membership base. The ALTCS/EPD Program has two rate cells: a rate cell for members who are dually eligible for Medicare and Medicaid ("duals") and a rate cell for members who are not eligible for Medicare ("non-duals"). The capitation rates fund prospective and prior period coverage (PPC) of members for long-term, acute, behavioral health and case management services. The rates also include coverage of acute care only (ACO) services for members that qualify for ALTCS but decline to receive long-term care services. Rates for the ALTCS/EPD population differ by GSA and Contractor. The experience used in the development of these rates only includes ALTCS/EPD Medicaid eligible expenses for ALTCS/EPD Medicaid eligible individuals.

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

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

Due to the public health emergency (PHE), and the maintenance of effort (MOE) requirements included in Families First Coronavirus Response Act, with a few exceptions as noted in the law, members who were eligible at the beginning of the PHE, or who become eligible during the PHE, will remain treated as eligible for such benefits through the end of the month in which the PHE ends. Given the lack of reliable and historical information for this unprecedented PHE, we did not adjust the capitation rates for foregone care, deferred care, and pent-up demand.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE 21 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Alternative Payment Model (APM) Initiative – Quality Measure Performance (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- APM Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- APM Initiative – Quality Measure Performance (Withhold Arrangement) (42 CFR § 438.6(b)(3) at 81 FR 27859)
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Nursing Facility Supplemental Payments (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

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

Not applicable. This rate certification does not cover retroactive adjustments.

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

Proposed differences among the CYE 21 capitation rates for the ALTCS/EPD Program are based on valid rate development standards and are not based on the rate of Federal Financial Participation (FFP) for the populations covered under the ALTCS/EPD Program.

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

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

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

The effective dates of changes to the ALTCS/EPD Program are consistent with the assumptions used to develop the CYE 21 capitation rates for the ALTCS/EPD Program.

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

The certified capitation rates allow each ALTCS/EPD Program Contractor to reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 21.

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

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

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

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

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 21 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 21 capitation rates for the ALTCS/EPD Program.

I.1.A.ix. Rate Certification Procedures

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

This section of the 2021 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.ix.(b) CMS Rate Certification Requirement for Rate Change

This rate certification documents that the ALTCS/EPD Program capitation rates will be changing effective October 1, 2020.

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

Not applicable. This rate certification will change the ALTCS/EPD Program capitation rates effective October 1, 2020. Additionally, AHCCCS will be including contract amendments with the submission of this rate certification which removes language which imposed an upper limit on administrative expenses for pharmacy benefit manager (PBM) subcontractors, the capitation rates certified herein were developed without the specified upper limit.

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

This section of the 2021 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell, in accordance with 42 CFR § 438.7(c)(3), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

A contract amendment will be submitted to CMS to reflect the ALTCS/EPD Program capitation rates changing effective October 1, 2020.

I.1.A.ix.(f) CMS Rate Amendment Requirement for Changes in Law

CMS requires a 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. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 21 capitation rates for the ALTCS/EPD Program.

I.1.B.ii. Rate Assumptions

This section of the 2021 Guide notes that it is not permissible to certify rate ranges, and the actuary must be responsible for all assumptions and adjustments underlying the certified capitation rates, and the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates vary between managed care plans, the certification must also describe the basis for the variation.

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

I.1.B.iii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2021 Guide. Sections of the 2021 Guide that do not apply are marked as “Not Applicable”; any section wherein all subsections are not applicable are collapsed to the section heading.

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

All covered populations under the ALTCS/EPD Program receive the regular Federal Medical Assistance Percentage (FMAP) of 70.01%[1] for federal fiscal year (FFY) 2021. The 6.2% FMAP enhancement available during the COVID-19 PHE is not reflected in the values provided in this certification.

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

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

The comparisons between the most recent certified Contract Year Ending 2020 (CYE 20) ALTCS/EPD Program capitation rates and the CYE 21 capitation rates being certified in this actuarial rate certification are available in Appendix 3a.

The 2021 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. For the purposes of the CYE 21 certified capitation rates, we 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 was a negative change in the rate. The 2021 Guide requests a comparison to the final certified rates in the previous rate certification. Those comparisons are available in Appendix 3a. One rate cell reflects a negative change over the most recent certified CYE 20 rates and two different rate cells reflect a change of more than 10% from the most recent certified CYE 20 capitation rates.

The percentage change in capitation from the rates effective January 1, 2020 is predominantly attributable to gross expense PMPM trend assumptions, prospective program changes, and an increase in the differential adjusted payments offset by the impact of the change in projected nursing facility (NF) and home and community-based settings (HCBS) placement mix. When composited across all rate cells, each Contractor's percentage change in capitation rate, from the rates effective January 1, 2020 to the rates effective October 1, 2020, does not vary much from the statewide average. Variations by rate cell from the statewide average change are primarily due to the impact of rebasing and the change in projected NF and HCBS placement mix. Unlike the other drivers identified above, which produce similar impacts to each Contractor and GSA, the impact of rebasing and changes in projected placement mix by individual rate cell can fluctuate.

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

There were no material changes to the capitation rate development process since the last rate certification other than those described elsewhere in the certification.

I.1.B.vi. Future Rate Amendments

There are no known amendments anticipated to be provided to CMS in the future which would impact capitation rates.

[1] Federal Register, December 3, 2019 (Vol 84, No. 232), pp 66204-66206

I.2. Data

This section provides documentation for the Data section of the 2021 Guide.

I.2.A. Rate Development Standards

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

AHCCCS provided validated encounter data and audited financial reports demonstrating experience for the populations to be served by the Contractor(s), for at least the three most recent and complete years prior to the rating period. We used the most appropriate base data, specific to the Medicaid population to be covered under the program, to develop the capitation rates. No exception request is required as the data being used to develop rates is no older than the three most recent and complete years prior to the rating period.

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

We submitted a formal data request to the AHCCCS Division of Health Care Management (DHCM) Actuarial Team to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) at 81 FR 27858.

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

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

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

The types of data that we relied upon for developing the CYE 21 capitation rates for the ALTCS/EPD program were:

- Adjudicated and approved encounter data from October 1, 2016 through September 30, 2019 submitted by ALTCS/EPD Contractors;
- Reinsurance payments for October 1, 2016 through September 30, 2019;
- Historical member month data for October 1, 2016 through September 30, 2020 from the PMMIS mainframe;
- Projected enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team for CYE 21;
- Quarterly and annual financial statements submitted by the Contractors for Contract Year Ending 2019 (CYE 19) and CYE 20 and reviewed by AHCCCS DHCM Finance & Reinsurance Team;
- Member level share of cost data provided by AHCCCS for October 1, 2016 through September 30, 2020.
- Supplemental historical and projected data associated with benefit and non-benefit costs for current rate cells provided by the Contractors.
- NF and HCBS placement data for October 1, 2016 through September 30, 2020.

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

The encounter data serving as the base experience in the capitation rate development process was incurred during October 1, 2018 to September 30, 2019 and paid through March 2020. We used the base period encounter data, combined with the base period historical enrollment and placement data, to develop the unadjusted base data per-member-per-month (PMPM) amounts. Member months were assigned to the NF or HCBS category of service (COS) based on how they were assigned in the placement data. In some cases, member months were unassigned in the placement data, but a placement was indicated based on the encounter data. In those cases, we assigned the member months based on the encounter data. The remaining member months were assigned as acute care only. Unadjusted base data PMPMs were calculated separately for NF and HCBS expenses using the assigned member months respectively for each. Unadjusted base data PMPMs were calculated for acute care expenses using all member months (NF, HCBS, and acute care only). The unadjusted base data PMPMs by rate cell and COS are shown in Appendix 4.

For the purposes of developing trend assumptions applied within the Contractor-specific CYE 21 capitation rates, we also reviewed encounter data from October 1, 2016 through September 30, 2018.

The historical enrollment data for ALTCS/EPD members aligned with the encounter data time periods of October 1, 2016 through September 30, 2019. It also aligned with the placement data time periods of October 1, 2016 through September 30, 2020.

The financial statement data, reviewed as part of the rate development process, included financial statements for CYE 19 and CYE 20 time periods.

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

The enrollment and encounter data were provided from the AHCCCS PMMIS mainframe. The projected enrollment data for CYE 21 was provided by the AHCCCS DBF Budget Team. The financial statement data were submitted by the ALTCS/EPD Contractors and reviewed by the AHCCCS DHCM Finance & Reinsurance team. Information regarding HCBS placement and member movement among Contractors was provided by the DHCM Operations Unit.

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

The ALTCS/EPD Contractors have sub-capitated/block purchasing arrangements. During FFY 19, the ALTCS/EPD Contractors paid approximately 1.1% of total medical expenditures through sub-capitated arrangements. The sub-capitated arrangements between the ALTCS/EPD Contractors and their providers still require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05, and health plan paid of zero (i.e. sub-capitated)) encounters to estimate a health plan valued amount for these encounters. The revised amounts from the repricing methodology were used in 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.

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

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

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

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

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

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

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

Through review of the encounter data provided from the AHCCCS PMMIS mainframe, we ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 21 capitation rates for the ALTCS/EPD program. Additionally, we ensured that only services covered under the state plan were included.

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

We compared the encounter data for all services provided by ALTCS/EPD Contractors to the annual financial statement data for the same entities for CYE 19. After adjustments to the encounter data for completion, the comparisons showed that the financial statements and the encounter data were consistent.

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

As required by ASOP No. 23, we disclose that the rate development process has relied upon encounter data submitted by the ALTCS/EPD Contractors and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the ALTCS/EPD Contractors and reviewed by the AHCCCS Finance & Reinsurance Team. We did not audit the data or financial statements and the rate development is dependent upon this reliance. We note additional reliance on data provided by the AHCCCS DHCM Rates & Reimbursement Team with regard to DAP and fee schedule impacts, on information and data provided by Mercer consultants with regard to pharmacy reimbursement savings, on information and data provided by Milliman consultants with regard to HEALTHII program, and on data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

We determined the October 1, 2018 through September 30, 2019 encounter data to be appropriate for the purposes of developing the CYE 21 capitation rates for the ALTCS/EPD program. Additionally, we deemed the October 1, 2016 through September 30, 2019 encounter data appropriate for use in trends.

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

There are no concerns with the availability or quality of data used.

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

The October 1, 2018 through September 30, 2019 encounter data was appropriate to use as the base data for developing the CYE 21 capitation rates for the ALTCS/EPD program.

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

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 21 capitation rates for the ALTCS/EPD Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 21 capitation rates for the ALTCS/EPD Program.

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

Not applicable. We did not rely on a data book to develop the CYE 21 capitation rates for the ALTCS/EPD Program.

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

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

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

No credibility adjustment was necessary.

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

An adjustment was made to the encounter data to reflect the level of completion. We calculated annualized completion factors by Contractor, rate cell, and COS using the development method with monthly encounter data from October 1, 2016 through September 30, 2019, paid through March 2020. The annualized completion factors were applied to the October 1, 2018 through September 30, 2019 base experience encounter data, for purposes of projection to the CYE 21 rating period. The annualized completion factors were applied to the October 1, 2016 through September 30, 2019 encounter data for purposes of trend development.

The aggregated completion factors applied to each COS, as a divisible factor, are shown in Appendix 4.

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

For one of the Contractors, the annualized October 1, 2018 through September 30, 2019 completion factors for the acute care service category received an additional manual adjustment based on review of a subset of their sub-capitated encounters in comparison with their supplemental data submission. After discussion with the AHCCCS Actuarial Team and an additional round of communication with the Contractor, we believe that the Contractor submitted these sub-capitated encounters to AHCCCS with incorrect amounts. Therefore, an adjustment was appropriate to reflect this subset of sub-capitated encounters provided in their supplemental data submission.

No other errors were found in the data.

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, 2018 through September 30, 2019) are described below. Additional adjustments for program and fee schedule changes which occurred on or before January 1, 2020 are also included below. All program and fee schedule changes which occurred after January 1, 2020 are described in Section I.3.B.ii.(a).

All of the impacts for program changes described below, except where noted, were developed by AHCCCS DHCM financial analysts, as described above in Section I.2.B.ii.(b)(ii), with oversight from the DHCM Clinical Quality Management Team and the Office of the Director's Chief Medical Officer. We relied upon the professional judgment of the financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. We reviewed the analyses that were used to develop the estimated amounts at a high level and asked the financial analysts clarifying questions to ensure an understanding of how they were derived. We 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 fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts except where authorized under applicable law, regulation or waiver, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding health plan fee schedules.

Effective October 1, 2019, AHCCCS updated provider fee schedules for certain providers based on access to care needs, Medicare / Arizona Department of Health Services (ADHS) fee schedule rate changes, and/or legislative mandates. The CYE 21 capitation rates have been adjusted to reflect these fee schedule changes. The data used by

the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to CYE 21 capitation rates was the base period encounter data across all programs. The AHCCCS DHCM Rates & Reimbursement Team applied the AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. We reviewed the results and applied the impacts for the ALTCS/EPD program.

The overall impacts by GSA for the ALTCS/EPD program are displayed below in Table 2. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 4, column "PFS 10/1/19", in the NF, HCBS, and Acute Expense tables.

Table 2: October 1, 2019 Provider Fee Schedule Changes

GSA	Dollar Impact	PMPM Impact
North	$ 3,339,695	$ 99.47
Central	$ 27,802,049	$ 118.49
South	$ 9,220,917	$ 114.50
Composite	**$ 40,362,661**	**$ 115.74**

PROPOSITION 206 PROVIDER FEE SCHEDULE CHANGES

Effective January 1, 2019, October 1, 2019 and January 1, 2020, AHCCCS increased fee schedule rates for select HCBS procedure codes, all NF revenue codes, and all Alternative Living Facility (ALF) procedure codes, to address the increased labor costs resulting from minimum wage increases approved on November 8, 2016 by the state's voters under Proposition 206 and by city of Flagstaff voters under Proposition 414. This assures that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. Through continued discussion with the Contractors, AHCCCS knows the increased rates are similarly adopted by the Contractors.

The CYE 21 capitation rates have been adjusted to reflect the minimum wage increases. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to CYE 21 capitation rates was the base period encounter data across all programs. The AHCCCS DHCM Rates & Reimbursement Team applied the AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. We then reviewed the results and applied the impacts for the ALTCS/EPD program.

The overall impacts by GSA for the ALTCS/EPD program are displayed below in Table 3. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 4, columns "Prop 206 Adjustment 1/1/19", "Prop 206 Adjustment 10/1/19", and "Prop 206 Adjustment 1/1/20" in the NF and HCBS Expense tables.

Table 3: Proposition 206 Provider Fee Schedule Changes

GSA	Dollar Impact	PMPM Impact
North	$ 4,204,058	$ 125.22
Central	$ 33,789,882	$ 144.01
South	$ 11,222,553	$ 139.35
Composite	**$ 49,216,492**	**$ 141.13**

PHARMACY BENEFIT MANAGER ADMINISTRATIVE SPREAD REMOVAL

In July 2019, AHCCCS provided additional guidance on several contract requirements that aim to increase transparency and cost-effectiveness. One requirement provides guidance on how the pass-through pricing model is to be implemented and administrative expenses reported. In accordance with contract requirements, we incorporated savings to medical expense costs associated with the removal of spread pricing from base period encounters. The percentages used to adjust pharmacy encounters for the removal of the PBM spread amounts were based on data provided by the Contractors through surveys, data requests, and additional clarifying communications between us and the Contractors. The non-benefit costs included in the CYE 21 capitation rates reflect the requirements for transparency in reporting PBM administrative expenses.

The overall impacts by GSA for the ALTCS/EPD program are displayed below in Table 4. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 4, column "PBM Spread Removal", in the Acute Expense table.

Table 4: Pharmacy Benefit Manager Administrative Spread Removal

GSA	Dollar Impact	PMPM Impact
North	$ 0	$ 0.00
Central	$ (354,425)	$ (1.51)
South	$ (63,800)	$ (0.79)
Composite	**$ (418,225)**	**$ (1.20)**

RETROSPECTIVE PROGRAM CHANGES

The capitation rates were adjusted for all retrospective program changes. However, if an individual program change had an impact of 0.2% or less for every individual rate cell across all GSAs, that program change was deemed non-material for the purpose of the actuarial rate certification. All programmatic changes which only affected base data for the Acute Expenses component of the capitation rate are non-material.

The overall impacts by GSA for the ALTCS/EPD program are displayed below in Table 5. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 4, column "Retrospective Program Changes", in the Acute Expense table. Brief descriptions of the individual program changes are provided below.

Table 5: Retrospective Program Change Adjustments

GSA	Dollar Impact	PMPM Impact
North	$ (13,190)	$ (0.39)
Central	$ (831,223)	$ (3.54)
South	$ (140,098)	$ (1.74)
Composite	**$ (984,511)**	**$ (2.82)**

Prenatal Syphilis Screens

In September 2018, the Arizona Department of Health Services (ADHS) declared a syphilis outbreak for women and babies in Arizona. In response to the outbreak, AHCCCS issued a joint position statement with ADHS on February 28, 2019 to clarify that AHCCCS covers 3 prenatal syphilis screens during a member's pregnancy. The statement aligns with screening recommendations from the Centers for Disease Control and Prevention (CDC) that all pregnant women receive a screen during their first prenatal visit, and again early in the third trimester and at the time of delivery if they are at high risk of syphilis.

Bilateral Cochlear Implants

Effective March 1, 2019, AHCCCS revised policy to specify coverage of bilateral cochlear impacts for children 20 years of age or younger. The change recognizes the latest standard of care and a CMS decision memo regarding the appropriateness of bilateral cochlear implants. Prior to the change, policy specified coverage of unilateral cochlear implants for children.

LISAC Mental Health Assessments

Effective November 1, 2018, AHCCCS included Licensed Independent Substance Abuse Counselors (LISAC) among qualifying providers that will be reimbursed for non-physician mental health assessments. The scope of practice for LISAC includes evaluation and treatment of substance abuse disorders, which can require use of mental health assessments. After unintendedly removing the permission for LISAC to bill for these services during the period from July 1, 2017 to October 31, 2018, the change restored that billing authority.

BHRF Personal Care Differential

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

Transportation Network Companies

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

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

Pharmacy and Therapeutics Committee Recommendations
On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 19 that impacted utilization and unit costs of Contractors' pharmacy costs in CYE 19. 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. Since CYE 19 is the base data year, we have normalized utilization and unit cost data by rate cell and GSA for the partial year before the P&T Committee changes were implemented to ensure the base year data is consistent with the current recommendations.

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

Substance Use Disorder Assessment
Effective October 1, 2018, AHCCCS updated provider fee schedules to include a targeted increase to providers who conduct a computer-guided, structured interview utilizing American Society of Addiction Medicine (ASAM) software. The service enables providers to determine the appropriate level of treatment based upon a set of medically accepted criteria. Due to a slower-than-anticipated adoption of the ASAM software, impacts of the change in the base period encounters are limited. For CYE 21 rate development, additional impacts for the change are included above any base period encounters.

Applied Behavior Analysis
AHCCCS policy was updated effective November 1, 2019 to include clarifying language on the requirement for the AHCCCS Complete Care and Regional Behavioral Health Authority programs to provide covered Applied Behavior Analysis (ABA) services to children not receiving these services through another program. The policy clarification is consistent with CMS guidance dated July 7, 2014, which directs states to cover medically necessary services for treatment of autism spectrum disorder as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children under 21 years of age. The policy guidance is expected to gradually raise awareness and increase utilization of these covered ABA services in CYE 20 and CYE 21.

REMOVAL OF DAP FROM BASE PERIOD

CYE 19 capitation rates funded DAP for Acute, HCBS, and NF expenses from October 1, 2018 through September 30, 2019 to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health, and reduce cost of care growth. As these payments expired September 30, 2019, we removed the impact of CYE 19 DAP payments from the base period. CYE 19 DAP amounts to remove were developed by applying the completion factors, as documented in item 2.B.iii.(b) above, to the DAP allowed (paid plus member share of cost) amounts in the CYE 19 base encounter data.

The overall impacts by GSA for the ALTCS/EPD program are displayed below in Table 6. Totals may not add up due to rounding. The PMPM amounts removed by rate cell are included in Appendix 4, column "DAP Payments Removed", in the NF, HCBS, and Acute Expense tables.

Table 6: Removal of DAP from Base Period

GSA	Dollar Impact	PMPM Impact
North	$ (784,021)	$ (23.35)
Central	$ (4,693,054)	$ (20.00)
South	$ (1,946,963)	$ (24.18)
Composite	**$ (7,424,037)**	**$ (21.29)**

See section I.4.D. below for information on adjustments included in CYE 21 rates for DAP that are effective from October 1, 2020 through September 30, 2021.

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

We ensured that all non-covered services were excluded from the encounter data used for developing the CYE 21 capitation rates.

I.2.B.iii.(f) Other Data Adjustments

The following base data adjustments described below are not policy or program changes.

IMD REPRICING

An adjustment was made to the base data to remove the costs associated with stays in an institution for mental disease (IMD) for enrollees age 21 to 64 in accordance with 42 CFR § 438.6(e) at 81 FR 27861. This adjustment is described further in Section I.3.A.v.

MEMBER SHARE OF COST ADD-ON

An adjustment was made to add FFY 19 NF and HCBS share of cost (SOC) payments to the base data. This adjustment grosses up the base encounter data to reflect both the provider and member liabilities prior to the application of trend and other prospective adjustments described in Section I.3.B. After application of those adjustments, the projected CYE 21 SOC payments were removed as described in Section I.3.B.ii.(a).

The overall impacts by GSA for the ALTCS/EPD program are displayed below in Table 7. Totals may not add up due to rounding. The PMPM amounts added by rate cell are included in Appendix 4, column “SOC Payments Added”, in the NF and HCBS Expense tables.

Table 7: Member Share of Cost Add-on

GSA	Dollar Impact	PMPM Impact
North	$ 7,579,142	$ 225.75
Central	$ 34,054,702	$ 145.14
South	$ 14,478,012	$ 179.78
Composite	**$ 56,111,856**	**$ 160.90**

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2021 Guide.

I.3.A. Rate Development Standards

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

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

I.3.A.ii. Variations in Assumptions

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

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

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

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

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

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

The projected benefit costs include costs for members age 21 to 64 that have a stay of no more than 15 cumulative days in a month in an IMD in accordance with 42 CFR § 438.6(e) at 81 FR 27861.

COSTS ASSOCIATED WITH AN IMD STAY

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

The overall impacts by GSA for the ALTCS/EPD program are displayed below in Table 8. Totals may not add up due to rounding. The PMPM amounts removed by rate cell are included in Appendix 4, column “IMD Repricing”, in the Acute Expense tables.

Table 8: IMD Repricing

GSA	Dollar Impact	PMPM Impact
North	$ 1,159	$ 0.03
Central	$ (7,010)	$ (0.03)
South	$ 1,876	$ 0.02
Composite	**$ (3,976)**	**$ (0.01)**

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

Appendix 7 contains the projected CYE 21 gross medical expenses PMPM by rate cell, Contractor, and GSA.

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

This section provides information on the projected benefit costs included in the CYE 21 capitation rates for the ALTCS/EPD Program.

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

The base period encounter data described in Section I.2.B.ii. was adjusted to reflect historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The adjusted base data PMPM expenditures for each COS was then trended forward 24 months, from the midpoint of the base period to the midpoint of the rating period by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a)(ii). The projected PMPMs were then adjusted for prospective program changes, provider reimbursement levels, and other adjustments that are described in this section below.

Appendix 4 illustrates the base data and base data adjustments, Appendix 5 contains the projected benefit cost trends, and Appendix 6 illustrates the projected gross and net medical expenses after applying prospective program and reimbursement changes, CYE 21 DAP, member share of cost offset, reinsurance offset, projected percentages of members receiving Long Term Services and Supports (LTSS), and projected percentages of LTSS members placed in NF or HCBS settings. Appendix 7 illustrates the capitation rate development, which includes the projected administrative expense, case management expense, underwriting (UW) gain, and premium tax.

All of the impacts for projected benefits costs described below, except where noted, were developed by AHCCCS DHCM financial analysts, as described above in Section I.2.B.ii.(b)(ii), with oversight from the DHCM Clinical Quality Management Team and the Office of the Director's Chief Medical Officer. We relied upon the professional judgment of the financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. We reviewed the analyses that were used to develop the estimated amounts at a high level and asked the financial analysts clarifying questions to ensure an understanding of how they were derived. We were unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

PROVIDER FEE SCHEDULE CHANGES

Provider Fee Schedule Changes

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

Additionally, the contract has requirements that the Contractors reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. The Provider Fee Schedule Changes includes a fee schedule adjustment to bring the encounter base data from CYE 19 FQHC PPS rates up to projected CYE 21 FQHC PPS rates.

Effective October 1, 2020, AHCCCS will be updating provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 21 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DHCM Rates & Reimbursement Team use the base period encounter data to develop the adjustment to the CYE 21 capitation rates. The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to determine

what the impacts would be for the CYE 21 time period. We then reviewed the results and applied the impacts for the ALTCS/EPD program.

In March 2020, the Arizona Legislature passed and Governor Ducey signed into law HB 2668 (Laws 2020, Chapter 46) which establishes a new hospital assessment effective October 1, 2020. Monies from this assessment are to be deposited into the Health Care Investment Fund (HCIF) and used to make directed payments to hospitals, as well as increase base reimbursement rates for services reimbursed under the dental fee schedule and physician fee schedule, not including the physician drug fee schedule, to the extent necessary as determined by AHCCCS to restore provider rates to those in existence prior to reductions implemented in state fiscal year 2009. In order to implement this legislation, AHCCCS has included a provision in the CYE 21 contracts requiring the percentage increases associated with HCIF provider rate increases be implemented by the Contractors. The AHCCCS DHCM Rates & Reimbursement Team used the base period encounter data to develop the adjustment to the CYE 21 capitation rates. The AHCCCS DHCM Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. We then reviewed the results and applied the impacts for the ALTCS/EPD program.

CMS expanded the range of Medicare codes that may be billed for services provided by a resident without the direct supervision of a primary care physician, using the GE modifier. AHCCCS has aligned with CMS by expanding the set of codes for which resident-provided services can be billed using the GE modifier. The DHCM financial analysts applied AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 21 time period. We then reviewed the results and applied the impacts by program as part of the fee schedule changes as the change is non-material for the ALTCS/EPD program when considered alone.

A technical issue was identified in the setting of CYE 19 fee for service rates for various Durable Medical Equipment (DME) codes. The CYE 21 capitation rates include a correction to these DME fee for service rates. This correction is non-material for the ALTCS/EPD program when considered alone.

Effective January 1, 2020, the Diagnosis Related Group (DRG) adjustor for burns increased. The increased costs for this change have been included with the fee schedule changes previously discussed as the DRG burn adjustor is non-material for the ALTCS/EPD program when considered alone.

The overall impacts of these changes by GSA for the ALTCS/EPD program are displayed below in Table 9. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 6, column "Provider Fee Schedule 10/1/20" in the NF, HCBS, and Acute Expense tables.

Table 9: Provider Fee Schedule Changes

GSA	Dollar Impact	PMPM Impact
North	$461,349	$13.65
Central	$7,648,015	$32.37
South	$1,839,353	$22.68
Composite	**$9,948,717**	**$28.33**

PROPOSITION 206 PROVIDER FEE SCHEDULE CHANGES

AHCCCS will additionally be increasing some fee schedule rates effective January 1, 2021 to recognize the next minimum wage increase resulting from the passing of Proposition 206 as described in Section 2.B.iii.(d).

The overall impacts of the change by GSA for the ALTCS/EPD program are displayed below in Table 10. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 6, column "Prop 206 Adjustment 1/1/21", in the NF and HCBS Expense tables.

Table 10: Proposition 206 Provider Fee Schedule Changes

GSA	Dollar Impact	PMPM Impact
North	$ 513,712	$ 15.20
Central	$ 3,455,095	$ 14.62
South	$ 1,141,615	$ 14.08
Composite	**$ 5,110,422**	**$ 14.55**

PHARMACY REIMBURSEMENT SAVINGS

Analysis of pharmacy claims for all AHCCCS managed care programs and AHCCCS FFS program identified significant variability across all Contractors. Analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to the lesser of Health Plan Paid amounts or AHCCCS FFS repriced amounts would result in an annual savings of $68.2 million or 5.6% of pharmacy spend for FFY 18 across all programs. AHCCCS Contractors should reasonably be able to achieve pharmacy pricing that is at or near that achieved by the AHCCCS FFS program. However, AHCCCS recognized that the full savings amount may not be reasonably achievable in a single year, and for CYE 20 therefore adjusted the base pharmacy data of each program by 33% of the savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing. Based on continued analysis, for CYE 21, AHCCCS is adjusting the base pharmacy data of each program by 66% of the savings identified in the analysis of CYE 18 pharmacy data. This is consistent with subsequent analysis of the CYE 19 pharmacy data.

The overall impact of the change by GSA for the ALTCS/EPD Program is displayed below in Table 11. Totals may not add up due to rounding. The PMPM impacts of this change by rate cell are included in Appendix 6, column "Rx Rebates / Pharmacy Savings", in the Acute Expense table.

Table 11: Pharmacy Reimbursement Savings

GSA	Dollar Impact	PMPM Impact
North	$ (55,804)	$ (1.65)
Central	$ (1,857,412)	$ (7.86)
South	$ (311,412)	$ (3.84)
Composite	**$ (2,224,628)**	**$ (6.34)**

PHARMACY REBATES ADJUSTMENT

An adjustment was made to the projected gross medical expenses to reflect the impact of Pharmacy Rebates because the base data does not include any adjustments for Pharmacy Rebates reported within the Contractors' financial statements. We reviewed the CYE 19 annual financial statement reports and the CYE 20 Q1 financial statement reports. From this review, we determined that it would be reasonable to apply an adjustment to the projected gross medical expense to reflect a level of reported Pharmacy Rebates. From the review of the above data, we assumed that each Contractor would be able to achieve the average rebate percent reported on CYE 19 financial statements and applied that percent as a reduction to the projected CYE 21 Pharmacy category of service.

The overall impact of the change by GSA for the ALTCS/EPD Program is displayed below in Table 12. Totals may not add up due to rounding. The PMPM impacts of this change by rate cell are included in Appendix 6, column "Rx Rebates / Pharmacy Savings", in the Acute Expense table.

Table 12: Pharmacy Rebates Adjustment

GSA	Dollar Impact	PMPM Impact
North	$ (52,613)	$ (1.56)
Central	$ (952,516)	$ (4.03)
South	$ (254,278)	$ (3.14)
Composite	**$ (1,259,407)**	**$ (3.59)**

MEDICARE PART A AND B DEDUCTIBLES ADJUSTMENT

We adjusted the base data to reflect anticipated increases to the Medicare Parts A and B deductibles. According to the 2020 Medicare Trustees Report[2], the CY 2021 Medicare Part A deductible is projected to be $1,452 and the CY 2021 Medicare Part B is projected to be $212.

For the Part A deductible, we observed that for each year between 2016 and 2019, claims with Medicaid liability less than or equal to the deductible were consistently averaging approximately 80% of the deductible cost. We adjusted the data to assume that claims less than or equal to the deductible in the base period would be adjusted, in aggregate, to 80% of the projected deductible.

[2] https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf

For the Part B deductible, we used historical experience to estimate the Medicaid paid amount as a percentage of the Medicare allowed amount separately for claims entirely under and entirely over the deductible. We adjusted the data by adding an amount equal to the following formula:

Added Medicaid Paid Amount per Member = (Rate Period Deductible – Base Period Deductible) * (Medicaid Paid % of Medicare Allowed Under Deductible – Medicaid Paid % of Medicare Allowed Under Coinsurance)

When multiplied by the number of members who exceeded the Part B deductible in the base period, this reflects the incremental impact of additional Medicaid spend under the increased deductible.

The overall impact of the change by GSA for the ALTCS/EPD Program is displayed below in Table 13. Totals may not add up due to rounding. The PMPM impacts of this change by rate cell are included in Appendix 6, column "Medicare Part A and B Deductible", in the Acute Expense table.

Table 13: Medicare Parts A & B Deductibles Adjustment

GSA	Dollar Impact	PMPM Impact
North	$ 59,365	$ 1.76
Central	$ 491,778	$ 2.08
South	$ 137,889	$ 1.70
Composite	**$ 689,033**	**$ 1.96**

PROSPECTIVE PROGRAM CHANGES

The capitation rates were adjusted for all prospective program changes. However, if an individual program change had an impact of 0.2% or less for every individual rate cell across all GSAs, that program change was deemed non-material and has been grouped in the Combined Miscellaneous Program Changes and COVID-19 Initiatives section below, along with a brief description of the non-material items.

Cystic Fibrosis Drug Approval

On October 21, 2019, the Food and Drug Administration (FDA) approved the cystic fibrosis transmembrane conductance regulator (CFTR) modulator drug Trikafta for treatment of cystic fibrosis in individuals ages 12 years and older. The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Trikafta on October 21, 2019. Effective October 1, 2020, all CFTR drugs (Trikafta, Symdeko, and Orkambi) are eligible for reinsurance.

Trikafta is indicated for treatment of approximately 91.2% of individuals aged 12 years and older with cystic fibrosis while previously covered CFTR modulator drugs are indicated for 61.9% of individuals with the condition. Clinical trials for Trikafta have also found moderate improvements in outcomes compared to other available drugs. As a result, the introduction of Trikafta is anticipated to increase member use of CFTR modulator drugs in the contract period.

To estimate the impact of this change, the DHCM financial analysts reviewed changes in CFTR modulator drug utilization during the period from October 2018 through April 2020. The number of users of the drug class grew by approximately 73% during the period from October 2019 to April 2020 following Trikafta's approval, relative to member use in the base period data from October 2018 to September 2019. With completion and continued growth, overall CFTR modulator drug use is projected to increase 113% in CYE 21, relative to the CYE 19 base period. Based on findings from the utilization review, it is also projected that 85% of the CYE 19 base period use of previously approved CFTR modulator drugs will shift to Trikafta for the CYE 21 period. After developing the utilization forecast of CFTR modulator drugs based on these projections, the DHCM financial analysts applied drug pricing to calculate the expenditure impact above the base period data.

For October 1, 2020 rate development, the projected change was allocated across rate cells and GSAs using base period encounter data of CFTR modulator drug use. The overall impact of the change by GSA for the ALTCS/EPD Program is displayed below in Table 14. Totals may not add up due to rounding. The impacts of this change by rate cell are included in Appendix 6, column "Prospective Program Changes", in the Acute Expense table.

Table 14: Cystic Fibrosis Drug Approval

GSA	Dollar Impact	PMPM Impact
North	$ 202,385	$ 5.99
Central	$ 379,145	$ 1.60
South	$ 277,761	$ 3.43
Composite	**$ 859,291**	**$ 2.45**

Sickle Cell Drugs Approval

In November 2019, the FDA approved the drugs Oxbryta and Adakveo for treatment of sickle cell disease. Collectively, the drugs are approved for treatment of individuals 12 years and older. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Oxbryta and Adakveo on November 25, 2019 and November 20, 2019, respectively.

To estimate the impact of this change, the DHCM financial analysts first reviewed base period encounters for members with sickle cell disease diagnoses that were ages 12 years and older. Of the identified members with sickle cell, 27.5% experienced a vaso-occlusive crisis event (VOC) which typically required emergency treatment. It was assumed that all individuals experiencing VOC in the base period would become recipients of the new drugs in the contract period. Drug costs for the projected recipients were estimated using drug pricing.

Based on clinical trial outcomes, it was assumed the drugs would reduce VOS events in recipients by 50% relative to the base period. Based on findings in another study of Oxbryta recipients, it was further assumed that the drugs would reduce use of blood transfusions and iron reducing medications by 60% relative to the base period. Collectively, these service reductions were estimated to offset 8.7% of the projected costs of the new drugs and those savings were incorporated in the estimates.

For October 1, 2020 rate development, the projected change was allocated across rate cells and GSAs using base period VOC encounter experience for individuals ages 12 years and older. The overall impact of the change by GSA for the ALTCS/EPD Program is displayed below in Table 15. Totals may not add up due to rounding. The impacts of this change by rate cell are included in Appendix 6, column “Prospective Program Changes”, in the Acute Expense table.

Table 15: Sickle Cell Drug Approval

GSA	Dollar Impact	PMPM Impact
North	$ 36	$ 0.00
Central	$ 957,084	$ 4.05
South	$ 98,989	$ 1.22
Composite	**$ 1,056,110**	**$ 3.01**

Duchenne Muscular Dystrophy Drug Approval

On December 12, 2019, the FDA approved Vyondys 53 for treatment of Duchenne muscular dystrophy in individuals with a mutation that is amenable to exon 53 skipping. The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Vyondys 53 on December 12, 2019.

To estimate the impact of the drug, the DHCM financial analysts first identified individuals in the base period encounters with a diagnosis of either Duchenne or Becker muscular dystrophy (ICD-10 code G7101). Based on prevalence data from the Centers for Disease Control and Prevention, 75% of the identified individuals were assumed to have Duchenne muscular dystrophy. Based on additional prevalence data from the Cure Duchenne organization, 7.9% of individuals with Duchenne muscular dystrophy were assumed to be amenable to the exon-53 skipping drug Vyondys 53. Lastly, based on member use of the exon 51 skipping sister drug, Exondys, it was assumed 50% of candidates for Vyondys 53 would ultimately receive the drug. After forecasting the number of members that would use Vyondys drugs, the DHCM financial analysts estimated additional costs to administer the drug to representative recipients.

For October 1, 2020 rate development, the projected impact was allocated across rate cells and GSAs using base period encounter data with a Duchenne or Becker muscular dystrophy diagnosis. The overall impact of the change by GSA for the ALTCS/EPD Program is displayed below in Table 16. Totals may not add up due to rounding. The impacts of this change by rate cell are included in Appendix 6, column "Prospective Program Changes", in the Acute Expense table.

Table 16: Duchenne Muscular Dystrophy Drug Approval

GSA	Dollar Impact	PMPM Impact
North	$ 32,047	$ 0.95
Central	$ 1,324,175	$ 5.61
South	$ 290,000	$ 3.58
Composite	**$ 1,646,222**	**$ 4.69**

All other prospective program changes are non-material for the ALTCS/EPD program and have been grouped in the Combined Miscellaneous Program Changes and COVID-19 Initiatives section below.

COVID-19 FLEXIBILITIES AND INITIATIVES

Following national and state emergency declarations in March 2020, AHCCCS has sought authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. As of this writing, Appendix K authorities are approved from March 13, 2020 to March 31, 2021 while other select 1115 waiver changes are approved from March 1, 2020 until 60 days after the end of the federal emergency declaration. For October 1, 2020 rate development, we have incorporated projected impacts of these authorities and other AHCCCS responses to the COVID-19 outbreak for portions of the contract period, as described in the subsections below.

ALTCS Home Delivered Meals

CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to expand the provision of home delivered meals to members enrolled in the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (ALTCS/DDD). The authority is effective retroactively from March 13, 2020 until March 31, 2021. While members of the ALTCS/EPD program were eligible for home delivered meals during the base period, it is anticipated that emergency preparedness and community social distancing efforts will increase use of these services in the program during the contract period. To estimate the impact of this change, the DHCM financial analysts first reviewed base period encounters of home delivered meals. Analysts assumed that the proportion of ALTCS/EPD child and adult members in home placements, receiving home delivered meals during the period of flexibility, would be 200% of the rate of use for members observed during the base period. It was further assumed that the average monthly amount of delivered meals per user during the period of flexibilities would equal the average monthly amount of meals per user in the base period.

For October 1, 2020 rate development, the projected utilization increase in home delivered meals in the ALTCS/EPD program was limited to the period from October 1, 2020 to March 31, 2021. The projected impact was allocated across rate cells and GSAs using base period encounters of home delivered meals. The overall impact of the change by GSA for the ALTCS/EPD program is displayed below in Table 17. Totals may not add up due to rounding. The impacts of this change by rate cell are included in Appendix 6, column "Prospective Program Changes", in the HCBS Expense table.

Table 17: ALTCS Home Delivered Meals

GSA	Dollar Impact	PMPM Impact
North	$ 230,691	$ 6.82
Central	$ 1,252,669	$ 5.30
South	$ 362,495	$ 4.47
Composite	**$ 1,845,855**	**$ 5.26**

Increase to Annual Respite Hour Limit

CMS approved AHCCCS' requested 1115 Waiver authority to increase the annual limit in covered respite care services that a member may receive from 600 hours to 720 hours a year. The authority is effective retroactively from March 1, 2020 until 60 days after the end of the federal emergency declaration. The estimates assume that the

authority will extend for the twelve months of CYE 21. To estimate the impact of this change, the DHCM financial analysts first reviewed base period encounters of respite care services. In projecting the impact of this change, analysts made the assumption that members currently receiving the full 600 hours of services permitted during the base period would begin receiving the full 720 hours of respite services permitted under the expanded 1115 waiver authority during the contract period. Analysts further assumed that use of respite care services by all other members using respite care services during the base period would increase by 20%, which equals the percentage increase in the annual cap.

For October 1, 2020 rate development, the projected impact of additional respite services was allocated across rate cells and GSAs using base period encounters. The overall impact of the change by GSA for the ALTCS/EPD program is displayed below in Table 18. Totals may not add up due to rounding. The impacts of this change by rate cell are included in Appendix 6, column "Prospective Program Changes", in the HCBS Expense table.

Table 18: Increase to Annual Respite Hour Limit

GSA	Dollar Impact	PMPM Impact
North	$ 228,747	$ 6.77
Central	$ 1,133,991	$ 4.80
South	$ 645,579	$ 7.96
Composite	**$ 2,008,316**	**$ 5.72**

Reimbursement for HCBS Delivered by Parents

CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to reimburse parents or legally responsible individuals for HCBS provided to a child under the age of 18 years. The authority is effective retroactively from March 13, 2020 until March 31, 2021. To estimate the impact, the DHCM financial analysts reviewed base period data for attendant care and habilitation services provided to AHCCCS members by family members as indicated by modifiers billed on the claim. Analysts made the assumption that the Appendix K authority would increase the amount of these services provided to children under 18 years of age by 50% during the contract period. It was further assumed that services provided by family members to individuals 18 years and older would increase by 5% above base period use during the contract period, due to increased demand during the COVID-19 outbreak. Any impact was calculated net of any impact associated with the Appendix K authority to eliminate the weekly service limit described in the section above.

For October 1, 2020 rate development, the projected impact of additional HCBS services was allocated across rate cells and GSAs using base period encounters of attendant care and habilitation services provided by family members. The overall impact of the change by GSA for the ALTCS/EPD program is displayed below in Table 19. Totals may not add up due to rounding. The impacts of this change by rate cell are included in Appendix 6, column "Prospective Program Changes", in the HCBS Expense table.

Table 19: Reimbursement for HCBS Delivered by Parents

GSA	Dollar Impact	PMPM Impact
North	$ 203,076	$ 6.01
Central	$ 2,584,067	$ 10.94
South	$ 775,621	$ 9.57
Composite	**$ 3,562,765**	**$ 10.15**

Other COVID-19 Initiatives

All other COVID-19 Initiatives are non-material for the ALTCS/EPD program and have been grouped in the Combined Miscellaneous Program Changes and COVID-19 Initiatives section below.

COMBINED MISCELLANEOUS PROGRAM CHANGES AND COVID 19 INITIATIVES

The following prospective program changes or COVID-19 Initiatives have been deemed non-material for the purpose of this actuarial rate certification. We aggregated the impact for the certification by summing the dollar impacts for each non-material adjustment. The overall impact of the aggregated changes by GSA for the ALTCS/EPD program is displayed below in Table 20. Totals may not add up due to rounding. The impacts of these changes by rate cell are included in Appendix 6, column "Prospective Program Changes", in the HCBS and Acute Expense tables. Brief descriptions of the individual changes are provided below.

Table 20: Combined Miscellaneous Program Changes and COVID 19 Initiatives

GSA	Dollar Impact	PMPM Impact
North	$ 73,307	$ 2.17
Central	$ 796,156	$ 3.37
South	$ 8,673	$ 0.11
Composite	**$ 878,136**	**$ 2.50**

Pharmacy and Therapeutics Committee Recommendations

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 20 that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 21. 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.

Peanut Allergy Drug Approval

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

Mantle Cell Lymphoma Drug Approval

On July 24, 2020, the FDA approved Tecartus for the treatment of adult patients with relapsed or refractory mantle cell lymphoma (MCL). The MDRP requires state Medicaid coverage of most FDA approved drugs in exchange for national rebates agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Tecartus on July 24, 2020. Beginning October 1, 2020, Tecartus will be eligible for reinsurance.

Spinal Muscular Atrophy

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

Opioid Treatment Program Reimbursement

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

Off Campus Hospital Outpatient Department Reimbursement

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

Adult Hepatitis C Screening Recommendation

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

Adult Human Papillomavirus Immunization Guidance

On August 16, 2019, the CDC Advisory Committee on Immunizations (ACIP) released a recommendation that adults 27 to 45 years of age at risk of contracting human papillomavirus immunization (HPV) are vaccinated. This

represents an expansion to previous guidance, which recommended HPV immunizations for adults 19 to 26 years of age. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the ACIP recommendation on HPV immunizations for adults.

Increased Frequency of Dental Fluoride Visits
Beginning February 1, 2020, AHCCCS increased the maximum number of dental fluoride varnish applications that members may receive, from 2 to 4 applications a year.

Inpatient Dental Hygienist Teeth Cleanings
As part of the 2019 Legislative session, the Arizona Legislature passed HB 2058 which permits dental hygienists to provide services in an inpatient hospital setting under supervision of a physician. The legislation is expected to increase provision of inpatient teeth cleanings for prevention of ventilator associated pneumonia (VAP).

Pay and Chase Guidance
Federal regulation 42 CRF 433.139, *Payment of Claims*, requires agencies and their Contractors to pay and chase claims for preventive pediatric care services, including EPSDT services, regardless of the existence of third party liability at the time the claim is filed. Preventive pediatric care refers to screening and diagnostic services to identify congenital, physical, mental health routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infectious and communicable diseases from occurring in children under 21 years of age. As a result of questions to AHCCCS regarding coordination of benefits for members with Autism Spectrum Disorder, the agency provided additional clarification to Contractors in CYE 20 on preventive services that must be reimbursed on a pay and chase basis. This clarification is anticipated to increase costs of Contractors in situations in which they are unable to successfully recover funding from liable third parties.

Depression and Anxiety Screening Codes
Effective August 1, 2020, AHCCCS began coverage of procedure code 96127 for brief emotional or behavioral assessments.

Remove Spouse Caregiver Weekly Hour Limit
CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to eliminate the 40 hour limit on reimbursable caregiver services provided by a member's spouse during a 7-day period. The authority is effective retroactively from March 13, 2020 until March 31, 2021.

Flu Vaccine Initiative
AHCCCS is implementing initiatives in the contract year to support use of influenza vaccinations during the COVID-19 outbreak. Effective September 1, 2020, the agency increased fee for service rates on influenza vaccination and administration codes and on administration codes for all Vaccine For Children (VFC) program vaccines by 10%. Effective September 1, 2020, AHCCCS also modified policy guidance to permit pharmacists to administer influenza vaccinations to children ages 3 - 18 years old and to permit qualified emergency medical service (EMS) providers to administer influenza vaccinations to members of all ages. Prior to the change, policy limited pharmacist-administered influenza vaccines to adults 19 years and older. Lastly, Contractors are providing a $10 gift card to members that receive an influenza vaccination in the contract period. AHCCCS anticipates this gift card incentive will increase member use of these services. Contractor costs to purchase and administer the gift cards are funded separately in the non-benefit portion of the CYE 21 capitation rates.

Expanded Telehealth Use
To ensure access to care during the PHE, AHCCCS has temporarily expanded coverage of telephonic codes and mandated that services delivered telephonically or through telehealth (TPTH) are reimbursed at the same rates as for in-person services, for both physical and behavioral health services. April and May 2020 data provided by Contractors indicates use of TPTH services has been essential for continued provision of services and represented annualized growth of 1,308% above base period use. Most growth in the use of these services during the public health emergency is expected to represent a cost-neutral shift from use of in-person services. Increased use of TPTH services are, however, expected to reduce the rate of missed appointments and lower use of NEMT and emergency department (ED) visits.

Supports During School Hours
Member students receive medically necessary services that are specified in an Individualized Education Program (IEP) from school-based providers participating in the School Based Claiming (SBC) fee for service program. Due to virtual learning environments necessitated by the PHE, it may not be feasible for schools to provide in-person attendant care and nursing services through SBC. It is therefore, anticipated that these services will transition to Contractor provider networks.

DIFFERENTIAL ADJUSTED PAYMENTS ADD-ON

We made an adjustment to add projected CYE 21 DAP PMPMs to the capitation rates based on amounts provided by AHCCCS. The PMPM amounts added by rate cell are included in Appendix 6, column "DAP PMPM Add-on", in the NF, HCBS, and Acute Expense tables.

See section I.4.D. below for information on adjustments included in the CYE 21 rates for DAP that will be effective from October 1, 2020 through September 30, 2021.

PROJECTED NF AND HCBS PLACEMENT MIX

The rate cells in the ALTCS / EPD program are considered blended rates, meaning that a member's long-term care setting does not determine the capitation paid for that member. We developed the costs for NF and HCBS independently for members receiving those services then weighted them together based upon the mix of nursing facility and HCBS members projected for the rating period. Since some members are eligible under the program but do not receive LTSS services, we dampened the NF and HCBS costs to reflect this before adding the acute care costs to develop the projected benefit expense costs.

We developed assumptions for the percentages of members receiving LTSS and placement in the nursing facility or HCBS settings based on the average percentages for July through September 2020, which was the most recent 3 month time period available in our member placement data.

Our assumptions for the mix percentages by rate cell are included in Appendix 6, columns "Pct of Member Receiving LTSS", "Projected NF Mix Pct", and "Projected HCBS Mix Pct", in the NF and HCBS Expense tables.

PROJECTED MEMBER SHARE OF COST REMOVAL

After application of trend and other prospective adjustments to our base period data described above, we removed projected CYE 21 member SOC payments from the nursing facility and HCBS service categories to reflect only Contractor liability in the capitation rates.

We projected CYE 21 SOC PMPM amounts by applying two years of trend to the base period PMPM amounts used in the member SOC add-on adjustment to the base data. We developed annualized trend assumptions, separately for dual and non-dual rate cells, based on review of historical member SOC PMPM trends using data from October 1, 2016 through September 30, 2020 and actuarial judgment.

The overall impact by GSA for the ALTCS/EPD program is displayed below in Table 22. Totals may not add up due to rounding. The PMPM amounts added by rate cell are included in Appendix 6, column "Projected SOC Payments Removed", in the NF and HCBS Expense tables. Note that these impacts are after application of the percentages for members receiving LTSS and placement in the NF or HCBS settings.

Table 22: Projected Member Share of Cost Removal

GSA	Dollar Impact	PMPM Impact
North	$ (7,038,941)	$ (208.22)
Central	$ (31,902,625)	$ (135.04)
South	$ (13,458,918)	$ (165.98)
Composite	**$ (52,400,484)**	**$ (149.23)**

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

There were no material changes to the components of the capitation rates or the process of their development, other than those changes described elsewhere in the certification.

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

The ALTCS/EPD program Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used to set the CYE 21 capitation rates therefore includes those adjustments.

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

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

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

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

Please see Section I.2.B.ii.(a) for the types of data that AHCCCS relied upon for developing the projected benefit cost trends for the CYE 21 capitation rates for the ALTCS/EPD Program.

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

Historical utilization, unit cost, and PMPM data from October 1, 2016 through September 30, 2019 were organized by incurred year and month and COS. The three years of data were completed and normalized for historical program and fee schedule changes. Trend rates were developed to adjust the midpoint of the base period (April 1, 2019) forward 24 months to the midpoint of the contract period (April 1, 2021). Projected benefit cost trends were based on actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. No simple formulaic solution exists to determine future trend; actuarial judgment is required.

For NF and HCBS service categories, we modeled trends gross of SOC to be consistent with how they are applied in the rate development model. For Acute trend selections, we relied on PMPM trends more than utilization and unit cost, which are more sensitive to changes in mix of the underlying acute care services.

Appendix 5 contains the projected benefit cost trends by rate cell and COS.

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

All PMPM trend assumptions for the affected COS were compared to similar assumptions made in prior years for ALTCS/EPD capitation rates and judged reasonable to assume for projection to CYE 21.

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

The 2021 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuary defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. There are no outlier or negative trends in the CYE 21 ALTCS/EPD capitation rate development.

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

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

The trend assumptions were developed by unit cost and utilization. Appendix 5 contains the projected benefit cost trends by rate cell and COS.

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

For nursing facility and HCBS service categories, the projected benefit cost trends were developed using utilization per 1000 and unit cost components.

For the acute care service category, the projected benefit cost trends were developed using PMPM amounts.

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

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

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

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

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

No other material adjustments were made to the trend assumptions.

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

No other adjustments were made to the trend assumptions.

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 DHCM Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA.

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

Services in alternative inpatient settings licensed by ADHS Division of Licensing Services (DLS) can be provided in lieu of services in an inpatient hospital (distinct and disparate from in-lieu-of services provided in an IMD). These services are then included in the ALTCS/EPD CYE 21 capitation rate development. Encounters which are in-lieu-of-services are not identified separately in the data. Thus, we cannot define the percentage of cost that in-lieu-of services represented in the capitation rate development categories of service. However, the in-lieu-of services are treated exactly the same as all other State Plan approved services in capitation rate development.

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 (PPC) refers to the time frame from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with ALTCS/EPD. ALTCS/EPD Contractors receive notification from AHCCCS of the member's enrollment. ALTCS/EPD Contractors are responsible for payment of all claims for medically necessary services covered by ALTCS/EPD and provided to members during PPC.

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

Encounters delivered during the PPC timeframe for each member are included in the base encounter data used for setting capitation rates.

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

Member months during the PPC timeframe are included in the base enrollment data used for setting capitation rates.

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

No specific adjustments are made to the CYE 21 capitation rates for the ALTCS/EPD program, given that the encounter and enrollment data are already included within the base data used for capitation rate development.

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

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

Adjustments related to covered benefit changes are discussed in Section I.3.B.ii.(a).

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

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

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

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

Adjustments related to provider reimbursement changes are discussed in Section I.3.B.ii.(a).

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

Adjustments related to Appendix K and select 1115 waiver changes are discussed in Section I.3.B.ii.(a).

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

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

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

Documentation regarding all changes for this rate revision, both material and non-material, has been provided above in Section I.3.B.ii.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

ALTERNATIVE PAYMENT MODEL (APM) INITIATIVE – QUALITY MEASURE PERFORMANCE

The incentive arrangement for the Alternative Payment Model (APM) Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of AHCCCS quality measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement. The maximum incentive pool possible is approximately $15.0M, which is the amount that would be available if every Contractor earned exactly 0% of the withhold described below. This is not anticipated to happen, and thus the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

APM INITIATIVE – PERFORMANCE BASED PAYMENTS

The CYE 21 capitation rates for the ALTCS/EPD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2) at 81 FR 27589, called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the ALTCS/EPD Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by ALTCS/EPD Contractors that are aimed at quality improvement, such as reducing costs, improving health outcomes or improving access to care. For reference, the CYE 19 APM Initiative – Performance Based Payment amounts are anticipated to be $1.9M for the ALTCS/EPD Program.

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

APM INITIATIVE – QUALITY MEASURE PERFORMANCE

The incentive arrangement includes quality measures impacting use of opioids at high dosage, comprehensive diabetes care, and breast cancer screening. All adult and child enrollees and providers utilizing or providing these services, respectively, are covered by the incentive arrangement, unless specifically stated otherwise.

APM INITIATIVE – PERFORMANCE BASED PAYMENTS

All enrollees, children and adults, may be covered by this incentive arrangement. Likewise, all network providers have the opportunity to participate in the APM arrangements and all covered services are eligible for inclusion. The ALTCS/EPD Contractors are mandated to utilize the APM strategies in the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 as defined at https://hcp-lan.org/workproducts/apm-whitepaper.pdf.

The ALTCS/EPD Contractors' provider contracts must include performance measures for quality and/or cost efficiency.

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

APM INITIATIVE – QUALITY MEASURE PERFORMANCE

The purpose of the APM Initiative – Quality Measure Performance incentive arrangement is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings. Contractors are required to meet a targeted percentage of total expenses under an APM contract arrangement in order to participate in the APM Initiative incentive.

APM INITIATIVE – PERFORMANCE BASED PAYMENTS

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

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

All ALTCS/EPD program incentive arrangements combined 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

APM INITIATIVE – QUALITY MEASURE PERFORMANCE

Incentive payments are not included in the certified capitation rates and had no effect on the development of the capitation rates. AHCCCS does not have analysis on the amount of the anticipated incentive payment, since it is dependent on the amount of unearned withhold across all Contractors, and that has yet to be determined. Incentive payments for the APM Initiative will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the contract year and the computation of the quality measures, and after the withhold payments are distributed and the value of the incentive pool determined.

APM INITIATIVE – PERFORMANCE BASED PAYMENTS

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 21 capitation rates for the ALTCS/EPD Program. Additionally, incentive payments for the APM Initiative – Performance Based Payments incentive arrangement had no impact on the development of the CYE 21 capitation rates for the ALTCS/EPD Program. The anticipated incentive payment amount will be paid by AHCCCS to the ALTCS/EPD Contractors through lump sum payments after the completion of CYE 21.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2021 Guide provides information on the definition and requirements of a withhold arrangement.

I.4.B.ii. Appropriate Documentation

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

The ALTCS/EPD program includes a percentage of capitation withhold arrangement which the Contractor may earn back. Contractors are required to engage in a minimally-set targeted percentage of total expenses under an APM purchasing arrangement in order to receive any payment from the payment withhold.

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

The time period of the withhold arrangement coincides with the rating period.

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

All enrollees, services, and providers are covered by this withhold arrangement.

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

The purpose of the ALTCS/EPD withhold is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings

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

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

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

It is highly unlikely that a Contractor will not receive some portion of the withhold back. The only scenario where a Contractor would earn none of the withhold back is if they failed to meet the targeted percentage of total expenses under an APM purchasing arrangement. However, we do not have the information needed to develop an estimate of the withheld amount that is not reasonably achievable.

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

We relied upon the AHCCCS DHCM Finance & Reinsurance Team's review. That review of the total withhold percentage of 1% of capitation revenue indicated that it is reasonable within the context of the capitation rate development, and that the magnitude of the withhold does not have a detrimental impact on the Contractors' financial operation needs and capital reserves. The AHCCCS DHCM Finance & Reinsurance Team's interpretation of financial operating needs relates to cash flow needs for the Contractors to pay claims and administer benefits for its covered populations. The AHCCCS DHCM Finance & Reinsurance Team evaluated the reasonableness of the withhold within this context by reviewing the Contractors' cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by AHCCCS. To evaluate the reasonableness of the withhold in relation to capitalization levels, the AHCCCS DHCM Finance & Reinsurance Team reviewed the surplus above the equity per member requirement, the performance bond amounts, and financial stability of each Contractor to pay all obligations. The AHCCCS DHCM Finance & Reinsurance Team reviewed cash and cash equivalent levels in relation to the withhold arrangement and has indicated the withhold arrangement is reasonable based on current cash levels.

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

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

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

The CYE 21 capitation rates documented in this rate certification are actuarially sound even if none of the withhold is earned back.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2021 Guide provides information on the requirements for risk-sharing mechanisms.

I.4.C.ii. Appropriate Documentation

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

The CYE 21 capitation rates for the ALTCS/EPD Program will include risk corridors.

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

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible

benefit to the stability of the Medicaid member. The CYE 21 capitation rates 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 2021 Guide. The ALTCS/EPD Contract refers to the risk corridor as reconciliation.

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

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

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

Table 23: Risk Corridor Illustration

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

Additional information regarding the CYE 21 risk corridors can be found in the Compensation section of the ALTCS/EPD Program contract.

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

The risk corridor did not have any effect on the development of the CYE 21 capitation rates for the ALTCS/EPD Program.

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

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

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

The contract does not include a remittance/payment requirement for being above/below a specified medical loss ratio (MLR). This section is not applicable.

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

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

AHCCCS provides a reinsurance program to the ALTCS/EPD 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 of inpatient facility medical services. Most of the other reinsurance cases fall under Catastrophic, including reinsurance for biotech drugs. Additionally, rather than the ALTCS/EPD Contractors paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical expense. One could view the reinsurance offset as a

premium. Historical encounter data and reinsurance payments are used as the base for development of the reinsurance offset.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the ALTCS/EPD Contractors for covered services incurred above the deductible. The deductible is the responsibility of the ALTCS/EPD Contractors.

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

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

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

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical 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 capitation PMPM rate.

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

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

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

The reinsurance offsets by rate cell are developed from historical reinsurance payments to the ALTCS/EPD Contractors for Regular and Catastrophic reinsurance cases associated with services incurred during the base period. The data is “brought current” by way of completion factors specific to reinsurance payments, adjustments for historical and prospective program and reimbursement changes, and has the same trend factors applied as the gross medical expense for acute care services, since LTC services are not eligible for consideration in reinsurance.

Changes to the reinsurance program from CYE 19 to CYE 21 included adding several drugs (Trikafta, Symdeko, Orkambi, Tecartus, and Evrysdi) to the list of drugs covered by the AHCCCS reinsurance program.

The projected costs of the additional drugs covered by the reinsurance program was calculated by taking the projected costs for CYE 21 for those drugs and applying a zero dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset.

The combined dollar impact of the reinsurance offsets for the ALTCS/EPD program is a reduction of approximately $31.7 million.

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

I.4.D.i. Rate Development Standards

This section of the 2021 Guide provides information on delivery system and provider payment initiatives authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

The only pre-prints addressed in this certification are the ones related to ALTCS/EPD. Those pre-prints are FQHC Differential Adjusted Payments, Differential Adjusted Payments, Nursing Facility Supplemental Payments, Access to Professional Services Initiative, Pediatric Service Initiative, and Hospital Enhanced Access Leading to Health Improvements Initiative. This certification combines the FQHC Differential Adjusted Payments under the Differential Adjusted Payments language.

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

DIFFERENTIAL ADJUSTED PAYMENTS

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 20.0%, depending on the provider type.

ACCESS TO PROFESSIONAL SERVICES INITIATIVE

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

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

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

PEDIATRIC SERVICE INITIATIVE

The PSI seeks to provide enhanced support to ensure financial viability of the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds.

The PSI provides a uniform dollar increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

NURSING FACILITY SUPPLEMENTAL PAYMENTS

AHCCCS seeks to provide enhanced support to nursing facilities in order to preserve access to these providers who deliver essential services to Medicaid recipients in Arizona. Contractors will provide a uniform dollar increase across all Contractors' reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The increase is intended to supplement, not supplant, payments to eligible providers.

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

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

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

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

All ALTCS/EPD rate cells are affected.

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

For Differential Adjusted Payments see Appendix 6 for medical impact by rate cell. See Appendix 8 for total impact by rate cell.

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

DIFFERENTIAL ADJUSTED PAYMENTS

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.5% increase; up to 13.5% for select services), Critical Access Hospitals (eligible for up to 10.0% increase; up to 20.0% for select services), other hospitals and inpatient facilities (eligible for up to 4.5% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 7.0% increase on all services provided), physicians, physician assistants, registered nurse practitioners, dental providers (all eligible for up to 2.0% increase), home and community based services providers (eligible for up to 1.0% increase on specified services at specified places of service) and Federally Qualified Health Centers (FQHCs) (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the base period encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 21 time period. We then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which we then aggregated to the specific rate cells for each program).

The overall impact by GSA for the ALTCS/EPD program is displayed below in Table 24. Totals may not add up due to rounding. The PMPM amounts added by rate cell are included in Appendix 6, column “DAP PMPM Add-on”, in the NF, HCBS, and Acute Expense tables.

Table 24: ALTCS/EPD Differential Adjusted Payments

GSA	Dollar Impact	PMPM Impact
North	$ 1,252,629	$ 37.05
Central	$ 8,737,719	$ 36.99
South	$ 3,115,779	$ 38.42
Composite	**$ 13,106,128**	**$ 37.32**

I.4.D.ii.(a)(ii)(D) Pre-Print Acknowledgement

DIFFERENTIAL ADJUSTED PAYMENTS

The Differential Adjusted Payments which are accounted for in the capitation rates, and described in the preceding sections, are being made under an approved §438.6(c) pre-print in a manner consistent with the pre-print approved by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

I.4.D.ii.(a)(ii)(E) Maximum Fee Schedule

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

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

The Access to Professional Services Initiative, Pediatric Service Initiative, Nursing Facility Supplemental Payments, and Hospital Enhanced Access Leading to Health Improvements Initiative are not included in the ALTCS/EPD certified capitation rates and will be paid out via lump sum payments.

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

ACCESS TO PROFESSIONAL SERVICES INITIATIVE

Anticipated payments including premium tax for APSI are approximately $2.7 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

PEDIATRIC SERVICE INITIATIVE

Anticipated payments including premium tax for PSI are approximately $2.5 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 21 utilization will be used to redistribute the payments. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

NURSING FACILITY SUPPLEMENTAL PAYMENTS

The anticipated total payments for Nursing Facility Supplemental Payments are approximately $107.8 million, inclusive of premium tax. Of that total, approximately $95.7 million will be paid through ALTCS/EPD Contractors, and the remainder is paid on a fee-for-service basis outside ALTCS/EPD. AHCCCS will distribute the supplemental payments in the form of quarterly lump sum payments to the Contractors. Quarterly lump sum payments will be based on the current available funds in the nursing facility assessment fund plus FMAP. The estimated PMPM amounts provided in the certification are for informational purposes only.

HOSPITAL ENHANCED ACCESS LEADING TO HEALTH IMPROVEMENTS INITIATIVE

Anticipated payments including premium tax for HEALTHII are approximately $42.2 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 21 utilization will be used to redistribute the payments. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

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 to 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 SERVICE INITIATIVE

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

NURSING FACILITY SUPPLEMENTAL PAYMENTS

The actuaries certify to 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 to 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) Providers Receiving Payment

ACCESS TO PROFESSIONAL SERVICES INITIATIVE

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

PEDIATRIC SERVICE INITIATIVE

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

NURSING FACILITY SUPPLEMENTAL PAYMENTS

The qualifying providers receiving the payments include nursing facilities who deliver essential services to ALTCS/EPD enrollees.

HOSPITAL ENHANCED ACCESS LEADING TO HEALTH IMPROVEMENTS INITIATIVE

The qualifying providers receiving the payments include hospitals providing contracted Medicaid Managed Care acute inpatient and ambulatory outpatient services.

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

ACCESS TO PROFESSIONAL SERVICES INITIATIVE

The distribution methodology for the CYE 21 APSI payments will be based on members' utilization of services from APSI qualified providers. The 62 percent uniform percentage increase will be applied to eligible services performed by APSI qualified providers as defined in the pre-print. The estimated amount for CYE 21 APSI was developed by applying the 62 percent uniform increase to base period utilization of eligible services based on encounters for the CYE 19 APSI qualified providers. The same definition of eligible services was used to develop the estimated amount. The APSI qualified providers were identified by Billing Provider Tax IDs in the AHCCCS encounter system. The base period utilization is used as the basis for where to distribute the quarterly lump sum payments. The final lump sum payment will use CYE 21 encounter data for APSI qualified providers. The CYE 21 encounter data used to distribute the final lump sum payment amount will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from the base period, as well as the distribution used to make the quarterly lump sum payments.

PEDIATRIC SERVICE INITIATIVE

The distribution methodology for PSI for CYE 21 will be based on members' utilization of inpatient and outpatient services at freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The uniform dollar increase will be applied to eligible services performed by providers eligible for the Pediatric Service Initiative (identified in the encounters by Servicing Provider Tax IDs). Eligible services are those submitted on UB-04 Inpatient Hospital and UB-04 Outpatient Hospital. Adjudicated and approved encounter data have been used to allocate the interim PSI payments by capitation rate cell. Base period utilization is the basis for the initial distribution of interim quarterly lump sum payments. After the end of the contract year, with sufficient run out, PSI interim quarterly payments will be reconciled using CYE 21 encounter utilization data to re-distribute the interim lump sum payments in the appropriate amounts. The CYE 21 encounter data will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from the base period.

NURSING FACILITY SUPPLEMENTAL PAYMENTS

The distribution methodology for Nursing Facility Supplemental Payments (NF-SP) is based on each facility's proportion of Medicaid resident bed days to total nursing facility Medicaid resident bed days for the most recent and complete contract year (i.e. CYE 19 for CYE 21 NF-SP). The distribution methodology will use base period adjudicated and approved encounter data to allocate the CYE 21 NF-SP by capitation rate cell. The encounter data for this allocation will include: nursing facility providers that maintain eligibility for NF-SP, relevant claim health plan information, relevant rate cell information, and counts of accommodation days. The AHCCCS DHCM Actuarial Team

will exclude FFS utilization from the development of the payments to ALTCS/EPD Program Contractors. After all exclusions, a payment for each ALTCS/EPD Program Contractor, including an adjustment for premium tax, will be developed.

The payments will be allocated by rate cells using the same encounter data listed above which had all relevant rate cell information included. The allocation of payments by Contractor will be driven by the percentage of total accommodation days that are assigned to each Contractor. The estimated amount for CYE 21 NF-SP was developed by using base period encounter data. Each quarterly payment will be paid based on the available funds in the nursing facility assessment fund plus FMAP.

HOSPITAL ENHANCED ACCESS LEADING TO HEALTH IMPROVEMENTS INITIATIVE

The distribution methodology for HEALTHII for CYE 21 will be based on the utilization of services by members with providers participating in the HEALTHII program. Adjudicated and approved encounter data have been used to allocate the interim HEALTHII payments by capitation rate cell. Base period utilization is the basis for the initial distribution of the interim quarterly lump sum payments. After the end of the contract year, with sufficient run out, HEALTHII interim quarterly payments will be reconciled using CYE 21 encounter utilization data to re-distribute the interim lump sum payments in the appropriate amounts. The CYE 21 encounter data will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 19.

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

Appendix 8 contains estimated PMPMs including premium tax by rate cell.

I.4.D.ii.(a)(iii)(F) Pre-Print Acknowledgement

ACCESS TO PROFESSIONAL SERVICES INITIATIVE

These payments are being made under the approved APSI §438.6(c) payment arrangement in a manner consistent with the pre-print approved by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

PEDIATRIC SERVICE INITIATIVE

These payments are being made under the approved PSI §438.6(c) payment arrangement in a manner consistent with the pre-print approved by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

NURSING FACILITY SUPPLEMENTAL PAYMENTS

These payments are being made under the approved Nursing Facility Supplemental Payments §438.6(c) payment arrangement in a manner consistent with the pre-print approved by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

HOSPITAL ENHANCED ACCESS LEADING TO HEALTH IMPROVEMENTS INITIATIVE

These payments are being made under the approved HEALTHII §438.6(c) payment arrangement in a manner consistent with the pre-print approved by CMS (inclusive of any/all correspondence between the state and CMS regarding the pre-print).

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

ACCESS TO PROFESSIONAL SERVICES INITIATIVE

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

PEDIATRIC SERVICE INITIATIVE

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

NURSING FACILITY SUPPLEMENTAL PAYMENTS

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

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

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

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

AHCCCS will be including contract amendments with the submission of this rate certification which replaces some minimum fee schedule requirements with notification requirements. There are no impacts to the capitation rates for these changes. If a Contractor plans to contract below a specified fee schedule, they will be required to notify AHCCCS in advance, and AHCCCS will evaluate at that time whether an adjustment to the Contractor's rates is warranted.

Additionally, AHCCCS will be including contract amendments with the submission of this rate certification which clarify the regulatory authority for any minimum fee schedule requirements which remain in contract language.

There are no other requirements regarding reimbursement rates the plans must pay to providers unless specifically specified in the certification as a directed payment or authorized under applicable law, regulation, or waiver.

I.4.E. Pass-Through Payments

Not applicable. There are no pass-through payments in the CYE 21 capitation rates for the ALTCS/EPD Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2021 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

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

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

The primary data sources used to develop the administrative component of the CYE 21 capitation rates for the EPD Program were administrative expense estimates submitted by Contractors for CYE 19 and CYE 20. In addition, Contractors were required to submit administrative expense estimates for CYE 21, which were reviewed to inform development of cost projections. Also reviewed were trends and forecasts for Consumer Price Index (CPI) and Employment Cost Index (ECI) data from IHS Markit and each contractor's quarterly financial statements.

ADMINISTRATIVE EXPENSES

For two of the Contractors, we used FFY 19 administrative (Admin) expenses and member months reported in their supplemental non-benefit cost data submission as the base experience for projecting CYE 21 Admin expenses. To address reporting concerns and mitigate unreasonably large increases in comparison to the CYE 20 capitation rates, an adjustment was made to one of these Contractor's reported Admin experience.

For one Contractor, we used calendar year 2019 Admin expenses and member months from their quarterly financial statements as the base experience for projecting CYE 21 Admin expenses. This Contractor indicated in email correspondence that an annual settlement of management fees in the fourth calendar quarter of the year can distort Admin expense amounts for contract year ending time periods. Therefore, for only this Contractor, we determined that using calendar year 2019 Admin expenses is more appropriate than CYE 19 expenses.

The wage-driven portion of the FFY 19 or calendar year 2019 Admin expenses was trended forward from the base period to the rating period by the projected CPI for wage earners. The trend factor was provided by AHCCCS based on data from an external firm, IHS Markit, which we reviewed and determined to be reasonable. A trend factor was not applied to the non-wage-driven portion of the FFY 19 or calendar year 2019 Admin expenses.

The CYE 21 projected wage-driven and non-wage driven and amounts, summed together, equal the projected CYE 21 Admin expenses prior to inclusion of several PMPM add-ons.

One PMPM add-on amount reflects the PBM spread that was removed from the CYE 19 base period encounters, as described is section I, item 2.B.iii.(d)., and will now be included in Admin in CYE 21.

Additional expenses were included in the projected administrative costs for requirements identified by AHCCCS for the upcoming year, inclusive of the administrative costs required to administer the flu vaccine gift card initiative, which would not have been reflected in the Contractors' supplemental non-benefit cost data submissions nor their financials.

CASE MANAGEMENT EXPENSES

Similar to Admin, we used either CYE 19 or calendar year 2019 case management (CM) expenses and member months, depending on the Contractor, reported in each Contractor's quarterly financial statements as the base experience for projecting CYE 21 CM expenses. To address reporting concerns and mitigate unreasonably large increases in comparison to the CYE 20 capitation rates, a similar adjustment was made to one Contractor's reported CM experience as was made for Admin.

Additional adjustments were then made for the change in HCBS mix percentage from the base experience period to the rating period and to increase the wage-driven portion of the base CM expenses by the projected CPI for wage earners (as described in the Admin section above).

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

There were no material changes to data, assumptions, or methodologies for projecting non-benefit costs since the previous 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 costs included in the capitation rate.

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

The projected non-benefit costs for each of the listed categories of costs in the 2021 Guide are shown in Appendix 7 for the CYE 21 capitation rates.

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

The administrative component of the CYE 21 ALTCS/EPD capitation rates is described above in Section I.5.B.i.(a). The PMPM amounts by rate cell, Contractor, and GSA are provided in Appendix 7.

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

The CYE 21 capitation rates for the ALTCS/EPD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 21 capitation rates for the ALTCS/EPD Program includes a provision of 1% for risk margin (i.e. underwriting gain), calculated net of premium tax.

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

No other material or non-material non-benefit costs are reflected in the CYE 21 capitation rates for the ALTCS/EPD Program.

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

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

I.5.B.iv. Health Insurance Provider's Fee

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

The capitation rates for the EPD Program reflected in this rate certification do not incorporate the Health Insurance Providers Fee (HIPF). The HIPF for Fee Year 2020 has been incorporated as a retroactive amendment to the initially certified capitation rates for CYE 20. Fee Year 2020 is the final HIPF, as the Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502 repealed the annual fee for calendar years beginning after December 31, 2020.

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

Not applicable. The HIPF is not included in the CYE 21 capitation rates for the ALTCS/EPD Program.

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

Not applicable. The HIPF is not included in the CYE 21 capitation rates for the ALTCS/EPD Program.

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

The capitation rates in this certification will not be adjusted to account for the HIPF at a later date.

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

Not applicable. The HIPF is not included in the CYE 21 capitation rates for the ALTCS/EPD Program.

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

For HIPF that have been paid in 2014, 2015, 2016, 2018, and 2020, the HIPF has been included in the capitation rates as a retroactive amendment to the initially certified capitation rates for each Contract Year Ending in the fee year.

I.6. Risk Adjustment and Acuity Adjustments

Not applicable. The CYE 21 capitation rates for the ALTCS/EPD Program do not include risk adjustment or acuity adjustments.

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

Section II of the 2021 Guide is applicable to the ALTCS/EPD Program because the CYE 21 capitation rates for ALTCS/EPD are subject to the applicable “actuarial soundness” provisions from 42 CFR § 438.4 at 81 FR 27858 and the ALTCS/EPD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. CMS Expectations

The rate development standards and appropriate documentation described in Section I of the 2021 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 2021 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

This is not applicable because a member’s long-term care setting does not determine the capitation paid for that member.

II.1.C. Appropriate Documentation

II.1.C.i. Considerations

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

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

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

Data, assumptions and methodologies used for the development of projected gross medical expenses, administrative expenses, and case management expenses are described above in Sections I.3 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/EPD Contractors other than what has already been described above in Sections I.4.A and I.4.C.

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

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

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

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

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

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

II.1.C.iii. Additional Information

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

Section III New Adult Group Capitation Rates

Section III of the 2021 Guide is not applicable to the ALTCS/EPD Program. As noted in Section I.1.B.iii, all covered populations under the ALTCS/EPD Program receive the regular FMAP.

Appendix 1: Actuarial Certification

I, Jill S. Herbold, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board. I have been retained by the Arizona Health Care Cost Containment System to perform an actuarial review and certification regarding the development of capitation rates for the Arizona Long Term Care System / Elderly and Physical Disability program effective October 1, 2020. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 21 capitation rates for the ALTCS/EPD Program have been documented according to the guidelines established by CMS in the 2021 Guide. The CYE 21 capitation rates for the ALTCS/EPD Program are effective for the twelve month time period from October 1, 2020 through September 30, 2021.

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

The capitation rates developed may not be appropriate for any specific Contractor. An individual Contractor will need to review the rates in relation to the benefits that it will be obligated to provide. The Contractor should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The Contractor may require rates above, equal to, or below the “actuarially sound” capitation rates that are associated with this certification.

At the time of this rate certification, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on setting capitation rates, including whether the pandemic will increase or decrease costs in CYE 21. Given the lack of reliable and historical information for this unprecedented public health emergency, we did not adjust the capitation rates for foregone care, deferred care, and pent-up demand. However, it is known that the COVID-19 pandemic could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this rate certification. 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. In times such as these, the risk-sharing arrangements are even more important to the stability of the system.

SIGNATURE ON FILE — November 13, 2020

Jill S. Herbold — Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

APPENDIX 2: CERTIFIED CAPITATION RATES

Appendix 2: Certified Capitation Rates

Rate Cell	Contractor	GSA	CYE 21 Capitation Rate (10/1/20)
Dual	UHC-LTC	North	$ 3,206.27
Dual	Banner-UFC	South	3,611.48
Dual	Mercy Care	South	3,493.02
Dual	UHC-LTC	Central	3,155.71
Dual	Banner-UFC	Central	3,924.55
Dual	Mercy Care	Central	3,858.49
Non-Dual	UHC-LTC	North	6,598.01
Non-Dual	Banner-UFC	South	7,164.14
Non-Dual	Mercy Care	South	7,518.07
Non-Dual	UHC-LTC	Central	7,869.24
Non-Dual	Banner-UFC	Central	8,919.62
Non-Dual	Mercy Care	Central	8,354.83

Notes:

1. This filing certifies to Capitation Rates effective October 1, 2020 through September 30, 2021.

APPENDIX 3A: COMPARISON OF CAPITATION RATES

Appendix 3a: Comparison of Capitation Rates

Rate Cell	Contractor	GSA	CYE 20 Capitation Rate (1/1/20)	CYE 21 Capitation Rate (10/1/20)	Pct Change
Dual	UHC-LTC	North	$ 3,125.28	$ 3,206.27	2.6%
Dual	Banner-UFC	South	3,685.05	3,611.48	(2.0%)
Dual	Mercy Care	South	3,438.80	3,493.02	1.6%
Dual	UHC-LTC	Central	3,020.21	3,155.71	4.5%
Dual	Banner-UFC	Central	3,889.23	3,924.55	0.9%
Dual	Mercy Care	Central	3,812.57	3,858.49	1.2%
Non-Dual	UHC-LTC	North	6,525.80	6,598.01	1.1%
Non-Dual	Banner-UFC	South	6,514.73	7,164.14	10.0%
Non-Dual	Mercy Care	South	7,211.35	7,518.07	4.3%
Non-Dual	UHC-LTC	Central	7,112.83	7,869.24	10.6%
Non-Dual	Banner-UFC	Central	7,875.23	8,919.62	13.3%
Non-Dual	Mercy Care	Central	7,855.05	8,354.83	6.4%

APPENDIX 3B: FISCAL IMPACT SUMMARY

Appendix 3b: Fiscal Impact Summary

Rate Cell	Contractor	GSA	Projected MMOS 10/1/20 - 9/30/21	CYE 21 Capitation Rate (10/1/20)	Projected Expenditures CYE 21
Dual	UHC-LTC	North	29,717	$ 3,206.27	$ 95,279,198
Dual	Banner-UFC	South	42,967	3,611.48	155,174,036
Dual	Mercy Care	South	26,779	3,493.02	93,539,067
Dual	UHC-LTC	Central	71,105	3,155.71	224,388,100
Dual	Banner-UFC	Central	25,893	3,924.55	101,617,767
Dual	Mercy Care	Central	97,844	3,858.49	377,529,433
Non-Dual	UHC-LTC	North	4,089	6,598.01	26,978,310
Non-Dual	Banner-UFC	South	6,617	7,164.14	47,402,572
Non-Dual	Mercy Care	South	4,727	7,518.07	35,535,772
Non-Dual	UHC-LTC	Central	11,271	7,869.24	88,693,605
Non-Dual	Banner-UFC	Central	4,731	8,919.62	42,198,160
Non-Dual	Mercy Care	Central	25,404	8,354.83	212,242,168

APPENDIX 4: UNADJUSTED AND ADJUSTED BASE DATA BY RATE CELL

Appendix 4: Unadjusted and Adjusted Base Data by Rate Cell

CYE 2021, Gross Nursing Facility (NF) Expenses PMPM

Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	DAP Payments Removed	SOC Payments Added	Prop 206 Adjustment 1/1/19	Prop 206 Adjustment 10/1/19	PFS 10/1/19	Prop 206 Adjustment 1/1/20	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 21
Dual	UHC-LTC	North	$ 4,715.19	0.9705	$ (64.11)	$ 822.17	1.0018	1.0185	1.0260	1.0130	1.0506	$ 6,257.33
Dual	Banner-UFC	South	5,020.95	0.9550	(67.35)	718.88	1.0017	1.0185	1.0260	1.0130	1.0506	6,583.40
Dual	Mercy Care	South	4,794.04	0.9570	(71.93)	697.61	1.0017	1.0185	1.0260	1.0130	1.0506	6,277.98
Dual	UHC-LTC	Central	5,399.95	0.9705	(51.82)	758.53	1.0017	1.0185	1.0260	1.0130	1.0506	6,986.08
Dual	Banner-UFC	Central	5,380.11	0.9550	(58.31)	751.02	1.0017	1.0185	1.0260	1.0130	1.0506	7,048.27
Dual	Mercy Care	Central	5,533.64	0.9570	(50.17)	732.34	1.0017	1.0185	1.0260	1.0130	1.0506	7,201.91
Non-Dual	UHC-LTC	North	6,789.45	0.9768	(57.02)	158.80	1.0018	1.0185	1.0260	1.0130	1.0506	7,856.89
Non-Dual	Banner-UFC	South	6,463.45	0.9740	(47.07)	111.38	1.0017	1.0185	1.0260	1.0130	1.0506	7,464.87
Non-Dual	Mercy Care	South	6,027.00	0.9391	(54.90)	131.96	1.0017	1.0185	1.0260	1.0130	1.0506	7,235.48
Non-Dual	UHC-LTC	Central	7,965.04	0.9768	(32.30)	65.46	1.0017	1.0185	1.0260	1.0130	1.0506	9,121.04
Non-Dual	Banner-UFC	Central	8,024.67	0.9740	(43.71)	102.03	1.0017	1.0185	1.0260	1.0130	1.0506	9,243.99
Non-Dual	Mercy Care	Central	7,782.19	0.9391	(42.90)	100.37	1.0017	1.0185	1.0260	1.0130	1.0506	9,295.79

CYE 2021 Gross Home-and-Community-Based Settings (HCBS) Expenses PMPM

Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	DAP Payments Removed	SOC Payments Added	Prop 206 Adjustment 1/1/19	Prop 206 Adjustment 10/1/19	PFS 10/1/19	Prop 206 Adjustment 1/1/20	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 21
Dual	UHC-LTC	North	$ 1,417.95	0.9843	$ 0.00	$ 17.89	1.0037	1.0356	1.0493	1.0258	1.0201	$ 1,664.44
Dual	Banner-UFC	South	1,712.60	0.9844	(0.02)	15.33	1.0035	1.0356	1.0493	1.0260	1.0201	2,002.93
Dual	Mercy Care	South	1,624.41	0.9295	-	21.79	1.0035	1.0356	1.0493	1.0259	1.0201	2,019.22
Dual	UHC-LTC	Central	1,569.26	0.9843	(0.01)	13.69	1.0034	1.0356	1.0493	1.0260	1.0201	1,834.93
Dual	Banner-UFC	Central	1,752.14	0.9844	-	10.67	1.0034	1.0356	1.0493	1.0260	1.0201	2,043.48
Dual	Mercy Care	Central	1,764.66	0.9295	-	15.76	1.0034	1.0356	1.0493	1.0259	1.0201	2,184.50
Non-Dual	UHC-LTC	North	1,489.86	0.9829	-	0.50	1.0037	1.0356	1.0493	1.0257	1.0000	1,696.30
Non-Dual	Banner-UFC	South	1,655.17	0.9872	(0.01)	1.77	1.0035	1.0356	1.0493	1.0258	1.0000	1,877.38
Non-Dual	Mercy Care	South	1,951.51	0.9332	-	6.11	1.0035	1.0356	1.0493	1.0255	1.0000	2,345.23
Non-Dual	UHC-LTC	Central	1,753.64	0.9829	(0.01)	2.18	1.0034	1.0356	1.0493	1.0258	1.0000	1,998.14
Non-Dual	Banner-UFC	Central	2,070.37	0.9872	-	0.07	1.0034	1.0356	1.0493	1.0258	1.0000	2,345.85
Non-Dual	Mercy Care	Central	2,069.14	0.9332	-	6.52	1.0034	1.0356	1.0493	1.0256	1.0000	2,486.76

CYE 2021, Gross Acute Care Expenses PMPM

Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	PBM Spread Removal	IMD Repricing	DAP Payments Removed	Retrospective Program Changes	PFS 10/1/19	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 21
Dual	UHC-LTC	North	$ 135.60	0.8536	1.0000	$ 0.01	$ (1.34)	0.9977	1.0000	1.0816	$ 170.00
Dual	Banner-UFC	South	230.09	0.9169	1.0000	(0.04)	(1.72)	0.9986	1.0000	1.0816	269.14
Dual	Mercy Care	South	218.77	0.9107	0.9996	0.08	(1.40)	0.9976	1.0000	1.0816	257.68
Dual	UHC-LTC	Central	201.23	0.8409	1.0000	0.15	(1.26)	1.0017	1.0000	1.0816	258.08
Dual	Banner-UFC	Central	351.74	0.9140	1.0000	0.00	(2.67)	1.0029	1.0000	1.0816	414.56
Dual	Mercy Care	Central	374.36	0.9100	0.9997	0.05	(2.84)	1.0007	1.0000	1.0816	442.09
Non-Dual	UHC-LTC	North	2,396.29	0.9335	1.0000	0.23	(33.35)	0.9997	1.0101	1.1475	2,936.25
Non-Dual	Banner-UFC	South	2,919.88	0.9347	1.0000	0.04	(40.10)	0.9973	1.0254	1.1475	3,618.52
Non-Dual	Mercy Care	South	2,939.77	0.9388	0.9958	0.30	(32.34)	0.9962	1.0056	1.1475	3,547.54
Non-Dual	UHC-LTC	Central	3,321.96	0.9331	1.0000	(0.92)	(53.15)	0.9922	1.0124	1.1475	4,041.25
Non-Dual	Banner-UFC	Central	3,246.51	0.9292	1.0000	(0.00)	(45.37)	0.9811	1.0150	1.1475	3,940.62
Non-Dual	Mercy Care	Central	3,310.91	0.9383	0.9962	(0.49)	(35.79)	0.9965	1.0129	1.1475	4,029.01

APPENDIX 5: PROJECTED TRENDS

Appendix 5: Projected Trends

CYE 2021 Projected Trends

Rate Cell	COS	Pct of Costs in Base	Annual Utilization Trend Rate	Annual Unit Cost Trend Rate	Annual PMPM Trend Rate
Dual	Nursing Facility	31.1%	0.0%	2.5%	2.5%
Dual	HCBS	33.1%	0.0%	1.0%	1.0%
Dual	Acute Care	6.3%	n/a	n/a	4.0%
Non-Dual	Nursing Facility	8.5%	0.0%	2.5%	2.5%
Non-Dual	HCBS	7.0%	0.0%	0.0%	0.0%
Non-Dual	Acute Care	14.0%	n/a	n/a	7.1%

APPENDIX 6: CYE 2021 PROJECTED GROSS AND NET MEDICAL EXPENSES PMPM

Appendix 6: CYE 2021 Projected Gross and Net Medical Expenses PMPM

Nursing Facility (NF) Expenses PMPM

Rate Cell	Contractor	GSA	Gross NF Expense Amount PMPM	Prop 206 Adjustment Factor 1/1/21	Provider Fee Schedule 10/1/20	DAP PMPM Add-on	Pct of Members Receiving LTSS	Projected NF Mix Pct	Projected SOC Payments Removed	Net NF Expense Amount PMPM 10/1/20
Dual	UHC-LTC	North	$ 6,257.33	1.0018	1.0000	$ 104.31	98.5%	26.1%	$ (217.49)	$ 1,419.00
Dual	Banner-UFC	South	6,583.40	1.0013	1.0000	105.52	98.6%	23.8%	(174.14)	1,400.85
Dual	Mercy Care	South	6,277.98	1.0014	1.0000	107.15	99.3%	24.0%	(171.39)	1,353.46
Dual	UHC-LTC	Central	6,986.08	1.0014	1.0000	98.92	98.3%	15.9%	(122.12)	986.67
Dual	Banner-UFC	Central	7,048.27	1.0013	1.0000	111.54	98.9%	23.5%	(179.59)	1,484.62
Dual	Mercy Care	Central	7,201.91	1.0013	1.0000	103.44	98.9%	20.7%	(154.22)	1,341.12
Non-Dual	UHC-LTC	North	7,856.89	1.0017	1.0000	118.53	96.1%	23.8%	(42.87)	1,785.18
Non-Dual	Banner-UFC	South	7,464.87	1.0014	1.0000	103.95	94.8%	23.8%	(29.64)	1,679.73
Non-Dual	Mercy Care	South	7,235.48	1.0013	1.0000	109.19	96.5%	27.3%	(41.07)	1,899.26
Non-Dual	UHC-LTC	Central	9,121.04	1.0014	1.0000	104.15	96.2%	22.8%	(16.91)	2,006.08
Non-Dual	Banner-UFC	Central	9,243.99	1.0013	1.0000	121.27	94.4%	29.0%	(32.98)	2,536.61
Non-Dual	Mercy Care	Central	9,295.79	1.0013	1.0000	114.21	95.2%	23.7%	(26.73)	2,100.47

HCBS Expenses PMPM

Rate Cell	Contractor	GSA	Gross HCBS Expense Amount PMPM	Prospective Program Changes	Prop 206 Adjustment Factor 1/1/21	Provider Fee Schedule 10/1/20	DAP PMPM Add-on	Pct of Members Receiving LTSS	Projected HCBS Mix Pct	Projected SOC Payments Removed	Net HCBS Expense Amount PMPM 10/1/20
Dual	UHC-LTC	North	$ 1,664.44	1.0169	1.0100	1.0000	$ 6.13	98.5%	73.9%	$ (13.42)	$ 1,236.36
Dual	Banner-UFC	South	2,002.93	1.0153	1.0081	1.0000	8.29	98.6%	76.2%	(11.86)	1,533.85
Dual	Mercy Care	South	2,019.22	1.0153	1.0075	1.0000	7.23	99.3%	76.0%	(16.93)	1,546.46
Dual	UHC-LTC	Central	1,834.93	1.0137	1.0078	1.0000	6.73	98.3%	84.1%	(11.66)	1,543.50
Dual	Banner-UFC	Central	2,043.48	1.0137	1.0076	1.0000	6.46	98.9%	76.5%	(8.31)	1,575.95
Dual	Mercy Care	Central	2,184.50	1.0137	1.0075	1.0000	8.82	98.9%	79.3%	(12.74)	1,744.31
Non-Dual	UHC-LTC	North	1,696.30	1.0203	1.0094	1.0000	6.78	96.1%	76.2%	(0.44)	1,283.74
Non-Dual	Banner-UFC	South	1,877.38	1.0208	1.0078	1.0000	8.69	94.8%	76.2%	(1.51)	1,400.20
Non-Dual	Mercy Care	South	2,345.23	1.0208	1.0075	1.0000	9.73	96.5%	72.7%	(5.05)	1,693.04
Non-Dual	UHC-LTC	Central	1,998.14	1.0189	1.0080	1.0000	8.17	96.2%	77.2%	(1.91)	1,528.10
Non-Dual	Banner-UFC	Central	2,345.85	1.0189	1.0075	1.0000	7.88	94.4%	71.0%	(0.06)	1,619.27
Non-Dual	Mercy Care	Central	2,486.76	1.0189	1.0075	1.0000	10.93	95.2%	76.3%	(5.59)	1,855.45

Acute Expenses PMPM

Rate Cell	Contractor	GSA	Gross Acute Expense Amount PMPM	Rx Rebates / Pharmacy Savings	Medicare Part A and B Deductible	Prospective Program Changes	Provider Fee Schedule 10/1/20	DAP PMPM Add-on	Reinsurance Offset PMPM	Net Acute Expense Amount PMPM 10/1/20
Dual	UHC-LTC	North	$ 170.00	$ (0.19)	$ 2.00	1.0005	1.0037	$ 1.71	$ (2.80)	$ 171.43
Dual	Banner-UFC	South	269.14	(0.23)	1.95	1.0028	1.0013	1.84	(7.77)	266.02
Dual	Mercy Care	South	257.68	(0.32)	2.02	1.0028	1.0013	1.46	(2.39)	259.52
Dual	UHC-LTC	Central	258.08	(0.08)	2.14	1.0072	1.0028	1.30	(17.00)	247.04
Dual	Banner-UFC	Central	414.56	(0.31)	2.41	1.0072	1.0006	2.57	(7.62)	414.87
Dual	Mercy Care	Central	442.09	(0.79)	2.84	1.0072	1.0008	2.73	(39.04)	411.40
Non-Dual	UHC-LTC	North	2,936.25	(25.13)	-	1.0214	1.0364	34.75	(211.29)	2,905.14
Non-Dual	Banner-UFC	South	3,618.52	(35.64)	-	1.0111	1.0433	46.22	(462.88)	3,362.77
Non-Dual	Mercy Care	South	3,547.54	(65.87)	-	1.0111	1.0467	34.39	(358.71)	3,360.40
Non-Dual	UHC-LTC	Central	4,041.25	(20.10)	-	1.0138	1.0386	57.08	(683.58)	3,607.63
Non-Dual	Banner-UFC	Central	3,940.62	(33.90)	-	1.0138	1.0438	39.41	(253.59)	3,919.93
Non-Dual	Mercy Care	Central	4,029.01	(91.80)	-	1.0138	1.0489	42.48	(453.05)	3,776.34

APPENDIX 7: CYE 2021 PROJECTED CAPITATION RATES PMPM

Appendix 7: CYE 2021 Projected Capitation Rates PMPM

CYE 2021 Capitation Rates

Rate Cell	Contractor	GSA	Net NF Expense Amount PMPM	Net HCBS Expense Amount PMPM	Net Acute Expense Amount PMPM	Case Mgmt PMPM	Admin Exp PMPM	UW Gain PMPM	Premium Tax PMPM	Final Net Capitation PMPM
Dual	UHC-LTC	North	$ 1,419.00	$ 1,236.36	$ 171.43	$ 168.12	$ 116.10	$ 31.14	$ 64.13	$ 3,206.27
Dual	Banner-UFC	South	1,400.85	1,533.85	266.02	144.58	158.84	35.12	72.23	3,611.48
Dual	Mercy Care	South	1,353.46	1,546.46	259.52	146.53	83.27	33.92	69.86	3,493.02
Dual	UHC-LTC	Central	986.67	1,543.50	247.04	169.85	114.75	30.79	63.11	3,155.71
Dual	Banner-UFC	Central	1,484.62	1,575.95	414.87	159.98	172.49	38.16	78.49	3,924.55
Dual	Mercy Care	Central	1,341.12	1,744.31	411.40	153.48	93.19	37.83	77.17	3,858.49
Non-Dual	UHC-LTC	North	1,785.18	1,283.74	2,905.14	171.67	254.20	66.11	131.96	6,598.01
Non-Dual	Banner-UFC	South	1,679.73	1,400.20	3,362.77	161.43	342.63	74.10	143.28	7,164.14
Non-Dual	Mercy Care	South	1,899.26	1,693.04	3,360.40	145.20	193.32	76.50	150.36	7,518.07
Non-Dual	UHC-LTC	Central	2,006.08	1,528.10	3,607.63	164.66	322.26	83.12	157.38	7,869.24
Non-Dual	Banner-UFC	Central	2,536.61	1,619.27	3,919.93	162.91	413.45	89.06	178.39	8,919.62
Non-Dual	Mercy Care	Central	2,100.47	1,855.45	3,776.34	153.24	216.68	85.55	167.10	8,354.83

APPENDIX 8: PROJECTED DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

Appendix 8: Projected Delivery System and Provider Payment Initiatives

CYE 2021 Capitation Rates

Rate Cell	Contractor	GSA	DAP Non-FQHC	DAP FQHC	APSI	PSI	Supplemental NF Payments	HEALTHII
Dual	UHC-LTC	North	$ 33.95	$ 0.01	$ 0.34	$ 0.00	$ 330.57	$ 25.28
Dual	Banner-UFC	South	33.86	0.02	0.36	-	319.56	29.41
Dual	Mercy Care	South	33.43	0.04	0.68	-	301.63	23.91
Dual	UHC-LTC	Central	23.01	0.01	0.27	0.00	197.52	18.33
Dual	Banner-UFC	Central	34.36	0.01	0.08	-	302.80	45.34
Dual	Mercy Care	Central	31.72	0.02	0.25	-	267.88	46.48
Non-Dual	UHC-LTC	North	68.76	0.13	18.01	15.42	318.81	597.18
Non-Dual	Banner-UFC	South	77.93	0.34	71.56	3.88	266.96	657.45
Non-Dual	Mercy Care	South	71.78	0.38	77.93	3.26	300.75	558.77
Non-Dual	UHC-LTC	Central	88.37	0.21	46.86	115.41	244.76	610.27
Non-Dual	Banner-UFC	Central	80.20	0.11	22.49	28.15	375.53	668.64
Non-Dual	Mercy Care	Central	78.40	0.13	42.08	38.80	274.63	512.63

Notes:

1. All amounts shown include premium tax. DAP amounts also include underwriting gain

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