



**Contract Year Ending 2023
Capitation Rate Certification
Arizona Long Term Care System/ Elderly and
Physical Disability Program**

October 1, 2022 through September 30, 2023

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

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

August 12, 2022

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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for Contract Year Ending 2023 (CYE 23) effective October 1, 2022 through September 30, 2023, for the Arizona Long Term Care System (ALTCS)/Elderly and Physical Disability (ALTCS/EPD) Program.

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

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2022-2023 Medicaid Managed Care Rate Development Guide (2023 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2023 Guide describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2023 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

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

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

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

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

As stated on pages 2 and 3 of the 2023 Guide, CMS will also use these three principles in applying the regulation standards:

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- 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.

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I.1. General Information

This section provides documentation for the General Information section of the 2023 Guide.

I.1.A. Rate Development Standards

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

The section of the 2023 Guide notes that standards and documentation expectations are not different for capitation rates and capitation rate ranges, except where otherwise stated.

I.1.A.ii. Rating Period

The CYE 23 capitation rates for the ALTCS/EPD Program are effective for the 12-month time period from October 1, 2022 through September 30, 2023.

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 23 capitation rates for the ALTCS/EPD Program, signed by Wenzhang Du, ASA, MAAA and Colby Schaeffer, ASA, MAAA, is in Appendix 1. Mr. Du and Mr. Schaeffer meet the requirements for the definition of an Actuary described at 42 CFR § 438.2 which is provided below for reference.

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

Mr. Du and Mr. Schaeffer certify that the CYE 23 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.

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

The final and certified capitation rates by rate cell are 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). 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 and the 2023 Guide.

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

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

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

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

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

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Table 1: Managed Care Plan(s) by GSA

| GSA | Counties | Contractors |
|---------|---|---|
| North | Apache, Coconino, Mohave, Navajo, and Yavapai | UnitedHealthcare Community Plan (UnitedHealthcare) |
| Central | Gila, Maricopa, and Pinal | Banner – University Family Care (Banner – UFC) Mercy Care (Mercy Care) UnitedHealthcare |
| South | Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma | Banner – UFC Mercy Care (Pima County Only) |

I.1.A.iii.(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.

For the CYE 23 rating period, the projected expenses associated with the administration of COVID-19 vaccines are not included in the capitation rates; all COVID-19 vaccine costs in the base data period were removed as part of rate developments, described below in Section I.2.B.iii.(d). AHCCCS Contractors are responsible for these expenses and will be reimbursed for these expenses on a non-risk basis via periodic cost-settlement payments based upon adjudicated/approved encounter data subject to the two-year claiming rule.

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

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

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

The rate certification for the CYE 23 capitation rates for the ALTCS/EPD Program is effective for the 12-month time period from October 1, 2022 through September 30, 2023.

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

The populations covered under 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.

The ALTCS/EPD Program has two risk groups: rate cells for members who are dually eligible for Medicare and Medicaid (“Duals”) and rates 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

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(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.

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

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

In practice, enrollment in the ALTCS/EPD program is predicated upon meeting the eligibility requirements for ALTCS, as defined in the contract and state statute, and being elderly and/or physically disabled; physical disabilities do not generally resolve, and health needs generally increase as members age, so it is unlikely a member would lose ALTCS eligibility on the basis of no longer needing the level of medical support required by the ALTCS eligibility statutes, but in that unlikely event, the member would transition to the ALTCS Transitional Program, for members who fail to be at “immediate risk of institutionalization”, which provides the same level of care as ALTCS with the exception of limiting institutional services to 90 days per admission. There are three allowable income limit definitions for ALTCS financial eligibility under the Arizona 1115 Waiver. The first definition is income equal to or less than 300 percent of the Federal Benefit Rate (approximately 222 percent of the Federal Poverty Limit (FPL)), as used by the Social Security Administration (SSA) to determine eligibility for Supplemental Security Income (SSI); the second and third definitions cover the “Freedom to Work” groups (state optional TXIX coverage groups under the ALTCS program in the 1115 Waiver), which cover a) individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL and b) employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL. These higher allowable income limits for ALTCS also make it unlikely a member would lose financial eligibility once determined eligible for ALTCS/EPD based on their age and/or physical disability, but in that unlikely event, the member would lose eligibility. The MOE requirements in place until the end of the month in which the PHE ends would continue the member’s eligibility under ALTCS in that case.

There are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the population to be covered under the EPD program during CYE 23.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6. The special contract provisions related to payment included in the CYE 23 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1))
- Reinsurance Arrangement (42 CFR § 438.6(b)(1))

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- Alternative Payment Model (APM) Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Withhold Arrangement) (42 CFR § 438.6(b)(3))
- Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) (42 CFR § 438.6(c)(1)(iii)(A))
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(C))
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(C))
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(C))
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(C))
- Nursing Facility Supplemental Payments (NF-SP) (42 CFR § 438.6(c)(1)(iii)(B))

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

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

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

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

Proposed differences among the CYE 23 capitation rates for the ALTCS/EPD Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the ALTCS/EPD Program.

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

The CYE 23 capitation rates were developed at the rate cell level. Payments from rate cells do not cross-subsidize payments of other rate cells.

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

The effective dates of changes to the ALTCS/EPD Program are consistent with the assumptions used to develop the CYE 23 capitation rates for the ALTCS/EPD Program.

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

The certified capitation rates were developed so each ALTCS/EPD Program Contractor would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 23.

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

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

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

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

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

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

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

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

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 23 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 23 capitation rates for the ALTCS/EPD Program.

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

This section of the 2023 Guide includes CMS recommendations for risk mitigation strategies for rating periods impacted by the PHE and reminds states of specific requirements related to risk mitigation strategies. All risk mitigation strategies are addressed in the contract and below in Section I.4.C. and will be submitted to CMS prior to the start of the rating period.

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

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

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Additional evaluation conducted related to the COVID-19 PHE which did not result in adjustments to the rate development for CYE 23 vary by program. The ALTCS/EPD Program is not impacted by the MOE requirements of the PHE in the same way that other AHCCCS programs are, as described above in Section I.1.A.iii.(c)(iv), which resulted in the evaluation of changes in acuity being negligible as stated below in I.1.B.x.(b), and so while the population was evaluated for acuity changes, no adjustments to the rate were made as they were unnecessary. The level of COVID-19 vaccinations within the AHCCCS membership was evaluated and did not result in adjustments to the rate development because the majority of the ALTCS EPD population were the first eligible groups for vaccination just a few months into the base data time period.

I.1.A.xiii. Rate Certification Procedures

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

This section of the 2023 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

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

This rate certification documents that the ALTCS/EPD Program capitation rates will be changing effective October 1, 2022.

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

Not applicable. This rate certification will prospectively change the ALTCS/EPD Program capitation rates effective October 1, 2022.

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

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

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

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

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

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

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

I.1.B. Appropriate Documentation

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

The actuaries are certifying capitation rates for each rate cell.

I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 23 capitation rates for the ALTCS/EPD Program.

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

This section of the 2023 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for the variation.

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

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

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

I.1.B.v. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2023 Guide. Sections of the 2023 Guide that do not apply will be marked as “Not Applicable”; any section wherein all subsections are not applicable will be collapsed to the section heading.

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

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

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

All covered populations under the ALTCS/EPD Program receive the regular FMAP.

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

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

The comparisons between the most recent certified CYE 22 ALTCS/EPD Program capitation rates and the CYE 23 capitation rates being certified in this actuarial rate certification are available in Appendix 3a.

The 2023 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. For the purposes of the CYE 23 certified capitation rates, the actuaries 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 2023 Guide requests a comparison to the final certified rates in the previous rate certification. Those comparisons are available in Appendix 3a. No rate cells reflect a negative change over the most recent certified CYE 22 rates, but as shown in Appendix 3a, there are eight rate cells where there was a change of more than 10% from the most recent certified CYE 22 capitation rates.

An important change to note is moving the base data year from Calendar Year 2019 (CalYr19) to CYE 21. This allows for the inclusion of experience from the COVID-19 pandemic. Unlike other AHCCCS programs, there was not a significant change in utilization during the PHE compared to the time before the PHE. The main driver in the increase over the capitation rates effective October 1, 2021 is predominantly attributable to provider reimbursement increases (mainly the Legislative Fee Schedule Increase for HCBS/NF described below in Section I.1.3.B.ii.(a)).

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

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

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

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

I.1.B.ix. Future Rate Amendments

The list of possible amendments which would impact capitation rates in the future are shown in Table 2 below, along with the potential submission date, and the reason why the current certification cannot account for the changes anticipated to be made to the rates.

Table 2: Future Rate Amendments

| Possible Amendment | Potential Submission Date | Reason for Not Including in Current Certification |
|---|---------------------------|--|
| American Rescue Plan Act (ARPA) proposals | Early 2023 | AHCCCS has received approval of various ARPA proposals from CMS and the Arizona State Legislature. However, the June 3, 2022 announcement of the extension of the timeline within which states can use ARPA funding means the spending plan is being revised and has not yet been finalized. |

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

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

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

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

Since the beginning of the COVID-19 pandemic, the AHCCCS DHCM Actuarial Team has read and discussed numerous articles (Health Affairs, Health Watch, KFF, Harvard, Science Alert, CMS FAQs, JAMA, etc.), attended several webinars discussing various aspects of the impacts of COVID-19 (enrollment mix changes, deferred versus foregone care, pandemic progression timelines, hospital utilization patterns, etc.), and monitored national data and trends with regard to unemployment and inflation reports published by the Bureau of Labor Statistics, as well as state and national COVID-19 case rates published by a variety of sources. The AHCCCS DHCM Actuarial Team continues to monitor national legislation which impacts Medicaid, as well as monitoring federal guidance on the PHE end date and, as mentioned in the bullets above, has analyzed changes in acuity of members due to MOE eligibility requirements in the FFCRA.

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

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

The CYE 23 capitation rates account for the direct and indirect impacts of the COVID-19 PHE by removing COVID-19 vaccine costs from the base data since AHCCCS has a non-risk based cost settlement with the Contractors for COVID-19 vaccines. The CYE 23 capitation rates are also adjusted by removing

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COVID-19 test costs from the base data period and modeling projected COVID-19 testing costs for the rating period. The CYE 23 capitation rates also account for the impacts of the COVID-19 PHE by using a base data experience period which reflects changes in service delivery that are expected to continue beyond the pandemic, such as increased telehealth usage. As noted above in Section I.1.A.iii.(c)(iv), the MOE requirements under the PHE are unlikely to impact the membership under the ALTCS/EPD Program, as eligibility is predicated upon needing the level of medical support required by the ALTCS eligibility statutes, and the allowable income limits are significantly higher than other AHCCCS programs. Any member leaving the ALTCS/EPD Program due to no longer meeting the ALTCS medical support requirements will have their Medicaid eligibility continued under the ALTCS Transitional Program, and members are unlikely to exceed the allowable income limits. Because of these unique aspects of eligibility for the ALTCS/EPD program, there are not measurable changes in the acuity of the membership due to the PHE and MOE requirement, so no acuity adjustment was necessary.

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

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

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

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 23 contract will continue AHCCCS' long-standing program policy and will include risk corridors. For the CYE 23 rating period, AHCCCS is continuing the cost-settlement for administration of COVID-19 vaccines and carving these costs out of the capitation rates. This is the only risk mitigation strategy utilized specifically for COVID-19.

I.2. Data

This section provides documentation for the Data section of the 2023 Guide.

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

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

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

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

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

The types of data that AHCCCS relied upon for developing the CYE 23 capitation rates for the ALTCS/EPD program were:

- Adjudicated and approved encounter data submitted by the ALTCS/EPD Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
 - Incurred from October 2017 through early February 2022
 - Adjudicated and approved through the second encounter cycle in February 2022
- Reinsurance payments made to the ALTCS/EPD Contractors for services
 - Incurred from December 2017 through September 2021 paid through April 2022
- Enrollment data for ALTCS/EPD Contractors from the AHCCCS PMMIS mainframe
 - October 2017 through February 2022
- Annual and quarterly financial statements submitted by the ALTCS/EPD Contractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
 - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
 - October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19)
 - October 1, 2019 through September 30, 2020 (CYE 20 or FFY 20)
 - October 1, 2020 through September 30, 2021 (CYE 21 or FFY 21)
 - October 1, 2021 through December 31, 2021 (First quarter of CYE 22)
- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement Team related to DAP, see Section I.4.D.

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- Data from AHCCCS DHCM Financial Analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership provided by the Contractors, including additional detail on claims runout and prior period adjustments included in financial statements
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CYE 21
- Projected CYE 23 enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
- Nursing Facility (NF) and Home and Community-Based Settings (HCBS) placement data for October 2017 through February 2022
- Member level share of cost data provided by AHCCCS for October 2017 through September 2021
- Any additional data used and not identified here will be identified in their applicable sections below

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

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

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

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

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

The ALTCS/EPD Contractors have sub-capitated/block purchasing arrangements. During CYE 21, the ALTCS/EPD Contractors paid approximately 1.02% of total medical expenditures through sub-capitated arrangements. The sub-capitated arrangements between the ALTCS/EPD Contractors and their providers require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e., formula) for sub-capitated encounters to estimate a health plan valued amount in place of the health plan paid amount of zero. The repricing methodology uses the minimum of AHCCCS fee schedule, the health plan billed amount, and the health plan allowed amount, less any third-party insurance amounts. The units of service data from the encounters and the estimated health plan valued amounts were used for the basis of calculating utilization and unit cost.

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

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specific to the AHCCCS Medicaid 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 DHCM 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 DHCM Actuarial Team reports the findings to the AHCCCS DHCM Data Management and Oversight (DMO) Team, who then works with the Contractors to identify causes. In addition, the AHCCCS DHCM DMO Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

AHCCCS Contractors know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides the 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 the 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 DHCM DMO Team performs encounter data validation studies to evaluate the completeness, accuracy, and timeliness of the collected encounter data.

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

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

The actuaries reviewed the encounter data provided from the AHCCCS PMMIS mainframe. The actuaries ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 23 capitation rates for the ALTCS/EPD Program. Additionally, the actuaries ensured that only services covered under the state plan were included.

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

The actuaries reviewed the encounter data for all services provided by ALTCS/EPD Contractors to the annual financial statement data for the same entities for CYE 21. The actuaries also compared the CYE 21 encounter data to the yearly supplemental data request from the ALTCS/EPD Contractors. After adjustments were made to the encounter data for completion, the comparisons showed that the financial statements, the AHCCCS encounter data, and the ALTCS/EPD Contractors' encounter data were consistent for capitation rate setting.

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

As required by ASOP No. 23, the actuaries 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. The actuaries did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuaries note additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP and fee schedule impacts, on data provided by the AHCCCS DHCM financial analysts with regard to some program changes, on information and data provided by Milliman consultants with regard to the HEALTHII program, on data provided by ALTCS/EPD Contractors in the yearly supplemental data request with regards to administrative and case management component, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

The actuaries have found the encounter data to be appropriate for the purposes of developing the CYE 23 capitation rates for the ALTCS/EPD Program.

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

The actuaries did not identify any material concerns with the availability or quality of the data.

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

The actuaries determined that the CYE 21 encounter data was appropriate to use as the base data for developing the CYE 23 capitation rates for the ALTCS/EPD program.

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

Not Applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 23 capitation rates for the ALTCS/EPD Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 23 capitation rates for the ALTCS/EPD Program.

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

Not applicable. The actuaries did not rely on a data book to develop the CYE 23 capitation rates for the ALTCS/EPD Program.

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

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

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

Not applicable. No credibility adjustments were made to the CYE 21 encounter data.

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

The actuaries developed completion factors using the development method with monthly encounter data from the Contractors spanning dates of service October 2017 through February 2022 by rate cell and category of service (COS). The actuaries then calculated annualized completion factors to apply to the CYE 21 base experience encounter data.

Aggregate completion factors by rate cell and category of service can be found in Appendix 4. Table 3 below displays the aggregate impact of completion by GSA.

Table 3: Impact of Completion Factors

| GSA | Before Completion | After Completion | Impact |
|--------------|-------------------|-------------------|-------------|
| North | \$2,956.20 | \$3,053.14 | 3.3% |
| Central | \$3,866.31 | \$4,034.00 | 4.3% |
| South | \$3,566.59 | \$3,726.40 | 4.5% |
| Total | \$3,712.11 | \$3,871.39 | 4.3% |

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

No errors were found in the data. Thus, no data adjustments were made for errors.

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2020 to September 30, 2021) are described below or in Section I.3.A.iv. for base data adjustments required with respect to IMD in-lieu-of-services. All other program and fee schedule changes which occurred or are effective on or after October 1, 2021 are described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the rate for every individual rate cell, that adjustment was deemed non-material and has been grouped in the other base data adjustment subset below.

Some of the impacts for base data adjustment changes described below (indicated by an asterisk *) were developed by AHCCCS DHCM financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS DHCM Clinical Quality Management (CQM) Team and the Office of the Director's Chief Medical Officer. The actuaries relied upon the professional judgment of the AHCCCS DHCM financial analysts regarding the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuaries met with the AHCCCS DHCM financial analysts to understand at a high level how the estimated amounts were

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derived, and the data used for the amounts. The actuaries were unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

Removal of COVID-19 Vaccine from Base Data

As noted above in Section I.1.B.x.(c), there is a separate mechanism to reimburse the Contractor for COVID-19 vaccines on a non-risk basis, so associated costs have been removed from the base encounter data. The impacts of removing COVID-19 vaccine expenses are displayed below in Table 4a. Totals may not add up due to rounding.

Table 4a: Removal of COVID-19 vaccine from Base Data

| GSA | Dollar Impact | PMPM Impact |
|--------------|-------------------|-----------------|
| North | (\$1,709) | (\$0.06) |
| Central | (\$52,452) | (\$0.24) |
| South | (\$15,779) | (\$0.21) |
| Total | (\$69,940) | (\$0.22) |

Removal of COVID-19 Tests from Base Data

As part of the monitoring of experience for the PHE, the DHCM Actuarial Team has reviewed utilization associated with COVID-19 testing each month. This review led the actuaries to the decision that it would be more appropriate to model these specific services as a COVID-19 specific adjustment than including the utilization and costs in the base data and proceeding as if no further adjustment would be needed to accurately project costs in the rating period. To that end, as part of the rate development process, all utilization and expenses associated with COVID-19 tests were removed from the base data, as well as from the data used to develop trends, and analyzed separately. The impacts of removing COVID-19 tests are displayed below in Table 4b. Totals may not add up due to rounding.

The impact of the specific adjustment for including COVID-19 tests in the rating period is addressed below in Section I.3.B.ii.(a).

Table 4b: Removal of COVID-19 tests from Base Data

| GSA | Dollar Impact | PMPM Impact |
|--------------|--------------------|-----------------|
| North | (\$76,011) | (\$2.54) |
| Central | (\$843,073) | (\$3.89) |
| South | (\$57,896) | (\$0.78) |
| Total | (\$976,979) | (\$3.04) |

Removal of Differential Adjusted Payments from Base Data

CYE 21 capitation rates funded DAP made from October 1, 2020 through September 30, 2021 to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health, and reduce cost of care growth. As these payments expired

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September 30, 2021, AHCCCS has removed the impact of DAP payments from the base period. To remove the impact, the AHCCCS DHCM Actuarial Team requested provider IDs for the qualifying providers for the CYE 21 DAP by specific measure from the AHCCCS Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 21 were then adjusted downward by the appropriate percentage bump specific to the DAP measure for the contract year. The associated costs removed from the base data are displayed below in Table 5. 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.

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

Table 5: Removal of DAP from Base Data

| GSA | Dollar Impact | PMPM Impact |
|--------------|----------------------|------------------|
| North | (\$793,749) | (\$27.03) |
| Central | (\$5,264,205) | (\$24.72) |
| South | (\$2,161,150) | (\$29.56) |
| Total | (\$8,219,103) | (\$26.06) |

Member Share of Cost Add-on

An adjustment was made to add CYE 21 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 23 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 6. 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 6: Member Share of Cost Add-on

| GSA | Dollar Impact | PMPM Impact |
|--------------|---------------------|-----------------|
| North | \$6,248,235 | \$212.79 |
| Central | \$29,172,280 | \$136.99 |
| South | \$13,098,623 | \$179.14 |
| Total | \$48,519,138 | \$153.81 |

Other Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less

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on the gross medical component for every individual rate cell across all GSAs, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 7. 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 tables. Brief descriptions of the individual program changes requiring base data adjustment are provided below.

- **Pharmacy and Therapeutics Committee Recommendations ***

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 21 that impacted utilization and unit costs of Contractors’ pharmacy costs in the base period. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

Table 7: Other Base Data Adjustments

| GSA | Dollar Impact | PMPM Impact |
|--------------|------------------|---------------|
| North | \$6,996 | \$0.24 |
| Central | \$90,452 | \$0.42 |
| South | \$8,450 | \$0.12 |
| Total | \$105,898 | \$0.34 |

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

The AHCCCS DHCM Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 23 capitation rates. Other base data adjustments which excluded services from the data (i.e., COVID-19 vaccine removal) are described above in Section I.2.B.iii.(d).

I.3. Projected Benefit Costs and Trends

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

I.3.A. Rate Development Standards

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

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

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

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

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

There are no in-lieu-of services allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an Institution for Mental Disease (IMD) in lieu of services in an inpatient hospital. For enrollees aged 21 to 64, for inpatient psychiatric or substance use disorder services provided in an 2a setting, the rate development has complied with the requirements of 42 CFR § 438.6(e), and this is described below in Section I.3.A.iv.

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

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

Costs Associated with an Institution for Mental Disease Stay

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

The data used to determine the base data adjustment was the CYE 21 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 21 encounter data, the AHCCCS DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the non-IMD price-per-day. The Non-IMD price-per-day used in the analysis was \$895.28 and was derived from the CYE 21 encounter data for similar IMD services that occurred within a non-IMD setting. The encounter data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because

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payments made by the health plans better reflect the intensity of the services within a non-IMD setting which may not be fully captured within the AHCCCS FFS fee schedule per diem rate.

The AHCCCS DHCM Actuarial Team identified all members aged 21-64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4).

Once a member was identified as having an IMD stay(s) greater than 15 cumulative days in a month, all encounter data for the member was pulled for the timeframe(s) they were in the IMD in order to remove those additional medical service costs from rate development.

The combined impacts of repricing all IMD stays to the cost of the same services through providers included under the State plan, removing IMD stays which exceeded 15 cumulative days in a month, and removing medical expenses related to problematic IMD stays by GSA for the ALTCS/EPD Program are displayed below in Table 8. Totals may not add up due to rounding. The PMPM amounts by rate cell are included in Appendix 4, column “IMD Repricing”, in the Acute Expense table.

Table 8: IMD Repricing and Removal of All Costs for Repriced Stays > 15 Cumulative Days in a Month

| GSA | Dollar Impact | PMPM Impact |
|--------------|------------------|-----------------|
| North | \$1,525 | \$0.05 |
| Central | \$3,583 | \$0.02 |
| South | (\$12,519) | (\$0.17) |
| Total | (\$7,411) | (\$0.02) |

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

Appendix 7a contains the projected net medical expenses PMPM by rate cell.

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

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

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

The base data described in Section I.2.B.ii. was adjusted to reflect completion and all base data adjustments described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in Section I.3.A.iv. The adjusted base data per-member-per-month (PMPM) expenditures for each COS were trended forward 24 months, from the midpoint of the CYE 21 time period to the midpoint of the CYE 23 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below. Appendix 4 contains the base data and base

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data adjustments by category of service and rate cell. Appendix 5 contains the projected benefit cost trends. Appendix 6 contains net medical expenses by category of service and rate cell after applying prospective program and reimbursement changes, CYE 23 DAP, Projected SOC Payments Removed, reinsurance offset. Appendix 7a contains projected percentages of members receiving LTSS and projected percentages of LTSS members placed in NF or HCBS settings. Appendix 7b illustrates the capitation rate development, which includes the projected administrative expense, case management expense, underwriting (UW) gain, and premium tax.

The capitation rates were adjusted for all program changes. If a program change had an impact of 0.2% or less on the gross medical component of the rate for every individual rate cell, that program change was deemed non-material and has been grouped in the combined miscellaneous program changes subset below, along with a brief description of the non-material items.

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

AHCCCS Fee Schedule Updates

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

Additionally, the contract has requirements that the Contractors reimburse FQHCs/RHCs at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates include adjustments to bring the base FQHC/RHC encounter data up to the projected CYE 23 FQHC/RHC PPS rates.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 23 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DHCM Rates & Reimbursement Team used the CYE 21 encounter data to develop the impacts of fee schedule changes between the base year and the rating period. The AHCCCS DHCM Rates & Reimbursement

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Team applied AHCCCS provider fee schedule changes as a unit cost change to calculate the adjustments to the CYE 21 base data. The actuaries then reviewed the results and applied aggregated percentage impacts by program, category of service, and rate cell.

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

In the 2022 legislative session, the legislature passed a general appropriations bill which included funding for the ALTCS/EPD program to implement provider fee schedule increases. Consistent with the additional funding, the DHCM Rates and Reimbursement Team increased HCBS and NF provider reimbursement rates by 11.0% effective October 1, 2022. The AHCCCS DHCM Actuarial Team similarly adjusted CYE 23 capitation rates to reflect AHCCCS' expectation that increased rates will be adopted by the Contractors. The changes are expected to increase statewide costs under the ALTCS/EPD program by \$123.3 million, or \$390.80 PMPM. The HCBS and NF fee schedule increases from the 2022 legislative session are in addition to the fee schedule increases for the same services from the 2021 legislative session which were described in the CYE 22 ALTCS/EPD capitation rate certification. The combined impacts of both years of legislatively mandated increases for HCBS and NF services are included in the table below which shows the overall impact of all provider fee schedule changes from October 1, 2021 and forward.

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

Effective October 1, 2022, AHCCCS is increasing the All Patients Refined Diagnosis Related Group (APR-DRG) base rate for rural hospitals. The overall impact of the AHCCCS FFS fee schedule updates by GSA is illustrated below in Table 9. Totals may not add up due to rounding.

Table 9: Aggregate AHCCCS FFS Fee Schedule Updates

| GSA | Dollar Impact | PMPM Impact |
|--------------|----------------------|-----------------|
| North | \$17,095,700 | \$582.20 |
| Central | \$135,332,279 | \$635.49 |
| South | \$47,165,192 | \$645.05 |
| Total | \$199,593,171 | \$632.74 |

Proposition 206 Reimbursement Rate Changes

Effective January 1 of each year AHCCCS increases fee schedule rates for select HCBS procedure codes, all NF revenue codes, and all ALF procedure codes, to address the increased labor costs resulting from minimum wage increases approved on November 8, 2016 by the state's voters under Proposition 206 and by city of Flagstaff voters under Proposition 414.

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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 impacts of these fee schedule changes, reflective of minimum wage increases, have been included by category of service based on utilization of the specific services in the base year. The overall impact by GSA is illustrated below in Table 10. Appendix 6, columns “Prop 206 Adjustment Factor” in the NF and HCBS Expense tables include these fee schedule adjustments by rate cell.

Table 10: Proposition 206 Reimbursement Rate Change

| GSA | Dollar Impact | PMPM Impact |
|--------------|---------------------|-----------------|
| North | \$2,919,069 | \$99.41 |
| Central | \$25,055,088 | \$117.65 |
| South | \$8,596,558 | \$117.57 |
| Total | \$36,570,714 | \$115.94 |

COVID-19 Tests

As noted above in Section I.2.B.iii.(d), the AHCCCS DHCM Actuarial Team has reviewed utilization associated with COVID-19 testing each month. As part of the rate development process, the AHCCCS DHCM Actuarial Team modeled projected utilization and costs for COVID-19 tests for the rating period. The projected utilization per 1000 was developed by averaging the utilization from the base period with more recent utilization from June 2021 through May 2022. The unit cost for different types of COVID-19 tests (lab/physician testing versus at-home test kits) was calculated with data specific to each type, and the distribution of tests by type provided the blend for an overall projected unit cost in the rating period. Combining projected utilization and unit cost into an overall PMPM for each program, the actuaries then applied utilization and unit cost relativities by each rate cell in the program to the overall PMPM to calculate appropriate PMPM adjustments for each rate cell. This modeling specifically incorporates more recent data than the base period in order to recognize that new variants and reduced public mitigation efforts have impacted the need for COVID-19 testing differently by population. No assumptions regarding vaccination rates were incorporated into the projections for use of tests. The overall impact of the change by GSA is displayed below in Table 11. Totals may not add up due to rounding.

Table 11: Projected COVID-19 Tests

| GSA | Dollar Impact | PMPM Impact |
|--------------|--------------------|---------------|
| North | \$89,691 | \$3.05 |
| Central | \$986,196 | \$4.63 |
| South | \$67,181 | \$0.92 |
| Total | \$1,143,069 | \$3.62 |

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Combined Miscellaneous Program Changes

The capitation rates were adjusted for all program changes. However, if an individual program change had an impact 0.2% or less on the gross medical component of the rate for every individual rate cell, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 12. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in the factors shown in Appendix 6, column “Prospective Program Changes” in the HCBS and Acute Expense tables, unless otherwise noted. Brief descriptions of the individual program changes are provided below.

- **Medicare Deductible**

The annual deductible that dual-eligible beneficiaries are subject to for their Medicare expenses changes annually. To account for this, AHCCCS adjusts the acute care costs that are within that deductible level by modeling how much this portion of costs would change with respect to a new deductible between the base period and the rating period.

- **Cancer Profiling Tests ***

Effective July 1, 2021 and October 1, 2021, AHCCCS began covering two medically necessary cancer profiling tests. The tests can assist providers in determining the most appropriate course of treatment for a patient’s cancer. As the data suggests utilization of the test that was first covered July 1, 2021 had not yet begun increasing during the fourth quarter of CYE 2021 base period, the adjustment for this item in CYE 2023 capitation rate setting reflects a full year impact.

- **Community Intervener Services ***

Effective January 1, 2023, AHCCCS is establishing policy for provision of community intervener services to ALTCS members with dual sensory loss (i.e., blind and hard of hearing). Community interveners intercede between the member and the environment, allowing access to information usually gained through vision and hearing. A reimbursement rate will be established for the community intervener services to be billed under procedure code S5135 and modifier CG. Adjustments for this item were included in the CYE 22 capitation rates, with the expectation that the service would be effective October 1, 2021. As described above, this change is now expected to be effective starting January 1, 2023.

- **EPSDT Visits and Developmental Screens ***

Effective October 1, 2021, AHCCCS revised policy to better align Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits and developmental screening requirements with CMS Core Measures and recommendations from the American Academy of Pediatrics. The policy revisions require an additional EPSDT visit for child members at 30 months of age and two specialized developmental screens at the child member’s 18-month and 24-month EPSDT visits.

- **Bus Passes ***

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

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generally billed with procedure code A0110. When offering a public transport pass, contractors should consider such things as location of the member, location of the member’s provider, public transportation schedules, and member ability to travel alone. CYE 23 adjustments to rates include projected costs of bus passes and increased use of medical services due to greater members options for transport, partly offset by savings from reduced use of more expensive alternative forms of NEMT.

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

Effective October 1, 2021, AHCCCS implemented an Emergency Triage, Treat, and Transport (ET3) model that is similar to the ET3 program that Medicare began in FFY 21. Under the state’s program, emergency service providers may bill for trips that result in delivery of on-site or telehealth services by a partner health professional or for trips to an outpatient non-emergency department provider. The AHCCCS DHCM financial analysts project that cost savings of diverting unnecessary emergency department visits to lower acuity settings under the ET3 model will be offset by additional costs of reimbursing emergency service providers for trips in which no or limited reimbursement was previously paid

- **Pharmacy and Therapeutics Committee Recommendations ***

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

- **Rx Rebates Adjustment**

An adjustment was made to reflect the impact of Rx Rebates reported within the ALTCS/EPD Program financial statements, as pharmacy encounter data does not include these adjustments. The data reviewed to develop the impact was the financial statement reports listed in I.2.B.ii.(a)(i). From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment to the projected gross medical expenses to reflect a level of reported Rx Rebates. The PMPM amounts removed by rate cell are included in Appendix 6, column “Rx Rebates”, in the Acute Expense table.

- **N95 Masks ***

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

- **Reimbursement for Discarded Drugs ***

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

- **Dental Cone Beam CT Capture ***

AHCCCS will reimburse for cone beam CT capture for dental imaging, beginning January 1, 2023. Cone-beam CT capture emits an x-ray beam shaped like a cone as opposed to the conventional fan-shaped beam. This procedure is expected to be used for any tooth extraction as well as for endodontic procedures such as molar and premolar root canals. This type of imaging would be

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done in addition to current X-ray imaging. AHCCCS estimates that 85-90% of conventional X-rays prior to extractions and 80% of root canals would be augmented by cone beam imaging to confirm results. AHCCCS will require prior authorization for fee-for-service coverage of cone beam CT capture.

- **Routine Care for Members Participating in Clinical Trials ***

AHCCCS will conform with federal guidance that routine care that is otherwise covered be covered for members participating in a clinical research study.

- **Adult Chiropractic Services ***

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

- **Diabetes Self-Management Training ***

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

Table 12: Combined Miscellaneous Program Changes

| GSA | Dollar Impact | PMPM Impact |
|--------------|------------------|---------------|
| North | \$65,904 | \$2.24 |
| Central | \$511,735 | \$2.40 |
| South | \$155,985 | \$2.13 |
| Total | \$733,624 | \$2.33 |

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. The actuaries 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, the actuaries dampened the NF and HCBS costs to reflect this before adding the acute care costs to develop the projected benefit expense costs.

The actuaries developed assumptions for the percentages of members receiving LTSS and placement in the nursing facility or HCBS settings based on the average percentages for December 2021 through

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February 2022, which was the most recent 3-month time period available in the member placement data.

Similarly, the actuaries developed the NF/HCBS mix prior to the PHE. Then the actuaries applied a 3/4 credibility to the prior-PHE NF/HCBS mix and 1/4 credibility to the post-PHE NF/HCBS mix to arrive at a combined NF/HCBS mix percentage.

Our assumptions for the mix percentages by rate cell are included in Appendix 7a, 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, the actuaries removed projected CYE 23 member SOC payments from the nursing facility and HCBS service categories to reflect only Contractor liability in the capitation rates. The CYE 23 projection for SOC payments was done by taking historical SOC experience (CYE 18 through CYE 21), analyzing year-over-year increases at the rate cell level, applying the average percentage increase for two years from CYE 21 to CYE 23, and adjusting for any outlier trends.

The overall impact by GSA for the ALTCS/EPD program is displayed below in Table 13 Totals may not add up due to rounding. The PMPM amounts added by rate cell are included in Appendix 6, column “Projected SOC”, 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 13: Projected Member Share of Cost Removal

| GSA | Dollar Impact | PMPM Impact |
|--------------|-----------------------|-------------------|
| North | (\$10,110,691) | (\$344.32) |
| Central | (\$42,999,538) | (\$201.92) |
| South | (\$18,573,013) | (\$254.01) |
| Total | (\$71,683,242) | (\$227.25) |

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

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

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

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 by the actuaries to set the CYE 23 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2017 through early February 2022 and adjudicated and approved through the second February encounter cycle. No adjustments were made with respect to potential COVID-19 induced underutilization during the base period because LTSS, as well as acute care services for the EPD population, did not exhibit such impacts like acute care services for traditional populations. The trend was developed primarily with actual experience from the Medicaid population.

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

Historical utilization, unit cost, and PMPM data from October 2017 through February 2022 were organized by incurred year and month and category of service (COS). The historical experience was adjusted for completion and normalized for historical program and fee schedule changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 21 (April 1, 2021) to the midpoint of the rating period for CYE 23 (April 1, 2023). 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. Each category of service was analyzed in the same manner.

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

All COS PMPM trend assumptions were compared to similar assumptions made in prior years for ALTCS/EPD capitation rates and judged reasonable to assume for projection to CYE 23.

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

The 2023 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuaries 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 assumed in the CYE 23 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 components of the projected benefit cost trend by risk group and COS.

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

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

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

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

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

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

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

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

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

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

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS DHCM Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. As of August 12, 2022, no additional services have been identified as necessary services to comply with MHPAEA.

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

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

I.3.B.vi. Retrospective Eligibility Periods

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

AHCCCS provides prior period coverage (PPC) for the period of time prior to the member's enrollment during which the member is eligible for covered services. 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

Encounter data related to PPC is included with the base data and is included in the capitation rate development process

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

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

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

No specific adjustments are made to the CYE 23 capitation rates for the ALTCS/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

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

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

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

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

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

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

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

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

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

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

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

There were no material adjustments made related to litigation.

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

All material and non-material changes have been included in the capitation rate development process and all requirements in this section of the 2023 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive 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 Initiative – Performance Based Payments

The CYE 23 capitation rates for the ALTCS/EPD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2), called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractors that are aimed at quality improvement, such as reducing costs, improving health outcomes, or improving access to care.

Alternative Payment Model Initiative – Quality Measure Performance

The incentive arrangement for the 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 performance 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 policy governing this incentive arrangement has been changed from previous years. The updated incentive policy still uses a ranked score to distribute available incentive dollars by AHCCCS performance measure, but Contractors will not be ranked if they did not earn either a performance achievement score or a performance improvement score for that measure. The maximum incentive pool possible is approximately \$16.3 million, 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; thus, the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

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

The time period of the incentive arrangements described herein is twelve months.

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

Alternative Payment Model 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

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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.

Alternative Payment Model Initiative – Quality Measure Performance

The incentive arrangement includes performance 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.

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

Alternative Payment Model 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.

Alternative Payment Model 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.

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

The total payments under the incentive arrangements for the ALTCS/EPD Program (i.e., capitation rate payments plus incentive payments) 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

Alternative Payment Model Initiative – Performance Based Payments

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 23 capitation rates and had no effect on the development of the capitation rates for the ALTCS/EPD Program. The incentive payments will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the CYE 23 contract year.

Alternative Payment Model Initiative – Quality Measure Performance

Incentive payments for the APM Initiative – Quality Measure Performance incentive arrangement are not included in the CYE 23 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 the performance measure results under the new policy will not be available until 18 months after the end of the contract year. Incentive payments for the APM Initiative will be paid by AHCCCS to the Contractors through lump sum

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payments after the completion of the contract year and the computation of the performance measures, and after the withhold payments are distributed and the value of the incentive pool determined.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2023 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. The policy governing the withhold arrangement has been changed from previous years. The updated withhold policy changes the way Contractors earn back the withhold amount by performance measure. Each Contractor's earnings are now based on their performance achievement score, using a threshold benchmark and a high-performance benchmark, and/or performance improvement score by measure, rather than based on rankings across Contractors for performance achievement by measure.

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 Program 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 performance 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 performance measures.

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

It is unlikely that a Contractor will not receive some portion of the withhold back. However, the AHCCCS DHCM Actuarial Team does not have the information needed to develop an estimate of the withheld amount that is not reasonably achievable, as the performance measure results under the new policy will not be available until 18 months after the end of the contract year.

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

The actuaries relied upon the AHCCCS DHCM Finance & Reinsurance Team's review. Their review indicated that the total withhold percentage of 1% of capitation revenue does not have a detrimental impact on the Contractors' financial operating 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 the 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 23 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 2023 Guide provides information on the requirements for risk-sharing mechanisms. For information on the COVID-19 costs covered on a non-risk basis, see Section I.1.B.x.(c).

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

I.4.C.ii. Appropriate Documentation

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

The CYE 23 contract for the ALTCS/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 23

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contract will continue AHCCCS’ long-standing program policy and will include risk corridors. This rate certification will use the term risk corridor to be consistent with the 2023 Guide. The ALTCS/EPD Contract refers to the risk corridor as a reconciliation.

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

There are two risk corridor type arrangements in the ALTCS/EPD Program. The first is a reconciliation of actual SOC payments to assumed SOC offsets in the capitation rates, and the second is a reconciliation of costs to reimbursement (tiered reconciliation).

The share of cost (SOC) risk corridor will reconcile the actual member share of cost (SOC) payments received by each Contractor during each federal fiscal 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.

The tiered risk corridor will 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 administrative component, the case management component, and the premium tax, plus any reinsurance payments. Each Contractor’s medical cost expenses are equal to the Contractor’s fully adjudicated encounters (excluding COVID-19 vaccine expenses for CYE 23) and sub-capitated/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 listed in Table 14 below.

Table 14: Tiered Risk Corridor Risk Bands

| 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 23 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 corridors did not have any effect on the development of the CYE 23 capitation rates for the ALTCS/EPD Program.

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

Risk-sharing mechanisms are developed in accordance with generally accepted actuarial principles and practices. The threshold amounts for the risk corridors was set using actuarial judgment with consideration of conversations between the AHCCCS DHCM Actuarial Team, the AHCCCS DHCM Finance & Reinsurance Team, and the AHCCCS Office of the Director.

I.4.C.ii.(a)(v) Risk-Sharing Arrangements Consistent with Pricing Assumptions

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

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

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

If experience in the rating period aligns with pricing assumptions used in capitation rate development, there will be no remittance/payment between AHCCCS and the Contractors associated with the risk corridors. The risk corridors protect the State against excessive Contractor profits and protect Contractors from excessive losses when experience in the rating period materially differs from the pricing assumptions. For the medical costs, there is no remittance/payment when profits and losses associated with medical costs compared to medical revenue are between the first +/- 2%, as shown in the table in Section I.4.C.ii.(a)(ii), which is consistent with pricing assumptions used in capitation rate development.

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

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

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

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

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

AHCCCS provides a reinsurance program to the AHCCCS Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types, with the majority of the reinsurance cases falling into the Regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under Catastrophic, including reinsurance for biologic drugs. Additionally, rather than the ALTCS/EPD Contractors paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance

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offset from the gross medical. 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 since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the ALTCS/EPD Contractors for covered services incurred above the deductible. The deductible is the responsibility of the ALTCS/EPD Contractors. The deductible for CYE 23 Regular reinsurance cases is \$75,000, an increase from the CYE 22 Regular reinsurance case deductible. The limit on High Dollar Catastrophic reinsurance is \$1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

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

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

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

The reinsurance offsets by rate cell are developed from CYE 21 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.

Other changes to the reinsurance program from the reinsurance base period to CYE 23 included adding several drugs to the list of drugs covered by the AHCCCS reinsurance program and increasing the deductible per Regular reinsurance case to \$75,000 as noted above. The projected costs of the additional drugs covered by the reinsurance program were calculated by taking the projected costs for CYE 23 for those drugs and applying a zero-dollar deductible and coinsurance limit of 85% to get the

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dollar impact to the reinsurance offset. The adjustments needed to reflect the higher deductible level for the Regular reinsurance case type were developed by calculating the total encounter costs associated with each Regular reinsurance case for which payments were made during CYE 21; applying completion factors, trend, and fee schedule changes to bring the encounter costs forward to the CYE 23 rating year; and calculating the reinsurance payments that would be made for each case when applying the new \$75,000 deductible and the coinsurance limit of 75%. The combined dollar impact of the reinsurance offsets for all reinsurance case types for the ALTCS/EPD Program is approximately \$33.6M.

I.4.D. State Directed Payments

I.4.D.i. State Directed Payments

This section of the 2023 Guide provides information on delivery system and provider payment initiatives (i.e., state directed payments) authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

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

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

Federally Qualified Health Centers and Rural Health Clinics

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

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that 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 0.25% to 20.0%, depending on the provider type.

Access to Professional Services Initiative

The APSI seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. APSI is a

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

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 25 percent as calculated by the Arizona Department of Health Services for calendar year 2014; or,
- A freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than one hundred (100) licensed pediatric beds, excluding nursery beds.

The APSI provides a uniform percentage increase of 70% to otherwise contracted rates for qualified practitioners-for all claims for which AHCCCS is the primary payer. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Pediatric Service Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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. The uniform dollar increase is across all Contractors' reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund plus FMAP and is expected to fluctuate based on utilization and available funds for each quarter. The increase is intended to supplement, not supplant, payments to eligible providers.

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

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

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

The FQHC/RHC minimum fee schedule and DAP initiative state directed payments impact all ALTCS/EPD rate cells.

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

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

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

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

Differential Adjusted Payments

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

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 21 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 23 time period. The actuaries then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 23 (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code and category of service level which the actuaries then aggregated to the specific risk groups and GSAs for each program).

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

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

AHCCCS has submitted the DAP 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described in the preceding sections, is included in the capitation rates in a manner consistent with the pre-print under CMS review.

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

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

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

The APSI, PSI, HEALTHII, and NF-SP are not included in the ALTCS/EPD certified capitation rates and will be paid out via lump sum payments. The 2023 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately \$3.9 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Service Initiative

Anticipated payments including premium tax for PSI are approximately \$2.1 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 23 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments including premium tax for HEALTHII are approximately \$55.1 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 23 utilization will be used to redistribute the payments.

Nursing Facility Supplemental Payments

The anticipated total payments for NF-SP are approximately \$118.5 million, inclusive of premium tax. AHCCCS will distribute the enhanced 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.

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

Access to Professional Services Initiative

The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Nursing Facility Supplemental Payments

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

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

Appendix 8b contains estimated PMPMs including premium tax by rate cell for informational purposes only; these payments are not made on a PMPM basis.

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

Access to Professional Services Initiative

AHCCCS has submitted the APSI 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

Pediatric Services Initiative

AHCCCS has submitted the PSI 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

Hospital Enhanced Access Leading to Health Improvements Initiative

AHCCCS has submitted the HEALTHII 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

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Nursing Facility Supplemental Payments

AHCCCS has submitted the NF-SP 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review.

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

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 included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

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

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

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

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

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

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

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2023 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

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

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

The primary data sources used to develop the administrative component of the CYE 23 capitation rates for the EPD Program was the historical and projected administrative expense data submitted by the Contractors per a supplemental data request, as noted in Section I.2.B.ii.(b)(ii). The Contractors' projected administrative expense estimates for CYE 23 were reviewed to inform development of cost projections. The ALTCS/EPD Contractors' supplemental administrative data request included amounts for administrative expenses for CYE 21 actuals, CYE 22 year-to-date (through 12/31/21) actuals, actual/projected amounts for CYE 22, and projected amounts for CYE 23. This data request included administrative breakouts into different categories for each of the time frames. The actuaries also reviewed Consumer Price Index (CPI) and Employment Cost Index (ECI) data from IHS Markit and each Contractor's quarterly financial statements for CYE 21 and CYE 22 Q1.

Administrative Expenses

The actuaries used CYE 21 administrative (Admin) expenses reported in the MCOs' supplemental non-benefit cost data submission as the base experience for projecting CYE 23 Admin expenses.

The wage-driven portion of the CYE 21 Admin expenses was trended forward from the base period to the rating period by the projected CPI for wage earners. The trend factor was based on data from an external firm, IHS Markit, which was reviewed and determined to be reasonable. A trend factor was not applied to the non-wage-driven portion of the CYE 21 Admin expenses.

The CYE 23 projected wage-driven and non-wage driven and amounts, summed together, equal the projected CYE 23 Admin expenses prior to inclusion of additional administrative costs due to ARPA.

Case Management Expenses

The actuaries used CYE 21 case management expenses reported in the MCOs' quarterly financial statements as the base experience for projecting CYE 23 Case Management expenses. The actuaries also evaluated each MCO's non-benefit cost data submission for reasonableness to make MCO-specific adjustments in developing the final case management expense.

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 case management expenses by the projected CPI for wage earners (as described in the Admin section above).

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

The data, assumptions, and methodology used to develop the CYE 23 projected administrative and case management costs are similar to the previous rating period and have been documented above. The previous methodology is documented in the CYE 22 actuarial rate certification.

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

No other material adjustments were applied to the projected non-benefit expenses 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 2023 Guide are shown in Appendix 7 for the CYE 23 capitation rates.

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

The administrative component of the CYE 23 ALTCS/EPD capitation rates is described above in Section I.5.B.i.(a). The PMPM amounts by rate cell are provided in Appendix 7b.

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

The CYE 23 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 23 capitation rate for the ALTCS/EPD Program includes a provision of 1.0% for risk margin (i.e., underwriting gain).

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

No other material or non-material non-benefit costs are reflected in the CYE 23 capitation rates for the ALTCS/EPD Program.

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

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

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

Not applicable. The CYE 23 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 2023 Guide is applicable to the ALTCS/EPD Program because the CYE 23 capitation rates for ALTCS/EPD are subject to the applicable “actuarial soundness” provisions from 42 CFR § 438.4 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 2023 Guide are applicable to the MLTSS rate development process.

II.1.B. Rate Development Standards

II.1.B.i. Rate Cell Structure

This section of the 2023 Guide provides the two most common approaches to structuring the rate cells.

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

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

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

Not applicable. A member’s 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.

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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 – Not Applicable

Section III of the 2023 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

We, Wenzhang Du, ASA, MAAA and Colby Schaeffer, ASA, MAAA, are employees of AHCCCS. We meet the qualification standards established by the American Academy of Actuaries and have followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries, the Actuarial Standards Board, CMS, and federal regulations.

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

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

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

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

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

The data, assumptions, and methodologies used to develop the CYE 23 capitation rates for the ALTCS/EPD Program have been documented according to the guidelines established by CMS in the 2023 Guide. The CYE 23 capitation rates for the ALTCS/EPD Program are effective from October 1, 2022 through September 30, 2023.

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

SIGNATURE ON FILE

August 12, 2022

Wenzhang Du

Date

Associate, Society of Actuaries

Member, American Academy of Actuaries

SIGNATURE ON FILE

August 12, 2022

Colby Schaeffer

Date

Associate, Society of Actuaries

Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Appendix 2: Certified Capitation Rates

| GSA | Contractor | Dual | Non-Dual |
|---------|---------------------------------|------------|-------------|
| North | UnitedHealthcare | \$3,739.84 | \$8,303.46 |
| Central | UnitedHealthcare | \$3,668.48 | \$8,569.16 |
| Central | Banner - University Family Care | \$4,820.91 | \$10,486.45 |
| Central | Mercy Care | \$4,894.91 | \$10,049.40 |
| South | Banner - University Family Care | \$4,615.57 | \$8,698.31 |
| South | Mercy Care | \$4,483.34 | \$8,615.91 |

Appendix 3a: Comparison of Capitation Rates

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Appendix 3a: Comparison of Capitation Rates

| Rate Cell | Contractor | GSA | CYE 22 Capitation Rate with ARPA (10/1/21) | CYE 23 Capitation Rate (10/1/22) | Percentage Change |
|-----------------|---------------------------------|------------------|--|---|----------------------|
| Dual | UnitedHealthcare | North | \$3,533.18 | \$3,739.84 | 5.85% |
| Dual | UnitedHealthcare | Central | \$3,507.31 | \$3,668.48 | 4.60% |
| Dual | Banner - University Family Care | Central | \$4,407.40 | \$4,820.91 | 9.38% |
| Dual | Mercy Care | Central | \$4,420.74 | \$4,894.91 | 10.73% |
| Dual | Banner - University Family Care | South | \$4,156.68 | \$4,615.57 | 11.04% |
| Dual | Mercy Care | South | \$4,062.17 | \$4,483.34 | 10.37% |
| Non-Dual | UnitedHealthcare | North | \$7,190.97 | \$8,303.46 | 15.47% |
| Non-Dual | UnitedHealthcare | Central | \$8,346.19 | \$8,569.16 | 2.67% |
| Non-Dual | Banner - University Family Care | Central | \$9,483.03 | \$10,486.45 | 10.58% |
| Non-Dual | Mercy Care | Central | \$9,102.16 | \$10,049.40 | 10.41% |
| Non-Dual | Banner - University Family Care | South | \$7,796.30 | \$8,698.31 | 11.57% |
| Non-Dual | Mercy Care | South | \$7,817.37 | \$8,615.91 | 10.21% |
| Dual | | Composite | \$4,035.84 | \$4,394.23 | 8.88% |
| Non-Dual | | Composite | \$8,597.65 | \$9,400.59 | 9.34% |
| Total | | Composite | \$4,824.84 | \$5,260.12 | 9.02% |

Appendix 3b: Fiscal Impact Summary

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 3b: Fiscal Impact Summary

| Rate Cell | Contractor | GSA | Projected MMs 10/1/22 - 9/30/23 | CYE 23 Capitation Rate (10/1/22) | Projected Expenditures CYE 23 |
|-----------------|---------------------------------|------------------|---------------------------------------|---|----------------------------------|
| Dual | UnitedHealthcare | North | 25,448 | \$3,739.84 | \$95,170,356 |
| Dual | UnitedHealthcare | Central | 64,500 | \$3,668.48 | \$236,617,307 |
| Dual | Banner - University Family Care | Central | 23,435 | \$4,820.91 | \$112,976,756 |
| Dual | Mercy Care | Central | 84,964 | \$4,894.91 | \$415,890,985 |
| Dual | Banner - University Family Care | South | 40,468 | \$4,615.57 | \$186,782,813 |
| Dual | Mercy Care | South | 22,068 | \$4,483.34 | \$98,938,085 |
| Non-Dual | UnitedHealthcare | North | 3,916 | \$8,303.46 | \$32,517,425 |
| Non-Dual | UnitedHealthcare | Central | 10,945 | \$8,569.16 | \$93,788,055 |
| Non-Dual | Banner - University Family Care | Central | 5,175 | \$10,486.45 | \$54,264,859 |
| Non-Dual | Mercy Care | Central | 23,939 | \$10,049.40 | \$240,576,937 |
| Non-Dual | Banner - University Family Care | South | 6,669 | \$8,698.31 | \$58,012,234 |
| Non-Dual | Mercy Care | South | 3,914 | \$8,615.91 | \$33,719,816 |
| Dual | | Composite | 260,882 | \$4,394.23 | \$1,146,376,302 |
| Non-Dual | | Composite | 54,558 | \$9,400.59 | \$512,879,325 |
| Total | | Composite | 315,441 | \$5,260.12 | \$1,659,255,628 |



Appendix 4: Unadjusted and Adjusted Base Data by Rate Cell

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 4: Unadjusted and Adjusted Base Data by Rate Cell

Appendix 4a. Nursing Facility

| Contractor | GSA | Rate Cell | Category of Service | I.2.B.ii | I.2.B.iii.(b) | Subtotal | I.2.B.iii.(d) | I.2.B.iii.(d) | I.3.A.iv | I.2.B.iii.(d) | I.2.B.iii.(d) | Subtotal | I.2.B.iii.(d) | Total |
|---------------------------------|---------|-----------|---------------------|-------------------------|--------------------|----------------|----------------|-------------------|----------|----------------------|-------------------------------|-------------|--------------------|-----------------------------|
| | | | | Uncompleted Gross Total | Completion Factors | Completed PMPM | COVID-19 Tests | COVID-19 Vaccines | IMD | DAP Payments Removed | Retrospective Program Changes | Subtotal | SOC Payments Added | Adjusted Base Gross Medical |
| UnitedHealthcare | North | Dual | NF | \$5,318.47 | 0.981 | \$5,423.15 | 0.00% | 0.00% | 0.00% | -1.46% | 0.00% | \$5,344.11 | \$971.48 | \$6,315.59 |
| UnitedHealthcare | Central | Dual | NF | \$5,441.42 | 0.981 | \$5,548.52 | 0.00% | 0.00% | 0.00% | -1.14% | 0.00% | \$5,485.27 | \$821.19 | \$6,306.46 |
| Banner - University Family Care | Central | Dual | NF | \$5,705.44 | 0.964 | \$5,919.54 | 0.00% | 0.00% | 0.00% | -1.27% | 0.00% | \$5,844.15 | \$813.59 | \$6,657.74 |
| Mercy Care | Central | Dual | NF | \$5,894.96 | 0.973 | \$6,058.55 | 0.00% | 0.00% | 0.00% | -1.04% | 0.00% | \$5,995.80 | \$773.56 | \$6,769.36 |
| Banner - University Family Care | South | Dual | NF | \$5,790.74 | 0.964 | \$6,008.04 | 0.00% | 0.00% | 0.00% | -1.39% | 0.00% | \$5,924.37 | \$780.93 | \$6,705.31 |
| Mercy Care | South | Dual | NF | \$5,199.87 | 0.973 | \$5,344.17 | 0.00% | 0.00% | 0.00% | -1.46% | 0.00% | \$5,265.91 | \$764.08 | \$6,029.99 |
| UnitedHealthcare | North | Non-Dual | NF | \$13,833.82 | 0.987 | \$14,013.57 | 0.00% | 0.00% | 0.00% | -1.19% | 0.00% | \$13,846.97 | \$169.37 | \$14,016.33 |
| UnitedHealthcare | Central | Non-Dual | NF | \$8,473.15 | 0.987 | \$8,583.24 | 0.00% | 0.00% | 0.00% | -0.93% | 0.00% | \$8,503.84 | \$70.04 | \$8,573.88 |
| Banner - University Family Care | Central | Non-Dual | NF | \$9,154.99 | 0.967 | \$9,465.79 | 0.00% | 0.00% | 0.00% | -1.04% | 0.00% | \$9,367.39 | \$87.04 | \$9,454.43 |
| Mercy Care | Central | Non-Dual | NF | \$10,348.98 | 0.975 | \$10,617.59 | 0.00% | 0.00% | 0.00% | -0.75% | 0.00% | \$10,537.47 | \$101.01 | \$10,638.48 |
| Banner - University Family Care | South | Non-Dual | NF | \$8,403.09 | 0.967 | \$8,688.36 | 0.00% | 0.00% | 0.00% | -1.44% | 0.00% | \$8,563.59 | \$141.89 | \$8,705.47 |
| Mercy Care | South | Non-Dual | NF | \$7,973.44 | 0.975 | \$8,180.39 | 0.00% | 0.00% | 0.00% | -1.40% | 0.00% | \$8,066.11 | \$154.04 | \$8,220.15 |

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 4: Unadjusted and Adjusted Base Data by Rate Cell

Appendix 4b. Home and Community Based Services

| Contractor | GSA | Rate Cell | Category of Service | I.2.B.ii | I.2.B.iii.(b) | Subtotal | I.2.B.iii.(d) | I.2.B.iii.(d) | I.3.A.iv | I.2.B.iii.(d) | I.2.B.iii.(d) | Subtotal | I.2.B.iii.(d) | Total |
|---------------------------------|---------|-----------|---------------------|-------------------------|--------------------|----------------|----------------|-------------------|----------|----------------------|-------------------------------|------------|--------------------|-----------------------------|
| | | | | Uncompleted Gross Total | Completion Factors | Completed PMPM | COVID-19 Tests | COVID-19 Vaccines | IMD | DAP Payments Removed | Retrospective Program Changes | Subtotal | SOC Payments Added | Adjusted Base Gross Medical |
| UnitedHealthcare | North | Dual | HCBS | \$1,478.65 | 0.962 | \$1,537.17 | 0.00% | 0.00% | 0.00% | -0.25% | 0.00% | \$1,533.36 | \$16.20 | \$1,549.56 |
| UnitedHealthcare | Central | Dual | HCBS | \$1,726.29 | 0.962 | \$1,794.60 | 0.00% | 0.00% | 0.00% | -0.19% | 0.00% | \$1,791.19 | \$13.60 | \$1,804.79 |
| Banner - University Family Care | Central | Dual | HCBS | \$2,025.54 | 0.964 | \$2,102.16 | 0.00% | 0.00% | 0.00% | -0.18% | 0.00% | \$2,098.28 | \$9.89 | \$2,108.17 |
| Mercy Care | Central | Dual | HCBS | \$2,251.89 | 0.976 | \$2,307.66 | 0.00% | 0.00% | 0.00% | -0.16% | 0.00% | \$2,304.01 | \$14.13 | \$2,318.14 |
| Banner - University Family Care | South | Dual | HCBS | \$1,934.82 | 0.964 | \$2,008.01 | 0.00% | 0.00% | 0.00% | -0.15% | 0.00% | \$2,004.92 | \$14.43 | \$2,019.35 |
| Mercy Care | South | Dual | HCBS | \$2,149.31 | 0.976 | \$2,202.54 | 0.00% | 0.00% | 0.00% | -0.13% | 0.00% | \$2,199.78 | \$22.12 | \$2,221.90 |
| UnitedHealthcare | North | Non-Dual | HCBS | \$1,375.75 | 0.982 | \$1,401.32 | 0.00% | 0.00% | 0.00% | -0.22% | 0.00% | \$1,398.21 | \$0.24 | \$1,398.45 |
| UnitedHealthcare | Central | Non-Dual | HCBS | \$1,902.71 | 0.982 | \$1,938.08 | 0.00% | 0.00% | 0.00% | -0.20% | 0.00% | \$1,934.20 | \$2.60 | \$1,936.80 |
| Banner - University Family Care | Central | Non-Dual | HCBS | \$2,203.84 | 0.969 | \$2,275.50 | 0.00% | 0.00% | 0.00% | -0.21% | 0.00% | \$2,270.62 | \$0.05 | \$2,270.67 |
| Mercy Care | Central | Non-Dual | HCBS | \$2,303.60 | 0.972 | \$2,370.10 | 0.00% | 0.00% | 0.00% | -0.13% | 0.00% | \$2,367.12 | \$5.89 | \$2,373.00 |
| Banner - University Family Care | South | Non-Dual | HCBS | \$1,766.34 | 0.969 | \$1,823.78 | 0.00% | 0.00% | 0.00% | -0.13% | 0.00% | \$1,821.43 | \$2.18 | \$1,823.60 |
| Mercy Care | South | Non-Dual | HCBS | \$2,384.78 | 0.972 | \$2,453.63 | 0.00% | 0.00% | 0.00% | -0.07% | 0.00% | \$2,451.88 | \$6.97 | \$2,458.86 |

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 4: Unadjusted and Adjusted Base Data by Rate Cell

Appendix 4c. Acute

| Contractor | GSA | Rate Cell | Category of Service | I.2.B.ii | I.2.B.iii.(b) | Subtotal | I.2.B.iii.(d) | I.2.B.iii.(d) | I.3.A.iv | I.2.B.iii.(d) | I.2.B.iii.(d) | Subtotal | I.2.B.iii.(d) | Total |
|---------------------------------|---------|-----------|---------------------|-------------------------|--------------------|----------------|----------------|-------------------|----------|----------------------|-------------------------------|------------|--------------------|-----------------------------|
| | | | | Uncompleted Gross Total | Completion Factors | Completed PMPM | COVID-19 Tests | COVID-19 Vaccines | IMD | DAP Payments Removed | Retrospective Program Changes | Subtotal | SOC Payments Added | Adjusted Base Gross Medical |
| UnitedHealthcare | North | Dual | Acute | \$136.63 | 0.937 | \$145.84 | -0.44% | -0.03% | 0.00% | -0.81% | 0.05% | \$144.04 | \$0.00 | \$144.04 |
| UnitedHealthcare | Central | Dual | Acute | \$206.43 | 0.937 | \$220.35 | -0.42% | -0.05% | 0.09% | -0.63% | 0.02% | \$218.17 | \$0.00 | \$218.17 |
| Banner - University Family Care | Central | Dual | Acute | \$357.53 | 0.902 | \$396.32 | -0.06% | 0.00% | -0.11% | -0.56% | 0.02% | \$393.45 | \$0.00 | \$393.45 |
| Mercy Care | Central | Dual | Acute | \$421.92 | 0.934 | \$451.77 | -0.11% | 0.00% | 0.01% | -0.50% | 0.02% | \$449.12 | \$0.00 | \$449.12 |
| Banner - University Family Care | South | Dual | Acute | \$223.64 | 0.902 | \$247.90 | -0.02% | -0.01% | 0.01% | -0.77% | 0.02% | \$246.00 | \$0.00 | \$246.00 |
| Mercy Care | South | Dual | Acute | \$249.50 | 0.934 | \$267.15 | -0.04% | 0.00% | 0.05% | -0.62% | 0.02% | \$265.55 | \$0.00 | \$265.55 |
| UnitedHealthcare | North | Non-Dual | Acute | \$2,957.41 | 0.943 | \$3,136.34 | -0.51% | -0.01% | 0.01% | -0.96% | 0.03% | \$3,091.66 | \$0.00 | \$3,091.66 |
| UnitedHealthcare | Central | Non-Dual | Acute | \$3,695.42 | 0.943 | \$3,919.01 | -0.44% | -0.01% | 0.01% | -1.06% | 0.05% | \$3,862.55 | \$0.00 | \$3,862.55 |
| Banner - University Family Care | Central | Non-Dual | Acute | \$3,480.04 | 0.908 | \$3,830.83 | -0.48% | -0.03% | 0.00% | -0.95% | 0.05% | \$3,776.66 | \$0.00 | \$3,776.66 |
| Mercy Care | Central | Non-Dual | Acute | \$3,759.30 | 0.904 | \$4,158.10 | -0.52% | -0.04% | -0.01% | -0.80% | 0.05% | \$4,103.59 | \$0.00 | \$4,103.59 |
| Banner - University Family Care | South | Non-Dual | Acute | \$3,114.36 | 0.908 | \$3,428.28 | -0.17% | -0.04% | 0.02% | -1.07% | 0.05% | \$3,386.80 | \$0.00 | \$3,386.80 |
| Mercy Care | South | Non-Dual | Acute | \$2,643.21 | 0.904 | \$2,923.61 | -0.16% | -0.07% | -0.18% | -0.81% | 0.05% | \$2,889.42 | \$0.00 | \$2,889.42 |

Appendix 5: CYE 23 Projected Trends by Rate Cell and Category of Service

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 5: CYE 23 Projected Trends by Rate Cell and Category of Service

| | | I.3.B.iii. | I.3.B.iii. | |
|-----------|-----------------------------------|----------------------|------------|------|
| Rate Cell | COS | Utilization per 1000 | Unit Cost | PMPM |
| Dual | Nursing Facility | 1.0% | 1.0% | 2.0% |
| Dual | Home and Community Based Services | 2.0% | 0.3% | 2.3% |
| Dual | Acute Care | 2.0% | 0.0% | 2.0% |
| Non-Dual | Nursing Facility | 1.6% | 1.9% | 3.5% |
| Non-Dual | Home and Community Based Services | 0.3% | 1.9% | 2.2% |
| Non-Dual | Acute Care | 1.0% | 2.4% | 3.4% |

**Appendix 6: CYE 23 Projected Gross and Net Medical Expenses PMPM
by COS and Rate Cell**

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 6: CYE 23 Projected Gross and Net Medical Expenses PMPM by COS and Rate Cell

Appendix 6a. Nursing Facility

| Contractor | GSA | Rate Cell | Category of Service | Appendix 4 Adjusted Base PMPM | Appendix 5 Trend | I.3.B.ii.(a) Rx Rebates | I.3.B.ii.(a) Prospective Program Changes | I.3.B.ii.(a) Provider Fee Schedule | I.3.B.ii.(a) Prop 206 All | I.3.B.ii.(a) COVID-19 Testing | I.4.D. DAP Add In | Subtotal | I.3.B.ii.(a) Projected SOC | I.4.C.ii.(c) Reinsurance | Total Net Projected Medical |
|---------------------------------|---------|-----------|---------------------|----------------------------------|---------------------|----------------------------|---|---------------------------------------|------------------------------|----------------------------------|----------------------|-------------|-------------------------------|-----------------------------|--------------------------------|
| UnitedHealthcare | North | Dual | NF | \$6,315.59 | 2.01% | 0.00% | 0.00% | 18.93% | 2.01% | 0.00% | 1.60% | \$8,101.20 | (\$1,380.04) | \$0.00 | \$6,721.16 |
| UnitedHealthcare | Central | Dual | NF | \$6,306.46 | 2.01% | 0.00% | 0.00% | 18.91% | 2.02% | 0.00% | 1.46% | \$8,077.33 | (\$1,007.55) | \$0.00 | \$7,069.78 |
| Banner - University Family Care | Central | Dual | NF | \$6,657.74 | 2.01% | 0.00% | 0.00% | 18.84% | 2.02% | 0.00% | 1.56% | \$8,530.42 | (\$1,015.48) | \$0.00 | \$7,514.94 |
| Mercy Care | Central | Dual | NF | \$6,769.36 | 2.01% | 0.00% | 0.00% | 19.08% | 2.02% | 0.00% | 1.59% | \$8,693.26 | (\$1,132.89) | \$0.00 | \$7,560.37 |
| Banner - University Family Care | South | Dual | NF | \$6,705.31 | 2.01% | 0.00% | 0.00% | 18.91% | 2.02% | 0.00% | 1.41% | \$8,584.64 | (\$1,011.09) | \$0.00 | \$7,573.55 |
| Mercy Care | South | Dual | NF | \$6,029.99 | 2.01% | 0.00% | 0.00% | 18.93% | 2.02% | 0.00% | 1.43% | \$7,722.40 | (\$1,116.19) | \$0.00 | \$6,606.21 |
| UnitedHealthcare | North | Non-Dual | NF | \$14,016.33 | 3.53% | 0.00% | 0.00% | 18.98% | 2.02% | 0.00% | 1.84% | \$18,571.66 | (\$304.06) | \$0.00 | \$18,267.60 |
| UnitedHealthcare | Central | Non-Dual | NF | \$8,573.88 | 3.53% | 0.00% | 0.00% | 19.01% | 2.02% | 0.00% | 1.90% | \$11,369.68 | (\$60.82) | \$0.00 | \$11,308.85 |
| Banner - University Family Care | Central | Non-Dual | NF | \$9,454.43 | 3.53% | 0.00% | 0.00% | 18.80% | 2.02% | 0.00% | 1.86% | \$12,510.16 | (\$208.89) | \$0.00 | \$12,301.27 |
| Mercy Care | Central | Non-Dual | NF | \$10,638.48 | 3.53% | 0.00% | 0.00% | 19.13% | 2.02% | 0.00% | 1.92% | \$14,124.83 | (\$106.12) | \$0.00 | \$14,018.71 |
| Banner - University Family Care | South | Non-Dual | NF | \$8,705.47 | 3.53% | 0.00% | 0.00% | 19.10% | 2.02% | 0.00% | 1.64% | \$11,523.81 | (\$117.38) | \$0.00 | \$11,406.43 |
| Mercy Care | South | Non-Dual | NF | \$8,220.15 | 3.53% | 0.00% | 0.00% | 19.06% | 2.02% | 0.00% | 1.81% | \$10,895.49 | (\$115.89) | \$0.00 | \$10,779.61 |

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 6: CYE 23 Projected Gross and Net Medical Expenses PMPM by COS and Rate Cell

Appendix 6b. Home and Community Based Services

| Contractor | GSA | Rate Cell | Category of Service | Appendix 4 | Appendix 5 | I.3.B.ii.(a) | I.3.B.ii.(a) | I.3.B.ii.(a) | I.3.B.ii.(a) | I.3.B.ii.(a) | I.4.D. | Subtotal | I.3.B.ii.(a) | I.4.C.ii.(c) | Total |
|---------------------------------|---------|-----------|---------------------|--------------------|------------|--------------|-----------------------------|-----------------------|--------------|------------------|------------|------------|---------------|--------------|-----------------------|
| | | | | Adjusted Base PMPM | Trend | Rx Rebates | Prospective Program Changes | Provider Fee Schedule | Prop 206 All | COVID-19 Testing | DAP Add In | Subtotal | Projected SOC | Reinsurance | Net Projected Medical |
| UnitedHealthcare | North | Dual | HCBS | \$1,549.56 | 2.31% | 0.00% | 0.00% | 19.04% | 4.03% | 0.00% | 0.92% | \$2,026.80 | (\$24.98) | \$0.00 | \$2,001.82 |
| UnitedHealthcare | Central | Dual | HCBS | \$1,804.79 | 2.31% | 0.00% | 0.00% | 18.86% | 4.02% | 0.00% | 1.11% | \$2,361.42 | (\$15.12) | \$0.00 | \$2,346.30 |
| Banner - University Family Care | Central | Dual | HCBS | \$2,108.17 | 2.31% | 0.00% | 0.00% | 17.78% | 4.04% | 0.00% | 1.11% | \$2,733.84 | (\$9.90) | \$0.00 | \$2,723.94 |
| Mercy Care | Central | Dual | HCBS | \$2,318.14 | 2.31% | 0.00% | 0.00% | 18.91% | 3.94% | 0.00% | 1.47% | \$3,042.60 | (\$15.77) | \$0.00 | \$3,026.82 |
| Banner - University Family Care | South | Dual | HCBS | \$2,019.35 | 2.31% | 0.00% | 0.00% | 18.04% | 4.02% | 0.00% | 1.28% | \$2,628.35 | (\$16.63) | \$0.00 | \$2,611.72 |
| Mercy Care | South | Dual | HCBS | \$2,221.90 | 2.31% | 0.00% | 0.00% | 19.05% | 3.93% | 0.00% | 1.25% | \$2,913.41 | (\$27.65) | \$0.00 | \$2,885.76 |
| UnitedHealthcare | North | Non-Dual | HCBS | \$1,398.45 | 2.21% | 0.00% | 0.00% | 19.45% | 3.79% | 0.00% | 1.05% | \$1,830.19 | (\$0.12) | \$0.00 | \$1,830.07 |
| UnitedHealthcare | Central | Non-Dual | HCBS | \$1,936.80 | 2.21% | 0.00% | 0.00% | 19.53% | 3.90% | 0.00% | 1.22% | \$2,543.18 | (\$3.05) | \$0.00 | \$2,540.13 |
| Banner - University Family Care | Central | Non-Dual | HCBS | \$2,270.67 | 2.21% | 0.00% | 0.00% | 18.37% | 3.81% | 0.00% | 1.18% | \$2,948.99 | (\$0.00) | \$0.00 | \$2,948.99 |
| Mercy Care | Central | Non-Dual | HCBS | \$2,373.00 | 2.21% | 0.00% | 0.00% | 19.48% | 3.42% | 0.00% | 1.61% | \$3,112.39 | (\$9.58) | \$0.00 | \$3,102.80 |
| Banner - University Family Care | South | Non-Dual | HCBS | \$1,823.60 | 2.21% | 0.00% | 0.00% | 18.94% | 3.76% | 0.00% | 1.64% | \$2,389.59 | (\$5.06) | \$0.00 | \$2,384.53 |
| Mercy Care | South | Non-Dual | HCBS | \$2,458.86 | 2.21% | 0.00% | 0.00% | 19.64% | 3.17% | 0.00% | 1.43% | \$3,215.57 | (\$8.64) | \$0.00 | \$3,206.93 |

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 6: CYE 23 Projected Gross and Net Medical Expenses PMPM by COS and Rate Cell

Appendix 6c. Acute

| Contractor | GSA | Rate Cell | Category of Service | Appendix 4 | Appendix 5 | I.3.B.ii.(a) | I.3.B.ii.(a) | I.3.B.ii.(a) | I.3.B.ii.(a) | I.3.B.ii.(a) | I.4.D. | Subtotal | I.3.B.ii.(a) | I.4.C.ii.(c) | Total |
|---------------------------------|---------|-----------|---------------------|--------------------|------------|--------------|-----------------------------|-----------------------|--------------|------------------|------------|------------|---------------|--------------|-----------------------|
| | | | | Adjusted Base PMPM | Trend | Rx Rebates | Prospective Program Changes | Provider Fee Schedule | Prop 206 All | COVID-19 Testing | DAP Add In | Subtotal | Projected SOC | Reinsurance | Net Projected Medical |
| UnitedHealthcare | North | Dual | Acute | \$144.04 | 2.00% | -0.01% | 4.45% | 0.02% | 0.00% | 0.49% | 1.54% | \$159.74 | \$0.00 | (\$1.66) | \$158.08 |
| UnitedHealthcare | Central | Dual | Acute | \$218.17 | 2.00% | -0.01% | 2.81% | 0.00% | 0.00% | 0.31% | 1.53% | \$237.65 | \$0.00 | (\$26.83) | \$210.82 |
| Banner - University Family Care | Central | Dual | Acute | \$393.45 | 2.00% | 0.00% | 2.03% | 0.00% | 0.00% | 0.17% | 1.22% | \$423.46 | \$0.00 | (\$4.60) | \$418.87 |
| Mercy Care | Central | Dual | Acute | \$449.12 | 2.00% | -0.03% | 2.14% | 0.00% | 0.00% | 0.15% | 1.12% | \$483.18 | \$0.00 | (\$38.03) | \$445.15 |
| Banner - University Family Care | South | Dual | Acute | \$246.00 | 2.00% | 0.00% | 2.57% | 0.01% | 0.00% | 0.03% | 2.60% | \$269.43 | \$0.00 | (\$5.80) | \$263.63 |
| Mercy Care | South | Dual | Acute | \$265.55 | 2.00% | -0.02% | 2.92% | 0.02% | 0.00% | 0.03% | 1.72% | \$289.31 | \$0.00 | (\$5.31) | \$284.00 |
| UnitedHealthcare | North | Non-Dual | Acute | \$3,091.66 | 3.42% | -0.20% | -0.01% | 1.56% | 0.00% | 0.54% | 0.87% | \$3,398.70 | \$0.00 | (\$502.43) | \$2,896.27 |
| UnitedHealthcare | Central | Non-Dual | Acute | \$3,862.55 | 3.42% | -0.19% | -0.01% | 0.82% | 0.00% | 0.52% | 1.27% | \$4,231.63 | \$0.00 | (\$818.35) | \$3,413.28 |
| Banner - University Family Care | Central | Non-Dual | Acute | \$3,776.66 | 3.42% | -0.03% | -0.01% | 0.21% | 0.00% | 0.53% | 0.89% | \$4,104.37 | \$0.00 | (\$369.85) | \$3,734.52 |
| Mercy Care | Central | Non-Dual | Acute | \$4,103.59 | 3.42% | -0.30% | -0.01% | 0.56% | 0.00% | 0.49% | 0.84% | \$4,459.23 | \$0.00 | (\$442.64) | \$4,016.59 |
| Banner - University Family Care | South | Non-Dual | Acute | \$3,386.80 | 3.42% | -0.03% | 0.03% | 0.78% | 0.00% | 0.16% | 1.11% | \$3,697.76 | \$0.00 | (\$357.90) | \$3,339.86 |
| Mercy Care | South | Non-Dual | Acute | \$2,889.42 | 3.42% | -0.29% | 0.03% | 0.54% | 0.00% | 0.19% | 1.00% | \$3,136.48 | \$0.00 | (\$161.52) | \$2,974.97 |

**Appendix 7: CYE 23 Projected Capitation Rates PMPM by Rate Cell,
Contractor, and GSA**

CYE 23 Capitation Rate Certification – ALTCS/EPD Program

Appendix 7a: CYE 23 Projected Net Projected Medical PMPM by Rate Cell, Contractor, and GSA

| Contractor | GSA | Rate Cell | Category of Service | Projected Member Months | I.3.B.ii.(a) Percent Members Receiving LTSS | I.3.B.ii.(a) Projected Mix | Subproduct Percentage Share | Appendix 6 Net Projected Medical | Total PMPM |
|---------------------------------|---------|-----------|-----------------------------------|-------------------------|--|-------------------------------|--------------------------------|-------------------------------------|---------------|
| UnitedHealthcare | North | Dual | Nursing Facility | | 97.47% | 27.6% | 26.9% | \$6,721.16 | \$1,808.92 |
| UnitedHealthcare | North | Dual | Home and Community Based Services | | 97.47% | 72.4% | 70.6% | \$2,001.82 | \$1,412.45 |
| UnitedHealthcare | North | Dual | Acute | | | 100.0% | 100.0% | \$158.08 | \$158.08 |
| UnitedHealthcare | North | Dual | Total | 25,448 | 97.47% | 100.0% | 100.0% | | \$3,379.45 |
| UnitedHealthcare | Central | Dual | Nursing Facility | | 97.29% | 17.8% | 17.3% | \$7,069.78 | \$1,224.21 |
| UnitedHealthcare | Central | Dual | Home and Community Based Services | | 97.29% | 82.2% | 80.0% | \$2,346.30 | \$1,876.43 |
| UnitedHealthcare | Central | Dual | Acute | | | 100.0% | 100.0% | \$210.82 | \$210.82 |
| UnitedHealthcare | Central | Dual | Total | 64,500 | 97.29% | 100.0% | 100.0% | | \$3,311.47 |
| Banner - University Family Care | Central | Dual | Nursing Facility | | 98.40% | 26.6% | 26.2% | \$7,514.94 | \$1,966.26 |
| Banner - University Family Care | Central | Dual | Home and Community Based Services | | 98.40% | 73.4% | 72.2% | \$2,723.94 | \$1,967.69 |
| Banner - University Family Care | Central | Dual | Acute | | | 100.0% | 100.0% | \$418.87 | \$418.87 |
| Banner - University Family Care | Central | Dual | Total | 23,435 | 98.40% | 100.0% | 100.0% | | \$4,352.82 |
| Mercy Care | Central | Dual | Nursing Facility | | 98.34% | 23.6% | 23.2% | \$7,560.37 | \$1,755.64 |
| Mercy Care | Central | Dual | Home and Community Based Services | | 98.34% | 76.4% | 75.1% | \$3,026.82 | \$2,273.84 |
| Mercy Care | Central | Dual | Acute | | | 100.0% | 100.0% | \$445.15 | \$445.15 |
| Mercy Care | Central | Dual | Total | 84,964 | 98.34% | 100.0% | 100.0% | | \$4,474.62 |
| Banner - University Family Care | South | Dual | Nursing Facility | | 98.84% | 27.0% | 26.7% | \$7,573.55 | \$2,024.88 |
| Banner - University Family Care | South | Dual | Home and Community Based Services | | 98.84% | 73.0% | 72.1% | \$2,611.72 | \$1,883.19 |
| Banner - University Family Care | South | Dual | Acute | | | 100.0% | 100.0% | \$263.63 | \$263.63 |
| Banner - University Family Care | South | Dual | Total | 40,468 | 98.84% | 100.0% | 100.0% | | \$4,171.70 |
| Mercy Care | South | Dual | Nursing Facility | | 98.52% | 26.2% | 25.8% | \$6,606.21 | \$1,704.95 |
| Mercy Care | South | Dual | Home and Community Based Services | | 98.52% | 73.8% | 72.7% | \$2,885.76 | \$2,098.19 |
| Mercy Care | South | Dual | Acute | | | 100.0% | 100.0% | \$284.00 | \$284.00 |
| Mercy Care | South | Dual | Total | 22,068 | 98.52% | 100.0% | 100.0% | | \$4,087.14 |
| UnitedHealthcare | North | Non-Dual | Nursing Facility | | 94.68% | 18.6% | 17.6% | \$18,267.60 | \$3,221.92 |
| UnitedHealthcare | North | Non-Dual | Home and Community Based Services | | 94.68% | 81.4% | 77.0% | \$1,830.07 | \$1,410.00 |
| UnitedHealthcare | North | Non-Dual | Acute | | | 100.0% | 100.0% | \$2,896.27 | \$2,896.27 |
| UnitedHealthcare | North | Non-Dual | Total | 3,916 | 94.68% | 100.0% | 100.0% | | \$7,528.20 |
| UnitedHealthcare | Central | Non-Dual | Nursing Facility | | 95.57% | 22.2% | 21.3% | \$11,308.85 | \$2,404.38 |
| UnitedHealthcare | Central | Non-Dual | Home and Community Based Services | | 95.57% | 77.8% | 74.3% | \$2,540.13 | \$1,887.50 |
| UnitedHealthcare | Central | Non-Dual | Acute | | | 100.0% | 100.0% | \$3,413.28 | \$3,413.28 |
| UnitedHealthcare | Central | Non-Dual | Total | 10,945 | 95.57% | 100.0% | 100.0% | | \$7,705.16 |
| Banner - University Family Care | Central | Non-Dual | Nursing Facility | | 95.42% | 31.4% | 30.0% | \$12,301.27 | \$3,690.45 |
| Banner - University Family Care | Central | Non-Dual | Home and Community Based Services | | 95.42% | 68.6% | 65.4% | \$2,948.99 | \$1,929.18 |
| Banner - University Family Care | Central | Non-Dual | Acute | | | 100.0% | 100.0% | \$3,734.52 | \$3,734.52 |
| Banner - University Family Care | Central | Non-Dual | Total | 5,175 | 95.42% | 100.0% | 100.0% | | \$9,354.15 |
| Mercy Care | Central | Non-Dual | Nursing Facility | | 95.99% | 22.7% | 21.8% | \$14,018.71 | \$3,049.52 |
| Mercy Care | Central | Non-Dual | Home and Community Based Services | | 95.99% | 77.3% | 74.2% | \$3,102.80 | \$2,303.54 |
| Mercy Care | Central | Non-Dual | Acute | | | 100.0% | 100.0% | \$4,016.59 | \$4,016.59 |
| Mercy Care | Central | Non-Dual | Total | 23,939 | 95.99% | 100.0% | 100.0% | | \$9,369.65 |
| Banner - University Family Care | South | Non-Dual | Nursing Facility | | 96.87% | 24.1% | 23.4% | \$11,406.43 | \$2,665.16 |
| Banner - University Family Care | South | Non-Dual | Home and Community Based Services | | 96.87% | 75.9% | 73.5% | \$2,384.53 | \$1,752.83 |
| Banner - University Family Care | South | Non-Dual | Acute | | | 100.0% | 100.0% | \$3,339.86 | \$3,339.86 |
| Banner - University Family Care | South | Non-Dual | Total | 6,669 | 96.87% | 100.0% | 100.0% | | \$7,757.85 |
| Mercy Care | South | Non-Dual | Nursing Facility | | 97.00% | 26.2% | 25.4% | \$10,779.61 | \$2,741.12 |
| Mercy Care | South | Non-Dual | Home and Community Based Services | | 97.00% | 73.8% | 71.6% | \$3,206.93 | \$2,295.09 |
| Mercy Care | South | Non-Dual | Acute | | | 100.0% | 100.0% | \$2,974.97 | \$2,974.97 |
| Mercy Care | South | Non-Dual | Total | 3,914 | 97.00% | 100.0% | 100.0% | | \$8,011.18 |

Appendix 7b: CYE 23 Projected Capitation Rates PMPM by Rate Cell, Contractor, and GSA

| Rate Cell | Contractor | GSA | Appendix 7a Net Medical | I.5.B.i. Case Management | I.5.B.i. Admin PMPM | I.5.B.ii.(c) UW Gain Percent | Calculation UW Gain PMPM | I.5.B.ii.(b) Premium Tax | Total Capitation Rate PMPM |
|-----------|---------------------------------|---------|----------------------------|-----------------------------|------------------------|------------------------------------|-----------------------------|-----------------------------|----------------------------------|
| Dual | UnitedHealthcare | North | \$3,379.45 | \$154.32 | \$94.61 | 1.0% | \$36.65 | \$74.80 | \$3,739.84 |
| Dual | UnitedHealthcare | Central | \$3,311.47 | \$154.99 | \$92.70 | 1.0% | \$35.95 | \$73.37 | \$3,668.48 |
| Dual | Banner - University Family Care | Central | \$4,352.82 | \$131.19 | \$193.23 | 1.0% | \$47.24 | \$96.42 | \$4,820.91 |
| Dual | Mercy Care | Central | \$4,474.62 | \$182.07 | \$92.34 | 1.0% | \$47.97 | \$97.90 | \$4,894.91 |
| Dual | Banner - University Family Care | South | \$4,171.70 | \$121.13 | \$185.20 | 1.0% | \$45.23 | \$92.31 | \$4,615.57 |
| Dual | Mercy Care | South | \$4,087.14 | \$178.23 | \$84.36 | 1.0% | \$43.94 | \$89.67 | \$4,483.34 |
| Non-Dual | UnitedHealthcare | North | \$7,528.20 | \$317.78 | \$210.04 | 1.0% | \$81.37 | \$166.07 | \$8,303.46 |
| Non-Dual | UnitedHealthcare | Central | \$7,705.16 | \$393.15 | \$215.49 | 1.0% | \$83.98 | \$171.38 | \$8,569.16 |
| Non-Dual | Banner - University Family Care | Central | \$9,354.15 | \$404.78 | \$415.02 | 1.0% | \$102.77 | \$209.73 | \$10,486.45 |
| Non-Dual | Mercy Care | Central | \$9,369.65 | \$187.05 | \$193.22 | 1.0% | \$98.48 | \$200.99 | \$10,049.40 |
| Non-Dual | Banner - University Family Care | South | \$7,757.85 | \$337.15 | \$344.10 | 1.0% | \$85.24 | \$173.97 | \$8,698.31 |
| Non-Dual | Mercy Care | South | \$8,011.18 | \$182.75 | \$165.22 | 1.0% | \$84.44 | \$172.32 | \$8,615.91 |

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Appendix 8a: State Directed Payments, CMS Prescribed Tables

Appendix 8a table 1: CMS Prescribed Table for I.4.D.ii.(a)(i)

| Control name of the state directed payment | Type of payment - Section I.4.D.ii.(a)(i)(A) | Brief description - Section I.4.D.ii.(a)(i)(B) | Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.D.ii.(a)(iii) |
|--|--|--|--|
| Federally Qualified Health Centers and Rural Health Clinics (a.k.a. FQHC/RHC) | Minimum Fee Schedule | Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Medicaid State plan as a minimum fee schedule for FQHC/RHC providers. | Rate Adjustment |
| AZ_Fee_IP.OP.PC_Renewal_20221001-20230931 (a.k.a. DAP) | Uniform Percentage Increase | Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP. | Rate Adjustment |
| AZ_Fee_AMC_Renewal_20221001-20230930 (a.k.a. APSI) | Uniform Percentage Increase | 70% increase to otherwise contracted rates for professional services provided by qualified practitioners affiliated with designated hospitals. | Separate Payment Term |
| AZ_Fee_IP.OP1_Renewal_20221001-20230930 (a.k.a. PSI) | Uniform Percentage Increase | Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. | Separate Payment Term |
| AZ_Fee_IP.OP2_Renewal_20221001-20230930 (a.k.a. HEALTHII) | Uniform Percentage Increase | Uniform percentage increase for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class's aggregate targeted pay to cost ratio for Medicaid Managed Care services. | Separate Payment Term |
| AZ_Fee_NF_Renewal_20221001-20230930 (a.k.a. NF Supplemental Payments) | Uniform Dollar Amount | Uniform dollar increase to be applied across all Contractor's reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund plus FMAP, and is expected to fluctuate based on utilization and available funds for each quarter. | Separate Payment Term |

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Appendix 8a table 2: CMS Prescribed Table for I.4.D.ii.(a)(ii)

| Control name of the state directed payment | Rate cells affected - Section I.4.D.ii.(a)(ii)(A) | Impact - Section I.4.D.(ii).(a)(ii)(B) | Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C) | Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D) | For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E) |
|---|---|--|--|--|--|
| Federally Qualified Health Centers and Rural Health Clinics (a.k.a. FQHC/RHC) | All EPD rate cells are affected. | See Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell. | <p>The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates, described in Section I.3.B.ii.(a).</p> <p>The AHCCCS DHCM Rates & Reimbursement Team developed the impacts of bringing the base FQHC/RHC encounter data up to the projected CYE 23 FQHC/RHC PPS rates, by applying the change in PPS rates as a unit cost change to the CYE 21 base data. The AHCCCS DHCM Actuarial Team then reviewed the FQHC/RHC results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting category of service as part of the overall fee schedule update.</p> | Not applicable | Not applicable. |
| AZ_Fee_IP.OP.PC_Renewal_20221001-20230931 (a.k.a. DAP) | All EPD rate cells are affected. | See Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell. | <p>The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.25% increase), Critical Access Hospitals (eligible for up to 10.75% increase), other hospitals and inpatient facilities (eligible for up to 5.0% increase), rehabilitation and long term acute care hospitals (eligible for a 0.25% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for up to a 1.0% increase), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated clinics (eligible for up to 8.5% increase), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), physicians, physician assistants, and registered nurse practitioners specialty types (obstetrics and gynecology, pediatrics, cardiology and nephrology) (eligible for a 1.0% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), HCBS providers (eligible for up to 3.0% increase), therapeutic foster homes (eligible for up to 20.0% increase), specific provider types that have or plan to have a workforce development plan (eligible for a 1.0% increase), specific provider types that meet employment staff training requirements (eligible for a 2.0% increase), and crisis providers (eligible for a 3.0% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.</p> <p>The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 21 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DHCM Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 23 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 23 (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).</p> | AHCCCS has submitted the Differential Adjusted Payments (DAP) §438.6(c) pre-print to CMS but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the pre-print under CMS review. | Not applicable. |

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Appendix 8a table 3: CMS Prescribed Table for I.4.D.ii.(a)(iii)

| Control name of the state directed payment | Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A) | Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B) | The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C) | Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D) | Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E) |
|--|---|--|--|--|--|
| AZ_Fee_AMC_Renewal_20221001-20230930 (a.k.a. APSI) | \$3,943,982 | The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. | See Appendix 8b | AHCCCS has submitted the Access to Professional Services Initiative (APSI) 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review. | After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed. |
| AZ_Fee_IP.OP1_Renewal_20221001-20230930 (a.k.a. PSI) | \$2,106,432 | The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. | See Appendix 8b | AHCCCS has submitted the Pediatric Service Initiative (PSI) 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The PSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review. | After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed. |
| AZ_Fee_IP.OP2_Renewal_20221001-20230930 (a.k.a. HEALTHII) | \$55,112,554 | The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. | See Appendix 8b | AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The HEALTHII payment arrangement is accounted for in a manner consistent with the pre-print under CMS review. | After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed. |
| AZ_Fee_NF_Renewal_20221001-20230930 (a.k.a. NF Supplemental Payments) | \$118,511,230 | The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. | See Appendix 8b | AHCCCS has submitted the Nursing Facility Supplemental Payments (NFSP) 42 CFR § 438.6(c) pre-print to CMS but has not yet received approval. The NFSP payment arrangement is accounted for in a manner consistent with the pre-print under CMS review. | After the rating period is complete and the final NFSP is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NFSP into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed. |

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Appendix 8b: Projected Delivery System and Provider Payment Initiatives

| Rate Cell | Contractor | GSA | I.3.B.ii. | I.4.D. | I.4.D. | I.4.D. | I.4.D. | I.4.D. |
|-----------|------------------|---------|-----------|----------|---------|---------|--------------------------|-------------------|
| | | | FQHC/RHC | DAP | APSI | PSI | Supplemental NF Payments | HEALTHII Payments |
| Dual | UnitedHealthCare | North | \$0.03 | \$51.39 | \$0.05 | \$0.00 | \$454.79 | \$27.54 |
| Dual | Banner-UFC | South | \$0.02 | \$64.72 | \$0.44 | \$0.00 | \$442.07 | \$38.27 |
| Dual | Mercy | South | \$0.05 | \$60.91 | \$0.64 | \$0.00 | \$429.80 | \$46.27 |
| Dual | UnitedHealthCare | Central | \$0.01 | \$45.85 | \$0.64 | \$0.01 | \$268.35 | \$29.48 |
| Dual | Banner-UFC | Central | \$0.01 | \$62.85 | \$0.91 | \$0.00 | \$397.94 | \$49.01 |
| Dual | Mercy | Central | \$0.00 | \$72.03 | \$0.58 | \$0.00 | \$342.35 | \$59.23 |
| NonDual | UnitedHealthCare | North | \$0.66 | \$105.31 | \$36.46 | \$28.62 | \$428.99 | \$792.57 |
| NonDual | Banner-UFC | South | \$3.52 | \$111.43 | \$98.55 | \$8.30 | \$438.36 | \$1,018.39 |
| NonDual | Mercy | South | \$2.59 | \$112.64 | \$70.95 | \$5.04 | \$483.46 | \$711.09 |
| NonDual | UnitedHealthCare | Central | \$1.36 | \$122.63 | \$71.22 | \$77.04 | \$384.99 | \$834.69 |
| NonDual | Banner-UFC | Central | \$0.84 | \$129.93 | \$72.18 | \$64.00 | \$548.52 | \$714.85 |
| NonDual | Mercy | Central | \$0.84 | \$134.49 | \$65.50 | \$31.08 | \$429.98 | \$762.20 |