Contract Year Ending 2019 Arizona Long Term Care System/ Elderly and Physical Disability Capitation Rate Certification

October 1, 2018 through September 30, 2019

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

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AHCCCS
Arizona Health Care Cost Containment System

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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 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for Contract Year Ending 2019 (CYE 19) effective October 1, 2018 through September 30, 2019, for the Arizona Long Term Care System (ALTCS)/Elderly and Physical Disability (ALTCS/EPD) Program. Due to one programmatic change (Proposition 206 Minimum Wage Increase) that will be implemented with an effective date of January 1, 2019, this certification will cover two sets of capitation rates. One set will apply for the time frame from October 1, 2018 through December 31, 2018, and another set will apply from January 1, 2019 through September 30, 2019. The rate development process is the same for both sets of capitation rates except the latter set includes the impact of the Proposition 206 Minimum Wage Increase adjustment. All comparisons to prior rates in this certification refer to the previously submitted actuarial memorandum for capitation rates as signed by Matthew C. Varitek dated January 1, 2018. 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 of 81 FR 27497 applicable to this rate certification, the 2019 Medicaid Managed Care Rate Development Guide (2019 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2019 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 2019 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

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

expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

As stated on page 2 of the 2019 Guide, CMS will also use these three principles in applying the regulation standards:

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

I.1. General Information

This section provides documentation for the General Information section of the 2019 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The CYE 19 capitation rates for the ALTCS/EPD Program are effective for the twelve month time period from October 1, 2018 through September 30, 2019.

I.1.A.ii. Required Elements

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

The actuarial certification letter for the CYE 19 capitation rates for the ALTCS/EPD Program, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854 provided below for reference.

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

Mr. Varitek certifies that the CYE 19 capitation rates for the ALTCS/EPD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 of 81 FR 27497.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ALTCS/EPD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856. The ALTCS/EPD contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 and the 2019 Guide.

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

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

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

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

Table 1: Managed Care Plan(s) by GSA

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

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

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

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

I.1.A.ii.(c)(i)(C) Area of State Covered and Lifetime of Program

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

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

The CYE 19 capitation rates for ALTCS/EPD are effective for the three month time period from October 1, 2018 through December 31, 2018 and the nine month time period from January 1, 2019 through September 30, 2019.

I.1.A.ii.(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.

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

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

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

There are no expected changes to the eligibility and enrollment criteria during CYE19 that could have an impact on the populations to be covered under the ALTCS/EPD Program.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE 19 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Reinsurance Arrangement (42 CFR § 438.6(b)(1) at 81 FR 27859)
- Alternative Payment Model (APM) Initiative – Quality Measure Performance (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- APM Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2) at 81 FR 27859)
- APM Initiative – Quality Measure Performance (Withhold Arrangement) (42 CFR § 438.6(b)(3) at 81 FR 27859)
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)
- Nursing Facility Enhanced Payments(42 CFR § 438.6(c)(1)(iii)(B) at 81 FR 27860)

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

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

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

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

Proposed differences among the CYE 19 capitation rates for the ALTCS/EPD Program are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the ALTCS/EPD Program.

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

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

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

The effective dates of changes to the ALTCS/EPD Program are consistent with the assumptions used to develop the CYE 19 capitation rates for the ALTCS/EPD Program.

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

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

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

I.1.A.vi.(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.vi.(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 19 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not Applicable. Capitation rates from previous rating periods are not used in the development of the CYE 19 capitation rates for the ALTCS/EPD Program.

I.1.A.viii. Rate Certification Procedures

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

This rate certification documents that the ALTCS/EPD Program capitation rates will be changing effective October 1, 2018 and January 1, 2019.

I.1.A.viii.(b) CMS Rate Certification Requirement for No Rate Change

Not Applicable. This rate certification will prospectively change the ALTCS/EPD Program capitation rates effective October 1, 2018 and January 1, 2019.

I.1.A.viii.(c) CMS Rate Certification Circumstances

This section of the 2019 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell, in accordance with 42 CFR §438.7(c)(3), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii).

I.1.A.viii.(d) CMS Contract Amendment Requirement

A contract amendment will be submitted to CMS to reflect the ALTCS/EPD Program capitation rates changing effective October 1, 2018 and January 1, 2019.

I.1.B. Appropriate Documentation

I.1.B.i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 19 capitation rates for the ALTCS/EPD Program.

I.1.B.ii. 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 2019 Guide. Sections of the 2019 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.iii. Differences in Federal Medical Assistance Percentage

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

I.1.B.iv. Comparison of Rates

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

The most recently submitted ALTCS/EPD Program capitation rates effective January 1, 2018, and the proposed capitation rates effective October 1, 2018 and January 1, 2019, are available in Appendix 2 for comparative purposes.

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

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

I.2. Data

This section provides documentation for the Data section of the 2019 Guide.

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

Since AHCCCS employs their own actuaries, a formal data request was not needed between the AHCCCS Division of Health Care Management (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) at 81 FR 27858.

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

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

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

The types of data that AHCCCS relied upon for developing the CYE 19 capitation rates for the ALTCS/EPD program were:

- Adjudicated and approved encounter data (October 1, 2014 through September 30, 2017 (Federal Fiscal Year (FFY) 15, FFY 16, and FFY 17)) submitted by ALTCS/EPD Contractors;
- The awarded Contractors' competitively bid gross medical, case management, and administrative expenses per member per month (PMPM) from the Request for Proposals (RFP) completed and awarded in early 2017;
- Reinsurance payments for FFY 15, FFY 16, and FFY 17;
- Historical member month data for FFY 15, FFY 16, and FFY 17 from the PMMIS mainframe;
- Projected enrollment data provided by the AHCCCS Division of Business and Finance (DBF) Budget Team for CYE 19;
- Quarterly and annual financial statements submitted by the Contractors for FFY 15, FFY 16, FFY 17, and FFY 18 and reviewed by the AHCCCS DHCM Finance & Reinsurance Team;

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

The encounter data serving as the base experience in the capitation rate development process was incurred during FFY 17 (October 1, 2016 to September 30, 2017) and paid through February 2018. For the purposes of developing trend assumptions and risk adjustments applied within the Contractor-specific CYE 19 capitation rates, AHCCCS also reviewed encounter data from FFY 15 (October 1, 2014 through September 30, 2015), FFY 16 (October 1, 2015 through September 30, 2016), and the first six months of FFY 18 (October 1, 2017 through March 31, 2018, paid through July 2018).

The historical enrollment data for ALTCS/EPD members aligned with the encounter data time periods of FFY 15, FFY 16, and FFY 17. The projected enrollment data for CYE 19 was provided by the AHCCCS Division of Business and Finance (DBF).

The financial statement data reviewed as part of the rate development process included financial statements for the FFY 15, FFY 16, and FFY 17 time periods.

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

The enrollment and encounter data were provided from the AHCCCS PMMIS mainframe. The projected enrollment data for CYE 19 was provided by the AHCCCS DBF Budget Team. The financial statement data were submitted by the ALTCS/EPD Contractors and reviewed by the DHCM Finance & Reinsurance team. Information regarding HCBS placement and member movement among Contractors was provided by the DHCM Operations Unit.

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

The ALTCS/EPD Contractors have sub-capitated/block purchasing arrangements. During FFY 17, the ALTCS/EPD Contractors paid approximately 1.2% of total medical expenditures through sub-capitated arrangements. The sub-capitated arrangements between the ALTCS/EPD Contractors and their providers still require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05, and health plan paid of zero (i.e. sub-capitated)) encounters to estimate a health plan valued amount for these encounters. The revised amounts from the repricing methodology were used in rate development.

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

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

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

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

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

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

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

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

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

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

Through the DHCM Actuarial team review of the encounter data provided from the AHCCCS PMMIS mainframe, the team ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 19 capitation rates for the ALTCS/EPD program. Additionally, the team ensured that only services covered under the state plan were included.

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

The AHCCCS DHCM Actuarial Team reviewed the encounter data for consistency by viewing month over month, year over year as well as encounter data versus financial statements. For calendar year 2017, the total expenses reported in financial statements differed from the total expenses from completed encounter data by 0.04%. As such, the encounter data was deemed to be consistent for capitation rate setting.

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

As required by ASOP No. 23, AHCCCS discloses that the rate development process has relied upon encounter data submitted by 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 Rates & Reimbursement Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

AHCCCS has determined the FFY 17 encounter data to be appropriate for the purposes of developing the CYE 19 capitation rates for the ALTCS/EPD program. Additionally, the FFY 15 and FFY 16 encounter data was deemed appropriate for use in trends.

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

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

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

The FFY 17 encounter data was appropriate to use as the base data for developing the CYE 19 capitation rates for the ALTCS/EPD program.

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

As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 19 capitation rates for the ALTCS/EPD Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 19 capitation rates for the ALTCS/EPD Program.

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

The rate development process of the capitation rates relied primarily on data extracted from the AHCCCS PMMIS mainframe and provided to the AHCCCCS DHCM Actuarial Team via a data book. The data book contained summarized monthly enrollment data by rate cell, county, GSA and FFY, and monthly encounter data by rate cell, county, GSA, FFY and COS.

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

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

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

No credibility adjustment was necessary.

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

An adjustment was made to the encounter data to reflect the level of completion. AHCCCS calculated completion factors using the development method with monthly encounter data from October 1, 2014 through September 30, 2017, paid through February 2018. The monthly completion factors were applied to the encounter data on a monthly basis. The aggregated CYE 17 completion factors applied to each COS are shown in Appendix 4a.

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, 2016 through September 30, 2017) are described below. All program and fee schedule changes which occurred or are effective on or after October 1, 2017 are described in Section I.3.B.ii.(a).

Removal of DAP from Base Period

CYE 17 capitation rates funded Differential Adjusted Payments (DAP) made from October 1, 2016 through September 30, 2017 to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health and reduce cost of care growth. As these payments expired September 30, 2017, AHCCCS has removed the impact of CYE 17 DAP payments from the base period. The change reduced the statewide costs for the base period by approximately $3.3 million or $10.01 PMPM. Table 1 details the magnitude of DAP payments removed from the base

data by rate cell and COS. See section I.4.D.ii below for information on adjustments included in CYE 19 rates for DAP that are effective from October 1, 2018 through September 30, 2019.

Table 1: PMPM Impact of DAP Removal by Rate Cell and COS

Rate Cell	COS	Change to PMPM
Dual	NF	($7.16)
Dual	HCBS	$0.00
Dual	Acute	($0.17)
Non-Dual	NF	($2.12)
Non-Dual	HCBS	$0.00
Non-Dual	Acute	($0.57)

Other adjustment factors to reflect historical changes applied to the base data period are provided in Appendix 4a and Appendix 5.

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 19 capitation rates.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2019 Guide.

I.3.A. Rate Development Standards

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

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

I.3.A.ii. Variations in Assumptions

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

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

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

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

AHCCCS programs have historically utilized Institution for Mental Diseases (IMD) settings to provide medically appropriate and cost effective in-lieu-of services, as allowed in 42 CFR § 438.3(e)(2) of 81 FR

27497, for inpatient treatment for behavioral health. With the 2016 Medicaid and CHIP Managed Care Final Rule, CMS requirements have changed regarding IMD in-lieu-of services, and additional information regarding stays in an IMD setting can be found in Section I.3.A.vi. of this rate certification.

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

Institution for mental disease (IMD) payments in accordance with 42 CFR § 438.6(e) at 81 FR 27861 are for enrollees aged 21 to 64. No adjustment was made to encounter data or capitation rates for the ALTCS/EPD Program, since there was immaterial utilization of IMDs for enrollees aged 21 to 64 in the encounter data used for the development of the capitation rate.

I.3.A.vi. Section 12002 of the 21st Century Cures Act (P.L. 114-255)

As requested by CMS, this section provides information in connection with Section 12002 of the 21st Century Cures Act (P.L. 114-255).

I.3.A.vi.(a) Number of Enrollees

There were 40 ALTCS/EPD members between the ages of 21 and 64 who received treatments in an IMD during FFY 17. The 40 members received a combined 460 days of care in an IMD during FFY 17.

I.3.A.vi.(b) Length of Stay

This section provides the range and average number of months and length of stay of members between the ages of 21 to 64 who received treatment in an IMD.

I.3.A.vi.(b)(i) Enrollees Information

The number of months assumed for the number of cumulative days a member had in an IMD is provided below in Table 2.

Table 2: Cumulative Days to Number of Months Assumed

Cumulative Days	# months
0-15	0
16-45	1

The minimum, maximum, mean and median number of months members between the ages of 21 to 64 who received treatment in an IMD, are provide below in Table 3.

Table 3: Ranges of Number of Months in an IMD

Measure	# Months
Minimum	0.00
Maximum	1.00
Mean	0.15
Median	0.00

I.3.A.vi.(b)(ii) Length of Stay Information

The minimum, maximum, mean and median length of stay of members between the ages of 21 to 64 who received treatment in an IMD, are provide below in Table 4.

Table 4: Ranges of Length of Stay in an IMD

Measure	Days
Minimum	2.00
Maximum	35.00
Mean	11.50
Median	11.00

I.3.A.vi.(b)(iii) Impact on Rates

No adjustment was made to the encounter data or CYE 19 capitation rates for repricing of these stays, as most of the utilization was incurred by members who were Medicare eligible. Thus the impact of repricing only the stays for members who weren't Medicare eligible was judged to be immaterial (PMPM impact of approximately $0.15). There were no stays in an IMD exceeding 15 cumulative days within a month, therefore no costs were removed.

I.3.A.vi.(c)(i) Amount of Capitation for IMD Services

The amounts of the capitation rates related to IMD stays are displayed below in Table 5 by GSA and rate cell.

Table 5: Benefit Costs Related to IMD Stays

Rate Cell	North	Central	South
Dual	$ -	$ 0.12	$ 0.27
Non-Dual	$ 5.78	$ 3.55	$ -
Total	$ 0.69	$ 0.71	$ 0.24

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

Appendix 7a and 7b contain the projected gross medical expenses PMPM by rate cell, Contractor, and GSA.

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

This section provides information on the projected benefit costs included in the CYE 19 capitation rates for the ALTCS/EPD Program.

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

The data described in Section I.2.B.ii.(a) was adjusted to reflect assumed completion, benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The per-member-per-month (PMPM) expenditures for each COS in the base year were trended forward to the midpoint of the effective period of the capitation rates by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in I.3.B.iii.(a).

DRG Reimbursement Rate Changes

AHCCCS transitioned from version 31 to version 34 of the All Patient Refined Diagnostic Related Groups (APR-DRG) payment classification system on January 1, 2018. To make the APR-DRG grouper fully ICD-10

code compliant, AHCCCS rebased the inpatient system by updating the DRG grouper version, relative weights and DRG base rates via payment simulation modeling using more recent data.

The AHCCCS DHCM Actuarial Team estimated and incorporated the impact of the DRG rebase in CYE 18 capitation rates. The method used to develop the CYE 18 capitation rates was deemed appropriate for continued use in developing CYE 19 capitation rates. The only adjustment from the method used to develop the CYE 18 capitation rates was to regroup into the new rate cells and program. This adjustment was possible because the CYE 18 method included AHCCCS rate code detail so there was a map from the old programs' rate cells to the new ACC program rate cells. This method was described in the CYE 18 certification and the language has been copied here for convenience of review.

> "Navigant Consulting did the rebase of the AHCCCS DRG system. Their modeling approach: "Rebasing calculations included updated base rates (both standardized amounts and wage indices), relative weights, and addition and change of policy adjusters. Outlier identification and payment methodology has not changed nor has any other underlying claim pricing calculation (notwithstanding the above noted changes to factors, indices, and statewide standardized base rate).
>
> To affect a budget neutral payment system change, Navigant first repriced the FFY 2016 claims under current APR-DRG v31 FFS rates, including changes to the payment system which have occurred since the FFY 2016 claims period (such as the removal of the transition factor, coding improvement factor, and the increase of the high acuity pediatric adjuster to 1.945). Navigant then repriced the same claims set using the APR-DRG v34 grouper and weights and calculated a statewide standardized amount (adjusted to each facility's labor cost using CMS's published FFY 2017 Final Rule Wage Indices). The statewide standardized amount was calculated to result in total simulated rebased payments equal to current system payments.
>
> The next modeling step was to increase select policy adjusters to meet program funding goals, as determined by AHCCCS. These adjustments included an increase of the high acuity pediatric policy adjuster to 2.30, the addition of a service policy adjuster for burn cases (as identified by APR-DRG groups 841-844) of 2.70, the increase of the policy adjuster for other adult services to 1.025, and the increase of the existing High Volume Hold Harmless adjuster to 1.11."

The PMPM adjustments to apply to each rate cell were then developed as the total simulated APR-DRG rebased payments with the new policy adjuster factors applied to each inpatient hospital admission during FFY 16 by members in each rate cell, minus the total actual payments associated with those admissions, divided by the FFY 16 member months for each rate cell.

The AHCCCS Division of Health Care Management (DHCM) Actuarial Team relied upon Navigant and AHCCCS DHCM Rates & Reimbursement Team for the reasonableness of these assumptions."

The overall impact of the DRG reimbursement program change by GSA is an increase of approximately $2.71 PMPM.

Emergency Dental for Adults (Aged 21 and Over)

As part of the 2017 Legislative session, the Arizona Legislature passed SB 1527, reinstating emergency adult dental services and extractions up to a limit of $1,000 annually, a covered service prior to October 1, 2010. AHCCCS restored this as a covered service effective October 1, 2017.

The AHCCCS DHCM Actuarial Team reviewed actual encounter data from the time period October 1, 2016 to April 30, 2018 to determine the change in expenditures based on the reinstatement of emergency adult dental, and found the original estimate described in CYE 18 certifications of approximately $2.33 PMPM to be appropriate in determining the PMPM cost for restoration of this benefit, and is continuing the same estimated PMPM for CYE 19 capitation rates. The language from the CYE 18 certifications is copied here for convenience of review.

> "To estimate the impact of restoring emergency adult dental services, the AHCCCS DHCM Actuarial Team used historical adult (21 and over) dental encounter data and member month data for the time frame October 1, 2009 through September 2011. While this data is outside of the requirement under §438.5(c) to use data from the most recent three years of the rating period to develop capitation rates, the AHCCCS DHCM Actuarial Team determined that this data was reasonable to use to estimate the impact of restoring the benefit. The time frame of October 1, 2009 through September 2011 includes the final year (FFY 10 (10/1/09 – 09/30/10)) AHCCCS covered emergency adult dental services and the first year (FFY 11 (10/1/10 – 09/30/11)) AHCCCS did not cover emergency adult dental services.
>
> The AHCCCS DHCM Actuarial Team developed dental PMPMs by rate cell and GSA for both the FFY10 and FFY11 time frames. The difference between FFY 10 PMPMs and FFY 11 PMPMs was assumed to be the impact of removing the emergency adult dental services. This difference between the FFY 10 PMPMs and FFY 11 PMPMs was trended forwarded to FFY 18 using an annualized trend of 2.0%. The 2.0% trend was derived using actuarial judgement with consideration of the following information:
>
> - Consumer Price Index - data from IHS Global Insight that was provided to the AHCCCS DHCM Rates & Reimbursement Team;
> - National Health Expenditures;
> - Encounter data for children dental; and
> - AHCCCS FFS fee schedule changes."

Hepatitis C (HCV) Treatment

In 2017, the AHCCCS Pharmacy and Therapeutics (P&T) Committee reviewed the HCV Direct Acting Antiviral Agents (DAA) and recommended Mavyret as the sole preferred agent to treat HCV based on both clinical efficacy and cost effectiveness. AHCCCS accepted the P&T's recommendation and also removed fibrosis level requirements that were previously necessary in order to access treatment and removed a one treatment per lifetime limitation effective January 1, 2018.

The AHCCCS DHCM Actuarial Team estimated and incorporated the impact of these changes to HCV Treatment in CYE 18 capitation rates. The method used to develop the CYE 18 capitation rates was deemed appropriate for continued use in developing CYE 19 capitation rates and the method description from the CYE 18 revised actuarial certification is included below for convenience of review.

> "The actuary extracted data for encounters and enrollment, grouped by rate cell and GSA for dates of service from October 1, 2016 through June 30, 2017. It was assumed that the encounter data required no adjustment for completion given historical run out patterns specific to HCV DAAs. The actuary then applied the anticipated unit cost for Mavyret treatment as provided by AHCCCS, in conjunction with the P&T Committee, to the encounter data to calculate a revised expenditure for the existing utilization. The actuary inflated the expected Mavyret utilization by 50%, relying on an assumption from the P&T Committee regarding the impact of removing the liver fibrosis requirement, to calculate a revised expenditure for the time period of encounter data and used the enrollment data from the time period of the encounter data to convert to the PMPM. The adjustment to Acute Care capitation rates is therefore the calculated PMPM expenditure by rate cell and GSA using the new assumptions less the observed PMPM expenditure by rate cell and GSA from encounter data."

The overall impact of the HCV Treatment program change is an increase of approximately $1.23 PMPM.

Skilled Nursing Facility Rate Increase

As part of the 2018 Legislative session, the Arizona Legislature passed SB 1520 which includes an appropriation to increase reimbursement by 3% for skilled nursing facilities and assisted living facilities. AHCCCS covers nursing facility services provided in institutional settings and assisted living facility services provided in home and community based settings to ALTCS/EPD members. AHCCCS is adjusting CYE 19 capitation rates effective October 1, 2018 for the 3% rate increase.

To estimate the impact, the AHCCCS DHCM Actuarial Team multiplied projected medical expenses for nursing facilities and assisted living facilities by the 3% provider rate increase. The change is expected to increase statewide costs under the ALTCS/EPD Program by $15.8 million annually, or $46.75 PMPM. Table 6 below provides the PMPM impact by rate cell.

Table 6: PMPM Impact (10/1/18-9/30/19) of 3% Rate Increase

Rate Cell	GSA	Change to PMPM
Dual	South	$49.81
Dual	Central	$42.87
Dual	North	$48.64
Non-Dual	South	$49.66
Non-Dual	Central	$53.67
Non-Dual	North	$55.89

Proposition 206 Reimbursement Rate Changes

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

The data used to develop an adjustment for the minimum wage increase was the CYE 17 encounter data for the HCBS procedure codes, NF revenue codes, and the ALF procedure codes. For HCBS, a 1.4% increase was applied to the encounter data to reflect a January 1, 2019 minimum wage adjustment. For NF and ALF, a 0.7% increase was applied to the encounter data to reflect a January 1, 2019 minimum wage adjustment. Table 7 below contains the loading factors applied by rate cell, GSA, and COS. The change is expected to increase statewide costs under the ALTCS/EPD Program by $7.2 million over nine months.

Table 7: Loading Factors Applied to Gross NF and HCBS Expenses

Rate Cell	GSA	Factor for NF Expenses	Factor for HCBS Expenses
Dual	North	1.0070	1.0138
Dual	South	1.0070	1.0139
Dual	Central	1.0070	1.0138
Non-Dual	North	1.0070	1.0130
Non-Dual	South	1.0070	1.0128
Non-Dual	Central	1.0070	1.0126

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, 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 their fee schedules.

Effective October 1, 2018, AHCCCS will be updating provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates.

The CYE 19 capitation rate have been adjusted to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to CYE 19 capitation rates was the CYE 17 encounter data across all programs. The AHCCCS DHCM Rates & Reimbursement Team applied the AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 19 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. The overall impact to the ALTCS/EPD Program is approximately $563,000, or $1.67 PMPM on an annual basis.

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

The methodology for developing the ALTCS/EPD capitation rate has changed since the CYE 18 capitation rate development process. The CYE 19 rates are developed using experience as the primary source of data under the methods described throughout this certification. The CYE 18 rates were developed using the bid gross medical expenses, case management expenses and administrative expenses PMPMs from the most recent RFP, with adjustments by GSA and Contractor as described in the CYE 2018 ALTCS/EPD Program Capitation Rate Certification dated October 1, 2017.

The CYE 19 rates preserve the cost savings achieved within the most recent RFP through the application of bid efficiency factors to the gross medical expense component of the CYE 19 capitation rate. The gross medical expense component was developed from base period data outside of the RFP contract period, and so did not reflect any cost efficiencies achieved through the competitive bidding process.The bid efficiency factors were developed by rate cell, GSA, Contractor, and COS. Each factor reflects the percentage by which a Contractor's awarded PMPM expense from the RFP prior to acuity adjustments for a given rate cell, GSA, and COS was below the top of the bid range for that rate cell, GSA, and COS as shown in Appendix 4a of the CYE 2018 ALTCS/EPD Program Capitation Rate Certification dated October 1, 2017. The gross medical expense amounts PMPM assumed in the CYE 18 rates were informed by the amounts bid by the Contractors in the most recent RFP, which were generally at or near the bottom of the bid ranges as shown in Appendix 4b of the CYE 2018 ALTCS/EPD Program Capitation Rate Certification dated October 1, 2017. The CYE 19 gross medical expense component was developed using a methodology comparable to how the top of the bid range was developed in CYE 18 for the RFP, and so it is reasonable to apply the bid efficiency factor to the component. In applying the bid efficiency factors, the DHCM Actuarial Team confirmed, through reviewing the Contractors' YTD CYE 18 financial reporting, that the medical expenses PMPM assumed in the CYE 18 rates were sufficient and attainable on a statewide basis, which validates the appropriateness of preserving the cost savings. The bid efficiency factors applied in the CYE 19 capitation rate development are provided in Appendix 6b.

The methodology for developing the reinsurance offset component of the ALTCS/EPD capitation rate has changed since the CYE 18 capitation rate development process. The development of the CYE 19 offset amounts is described in section I.4.C.ii.(c).(iv). Prior to October 1, 2017, all acute care services received by an ALTCS/EPD member during a federal fiscal year were eligible to accumulate towards the deductible and coinsurance for a regular reinsurance case, provided that the member incurred an inpatient stay at some point during the FFY to trigger the creation of a reinsurance case. Effective October 1, 2017, services provided by professional under Form Type A (CMS 1500) were no longer

eligible to accumulate towards payments on regular reinsurance cases. This change resulted in a reduction in the projected reinsurance payments during CYE 18, which had the effect of increasing CYE 18 ALTCS/EPD capitation rates. Effective October 1, 2018, remaining non-inpatient services are no longer eligible to accumulate towards payments on regular reinsurance cases. The estimated CYE 19 impact is an increase to capitation of approximately $9.3 million.

As described in section I.1.B.iv.(b), CYE 19 ALTCS/EPD Program capitation rates were developed for two rate cells that cover all prospective and PPC costs of duals and non-duals. CYE 18 capitation rates were developed for four rate cells: a prospective dual rate, a prospective non-dual rate, a PPC rate and an ACO rate.

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

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

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

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

Please see Section I.2.B.ii.(a) for the types of data that AHCCCS relied upon for developing the projected benefit cost trends for the CYE 19 capitation rates for the ALTCS/EPD Program.

All data used was specific to the ALTCS/EPD population but comparisons were made to other AHCCCS populations to determine reasonability of observed trends.

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

Historical utilization, unit cost, and PMPM data from contract years 2015, 2016, and 2017 were organized by incurred year and month and category of service (COS). The three years of data were normalized for historical program and fee schedule changes. Trend rates were developed to adjust the base data (midpoint April 1, 2017) forward 24 months to the midpoint of the contract period (April 1, 2019). 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 revised PMPM trend assumptions for the affected COS were compared to similar assumptions made in prior years for ALTCS/EPD capitation rates and judged reasonable to assume for projection to CYE 19.

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. Table 8 contains the components of the projected benefit cost trend by COS for NF, HCBS, and Acute Care services.

Table 8: Projected PMPM Trends, by Rate Cell and Category of Service

Rate Cell	COS	Annual Utilization Trend Rate	Annual Unit Cost Trend Rate	Annual PMPM Trend Rate
Dual	Nursing Facility	0.3%	1.8%	2.1%
Dual	HCBS	0.3%	1.8%	2.1%
Dual	Acute Care	0.7%	2.5%	3.2%
Non-Dual	Nursing Facility	3.3%	0.1%	3.4%
Non-Dual	HCBS	0.2%	0.1%	0.3%
Non-Dual	Acute Care	0.8%	3.4%	4.2%

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

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

No other components were used in the development of the annualized trend assumptions provided in the table in I.3.B.iii.(b).(i).

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

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

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

No other material adjustments were made to the trend assumptions.

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

No other adjustments were made to the trend assumptions.

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

The AHCCCS DHCM Medical Management Team, the AHCCCS Office of Administrative Legal Services (OALS) Legal Counsel Team, and the AHCCCS Office of the Director, have completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA.

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

Services in alternative inpatient settings licensed by ADHS/DLS can be provided in lieu of services in an inpatient hospital (distinct and disparate from in-lieu-of services provided in an IMD). These services are then included in the ALTCS/EPD CYE 19 capitation rate development categories of service. Encounters which are in-lieu-of-services are not identified separately in the data. Thus, the actuary cannot define the percentage of cost that in-lieu-of services represented in the capitation rate development categories of service. However, the in-lieu-of services are treated exactly the same as all other State Plan approved services in capitation rate development.

I.3.B.vi. Retrospective Eligibility Periods

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

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

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

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

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

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

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

To be consistent with the rate structure of all other AHCCCS managed care programs, a separate PPC capitation rate was not developed for the ALTCS/EPD CYE 19 rates. All covered expenses and member months are included in the Dual and Non-Dual CYE 19 capitation rate cells. See section I.1.B.iv.(b) for more information about changes to methodology in developing CYE 19 rates.

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

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

There were no material changes since the last rate certification related to changes in covered benefits.

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

Base period data was not adjusted to reflect recoveries of overpayments made to providers because Contractors are required to adjust encounters for recovery of overpayments, per the following contract requirement:

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

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

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

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

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 changes since the last rate certification related to litigation.

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

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

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

An incentive arrangement, as defined in 42 CFR §438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract. All ALTCS/EPD program incentive arrangements combined will not exceed 105% of the capitation payments to comply with 42 CFR §438.6(b)(2).

I.4.A.ii. Appropriate Documentation

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

Alternative Payment Model (APM) Initiative – Quality Measure Performance

The incentive arrangement for the Alternative Payment Model (APM) Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of AHCCCS quality measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement. The maximum incentive pool possible is approximately $11.8 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, and thus the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

APM Initiative – Performance Based Payments

The CYE 19 capitation rates for the ALTCS/EPD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2) at 81 FR 27589, called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the ALTCS/EPD Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by ALTCS/EPD Contractors that are aimed at quality improvement, such as reducing costs, improving health outcomes or improving access to care. For reference, the CYE 17 APM Initiative – Performance Based Payment amounts were $34 million.

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

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

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

APM Initiative – Quality Measure Performance

The incentive arrangement includes quality measures impacting emergency department and inpatient hospital services, comprehensive diabetes management, and flu shots for adults. All adult and child enrollees and providers utilizing/providing these services, respectively, are covered by the incentive arrangement, unless specifically stated otherwise.

APM Initiative – Performance Based Payments

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

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

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

APM Initiative – Quality Measure Performance

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

APM Initiative – Performance Based Payments

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

I.4.A.ii.(a)(iv) Effect on Capitation Rate Development

APM Initiative – Quality Measure Performance

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

APM Initiative – Performance Based Payments

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 19 capitation rates for the ALTCS/EPD Program. Additionally, incentive payments for the APM Initiative – Performance Based Payments incentive arrangement had no impact on the development of the CYE 19 capitation rates for the ALTCS/EPD Program. The anticipated incentive payment amount of at least $1.34 million will be paid by AHCCCS to the ALTCS/EPD Contractors through lump sum payments after the completion of the CYE 19 contract year.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2019 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 purpose of the ALTCS/EPD withhold is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings. Contractors are required to engage in a minimally-set targeted percentage of total expenses under an APM purchasing arrangement in order to receive any payment from the APM payment withhold.

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

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

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

AHCCCS has established a quality withhold of 1% of the Contractor's prospective capitation and a percentage (up to 100%) of the withheld amount will be paid to the Contractor for performance on select quality measures including emergency department utilization, hospital readmissions, comprehensive diabetes management (including HbA1c testing and LDL-C screening), and flu shots for adults over the age of 18. AHCCCS will determine the portion of the withheld amount to be returned based on a review of each Contractor's Healthcare Effectiveness Data and Information Set (HEDIS) data and the Contractor's compliance with these quality measures.

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

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

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

The actuary relied upon the AHCCCS DHCM Finance & Reinsurance Team's review. That review of the total withhold percentage of 1% of capitation revenue indicated that it is reasonable within the context

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

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

The capitation rates shown in this rate certification are illustrated before offset for the withhold amount; however the CYE19 capitation rates documented in this report 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 2019 Guide provides information on the requirements for risk-sharing mechanisms.

I.4.C.ii. Appropriate Documentation

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

The CYE 19 capitation rates for the ALTCS/EPD Program will include risk corridors.

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

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 19 capitation rates will continue AHCCCS' long-standing program policy and will include risk corridors. This rate certification will use the term risk corridor to be consistent with the 2019 Guide. The ALTCS/EPD Contract refers to the risk corridor as reconciliation.

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

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.

Beginning with the CYE 19 ALTCS/EPD Program capitation rates, AHCCCS will use a tiered risk corridor to reconcile each Contractor's medical cost expenses to the net capitation paid to each Contractor. Net capitation is equal to the capitation rates paid less the SOC, the premium tax, the health insurer fee (if applicable) and the administrative component plus the Reinsurance payments. Each Contractor's medical cost expenses are equal to the Contractor's fully adjudicated encounters and subcapitated/block purchase expenses as reported by the Contractor with dates of service during the contract year. The tiered risk corridor for CYE 19 replaces PPC and HCBS mix risk corridors used for CYE 18. For more information about PPC and HCBS mix risk corridors, please refer to the CYE 18 ALTCS/EPD Program Rate Certification dated October 1, 2017.

Additional information regarding the CYE 19 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 19 capitation rates for the ALTCS/EPD Program.

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

The predetermined threshold amounts for the risk corridors were set using actuarial judgement 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.(b) Description of Medical Loss Ratio

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

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

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

AHCCCS provides a reinsurance program to the ALTCS/EPD Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the regular reinsurance case type. Regular reinsurance cases cover partial reimbursement of inpatient facility medical services. Most of the other reinsurance cases fall under catastrophic, including reinsurance for biotech drugs. Additionally, rather than the ALTCS/EPD Contractors paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical. One could view the reinsurance offset as a premium. Historical reinsurance experience is the basis of the reinsurance offset.

The AHCCCS reinsurance program has been in place for more than twenty years and is funded with General Fund for 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 is the responsibility of the ALTCS/EPD Contractors

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

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

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

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical 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 data used to develop the reinsurance offset are historical reinsurance payments to the ALTCS/EPD Contractors for services incurred during FFY 17. The data is "brought current" by way of completion factors specific to reinsurance payments, adjustments for historical and proposed 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. See Section I.3.B.ii.(b) for additional information about changes in the reinsurance program. See Appendix 4c for the development of the offset.

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

I.4.D.i. Rate Development Standards

This section of the 2019 Guide provides information on delivery system and provider payment initiatives.

I.4.D.ii. Appropriate Documentation

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

I.4.D.ii.(a)(i) Description

Differential Adjusted Payments

The Differential Adjusted Payment (DAP) initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost

of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 10%, depending on the provider type.

Nursing Facility Enhanced Payments

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

I.4.D.ii.(a)(ii) Amount

Differential Adjusted Payments

The total amount of DAP payments before premium tax, admin or underwriting gain included as an adjustment to the capitation rates is approximately $6.0 million or $17.82 PMPM. Appendix 8 contains DAP PMPMs by rate cell.

Nursing Facility Enhanced Payments

Nursing facility enhanced payments are not included in the capitation rates. AHCCCS will adjust capitation rates in the form of an annual lump sum payment to the Contractors after the completion of the contract year. Anticipated enhanced nursing facility payments before premium tax are approximately $106.0 million, of which approximately $96.2 million will be paid to ALTCS/EPD Contractors, and the remainder is paid on a fee-for-service basis outside ALTCS/EPD. Enhanced nursing facility payments will be paid by AHCCCS to the Contractors outside capitation, either as a per member per month adjustment or through lump sum payments after each contract year quarter. The estimated PMPMs by rate cell and GSA are displayed by rate cell in Table 9.

Table 9: Projected Enhanced Nursing Facility Payment PMPMs

Rate Cell	GSA	PMPM
Dual	North	$ 307.42
Dual	South	$ 316.35
Dual	Central	$ 276.36
Non-Dual	North	$ 162.99
Non-Dual	South	$ 273.74
Non-Dual	Central	$ 272.07

I.4.D.ii.(a)(iii) Providers Receiving Payment

Differential Adjusted Payments

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to a 3.5% increase), other hospitals and inpatient facilities (eligible for up to a 3.5% increase), nursing facilities (eligible for up to a 2.0% increase), integrated clinics (eligible for a 10% increase on a limited set of codes), , physicians, physician assistants, and registered nurse practitioners (all eligible for a 1.0% increase), and federally qualified health centers (eligible for up to a 1.5% increase).

All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

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

I.4.D.ii.(a)(iv) Effect on Capitation Rate Development

Differential Adjusted Payments
The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP and for the distribution methodology to the individual rate cells. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP was the CYE 17 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 19 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program). AHCCCS describes the methodology, data and assumptions related to the DAP within the 438.6(c) pre-prints, which have been submitted but not yet approved.

Nursing Facility Enhanced Payments
Nursing facility enhanced payments had no effect on the development of the capitation rates. The allocation methodology is a uniform dollar increase based on each facility's proportion of Medicaid resident bed days to total nursing facility Medicaid resident bed days. AHCCCS will submit to CMS a notification letter when all the nursing facility enhanced payments are made detailing the actual amount of the payment. That letter will describe the distribution methodology of the total payments to the individual rate cells. AHCCCS describes the methodology, data and assumptions related to the enhanced nursing facility payments within the 438.6(c) pre-print, which has been submitted but not yet approved.

I.4.D.ii.(a)(v) Description of How the Payments are Included in the Capitation Rates

Differential Adjusted Payments
Funding for DAP is included in the certified capitation rates.

Nursing Facility Enhanced Payments
Funding for nursing facility enhanced payments is not included in the certified capitation rates and will be paid out as a lump sum payment.

I.4.E. Pass-Through Payments

Not applicable. There are no pass-through payments in the CYE 19 capitation rates for the ALTCS/EPD Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2019 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 19 capitation rates for the EPD Program were reported administrative expenses from the CYE 17 annual and CYE 18 Q1 and Q2 financial statements, as well as administrative expense estimates submitted by Contractors for CYE 18. In addition, Contractors were required to submit administrative expense estimates for CYE 19, which were reviewed to inform development of cost projections. Also reviewed were trends and forecasts for Consumer Price Index (CPI) and Employment Cost Index (ECI) data from IHS Global Insight.

Reported administrative costs and CYE 18 expenditure projections were reviewed for each Contractor separately and trended forward to produce CYE 19 projected administrative expenses. The CYE 18 expenditure projections were reviewed in comparison to CYE 17 actual expenses in the aggregate and on a PMPM basis, as well as compared to CYE 18 Q1 and Q2 financials, and judged to be reasonable and appropriate. The CYE 18 projection was adjusted to reflect changes in variable costs due to projected changes in member months for covered populations, and then compensation, professional and outside services (P&O), and other administrative costs were inflated by the estimated change in CPI for wage earners in the period, in order to produce CYE 19 projected costs.

Each Contractor's CYE 19 projected costs were expressed on a PMPM basis and compared to the CYE 18 weighted average administrative PMPM for all rate cells to determine an overall percentage change. The percentage change was then applied to the administrative component of each Contractor's rate for each GSA and rate cell. The actuaries have relied upon administrative projections for the ALTCS/EPD Contractors developed by an AHCCCS financial analyst with more expertise regarding administrative requirements than the actuaries. The data, assumptions, and methodology included here have not been audited by the actuaries to determine whether they would have made different assumptions as they relied upon the available expertise of the financial analyst.

The projected case management expenses were developed as adjustments to CYE 18 PMPMs. Those prior year case management PMPMs reflected amounts awarded to each Contractor from the most recent request for proposal. The actuary compared expenses reported on the Contractor financial statements for the CYE 18 Q1 and Q2 periods to awarded amounts funded in the CYE 18 rates in the aggregate and on a PMPM basis. In developing the CYE 19 capitation rates, each Contractor's case management PMPM was updated for year-to-date experience reflected in the financial statement data. The actuary further adjusted the case management PMPMs to reflect updated projections of each Contractor's HCBS mix.

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

The data and methodology used for developing the ALTCS/EPD non-benefit component of the capitation rates has changed since the CYE 18 capitation rate development process. The CYE 19 non-benefit components of the capitation rates were developed with consideration for experience and projected expenses, as discussed in section I.5.B.i.(a), while the CYE 18 non-benefit components were developed using the awarded administrative and case management expenses PMPM from the most recent request for proposal.

There were no other material changes to data, assumption or methodologies for projecting non-benefit costs since the last rate certification.

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

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

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

The projected non-benefit costs for each of the listed categories of costs in the 2019 Guide are shown in Appendix 4b for the CYE 19 capitation rates.

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

The administrative component of the CYE 19 ALTCS/EPD capitation rates is described above in Section I.5.B.i.(a). The PMPM amounts by rate cell, Contractor, and GSA are provided in Appendix 4b and 7c.

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

The CYE 19 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. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. 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 19 capitation rate for the ALTCS/EPD Program includes a provision of 1% 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 19 capitation rates for the ALTCS/EPD Program.

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

AHCCCS will not be adjusting the capitation rates for the Health Insurance Providers Fee (HIPF) at this time. The HIPF is addressed by AHCCCS each year in a separate certification specific to the program and year.

I.6. Risk Adjustment and Acuity Adjustments

I.6.A. Rate Development Standards

I.6.A.i. Risk Adjustment

The CYE 19 capitation rates have risk adjustment factors applied to them. The risk adjustment factors applied to the CYE 19 rates were developed to be budget neutral using non-diagnostic based population risk adjustment factors calculated by rate cell, GSA, category of service and Contractor. The risk adjustment factors were developed to reflect the relationship of historical encounter PMPM data by rate cell, GSA, category of service and Contractor to the historical encounter data by rate cell, GSA and category of service. The historical encounter cost data used were AHCCCS Allowed amounts that reprice each encounter at the AHCCCS Fee Schedule and do not take into account a Contractor's provider contracting. The risk adjustment factors in this certification are based off of initial member assignment and off of an experience period of April 1, 2017 through March 31, 2018.

I.6.A.ii. Budget Neutrality

In accordance with 42 CFR §438.5(g), risk adjustment will be applied in a budget neutral manner.

I.6.A.iii. Acuity Adjustment

This section of the 2019 Guide provides information on acuity adjustments. Not applicable.

I.6.B. Appropriate Documentation

I.6.B.i. Prospective Risk Adjustment

I.6.B.i.(a) Data and Data Adjustments

Encounter and member data is used for the risk adjustment factors. AHCCCS regularly performs testing on encounters to identify any potential areas of concern. If AHCCCS identifies any encounter gaps, AHCCCS contacts the Contractor and works with them to improve encounter submissions. AHCCCS monitors the encounters by reviewing encounter data by date of service and form type to identify potential issues.

The results of these analyses assist in determining if any encounter data is deemed unusable for the risk adjustment process and if any adjustments to the encounter data will be required.

I.6.B.i.(b) Model and Model Adjustments

AHCCCS is using encounter data of AHCCCS Allowed amounts and will not be using a standard national model or diagnostic based risk adjustment. The following encounters were excluded from the risk adjustment model:

1. Non-Subcapitated Encounters with Health Plan Paid of zero
2. Encounters with Medicare Payment

I.6.B.i.(c) Risk Factor Methodology

The risk adjustment method described below is reasonable and appropriate in measuring the risk factors of the respective population.

To calculate the risk adjustment factors, the actuary used a list of members (AHCCCS IDs) as of July 2018. This list of members was used to extract the members' historical adjudicated and approved encounters and the respective member months for the experience timeframe of April 1, 2017 through March 31, 2018 dates of service, paid through July 2018. The cost field used to develop the risk adjustment factors is the AHCCCS Allowed cost field. AHCCCS Allowed PMPMs were developed by rate cell, GSA and Contractor. Risk adjustment factors were then calculated by dividing the Contractor-specific PMPM per category of service by the average PMPM per category of service for the rate cell and GSA.

I.6.B.i.(d) Magnitude of Adjustment by MCO

The detailed risk adjustments by rate cell, Contractor, GSA, and COS are provided in Appendix 6.

I.6.B.i.(e) Predictive Value Assessment

The r-squared for the non-diagnostic based risk adjustment is 0.544.

I.6.B.i.(f) Actuarial Concerns

The actuary has no concerns with the risk adjustment process.

I.6.B.ii. Retrospective Risk Adjustment

Not applicable. The CYE 19 capitation rates for the ALTCS/EPD Program do not include retrospective risk adjustment.

I.6.B.iii. Additional Items on Risk Adjustment

I.6.B.iii.(a) Model Changes to Risk Adjustment Model

The actuary developed a new model of risk adjustment, as described in section I.6.B.i.(b), for use in preparing CYE 19 capitation rates. CYE 18 rates were developed by applying acuity adjustments by rate cell, Contractor, GSA, and COS to gross medical expense PMPM amounts bid by Contractors.

I.6.B.iii.(b) Budget Neutrality

The model is budget neutral in accordance with 42 CFR §438.5(g). The budget neutrality adjustment is the last step to calculate the final risk adjustment factor. The final risk adjustment factor is calculated by dividing the risk adjustment factors before budget neutrality by the budget neutrality adjustment. The first step in calculating the budget neutrality adjustment is multiplying the CYE 19 capitation rates before risk adjustment by the risk adjustment factor before budget neutrality and multiplying by the CYE 19 projected member months. The resulting amount is then divided by the CYE 19 capitation rates before risk adjustment multiplied by the CYE 19 projected member months.

I.6.B.iv. Acuity Adjustment Description

Not applicable. The CYE 19 capitation rates for the ALTCS/EPD Program do not include acuity adjustment.

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

Section II of the 2019 Guide is applicable to the ALTCS/EPD Program because the CYE 19 capitation rates for ALTCS/EPD are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 at 81 FR 27858 and the ALTCS/EPD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. CMS Expectations

The rate development standards and appropriate documentation described in Section I of the 2019 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 2019 Guide provides the two most common approaches to structuring the rate cells.

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

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

II.1.B.i.(b) Non-Blended Capitation Rate

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

II.1.C. Appropriate Documentation

II.1.C.i. Considerations

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

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

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

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

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

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

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

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

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

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

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

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

II.1.C.iii. Additional Information

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

Section III New Adult Group Capitation Rates

Section III of the 2019 Guide is not applicable to the ALTCS/EPD Program. As noted in Section I.1.B.iii, all covered populations under the ALTCS/EPD Program receive the regular FMAP.

Appendix 1: Actuarial Certification

I, Matthew C. Varitek, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

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

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

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 19 capitation rates for the ALTCS/EPD Program have been documented according to the guidelines established by CMS in the 2019 Guide. The CYE 19 capitation rates for the ALTCS/EPD Program are effective for the three month time period from October 1, 2018 through December 31, 2018 and the nine month time period from January 1, 2019 through September 30, 2019.

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

SIGNATURE ON FILE	August 21, 2018
Matthew C. Varitek	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Rate Cell	Contractor	GSA	CYE 18 Capitation (1/1/18)	CYE 19 Capitation Rate (10/1/18)	CYE 19 Capitation Rate (1/1/19)
Dual	UHC-LTC	North	$2,726.92	$2,879.08	$2,904.09
Dual	Banner-UFC	South	$2,885.37	$3,156.91	$3,185.61
Dual	Mercy Care	South	$3,064.07	$3,034.21	$3,060.87
Dual	UHC-LTC	Central	$2,628.72	$2,540.77	$2,564.44
Dual	Banner-UFC	Central	$3,071.72	$3,625.06	$3,657.53
Dual	Mercy Care	Central	$3,199.84	$3,397.63	$3,428.35
Non-Dual	UHC-LTC	North	$5,047.60	$5,516.93	$5,543.97
Non-Dual	Banner-UFC	South	$5,175.32	$5,534.21	$5,560.64
Non-Dual	Mercy Care	South	$5,829.88	$5,955.21	$5,985.19
Non-Dual	UHC-LTC	Central	$5,560.79	$5,993.97	$6,024.69
Non-Dual	Banner-UFC	Central	$6,214.78	$7,331.72	$7,370.46
Non-Dual	Mercy Care	Central	$6,654.19	$6,439.51	$6,470.18

Notes:

1. This filing certifies to the Revised Capitation Rate effective October 1, 2018 through December 31, 2018 and January 1, 2019 through September 30, 2019.
2. CYE 18 capitation rates effective from January 1, 2018 reflect weighted averages of prospective, prior period coverage, and acute care only rates for dual and non-dual rate cells.

Appendix 3: Fiscal Impact Summary

Capitation Rates (10/1/2018)

Rate Cell	Projected CYE 19 (Oct-Dec) Member Months	CYE 18 Capitation Rate (1/1/18)	CYE 19 Capitation Rate (10/1/18)	Projected Expenditures (1/1/18 Rate)	Projected Expenditures (10/1/18 Rate)	Dollar Impact	Percentage Impact
Dual	70,649	$2,954.08	$ 3,103.60	$ 208,703,368	$ 219,267,000	$ 10,563,632	5.06%
Non-Dual	13,695	$6,042.68	$ 6,206.03	$ 82,756,671	$ 84,993,780	$ 2,237,109	2.70%
Total				$ 291,460,038	$ 304,260,779	$ 12,800,741	4.39%

Capitation Rates (1/1/2019)

Rate Cell	Projected CYE 19 (Jan-Sept) Member Months	CYE 19 Capitation Rate (10/1/18)	CYE 19 Capitation Rate (1/1/19)	Projected Expenditures (10/1/18 Rate)	Projected Expenditures (1/1/19 Rate)	Dollar Impact	Percentage Impact
Dual	212,019	$ 3,103.60	$ 3,131.63	$ 658,021,765	$ 663,964,744	$ 5,942,979	0.90%
Non-Dual	41,100	$ 6,206.03	$ 6,236.51	$ 255,066,915	$ 256,319,820	$ 1,252,905	0.49%
Total				$ 913,088,680	$ 920,284,564	$ 7,195,884	0.79%

Weighted Capitation Rates (10/1/2018 - 9/30/2019) (For Informational Purposes Only)

Rate Cell	Projected CYE 19 (Oct-Sept) Member Months	CYE 18 Capitation Rate (1/1/18)	CYE 19 Capitation Rate (10/1/18 to 9/30/19)	Projected Expenditures (1/1/18 Rate)	Projected Expenditures (10/1/18 - 9/30/19 Rates)	Dollar Impact	Percentage Impact
Dual	282,668	$ 2,954.08	$ 3,124.63	$ 835,023,602	$ 883,231,744	$ 48,208,142	5.77%
Non-Dual	54,795	$ 6,042.68	$ 6,228.89	$ 331,110,005	$ 341,313,600	$ 10,203,595	3.08%
Total				$ 1,166,133,607	$ 1,224,545,344	$ 58,411,736	5.01%

Notes:
The Updated CYE 18 Capitation Rates shown here is an average of the Prospective, PPC, and Acute capitation rates effective January 1, 2018 for Dual and Non-Dual members. The CYE 19 Capitation Rate represents an average of the rates effective October 1, 2018 and January 1, 2019.

Appendix 4a: Unadjusted and Adjusted Base Data by Rate Cell

CYE 19, Gross Nursing Facility (NF) Expenses PMPM						
Rate Cell	GSA	Unadjusted Base Data PMPMs	Completion Factors	Reimbursement/Program Changes	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 19
Dual	North	$5,089.23	0.9429	1.0091	2.11%	$5,622.88
Dual	South	$5,338.39	0.9429	1.0092	2.11%	$5,909.93
Dual	Central	$5,640.12	0.9429	1.0093	2.11%	$6,244.24
Non-Dual	North	$6,189.06	0.9430	1.0097	3.40%	$7,081.70
Non-Dual	South	$5,910.35	0.9430	1.0098	3.40%	$6,756.05
Non-Dual	Central	$7,071.33	0.9430	1.0098	3.40%	$8,090.58

CYE 19, Gross Home- and Community-Based Settings (HCBS) Expenses PMPM						
Rate Cell	GSA	Unadjusted Base Data PMPMs	Completion Factors	Reimbursement/Program Changes	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 19
Dual	North	$1,195.78	0.9747	1.0449	2.11%	$1,336.33
Dual	South	$1,434.65	0.9747	1.0449	2.11%	$1,603.28
Dual	Central	$1,592.80	0.9747	1.0444	2.11%	$1,779.31
Non-Dual	North	$1,365.30	0.9748	1.0402	0.30%	$1,465.81
Non-Dual	South	$1,605.23	0.9748	1.0402	0.30%	$1,723.32
Non-Dual	Central	$1,929.86	0.9748	1.0403	0.30%	$2,071.99

CYE 19, Gross Acute Care Expenses PMPM						
Rate Cell	GSA	Unadjusted Base Data PMPMs	Completion Factors	Reimbursement/Program Changes	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 19
Dual	North	$145.03	0.9749	1.0107	3.22%	$160.30
Dual	South	$196.19	0.9749	1.0108	3.22%	$216.61
Dual	Central	$280.75	0.9749	1.0108	3.22%	$310.12
Non-Dual	North	$2,240.00	0.9571	1.0048	4.23%	$2,563.10
Non-Dual	South	$2,539.74	0.9571	1.0048	4.23%	$2,888.52
Non-Dual	Central	$2,634.61	0.9571	1.0047	4.23%	$3,006.17

Appendix 4b: Projected Member Share of Cost and Reinsurance Payments, Case Management Expenses, and Administrative Expenses PMPM by Rate Cell

Capitation Rates (October 1, 2018 through September 30, 2019)

Rate Cell	Contractor	GSA	SOC PMPM	Reinsurance PMPM	Case Mgmt PMPM	Admin Exp PMPM
Dual	UHC-LTC	North	$ (264.80)	$ (6.75)	$ 165.46	$ 175.69
Dual	Banner-UFC	South	$ (222.74)	$ (11.63)	$ 141.11	$ 159.00
Dual	Mercy Care	South	$ (222.16)	$ (17.83)	$ 146.13	$ 45.46
Dual	UHC-LTC	Central	$ (147.42)	$ (37.28)	$ 161.02	$ 175.69
Dual	Banner-UFC	Central	$ (244.86)	$ (48.20)	$ 132.72	$ 170.89
Dual	Mercy Care	Central	$ (212.83)	$ (63.28)	$ 147.90	$ 47.25
Non-Dual	UHC-LTC	North	$ (33.16)	$ (358.02)	$ 160.62	$ 175.69
Non-Dual	Banner-UFC	South	$ (35.68)	$ (369.55)	$ 142.04	$ 314.43
Non-Dual	Mercy Care	South	$ (43.24)	$ (418.72)	$ 150.04	$ 221.23
Non-Dual	UHC-LTC	Central	$ (22.92)	$ (236.95)	$ 160.06	$ 175.69
Non-Dual	Banner-UFC	Central	$ (41.85)	$ (226.44)	$ 132.56	$ 365.52
Non-Dual	Mercy Care	Central	$ (29.12)	$ (286.08)	$ 154.35	$ 258.34

Appendix 4c: Data and Development of Reinsurance Estimates

Rate Cell	Contractor	GSA	CYE 17 Regular RI Payments PMPM	CYE 17 Non-Regular RI Payments PMPM	Factor to Apply to Regular RI Payments to remove Non-Inpatient Encounters	PMPM Impact of High Acuity Pediatrics Adjustments (NonDuals Only)	Trend Assumed	PMPM Impact of DRG Rebase and HCP (Effective 1/1/18)	Risk Adjustments	CYE 19 Projected RI Offset PMPM
Dual	UHC-LTC	North	$0.24	$6.36	0.00%	$ -	3.22%	($0.02)	1.0000	-$6.75
Dual	Banner-UFC	South	$1.88	$12.95	21.26%	$ -	3.22%	($0.18)	0.8293	-$11.63
Dual	Mercy Care	South	$1.88	$12.95	21.26%	$ -	3.22%	($0.18)	1.2717	-$17.83
Dual	UHC-LTC	Central	$5.81	$48.48	19.25%	$ -	3.22%	($0.04)	0.7061	-$37.28
Dual	Banner-UFC	Central	$5.81	$48.48	19.25%	$ -	3.22%	($0.04)	0.9128	-$48.20
Dual	Mercy Care	Central	$5.81	$48.48	19.25%	$ -	3.22%	($0.04)	1.1984	-$63.28
Non-Dual	UHC-LTC	North	$284.72	$277.20	19.09%	$ 0.46	4.23%	($2.44)	1.0000	-$358.02
Non-Dual	Banner-UFC	South	$380.24	$264.91	26.71%	$ 0.46	4.23%	($6.97)	0.9450	-$369.55
Non-Dual	Mercy Care	South	$380.24	$264.91	26.71%	$ 0.46	4.23%	($6.97)	1.0707	-$418.72
Non-Dual	UHC-LTC	Central	$573.80	$133.71	20.40%	$ 0.46	4.23%	($5.56)	0.8880	-$236.95
Non-Dual	Banner-UFC	Central	$573.80	$133.71	20.40%	$ 0.46	4.23%	($5.56)	0.8486	-$226.44
Non-Dual	Mercy Care	Central	$573.80	$133.71	20.40%	$ 0.46	4.23%	($5.56)	1.0721	-$286.08

Notes:

1. The reinsurance (RI) offset is the negative of the projected RI payments.

Appendix 5: Base Data Programmatic and Reimbursement Changes

Effective Date	Programmatic Change	Dual PMPM Impact	NonDual PMPM Impact	Original Rate Certification Description
1/1/2017	High Acuity Pediatrics Adjustor	$0.00	$7.62	On January 1, 2016, AHCCCS addressed the costs associated with high-acuity pediatric cases by using an adjustment factor of 1.60 in place of the above pediatric policy adjustor in the following instances only: for inpatient stays, where an APR-DRG assignment of level 3 or 4 Severity of Illness is indicated. Effective January 1, 2017, AHCCCS will change the adjustment factor of 1.60 established January 1, 2016 to 1.945.
10/1/2017	Adult Emergency Dental	$1.95	$4.23	As part of the 2017 Legislative session, the Arizona Legislature passed SB 1527, reinstating emergency adult dental services and extractions up to a limit of $1,000 annually, a covered service prior to October 1, 2010. AHCCCS will restore this as a covered service effective October 1, 2017.
1/1/2018	DRG Reimbursement Rate Changes	$0.54	$13.55	AHCCCS will transition from version 31 to version 34 of the All Patient Refined Diagnostic Related Groups (APR-DRG) payment classification system on January 1, 2018. AHCCCS has used v31 APR-DRG national weights published by 3M since the initial implementation of the system on October 1, 2014 until present. To make the APR-DRG grouper fully ICD-10 code compliant, AHCCCS will rebase the inpatient system and update to APR-DRG v34 effective January 1, 2018. Rebasing involves updating the DRG grouper version, relative weights and DRG base rates via payment simulation modeling using more recent data.
1/1/2018	Hepatitis C Treatment	$0.00	-$7.37	The AHCCCS Pharmacy and Therapeutics (P&T) Committee reviewed the HCV Direct Acting Antiviral Agents (DAA) and recommended Mavyret as the sole preferred agent to treat HCV based on both clinical efficacy and cost effectiveness. AHCCCS has accepted the P&T's recommendation. The AHCCCS Policy Committee (APC) reviewed the AHCCCS Medical Policy Manual, Policy 320 N, Hepatitis C Prior Authorization Requirements for Direct Acting Antiviral Medication and removed the fibrosis level requirements that were previously necessary in order to access treatment. The APC also removed the one treatment per lifetime limitation from the policy and added retreatment guidelines. These changes are effective January 1, 2018.

Historical Provider Fee Schedule (PFS) Changes Applied as PMPM Change

Effective Date	COS	Dual PMPM Impact	NonDual PMPM Impact
10/1/2015	Acute Care	-$0.44	-$3.85
10/1/2016	Acute Care	$0.07	$0.52
10/1/2017	Acute Care	$0.43	$4.06

Historical Provider Fee Schedule (PFS) Changes Applied as Percentage Change

Effective Date	COS	Dual Percentage Impact	NonDual Percentage Impact
10/1/2016	NF	1.0%	1.0%
1/1/2017	NF	3.5%	3.5%
7/1/2017	NF	0.3%	0.3%
1/1/2018	NF	0.7%	0.7%
10/1/2016	HCBS	2.0%	2.0%
1/1/2017	HCBS	6.8%	6.1%
7/1/2017	HCBS	1.89%	1.70%
1/1/2018	HCBS	1.38%	1.25%

Appendix 6a: Risk Adjustments by Rate Cell, Contractor, GSA, and COS

Rate Cell	Contractor	GSA	NF Risk Adjustment	HCBS Risk Adjustment	Acute Risk Adjustment
Dual	UHC-LTC	North	1.0000	1.0000	1.0000
Dual	Banner-UFC	South	0.9792	1.0690	0.8293
Dual	Mercy Care	South	1.0331	0.8918	1.2717
Dual	UHC-LTC	Central	0.7974	0.8867	0.7061
Dual	Banner-UFC	Central	1.0659	1.0996	0.9128
Dual	Mercy Care	Central	1.0990	1.0233	1.1984
Non-Dual	UHC-LTC	North	1.0000	1.0000	1.0000
Non-Dual	Banner-UFC	South	1.1386	0.8645	0.9450
Non-Dual	Mercy Care	South	0.8543	1.1780	1.0707
Non-Dual	UHC-LTC	Central	1.2188	0.8709	0.8880
Non-Dual	Banner-UFC	Central	1.2697	0.9774	0.8486
Non-Dual	Mercy Care	Central	0.8599	1.0616	1.0721

Appendix 6b: Bid Efficiency Factors

Rate Cell	Contractor	GSA	COS	Range Top	Range Bottom	Bid Rate	Efficiency Factor
Dual	UHC-LTC	North	NF	$5,303.96	$5,244.63	$5,259.46	0.9916
Dual	Banner-UFC	South	NF	$5,609.95	$5,549.61	$5,549.61	0.9892
Dual	Mercy Care	South	NF	$5,609.95	$5,549.61	$5,549.61	0.9892
Dual	UHC-LTC	Central	NF	$6,019.12	$5,910.20	$5,910.20	0.9819
Dual	Banner-UFC	Central	NF	$6,019.12	$5,910.20	$5,910.20	0.9819
Dual	Mercy Care	Central	NF	$6,019.12	$5,910.20	$5,915.62	0.9828
Non-Dual	UHC-LTC	North	NF	$5,857.89	$5,814.96	$5,825.69	0.9945
Non-Dual	Banner-UFC	South	NF	$7,224.29	$7,100.45	$7,100.45	0.9829
Non-Dual	Mercy Care	South	NF	$7,224.29	$7,100.45	$7,100.45	0.9829
Non-Dual	UHC-LTC	Central	NF	$7,863.12	$7,698.01	$7,698.01	0.9790
Non-Dual	Banner-UFC	Central	NF	$7,863.12	$7,698.01	$7,698.01	0.9790
Non-Dual	Mercy Care	Central	NF	$7,863.12	$7,698.01	$7,698.01	0.9790
Dual	UHC-LTC	North	HCBS	$1,180.98	$1,161.21	$1,166.15	0.9874
Dual	Banner-UFC	South	HCBS	$1,507.29	$1,464.34	$1,464.34	0.9715
Dual	Mercy Care	South	HCBS	$1,507.29	$1,464.34	$1,464.34	0.9715
Dual	UHC-LTC	Central	HCBS	$1,655.33	$1,585.73	$1,585.73	0.9580
Dual	Banner-UFC	Central	HCBS	$1,655.33	$1,585.73	$1,585.73	0.9580
Dual	Mercy Care	Central	HCBS	$1,655.33	$1,585.73	$1,585.73	0.9580
Non-Dual	UHC-LTC	North	HCBS	$1,513.28	$1,451.18	$1,466.71	0.9692
Non-Dual	Banner-UFC	South	HCBS	$1,792.82	$1,748.56	$1,748.56	0.9753
Non-Dual	Mercy Care	South	HCBS	$1,792.82	$1,748.56	$1,748.56	0.9753
Non-Dual	UHC-LTC	Central	HCBS	$2,123.74	$2,038.63	$2,038.63	0.9599
Non-Dual	Banner-UFC	Central	HCBS	$2,123.74	$2,038.63	$2,038.63	0.9599
Non-Dual	Mercy Care	Central	HCBS	$2,123.74	$2,038.63	$2,038.63	0.9599
Dual	UHC-LTC	North	Acute	$136.66	$125.60	$128.37	0.9393
Dual	Banner-UFC	South	Acute	$183.04	$174.03	$174.03	0.9508
Dual	Mercy Care	South	Acute	$183.04	$174.03	$174.03	0.9508
Dual	UHC-LTC	Central	Acute	$236.41	$234.71	$234.71	0.9928
Dual	Banner-UFC	Central	Acute	$236.41	$234.71	$234.71	0.9928
Dual	Mercy Care	Central	Acute	$236.41	$234.71	$234.71	0.9928
Non-Dual	UHC-LTC	North	Acute	$2,670.37	$2,568.68	$2,594.10	0.9714
Non-Dual	Banner-UFC	South	Acute	$2,743.40	$2,515.25	$2,515.25	0.9168
Non-Dual	Mercy Care	South	Acute	$2,743.40	$2,515.25	$2,515.25	0.9168
Non-Dual	UHC-LTC	Central	Acute	$2,979.05	$2,823.16	$2,823.16	0.9477
Non-Dual	Banner-UFC	Central	Acute	$2,979.05	$2,823.16	$2,823.16	0.9477
Non-Dual	Mercy Care	Central	Acute	$2,979.05	$2,823.16	$2,823.16	0.9477

Appendix 7a: CYE 19 Projected Gross and Net Medical Expenses PMPM by COS and Rate Cell (October 1, 2018 Rates)

Nursing Facility (NF) Expenses PMPM (October 1, 2018)

Rate Cell	Contractor	GSA	Gross NF Expense Amount PMPM	NF Risk Adj	Bid Efficiency Factor	Members Receiving LTSS	Prog/Reimb Adjustments	Projected NF Mix Pct	Projected SOC PMPM	Net NF Expense Amount PMPM
Dual	UHC-LTC	North	$5,622.88	1.0000	0.9916	99.2%	1.0300	28.43%	-$264.80	$1,355.67
Dual	Banner-UFC	South	$5,909.93	0.9792	0.9892	98.9%	1.0300	27.83%	-$222.74	$1,399.82
Dual	Mercy Care	South	$5,909.93	1.0331	0.9892	99.4%	1.0300	27.76%	-$222.16	$1,494.74
Dual	UHC-LTC	Central	$6,244.24	0.7974	0.9819	98.6%	1.0300	16.99%	-$147.42	$696.45
Dual	Banner-UFC	Central	$6,244.24	1.0659	0.9819	98.9%	1.0300	28.22%	-$244.86	$1,634.95
Dual	Mercy Care	Central	$6,244.24	1.0990	0.9828	99.1%	1.0300	24.53%	-$212.83	$1,476.20
Non-Dual	UHC-LTC	North	$7,081.70	1.0000	0.9945	97.1%	1.0300	26.44%	-$33.16	$1,828.78
Non-Dual	Banner-UFC	South	$6,756.05	1.1386	0.9829	95.3%	1.0300	22.97%	-$35.68	$1,669.42
Non-Dual	Mercy Care	South	$6,756.05	0.8543	0.9829	97.8%	1.0300	27.84%	-$43.24	$1,547.89
Non-Dual	UHC-LTC	Central	$8,090.58	1.2188	0.9790	97.6%	1.0300	18.39%	-$22.92	$1,761.28
Non-Dual	Banner-UFC	Central	$8,090.58	1.2697	0.9790	92.7%	1.0300	33.58%	-$41.85	$3,181.70
Non-Dual	Mercy Care	Central	$8,090.58	0.8599	0.9790	93.6%	1.0300	23.36%	-$29.12	$1,505.26

HCBS Expenses PMPM (October 1, 2018)

Rate Cell	Contractor	GSA	Gross HCBS Expense Amount PMPM	HCBS Risk Adj	Bid Efficiency Factor	Members Receiving LTSS	Prog/Reimb Adjustments	Projected HCBS Mix Pct	Net HCBS Expense Amount PMPM
Dual	UHC-LTC	North	$1,336.33	1.0000	0.9874	0.9924	1.0000	71.57%	$937.24
Dual	Banner-UFC	South	$1,603.28	1.0690	0.9715	0.9889	1.0000	72.17%	$1,188.30
Dual	Mercy Care	South	$1,603.28	0.8918	0.9715	0.9943	1.0000	72.24%	$997.87
Dual	UHC-LTC	Central	$1,779.31	0.8867	0.9580	0.9862	1.0000	83.01%	$1,237.21
Dual	Banner-UFC	Central	$1,779.31	1.0996	0.9580	0.9894	1.0000	71.78%	$1,331.05
Dual	Mercy Care	Central	$1,779.31	1.0233	0.9580	0.9911	1.0000	75.47%	$1,304.58
Non-Dual	UHC-LTC	North	$1,465.81	1.0000	0.9692	0.9708	1.0000	73.56%	$1,014.56
Non-Dual	Banner-UFC	South	$1,723.32	0.8645	0.9753	0.9531	1.0000	77.03%	$1,066.68
Non-Dual	Mercy Care	South	$1,723.32	1.1780	0.9753	0.9782	1.0000	72.16%	$1,397.62
Non-Dual	UHC-LTC	Central	$2,071.99	0.8709	0.9599	0.9757	1.0000	81.61%	$1,379.23
Non-Dual	Banner-UFC	Central	$2,071.99	0.9774	0.9599	0.9266	1.0000	66.42%	$1,196.34
Non-Dual	Mercy Care	Central	$2,071.99	1.0616	0.9599	0.9361	1.0000	76.64%	$1,514.80

Acute Expenses PMPM (October 1, 2018)

Rate Cell	Contractor	GSA	Gross Acute Expense Amount PMPM	Acute Risk Adj	Bid Efficiency Factor	Prog/Reimb Adjustments	DAP 10/1/18	Reinsurance Offset PMPM	Net Acute Expense Amount PMPM
Dual	UHC-LTC	North	$160.30	1.0000	0.9393	$ 0.49	$15.12	-$6.75	$159.44
Dual	Banner-UFC	South	$216.61	0.8293	0.9508	$ 0.68	$14.97	-$11.63	$174.80
Dual	Mercy Care	South	$216.61	1.2717	0.9508	$ 0.68	$14.97	-$17.83	$259.72
Dual	UHC-LTC	Central	$310.12	0.7061	0.9928	$ 1.25	$13.20	-$37.28	$194.56
Dual	Banner-UFC	Central	$310.12	0.9128	0.9928	$ 1.25	$13.20	-$48.20	$247.30
Dual	Mercy Care	Central	$310.12	1.1984	0.9928	$ 1.25	$13.20	-$63.28	$320.16
Non-Dual	UHC-LTC	North	$2,563.10	1.0000	0.9714	$ 2.92	$35.08	-$358.02	$2,169.88
Non-Dual	Banner-UFC	South	$2,888.52	0.9450	0.9168	$ 2.97	$37.54	-$369.55	$2,173.61
Non-Dual	Mercy Care	South	$2,888.52	1.0707	0.9168	$ 2.97	$37.54	-$418.72	$2,457.40
Non-Dual	UHC-LTC	Central	$3,006.17	0.8880	0.9477	$ 5.34	$39.26	-$236.95	$2,337.33
Non-Dual	Banner-UFC	Central	$3,006.17	0.8486	0.9477	$ 5.34	$39.26	-$226.44	$2,235.58
Non-Dual	Mercy Care	Central	$3,006.17	1.0721	0.9477	$ 5.34	$39.26	-$286.08	$2,812.67

Appendix 7b: CYE 19 Projected Gross and Net Medical Expenses PMPM by COS and Rate Cell (January 1, 2019 Rates)

Nursing Facility (NF) Expenses PMPM (January 1, 2019)

Rate Cell	Contractor	GSA	Gross NF Expense Amount PMPM	NF Risk Adj	Bid Efficiency Factor	Members Receiving LTSS	Prop 206 Adjustments	Prog/Reimb Adjustments	Projected NF Mix Pct	Projected SOC PMPM	Net NF Expense Amount PMPM
Dual	UHC-LTC	North	$5,622.88	1.0000	0.9916	99.24%	1.0070	1.0300	28.43%	-$264.80	$1,367.02
Dual	Banner-UFC	South	$5,909.93	0.9792	0.9892	98.89%	1.0070	1.0300	27.83%	-$222.74	$1,411.18
Dual	Mercy Care	South	$5,909.93	1.0331	0.9892	99.43%	1.0070	1.0300	27.76%	-$222.16	$1,506.76
Dual	UHC-LTC	Central	$6,244.24	0.7974	0.9819	98.62%	1.0070	1.0300	16.99%	-$147.42	$702.36
Dual	Banner-UFC	Central	$6,244.24	1.0659	0.9819	98.94%	1.0070	1.0300	28.22%	-$244.86	$1,648.11
Dual	Mercy Care	Central	$6,244.24	1.0990	0.9828	99.11%	1.0070	1.0300	24.53%	-$212.83	$1,488.02
Non-Dual	UHC-LTC	North	$7,081.70	1.0000	0.9945	97.08%	1.0070	1.0300	26.44%	-$33.16	$1,841.81
Non-Dual	Banner-UFC	South	$6,756.05	1.1386	0.9829	95.31%	1.0070	1.0300	22.97%	-$35.68	$1,681.35
Non-Dual	Mercy Care	South	$6,756.05	0.8543	0.9829	97.82%	1.0070	1.0300	27.84%	-$43.24	$1,559.02
Non-Dual	UHC-LTC	Central	$8,090.58	1.2188	0.9790	97.57%	1.0070	1.0300	18.39%	-$22.92	$1,773.77
Non-Dual	Banner-UFC	Central	$8,090.58	1.2697	0.9790	92.66%	1.0070	1.0300	33.58%	-$41.85	$3,204.27
Non-Dual	Mercy Care	Central	$8,090.58	0.8599	0.9790	93.61%	1.0070	1.0300	23.36%	-$29.12	$1,516.00

HCBS Expenses PMPM (January 1, 2019)

Rate Cell	Contractor	GSA	Gross HCBS Expense Amount PMPM	HCBS Risk Adj	Bid Efficiency Factor	Members Receiving LTSS	Prop 206 Adjustments	Prog/Reimb Adjustments	Projected HCBS Mix Pct	Net HCBS Expense Amount PMPM
Dual	UHC-LTC	North	$1,336.33	1.0000	0.9874	0.9924	1.0138	1.0000	71.57%	$950.16
Dual	Banner-UFC	South	$1,603.28	1.0690	0.9715	0.9889	1.0139	1.0000	72.17%	$1,204.79
Dual	Mercy Care	South	$1,603.28	0.8918	0.9715	0.9943	1.0139	1.0000	72.24%	$1,011.72
Dual	UHC-LTC	Central	$1,779.31	0.8867	0.9580	0.9862	1.0138	1.0000	83.01%	$1,254.26
Dual	Banner-UFC	Central	$1,779.31	1.0996	0.9580	0.9894	1.0138	1.0000	71.78%	$1,349.40
Dual	Mercy Care	Central	$1,779.31	1.0233	0.9580	0.9911	1.0138	1.0000	75.47%	$1,322.56
Non-Dual	UHC-LTC	North	$1,465.81	1.0000	0.9692	0.9708	1.0130	1.0000	73.56%	$1,027.76
Non-Dual	Banner-UFC	South	$1,723.32	0.8645	0.9753	0.9531	1.0128	1.0000	77.03%	$1,080.38
Non-Dual	Mercy Care	South	$1,723.32	1.1780	0.9753	0.9782	1.0128	1.0000	72.16%	$1,415.57
Non-Dual	UHC-LTC	Central	$2,071.99	0.8709	0.9599	0.9757	1.0126	1.0000	81.61%	$1,396.55
Non-Dual	Banner-UFC	Central	$2,071.99	0.9774	0.9599	0.9266	1.0126	1.0000	66.42%	$1,211.37
Non-Dual	Mercy Care	Central	$2,071.99	1.0616	0.9599	0.9361	1.0126	1.0000	76.64%	$1,533.82

Acute Expenses PMPM (January 1, 2019)

Rate Cell	Contractor	GSA	Gross Acute Expense Amount PMPM	Acute Risk Adj	Bid Efficiency Factor	Prog/Reimb Adjustments	DAP 10/1/18	Reinsurance Offset PMPM	Net Acute Expense Amount PMPM
Dual	UHC-LTC	North	$160.30	1.0000	0.9393	$ 0.49	$15.12	-$6.75	$159.44
Dual	Banner-UFC	South	$216.61	0.8293	0.9508	$ 0.68	$14.97	-$11.63	$174.80
Dual	Mercy Care	South	$216.61	1.2717	0.9508	$ 0.68	$14.97	-$17.83	$259.72
Dual	UHC-LTC	Central	$310.12	0.7061	0.9928	$ 1.25	$13.20	-$37.28	$194.56
Dual	Banner-UFC	Central	$310.12	0.9128	0.9928	$ 1.25	$13.20	-$48.20	$247.30
Dual	Mercy Care	Central	$310.12	1.1984	0.9928	$ 1.25	$13.20	-$63.28	$320.16
Non-Dual	UHC-LTC	North	$2,563.10	1.0000	0.9714	$ 2.92	$35.08	-$358.02	$2,169.88
Non-Dual	Banner-UFC	South	$2,888.52	0.9450	0.9168	$ 2.97	$37.54	-$369.55	$2,173.61
Non-Dual	Mercy Care	South	$2,888.52	1.0707	0.9168	$ 2.97	$37.54	-$418.72	$2,457.40
Non-Dual	UHC-LTC	Central	$3,006.17	0.8880	0.9477	$ 5.34	$39.26	-$236.95	$2,337.33
Non-Dual	Banner-UFC	Central	$3,006.17	0.8486	0.9477	$ 5.34	$39.26	-$226.44	$2,235.58
Non-Dual	Mercy Care	Central	$3,006.17	1.0721	0.9477	$ 5.34	$39.26	-$286.08	$2,812.67

Appendix 7c: CYE 19 Projected Capitation Rates PMPM by Rate Cell, Contractor, and GSA

October 1, 2018 Capitation Rates

Rate Cell	Contractor	GSA	Net NF Expense Amount PMPM	Net HCBS Expense Amount PMPM	Net Acute Expense Amount PMPM	Case Mgmt PMPM	Admin Exp PMPM	UW Gain PMPM	Premium Tax PMPM	Final Net Capitation PMPM
Dual	UHC-LTC	North	$1,355.67	$937.24	$159.44	$165.46	$175.69	$28.00	$57.58	$2,879.08
Dual	Banner-UFC	South	$1,399.82	$1,188.30	$174.80	$141.11	$159.00	$30.75	$63.14	$3,156.91
Dual	Mercy Care	South	$1,494.74	$997.87	$259.72	$146.13	$45.46	$29.62	$60.68	$3,034.21
Dual	UHC-LTC	Central	$696.45	$1,237.21	$194.56	$161.02	$175.69	$25.02	$50.82	$2,540.77
Dual	Banner-UFC	Central	$1,634.95	$1,331.05	$247.30	$132.72	$170.89	$35.65	$72.50	$3,625.06
Dual	Mercy Care	Central	$1,476.20	$1,304.58	$320.16	$147.90	$47.25	$33.59	$67.95	$3,397.63
Non-Dual	UHC-LTC	North	$1,828.78	$1,014.56	$2,169.88	$160.62	$175.69	$57.08	$110.34	$5,516.93
Non-Dual	Banner-UFC	South	$1,669.42	$1,066.68	$2,173.61	$142.04	$314.43	$57.36	$110.68	$5,534.21
Non-Dual	Mercy Care	South	$1,547.89	$1,397.62	$2,457.40	$150.04	$221.23	$61.93	$119.10	$5,955.21
Non-Dual	UHC-LTC	Central	$1,761.28	$1,379.23	$2,337.33	$160.06	$175.69	$60.51	$119.88	$5,993.97
Non-Dual	Banner-UFC	Central	$3,181.70	$1,196.34	$2,235.58	$132.56	$365.52	$73.38	$146.63	$7,331.72
Non-Dual	Mercy Care	Central	$1,505.26	$1,514.80	$2,812.67	$154.35	$258.34	$65.31	$128.79	$6,439.51

January 1, 2019 Capitation Rates

Rate Cell	Contractor	GSA	Net NF Expense Amount PMPM	Net HCBS Expense Amount PMPM	Net Acute Expense Amount PMPM	Case Mgmt PMPM	Admin Exp PMPM	UW Gain PMPM	Premium Tax PMPM	Final Net Capitation PMPM
Dual	UHC-LTC	North	$1,367.02	$950.16	$159.44	$165.46	$175.69	$28.25	$58.08	$2,904.09
Dual	Banner-UFC	South	$1,411.18	$1,204.79	$174.80	$141.11	$159.00	$31.03	$63.71	$3,185.61
Dual	Mercy Care	South	$1,506.76	$1,011.72	$259.72	$146.13	$45.46	$29.88	$61.22	$3,060.87
Dual	UHC-LTC	Central	$702.36	$1,254.26	$194.56	$161.02	$175.69	$25.25	$51.29	$2,564.44
Dual	Banner-UFC	Central	$1,648.11	$1,349.40	$247.30	$132.72	$170.89	$35.97	$73.15	$3,657.53
Dual	Mercy Care	Central	$1,488.02	$1,322.56	$320.16	$147.90	$47.25	$33.89	$68.57	$3,428.35
Non-Dual	UHC-LTC	North	$1,841.81	$1,027.76	$2,169.88	$160.62	$175.69	$57.34	$110.88	$5,543.97
Non-Dual	Banner-UFC	South	$1,681.35	$1,080.38	$2,173.61	$142.04	$314.43	$57.61	$111.21	$5,560.64
Non-Dual	Mercy Care	South	$1,559.02	$1,415.57	$2,457.40	$150.04	$221.23	$62.22	$119.70	$5,985.19
Non-Dual	UHC-LTC	Central	$1,773.77	$1,396.55	$2,337.33	$160.06	$175.69	$60.80	$120.49	$6,024.69
Non-Dual	Banner-UFC	Central	$3,204.27	$1,211.37	$2,235.58	$132.56	$365.52	$73.76	$147.41	$7,370.46
Non-Dual	Mercy Care	Central	$1,516.00	$1,533.82	$2,812.67	$154.35	$258.34	$65.61	$129.40	$6,470.18

Appendix 8: CYE 19 Projected CYE 19 Differential Adjusted Payment PMPM by Provider Type

Rate Cell	GSA	E-Prescribing	Integrated Clinic	Inpatient Hospital	Nursing Facility	Other Hospital	FQHC/RHC	Total
Dual	North	$ 0.09	$ 0.00	$ 1.10	$ 13.83	$ 0.10	$ 0.00	$ 15.12
Dual	South	$ 0.11	$ 0.00	$ 1.32	$ 13.48	$ 0.05	$ 0.00	$ 14.97
Dual	Central	$ 0.15	$ 0.00	$ 1.68	$ 11.32	$ 0.04	$ 0.01	$ 13.20
NonDual	North	$ 0.83	$ 0.00	$ 22.65	$ 11.22	$ 0.37	$ 0.01	$ 35.08
NonDual	South	$ 1.08	$ 0.00	$ 25.91	$ 10.07	$ 0.48	$ 0.01	$ 37.54
NonDual	Central	$ 1.30	$ 0.00	$ 28.46	$ 8.58	$ 0.84	$ 0.08	$ 39.26
Total EPD		$ 0.31	$ 0.00	$ 5.72	$ 11.62	$ 0.16	$ 0.02	$ 17.82