AHCCCS
Arizona Health Care Cost Containment System

Contract Year Ending 2022
Arizona Long Term Care System/ Elderly and Physical Disability Capitation Rate Certification

October 1, 2021 through September 30, 2022

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Health Care Management

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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. This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for Contract Year Ending 2022 (CYE 22) effective October 1, 2021 through September 30, 2022, for the Arizona Long Term Care System (ALTCS)/Elderly and Physical Disability (ALTCS/EPD) Program.

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

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2021-2022 Medicaid Managed Care Rate Development Guide (2022 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2022 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 2022 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

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

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

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

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

As stated on pages 2 and 3 of the 2022 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 2022 Guide.

I.1.A. Rate Development Standards

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

The section of the 2022 Guide notes that standards and documentation expectations are not different for capitation rates and capitation rate ranges, except where otherwise stated.

I.1.A.ii. Rating Period

The CYE 22 capitation rates for the ALTCS/EPD Program are effective for the 12-month time period from October 1, 2021 through September 30, 2022.

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 22 capitation rates for the ALTCS/EPD Program, signed by Wenzhang Du, ASA, MAAA and Colby Schaeffer, ASA, MAAA, is in Appendix 1. Mr. Du and Mr. Schaeffer meet the requirements for the definition of an Actuary described at 42 CFR § 438.2 which is provided below for reference.

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

Mr. Du and Mr. Schaeffer certify that the CYE 22 capitation rates for the ALTCS/EPD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

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

The final and certified capitation rates by rate cell are in Appendix 2. Additionally, the ALTCS/EPD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ALTCS/EPD contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 and the 2022 Guide.

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

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

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

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

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

Table 1: Managed Care Plan(s) by GSA

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

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

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

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

For the CYE 22 rating period, the projected expenses associated with the administration of COVID-19 vaccines are not included in the capitation rates. The Contractors are responsible for these expenses and will be reimbursed for these expenses via periodic cost-settlement payments based upon adjudicated/approved encounter data subject to the two-year claiming rule.

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

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

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

The CYE 22 capitation rates for ALTCS/EPD are effective for the 12-month time period from October 1, 2021 through September 30, 2022.

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

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

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

The ALTCS/EPD Program has two 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.

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

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

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

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6. The special contract provisions related to payment included in the CYE 22 capitation rates are:

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

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

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

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

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

Proposed differences among the CYE 22 capitation rates for the ALTCS/EPD Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the ALTCS/EPD Program.

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

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

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

The effective dates of changes to the ALTCS/EPD Program are consistent with the assumptions used to develop the CYE 22 capitation rates for the ALTCS/EPD Program.

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

The certified capitation rates allow each ALTCS/EPD Program Contractor to reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 22.

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

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

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

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

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

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

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

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

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 22 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 22 capitation rates for the ALTCS/EPD Program.

I.1.A.xii. COVID-19 PHE Risk Mitigation

This section of the 2022 Guide includes CMS recommendations for risk mitigation strategies for rating periods impacted by the PHE and reminds states of specific requirements related to risk mitigation strategies. All risk mitigation strategies are addressed in the contract and below in Section I.4.C. and will be submitted to CMS prior to the start of the rating period.

I.1.A.xiii. Rate Certification Procedures

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

This section of the 2022 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

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

This rate certification documents that the ALTCS/EPD Program capitation rates will be changing effective October 1, 2021.

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

Not applicable. This rate certification will prospectively change the ALTCS/EPD Program capitation rates effective October 1, 2021.

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

This section of the 2022 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell for certified rates per rate cell, in accordance with 42 CFR § 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.7(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

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

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

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

I.1.B. Appropriate Documentation

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

The actuaries are certifying capitation rates for each rate cell.

I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 22 capitation rates for the ALTCS/EPD Program.

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

This section of the 2022 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for the variation.

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

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

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

I.1.B.v. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2022 Guide. Sections of the 2022 Guide that do not apply will be marked as "Not Applicable"; any section wherein all subsections are not applicable will be collapsed to the section heading.

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

All proposed differences in the assumptions, methodologies, or factors used to develop the certified CYE 22 capitation rates for the ALTCS/EPD Program's covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

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

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

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

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

The comparisons between the most recent certified CYE 21 ALTCS/EPD Program capitation rates and the CYE 22 capitation rates being certified in this actuarial rate certification are available in Appendix 3a.

The 2022 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. For the purposes of the CYE 22 certified capitation rates, the actuaries defined any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year was a negative change in the rate. The 2022 Guide requests a comparison to the final certified rates in the previous rate certification. Those comparisons are available in Appendix 3a. No rate cells reflect a negative change over the most recent certified CYE 21 rates, but as shown in Appendix 3a, all Dual rate cells reflect a change of more than 10% from the most recent certified CYE 21 capitation rates.

The increase over the capitation rates effective October 1, 2020 is predominantly attributable to provider reimbursement increases (mainly the Legislative Fee Schedule Increase for HCBS/NF).

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

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

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

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

I.1.B.ix. Future Rate Amendments

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

Table 2: Future Rate Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
American Rescue Plan Act (ARPA) proposals	February 2022	AHCCCS has submitted ARPA proposals to CMS for review and approval. AHCCCS also needs approval from the Arizona State Legislature for implementation of any approved ARPA items.

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

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

The AHCCCS Division of Health Care Management (DHCM) Actuarial Team has read and discussed numerous articles (Health Affairs, Health Watch, KFF, Harvard, Science Alert, CMS FAQs, JAMA, etc.), attended several webinars discussing various aspects of the impacts of COVID-19 (enrollment mix changes, deferred versus foregone care, pandemic progression timelines, hospital utilization patterns, etc.), and monitored national trends and information such as unemployment reports published by the Bureau of Labor Statistics, emerging COVID-19 case rates, and projections of vaccine utilization. The AHCCCS DHCM Actuarial Team continues to monitor national legislation and federal guidance on the PHE end date and plans to analyze changes in acuity of members due to maintenance of effort eligibility requirements in the FFCRA.

The AHCCCS DHCM Actuarial Team has found the following data to be applicable for determining how to address the COVID-19 PHE in rate setting:

- Arizona Medicaid data (before and during the PHE)
- Arizona school closure data
- Arizona, regional, and national COVID-19 vaccination data
- Arizona Medicaid telehealth data along with national projections

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

The CYE 22 capitation rates account for the direct and indirect impacts of the COVID-19 PHE by including projected costs associated with expanding service and telehealth coverage, reimbursement for COVID-19 testing, and approved flexibilities under Appendix K authority and select 1115 waiver changes. The CYE 22 capitation rates do not include costs for administration of COVID-19 vaccines, as there is a new cost-settlement arrangement in place for CYE 22 for those expenses. AHCCCS will continue to monitor encounters and has plans to view member acuity.

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

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 22 capitation rates will continue AHCCCS' long-standing program policy and will include risk corridors. For the CYE 22 rating period, AHCCCS is adding a cost-settlement for administration of COVID-19 vaccines and carving these costs outside of the capitation rates. This is the only risk mitigation strategy utilized specifically for COVID-19 and is the only change from the prior rating period in terms of risk strategies being utilized.

I.2. Data

This section provides documentation for the Data section of the 2022 Guide.

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

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

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

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

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

The types of data that AHCCCS relied upon for developing the CYE 22 capitation rates for the ALTCS/EPD program were:

- Adjudicated and approved encounter data submitted by the ALTCS/EPD Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2016 through early February 2021
  - Adjudicated and approved through the second encounter cycle in February 2021
- Reinsurance payments made to the ALTCS/EPD Contractors for services
  - Incurred from October 2016 through September 2020 paid through February 2021
- Enrollment data for ALTCS/EPD Contractors from the AHCCCS PMMIS mainframe
  - October 2016 through February 2021
- Annual and quarterly financial statements submitted by the ALTCS/EPD Contractors and reviewed by the AHCCCS DHCM Finance & Reinsurance Team
  - October 1, 2016 through September 30, 2017 (CYE 17 or FFY 17)
  - October 1, 2017 through September 30, 2018 (CYE 18 or FFY 18)
  - October 1, 2018 through September 30, 2019 (CYE 19 or FFY 19)
  - October 1, 2019 through September 30, 2020 (CYE 20 or FFY 20)

- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DHCM Rates & Reimbursement Team
- Data from AHCCCS DHCM Rates & Reimbursement Team related to DAP, see Section I.4.D
- Data from AHCCCS DHCM Financial Analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership provided by the Contractors
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CalYr19
- Projected CYE 22 enrollment data provided by AHCCCS Division of Business and Finance (DBF) Budget Team
- Nursing Facility (NF) and Home and Community-Based Settings (HCBS) placement data for October 2016 through February 2021
- Member level share of cost data provided by AHCCCS for October 2016 through September 2020
- Any additional data used and not identified here will be identified in their applicable sections below

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

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

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

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

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

The ALTCS/EPD Contractors have sub-capitated/block purchasing arrangements. During CalYr19, 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 repricing methodology uses the minimum of AHCCCS fee schedule, the health plan billed amount, and the health plan allowed amount, less any third-party insurance amounts. The units of service data from the encounters and the estimated health plan valued amounts were used for the basis of calculating utilization and unit cost.

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

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

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

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

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

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

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

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

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

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

The AHCCCS DHCM Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe. The AHCCCS DHCM Actuarial Team ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 22 capitation rates for the ALTCS/EPD Program. Additionally, the AHCCCS DHCM Actuarial Team ensured that only services covered under the state plan were included.

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

The AHCCCS DHCM Actuarial Team reviewed the encounter data for all services provided by ALTCS/EPD Contractors to the annual financial statement data for the same entities for CalYr19. The actuaries also compared the CalYr19 encounter data to the yearly supplemental data request from the ALTCS/EPD Contractors. After adjustments to the encounter data for completion, the comparisons showed that the financial statements, the AHCCCS encounter data, and the ALTCS/EPD Contractors' encounter data were consistent.

I.2.B.ii.(b)(ii) Actuaries' 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 Finance & Reinsurance Team. The AHCCCS DHCM Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuaries note additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP and fee schedule impacts, on data provided by the AHCCCS DHCM financial analysts with regard to some program changes, on information and data provided by Mercer consultants with regards to pharmacy reimbursement savings, on information and data provided by Milliman consultants with regard to the HEALTHII program, on data provided by ALTCS/EPD Contractors in the yearly supplemental data request with regards to administrative and case management component, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

The AHCCCS DHCM Actuarial Team has found the encounter data to be appropriate for the purposes of developing the CYE 22 capitation rates for the ALTCS/EPD Program.

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

The AHCCCS DHCM Actuarial Team did not identify any material concerns with the availability or quality of the data.

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

The AHCCCS DHCM Actuarial Team determined that the CalYr19 encounter data was appropriate to use as the base data for developing the CYE 22 capitation rates for the ALTCS/EPD program.

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

Not Applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 22 capitation rates for the ALTCS/EPD Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 22 capitation rates for the ALTCS/EPD Program.

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

Not applicable. The AHCCCS DHCM Actuarial Team did not rely on a data book to develop the CYE 22 capitation rates for the ALTCS/EPD Program.

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

This section describes adjustments made to the CalYr19 encounter data that was used as the base data for developing the CYE 22 capitation rates for the ALTCS/EPD Program.

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

Not applicable. No credibility adjustments were made to the CalYr19 encounter data.

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

The AHCCCS DHCM Actuarial Team developed completion factors to apply to the CalYr19 encounter data. The completion factors were developed by major category of service and by month of service.

An adjustment was made to the encounter data to reflect the level of completion. The AHCCCS DHCM Actuarial Team calculated annualized completion factors by Contractor, rate cell, and category of service (COS) using the development method with monthly encounter data from October 2016 through February 2021, paid through March 2021. The annualized completion factors were applied to the base experience encounter data, for purposes of projection to the CYE 22 rating period. The annualized completion factors were applied to the October 2016 through February 2021 encounter data for purposes of trend development.

The aggregated CalYr19 completion factors applied to each COS are shown in Appendix 4.

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 (January 1, 2019 to December 31, 2019), with the exception of the October 1, 2019 fee schedule changes, are described below or in Section I.3.A.iv. for base data adjustments required with respect to IMD in-lieu-of services. All program changes which occurred or are effective on or after January 1, 2020 are described in Section I.3.B.ii.(a). All fee schedule changes which occurred on or after October 1, 2019 are also described in Section I.3.B.ii.(a).

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

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

Removal of DAP from Base Data

CYE 19 and CYE 20 capitation rates funded DAP made from October 1, 2018 through September 30, 2019 and from October 1, 2019 through September 30, 2020 to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health, and reduce cost of care growth. As these payments expired September 30, 2019, and September 20, 2020, AHCCCS has removed the impact of DAP payments from the base period CalYr19. To remove the impact, the AHCCCS DHCM Actuarial Team requested provider IDs for the qualifying providers for the CYE 19 and CYE 20 DAP by specific measure from the AHCCCS Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 19 and CYE 20 were then adjusted downward by the appropriate percentage bump specific to the DAP measure for each respective contract year. The associated costs removed from the base data are displayed below in Table 3. Totals may not add up due to rounding. The PMPM amounts removed by rate cell are included in Appendix 4, column "DAP Payments Removed", in the NF, HCBS, and Acute Expense tables.

See Section I.4.D. for information on adjustments included in CYE 22 capitation rates for DAP that are effective from October 1, 2021 through September 30, 2022.

Table 3: Removal of DAP from Base Data

GSA	Dollar Impact	PMPM Impact
North	($676,591)	($21.95)
Central	($4,357,797)	($20.09)
South	($1,726,145)	($23.20)
Total	($6,760,533)	($20.99)

Pharmacy Benefit Manager (PBM) Administrative Spread Removal

In July 2019, AHCCCS provided additional guidance on several contract requirements that aim to increase transparency and cost-effectiveness. One requirement provided guidance on how the PBM pass-through pricing model was to be implemented and administrative expenses reported. In accordance with contract requirements, the AHCCCS DHCM Actuarial Team has incorporated savings to medical expense costs associated with the removal of admin spread from CalYr19 base period encounters. The percentages used to adjust pharmacy encounters for the removal of PBM admin spread

from the base data encounters were developed based on additional data provided by the Contractors through surveys, supplemental data requests, and additional clarifying communications between AHCCCS and the Contractors.

The amount of the base data adjustment for PBM admin spread removal for the ALTCS/EPD Program is shown below in Table 4. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 4, column "PBM Spread Removal" in the Acute Expense table.

Table 4: PBM Administrative Spread Removal

GSA	Dollar Impact	PMPM Impact
North	($135,488)	($4.40)
Central	($772,208)	($3.56)
South	($76,419)	($1.03)
Total	($984,116)	($3.06)

MEMBER SHARE OF COST ADD-ON

An adjustment was made to add CalYr19 NF and HCBS share of cost (SOC) payments to the base data. This adjustment grosses up the base encounter data to reflect both the provider and member liabilities prior to the application of trend and other prospective adjustments described in Section I.3.B. After application of those adjustments, the projected CYE 22 SOC payments were removed as described in Section I.3.B.ii.(a).

The overall impacts by GSA for the ALTCS/EPD program are displayed below in Table 5. Totals may not add up due to rounding. The PMPM amounts added by rate cell are included in Appendix 4, column "SOC Payments Added", in the NF and HCBS Expense tables.

Table 5: Member Share of Cost Add-on

GSA	Dollar Impact	PMPM Impact
North	$7,049,376	$228.73
Central	$31,729,325	$146.28
South	$13,518,592	$181.70
Total	$52,297,293	$162.35

Other Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less for every individual rate cell across all GSAs, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 6. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 4, column "Retrospective Program Changes" in the Acute

Expense tables. Brief descriptions of the individual program changes requiring base data adjustment are provided below.

- **3D Mammography ***
  Effective June 1, 2019, upon recommendation of the AHCCCS DHCM CQM Team, AHCCCS began covering digital breast tomosynthesis (3D mammograms) for preventive screening and diagnosis of adults 21 years of age and older. The AHCCCS DHCM CQM Team made the recommendation in recognition of studies that find use of 3D mammograms in addition to or in place of 2D services has at times improved detection of breast cancer in some populations. Contractors are permitted to use prior authorization criteria in evaluating medical necessity of 3D services for members.
- **Behavioral Health Residential Facilities (BHRF) Personal Care Differential ***
  Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team established a differentiated FFS rate for BHRF that are licensed by ADHS to provide personal care services.
- **Pay and Chase Guidance ***
  Federal regulation 42 CRF 433.139, Payment of Claims, requires agencies and their Contractors to pay and chase claims for preventive pediatric care services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, regardless of the existence of third-party liability at the time the claim is filed. Preventive pediatric care refers to screening and diagnostic services to identify congenital, physical, mental health routine examinations performed in the absence of complaints and screening or treatment designed to avert various infectious and communicable diseases from occurring in children under 21 years of age. As a result of questions to AHCCCS regarding coordination of benefits for members with Autism Spectrum Disorder, the agency provided additional clarification to Contractors in CalYr19 on preventive services that must be reimbursed on a pay and chase basis. This clarification is anticipated to increase costs of Contractors in situations in which they are unable to successfully recover funding from liable third parties.
- **Pharmacy and Therapeutics Committee Recommendations – Base Year ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy and drug coverage changes during CalYr19 that impacted utilization and unit costs of Contractors' pharmacy costs in the base period. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.
- **Substance Use Disorder Assessment ***
  Effective October 1, 2018, AHCCCS updated provider fee schedules to include a targeted increase to providers who conduct a computer-guided, structured interview utilizing American Society of Addiction Medicine (ASAM) software. The service enables providers to determine the appropriate level of treatment based upon a set of medically accepted criteria. Slower-than-anticipated adoption of the ASAM software caused by compatibility issues with provider

electronic health record (EHR) systems limited use of ASAM in the base period. To raise adoption of the software during CYE 22, AHCCCS is providing a differential adjusted payment for providers that submit a letter of intent to complete integration of ASAM with their EHR system. For CYE 22 rate development, additional impacts for the fee schedule and incentivized adoption of ASAM are included above any base period encounters.

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

Table 6: Other Base Data Adjustments

GSA	Dollar Impact	PMPM Impact
North	$11,260	$0.37
Central	$626,739	$2.89
South	$36,325	$0.49
Total	$674,324	$2.09

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 22 capitation rates.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2022 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) and 42 CFR § 438.3(e).

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

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

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

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

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

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

Costs Associated with an Institution for Mental Disease Stay

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

The data used to determine the base data adjustment was the CalYr19 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CalYr19 encounter data, the AHCCCS DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the non-IMD price-per-day. The Non-IMD price-per-day used in the analysis was $890.14 and was derived from the CalYr19 encounter data for similar IMD services that occurred within a non-IMD setting. The encounter

data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a non-IMD setting which may not be fully captured within the AHCCCS FFS fee schedule per diem rate.

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

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

The combined impacts of repricing all IMD stays to the cost of the same services through providers included under the State plan, removing IMD stays which exceeded 15 cumulative days in a month, and removing medical expenses related to problematic IMD stays by GSA for the ALTCS/EPD Program are displayed below in Table 7. Totals may not add up due to rounding. The PMPM amounts by rate cell are included in Appendix 4, column "IMD Repricing", in the Acute Expense table.

Table 7: IMD Repricing

GSA	Dollar Impact	PMPM Impact
North	$4,085	$0.13
Central	($21,436)	($0.10)
South	$7,474	$0.10
Total	($9,877)	($0.03)

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

Appendix 7 contains 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 22 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. was adjusted to reflect historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. Further data adjustments for required IMD changes are described in Section I.3.A.iv. The adjusted base data per-member-per-month (PMPM) expenditures for each category of service (COS) were trended forward 33 months, from the midpoint of the CalYr19 time period to the midpoint of the CYE 22 rating period by applying assumed annual utilization and unit cost trends for each COS, using the methodology described below in

I.3.B.iii.(a)(ii). The projected PMPMs were then adjusted for prospective program changes that are described in this section. Appendix 4 contains the base data and base data adjustments, Appendix 5 contains the projected benefit cost trends, and Appendix 6 contains the projected gross and net medical expenses after applying prospective program and reimbursement changes, CYE 22 DAP, Projected SOC Payments Removed, reinsurance offset, projected percentages of members receiving LTSS, and projected percentages of LTSS members placed in NF or HCBS settings. Appendix 7 illustrates the capitation rate development, which includes the projected administrative expense, case management expense, underwriting (UW) gain, and premium tax.

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

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

Following national and state emergency declarations in March 2020, AHCCCS has sought authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. As of this writing, Appendix K authorities are projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end, while other select 1115 waiver changes are approved from March 1, 2020 until 60 days after the end of the federal emergency declaration. For CYE 22 rate development, the actuaries have incorporated projected impacts of these authorities and other AHCCCS responses to the COVID-19 outbreak for portions of the contract period, these are indicated by a ≠ symbol.

AHCCCS Fee Schedule Updates

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

information is known through health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding health plan fee schedules.

Additionally, the contract has requirements that the Contractors reimburse Federally Qualified Health Centers (FQHCs) at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates program change includes a fee schedule adjustment to bring the encounter base data from CalYr19 FQHC PPS rates up to projected CYE 22 FQHC PPS rates.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 22 capitation rates have been adjusted to reflect these fee schedule changes. For CYE 22 capitation rate development, the actuaries used data provided by the AHCCCS DHCM Rates & Reimbursement Team to determine the impact of the annual October 1 fee schedule changes which should be applied to the base data year CalYr19. The impacts applied are the October fee schedule changes for 2019 through 2021. The CalYr19 data required nine months of the October 2019 change, and the full year impacts of the October 2020 and October 2021 fee schedule changes, to bring the data to the rating period. Additional detail on specific changes within the fee schedules are addressed below.

For the duration of the COVID-19 PHE, CMS expanded the range of Medicare codes that may be billed for services provided by a resident without the direct supervision of a primary care physician, using the GE modifier. AHCCCS has aligned with CMS by expanding the set of codes for which resident-provided services can be billed using the GE modifier. The AHCCCS DHCM Actuarial Team applied the impacts by program as part of the fee schedule changes as the change is non-material for each program and rate cell when considered alone.

Effective January 1, 2020, the All Patients Refined Diagnosis Related Group (APR-DRG) adjustor for burns increased. The increased costs for this change have been included with the fee schedule changes already discussed as the APR-DRG burn adjustor is non-material for each program and rate cell when considered alone.

The October 1, 2020 fee schedule changes incorporated increased base reimbursement rates for services reimbursed under the dental fee schedule and physician fee schedule, not including the physician drug fee schedule, to restore provider rates to those in existence prior to reductions implemented in state fiscal year 2009, per Arizona State HB 2668 (Laws 2020, Chapter 46).

In the 2021 legislative session, the legislature passed a general appropriations bill which included funding for the ALTCS programs to implement provider fee schedule increases. Consistent with the additional funding, the DHCM Rates and Reimbursement Team increased HCBS and NF provider reimbursement rates by 7.2% effective October 1, 2021.

AHCCCS will transition from version 34 to version 38 of the APR-DRG payment classification system on October 1, 2021. AHCCCS has used v34 APR-DRG national weights published by 3M since January 1, 2018 until present. In addition to updating to version 38, AHCCCS will rebase the inpatient system and update to APR-DRG v38 effective October 1, 2021. Rebasing involves updating the DRG grouper version, relative weights and DRG base rates via payment simulations modeling using more recent data. Guidehouse did the rebase of the AHCCCS DRG system. The rebase followed the same methodology as that used in the January 2018 rebase, included here for reference:

> "Rebasing calculations included updated base rates (both standardized amounts and wage indices), relative weights, 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)."

After adjusting the base rates and wage indices to maintain a budget neutral rebase, AHCCCS adjusted one service policy adjuster during the rebase to meet program funding goals. The high acuity pediatric policy adjuster was increased from 2.3 to 2.4 in this rebase process. The AHCCCS DHCM Actuarial Team relied upon Guidehouse and the AHCCCS DHCM Rates & Reimbursement Team for the reasonableness of the changes. The combined impact for the rebase and policy adjuster change has been included with the fee schedule changes already discussed.

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

The overall impact of the AHCCCS FFS fee schedule updates by GSA is illustrated below in Table 8. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 6, columns "Provider Fee Schedule" in the NF, HCBS, and Acute Expense tables include these fee schedule adjustments by rate cell.

Table 8: Aggregate AHCCCS FFS Fee Schedule Updates

GSA	Dollar Impact	PMPM Impact
North	$8,649,525	$280.65
Central	$72,414,122	$333.85
South	$24,231,510	$325.69
Total	$105,295,157	$326.87

Proposition 206 Reimbursement Rate Changes

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

This assures that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. Through continued discussion with the Contractors, AHCCCS knows the increased rates are similarly adopted by the Contractors. The impacts of these fee schedule changes, reflective of minimum wage increases, have been included by category of service based on utilization of the specific services in the base year. The overall impact by GSA is illustrated below in Table 9. Appendix 6, columns "Prop 206 Adjustment Factor" in the NF and HCBS Expense tables include these fee schedule adjustments by rate cell.

Table 9: *Proposition 206 Reimbursement Rate Changes*

GSA	Dollar Impact	PMPM Impact
North	$5,522,679	$179.19
Central	$45,548,701	$209.99
South	$15,457,009	$207.75
Total	$66,528,389	$206.53

Pharmacy Reimbursement Savings

Analysis of pharmacy claims for all AHCCCS managed care programs and AHCCCS FFS program identified significant variability across all Contractors, and analysis of repriced claims data compared to CMS National Average Drug Acquisition Cost (NADAC), AHCCCS FFS pricing, and industry benchmark pricing identified that valuing claims data to AHCCCS FFS repriced amounts would result in an annual savings of $71.5 million or 4.8% of pharmacy spend for CalYr19 across all programs. AHCCCS Contractors should reasonably be able to achieve pharmacy pricing that is at or near that achieved by the AHCCCS FFS program. In past years, AHCCCS recognized that the full savings amount identified in similar analyses may not be reasonably achievable in a single year. As a result, the base pharmacy data of each program was adjusted by 33% in CYE 20 and 66% in CYE 21 of the amount identified in the original CYE 18 analysis as savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing. Based on the updated analysis of CalYr19 which only considers savings based on AHCCCS FFS pricing and does not include savings base on a lesser of calculation, for CYE 22, AHCCCS is adjusting the base pharmacy data of each program by 90% of the savings identified in the analysis of CalYr19 pharmacy data for valuing claims data to AHCCCS FFS prices.

The amount of the base data adjustment for pharmacy reimbursement savings for the ALTCS/EPD Program is displayed below in Table 10. Totals may not add up due to rounding. The PMPM amounts removed by rate cell are included in Appendix 6, column "Pharmacy Savings", in the Acute Expense table.

Table 10: Pharmacy Reimbursement Savings

GSA	Dollar Impact	PMPM Impact
North	($161,093)	($5.23)
Central	($3,293,969)	($15.19)
South	($590,254)	($7.93)
Total	($4,045,316)	($12.56)

Alzheimer's Drug Approval *

On June 7, 2021, the FDA gave accelerated approval to Aduhelm for the treatment of patients with mild cognitive impairment or mild dementia stage of Alzheimer's disease (AD). Continued approval of the drug is contingent on additional trials that show clinical benefit of the drug. The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. In accordance with requirements of participation in the MDRP, AHCCCS began coverage of Aduhelm on June 15, 2021.

To estimate prevalence of AD in the AHCCCS membership, the AHCCCS DHCM financial analysts first reviewed encounters with use of diagnosis codes for AD or cognitive impairment. It was determined that some codes for cognitive impairment also include non-AD diagnoses and would not be appropriate for determining the prevalence. The analysts reviewed 2021 studies by the Alzheimer's Association, which included estimates of Arizona residents with AD and the percent of individuals with AD that were enrolled in their state's Medicaid program. These report findings were then used to project the number of AHCCCS members with AD. Biogen, maker of Aduhelm, has projected that about 16-32% of AD cases nationwide may meet the drug's indication for mild forms of AD. Using the low end of Biogen's range, the AHCCCS DHCM financial analysts assumed that 16% of AHCCCS members with AD may be considered candidates for receiving the drug. Due to potential questions of the drug's efficacy, it was further assumed that only 25% of drug candidates would begin treatment in CYE 22. After forecasting the number of members that would use Aduhelm, the AHCCCS DHCM financial analysts estimated annual costs of the drug, infusion services, and neuroimaging that would be provided to representative recipients as part of the drug regimen. Costs for dual eligible members were assumed to be covered under Medicare at 80%, and the remaining 20% coinsurance was included for capitation rate development.

For CYE 22 rate development, the projected impact was allocated across rate cells and GSAs using base period distribution of members with used of certain AD diagnosis code. The overall impact of the change by GSA is displayed below in Table 11. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in the factors shown in Appendix 6, column "Prospective Program Changes" in the HCBS and Acute Expense tables.

Table 11: Alzheimer's Drug Approval

GSA	Dollar Impact	PMPM Impact
North	$1,332,529	$43.24
Central	$11,145,413	$51.38
South	$2,796,208	$37.58
Total	$15,274,150	$47.42

ALTCS Home Delivered Meals * ‡

CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to expand the provision of home delivered meals to members enrolled in the Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (ALTCS/DDD). The authority is projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end. While members of the ALTCS Elderly and Physical Disabilities (ALTCS/EPD) program were eligible for home delivered meals during the base period, it is anticipated that emergency preparedness and community social distancing efforts will increase use of these services in the program during the contract period. To estimate the impact of this change, the AHCCCS DHCM financial analysts reviewed encounters for the period March to December 2020. It was assumed that monthly service use from October 1, 2021 to March 31, 2022 of the contract period would be similar to monthly use in the encounters reviewed.

For CYE 22 rate development, the projected impact was allocated across rate cells and GSAs using base period encounters of home delivered meals. The overall impact of the change by GSA is displayed below in Table 12. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in the factors shown in Appendix 6, column "Prospective Program Changes" in the HCBS and Acute Expense tables.

Table 12: ALTCS Home Delivered Meals

GSA	Dollar Impact	PMPM Impact
North	$146,953	$4.77
Central	$873,582	$4.03
South	$243,465	$3.27
Total	$1,264,000	$3.92

Expanded Telehealth Use * ‡

To ensure access to care during the COVID-19 PHE, AHCCCS expanded coverage of telephonic codes and telehealth (TPTH) and mandated that services delivered through TPTH are reimbursed at the same rates as for in-person services, for both physical and behavioral health services. A review of encounters from April 1, 2020 to December 31, 2020 indicates that use of TPTH services has been essential for continued provision of services and represented annualized growth of 1,049% above base period use. Most growth in the use of these services is expected to represent a cost-neutral shift from use of in-person services.

Increased use of TPTH services in the rating period are, however, expected to reduce the rate of missed appointments and lower use of NEMT, emergency department (ED) visits, and specialty visits.

For purposes of projecting TPTH use during the rating period, AHCCCS DHCM financial analysts relied on a national projection developed by McKinsey & Co. of potential TPTH use following the PHE. The AHCCCS percent share of McKinsey's national projection was estimated to equal AHCCCS' percent share of 2018 National Health Expenditures. It was further assumed that use would be phased in at 67% of long-run AHCCCS projected TPTH services during the rating period. The projection suggests that 76% of annualized TPTH service growth encountered between April 1, 2020 and December 31, 2020 would be maintained in CYE 22.

As more services shift from being provided in person to through TPTH, the rate of missed appointments is expected to decrease, resulting in additional program service use. Based on a literature review, it was assumed that the missed appointment rate for TPTH-eligible services was 25% during the base period. Based on findings from additional studies, it was assumed that TPTH-provided services could result in a 50% reduction in missed appointments compared to in-person appointments. Combining these assumptions, the AHCCCS DHCM financial analysts estimated that 14.3% of growth in TPTH during CYE 22 would represent new services.

Use of TPTH is expected to reduce the need for NEMT services. AHCCCS DHCM financial analysts determined that 11.0% of claims for in-person services of the most heavily used TPTH codes were accompanied by same day use of NEMT during FFY 19. It was therefore, estimated that 11.0% of the increase to TPTH services in CYE 22 would result in a reduction in NEMT rides. Cost savings was calculated using the average trip and mileage costs of NEMT rides multiplied by the estimated reduction in rides.

Use of TPTH is additionally expected to reduce the use of low-to-moderate severity ED visits. The McKinsey & Co. national projection noted above assumed that 20% of all ED visits could transition to TPTH following the PHE. Consistent with the 67% phase-in assumption above for projected TPTH services, AHCCCS DHCM financial analysts projected a 13.4% reduction (67% phase-in of a 20% reduction) in ED visits in CYE 22 resulting from TPTH use. Cost savings from the change was calculated using the cost reduction of TPTH services relative to the cost of low-to-moderate severity ED visits, multiplied by the estimated reduction in ED visits.

For CYE 22 rate development, the projected impact of growth in TPTH services was allocated across rate cells and GSAs using base period encounters of TPTH-eligible services, NEMT, and ED visits. The overall impact of the change by GSA is displayed below in Table 13. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in the factors shown in Appendix 6, column "Prospective Program Changes" in the HCBS and Acute Expense tables.

Table 13: Net Impacts of Expanded Telehealth Use

GSA	Dollar Impact	PMPM Impact
North	$28,358	$0.92
Central	$450,528	$2.08
South	$117,693	$1.58
Total	$596,579	$1.85

Combined Miscellaneous Program Changes

The capitation rates were adjusted for all program changes. However, if an individual program change had an impact of 0.2% or less for every individual rate cell across all GSAs, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 14. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in the factors shown in Appendix 6, column "Prospective Program Changes" in the HCBS and Acute Expense tables, unless otherwise noted. Brief descriptions of the individual program changes are provided below.

- **Opioid Treatment Program Reimbursement ***
  Pursuant to final rule 2019-24086, Medicare began reimbursing Opioid Treatment Programs (OTPs) for opioid use disorder (OUD) treatment services provided to individuals with Medicare Part B insurance on and after January 1, 2020. Under the change, reimbursement of OTP services and Medication Assisted Treatment (MAT) drugs to members dually enrolled in Medicare and Medicaid for treatment of OUD are shifting from AHCCCS Contractors and Medicare Part D to Medicare Part B. Medicare OTP services on and after January 1, 2020 are not subject to the traditional Medicare Part B 20% coinsurance during the rating period.
- **Increased Frequency of Dental Fluoride Visits ***
  Beginning February 1, 2020, AHCCCS increased the maximum number of dental fluoride varnish applications that members may receive, from two to four applications a year.
- **Inpatient Dental Hygienist Teeth Cleanings ***
  As part of the 2019 Legislative session, the Arizona Legislature passed HB 2058 which permits dental hygienists to provide services in an inpatient hospital setting under supervision of a physician. The legislation is expected to increase provision of inpatient teeth cleanings for prevention of ventilator associated pneumonia.
- **COVID-19 Tests *ǂ**
  Since February 2020, AHCCCS has covered a range of medically necessary diagnostic and antibody tests for detecting COVID-19. The AHCCCS DHCM Actuarial Team is adjusting CYE 22 rates to reflect the projected use of these tests, which were not covered during the base period.
- **Depression and Anxiety Screening Codes ***
  Effective August 1, 2020, AHCCCS began coverage of procedure code 96127 for brief emotional or behavioral assessments.

- **Child Flu Shots at Pharmacies ***
  Effective September 1, 2020, AHCCCS modified policy guidance to permit pharmacists to administer influenza vaccinations to children ages 3 -to 18 years old. Prior to the change, policy limited pharmacist-administered influenza vaccines to adults 19 years and older.
- **Adult Hepatitis C Screening Recommendation ***
  On March 2, 2020, the U.S. Preventive Services Task Force (USPSTF) published a final recommendation that all adults 19 to 79 years of age be screened for hepatitis C. This represents an expansion of recommended screening from the previous guidance that adults born between 1945 and 1965 be screened. Effective October 1, 2020, AHCCCS modified policy guidance to reflect the USPSTF final recommendation on hepatitis screenings for adults.
- **Off Campus Hospital Outpatient Department Reimbursement ***
  Effective October 1, 2020, AHCCCS is reimbursing services billed at off campus hospital outpatient departments on a UB-04 form with PO or PN modifiers according to the physician or ambulatory surgical center fee schedules. The change will represent a decrease in reimbursement relative to outpatient hospital fee schedule rates that providers billed before the change.
- **Outpatient Psychiatric Hospital Reimbursement ***
  Beginning October 1, 2020, AHCCCS is implementing an outpatient hospital fee schedule reimbursement methodology for outpatient services provided by psychiatric hospitals. Prior to this change, AHCCCS manually approved Contractor payments to psychiatric hospitals for outpatient services, which were not subject to a specific reimbursement methodology. To estimate the impact, the AHCCCS DHCM financial analysts repriced base period encounters at outpatient hospital fee schedule rates.
- **Genetic Testing for Cardiovascular Disorders ***
  AHCCCS began covering genetic tests for rare inherited cardiovascular disorders effective October 23, 2020. The tests are primarily recommended for identification of Long QT syndrome (LQTS) in first degree relatives of individuals with the disorder.
- **Cancer Profiling Tests ***
  Effective July 1, 2021, AHCCCS began covering two medically necessary cancer profiling tests. The tests can assist providers in determining the most appropriate course of treatment for a patient's cancer.
- **Community Intervener Services ***
  Effective October 1, 2021, AHCCCS is establishing policy for provision of community intervener services to ALTCS members with dual sensory loss (i.e., blind and hard of hearing). Community interveners intercede between the member and the environment, allowing access to information usually gained through vision and healing. A reimbursement rate will be established for the community intervener services to be billed under procedure code S5135 and modifier CG.

- **EPSDT Visits and Developmental Screens ***
  Effective October 1, 2021, AHCCCS is revising policy to better align EPSDT visits and developmental screening requirements with CMS Core Measures and recommendations from the American Academy of Pediatrics. The policy revisions require an additional EPSDT visit for child members at 30 months of age and two specialized developmental screens at the child member's 18-month and 24-month EPSDT visits.
- **Bus Passes ***
  Effective October 1, 2021, AHCCCS is revising policy to clarify that Contractors may reimburse public transport passes as NEMT. Passes would generally be billed with procedure code A0110. When offering a public transport pass, contractors should consider such things as location of the member, location of the member's provider, public transportation schedules, and member ability to travel alone. CYE 22 adjustments to rates include projected costs of bus passes and increased use of medical services due to greater members options for transport, partly offset by savings from reduced use of more expensive alternative forms of NEMT.
- **Emergency Triage, Treat, and Transport ***
  Effective October 1, 2021, AHCCCS will implement an Emergency Triage, Treat, and Transport (ET3) model that is similar to the ET3 program that Medicare began in FFY 21. Under the state's program, emergency service providers may begin billing for trips that result in delivery of on-site or telehealth services by a partner health professional or for trips to an outpatient non-ED provider. The AHCCCS DHCM financial analysts project that cost savings of diverting unnecessary ED visits to lower acuity settings under the ET3 model will be offset by additional costs of reimbursing emergency service providers for trips in which no or limited reimbursement was previously paid.
- **Reimbursement for HCBS Delivered by Parents *** ǂ
  CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to reimburse parents or legally responsible individuals for HCBS provided to a child under the age of 18 years. The authority is projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end.
- **Remove Spouse Caregiver Weekly Hour Limit *** ǂ
  CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to eliminate the 40-hour limit on reimbursable caregiver services provided by a member's spouse during a 7-day period. The authority is projected to be effective until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end.
- **Pharmacy and Therapeutics Committee Recommendations ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 22. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

- **Rx Rebates Adjustment**
  An adjustment was made to reflect the impact of Rx Rebates reported within the ALTCS/EPD Program financial statements, as pharmacy encounter data does not include these adjustments. The data reviewed to develop the impact was the CYE 17, CYE 18, CYE 19, CYE 20, and CYE 21 Q1 financial statement reports. From this review, the AHCCCS DHCM Actuarial Team determined that it would be reasonable to apply an adjustment to the projected gross medical expenses to reflect a level of reported Rx Rebates. The PMPM amounts removed by rate cell are included in Appendix 6, column "Rx Rebates", in the Acute Expense table.
- **COVID IP HCBS * ǂ**
  CMS approved AHCCCS' requested 1115 Waiver Appendix K authority to reimburse for personal care services delivered to an ALTCS member during an acute care hospital or short-term institutional stay. The authority is projected to be effective retroactively from March 13, 2020 until March 31, 2022, the last day of the quarter in which the federal emergency declaration is projected to end.

Table 14: Combined Miscellaneous Program Changes

GSA	Dollar Impact	PMPM Impact
North	(132,421)	($4.30)
Central	(2,172,454)	($10.02)
South	(809,478)	($10.88)
Total	(3,114,353)	($9.67)

PROJECTED NF AND HCBS PLACEMENT MIX

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

The actuaries developed assumptions for the percentages of members receiving LTSS and placement in the nursing facility or HCBS settings based on the average percentages for October through February 2021, which was the most recent 5-month time period available in our member placement data.

Similarly, the actuaries developed the NF/HCBS mix prior to the PHE. Then the actuaries applied a 2/3 credibility to the prior-PHE NF/HCBS mix and 1/3 credibility to the post-PHE NF/HCBS mix to arrive at a combined NF/HCBS mix percentage.

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

PROJECTED MEMBER SHARE OF COST REMOVAL

After application of trend and other prospective adjustments to our base period data described above, the actuaries removed projected CYE 22 member SOC payments from the nursing facility and HCBS service categories to reflect only Contractor liability in the capitation rates.

The overall impact by GSA for the ALTCS/EPD program is displayed below in Table 15. Totals may not add up due to rounding. The PMPM amounts added by rate cell are included in Appendix 6, column "Projected SOC", in the NF and HCBS Expense tables. Note that these impacts are after application of the percentages for members receiving LTSS and placement in the NF or HCBS settings.

Table 15: Projected Member Share of Cost Removal

GSA	Dollar Impact	PMPM Impact
North	($7,236,874)	($234.81)
Central	($32,463,165)	($149.66)
South	($14,141,863)	($190.08)
Total	($53,841,901)	($167.14)

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

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

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

The ALTCS/EPD Program Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuaries to set the CYE 22 capitation rates therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2016 through early February 2021 and adjudicated and approved through the first encounter cycle in March 2021. The data was truncated to avoid including any COVID-19 time period which had large and varied impacts on most categories of service which are not anticipated to be continued into the rating period, making the COVID-19 time period data inappropriate for use in developing trend projections. The trend was developed primarily with actual experience from the Medicaid population.

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

Historical utilization, unit cost, and PMPM data from contract years ending in 2017through 2020 were organized by incurred year and month and category of service (COS). The four years of data were normalized for historical program and fee schedule changes. Projected benefit cost trends were developed to project the base data forward 33 months, from the midpoint of CalYr19 (July 1, 2019) to the midpoint of the rating period for CYE 22 (April 1, 2022). 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 22.

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

The 2022 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuaries defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. There are no outlier or negative trends in the CYE 22 ALTCS/EPD capitation rate development.

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

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

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

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

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

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

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

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

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

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

No other material adjustments were made to the trend assumptions.

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

No other adjustments were made to the trend assumptions.

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS DHCM Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. As of August 13, 2021, no additional services have been identified as necessary services to comply with MHPAEA.

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

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

I.3.B.vi. Retrospective Eligibility Periods

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

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

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

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

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

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

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

No specific adjustments are made to the CYE 22 capitation rates for the ALTCS/EPD Program, given that the encounter and enrollment data are already included within the base data used for capitation rate development.

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

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

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

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

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

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

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

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

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

There were no material adjustments made related to waiver requirements or conditions.

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

There were no material adjustments made related to litigation.

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

All material and non-material changes have been included in the capitation rate development process and all requirements in this section of the 2022 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

Alternative Payment Model Initiative – Performance Based Payments

The CYE 22 capitation rates for the ALTCS/EPD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2), called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the 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 the ALTCS/EPD Contractors that are aimed at quality improvement, such as reducing costs, improving health

outcomes, or improving access to care. For reference, the ALTCS/EPD Program CYE 21 APM Initiative – Performance Based Payment amounts are anticipated to be $3.5 million.

Alternative Payment Model Initiative – Quality Measure Performance

The incentive arrangement for the APM Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of AHCCCS performance measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement. The maximum incentive pool possible is approximately $15.4M, which is the amount that would be available if every Contractor earned exactly 0% of the withhold described below. This is not anticipated to happen; thus, the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

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

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

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

Alternative Payment Model Initiative – Performance Based Payments

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

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

Alternative Payment Model Initiative – Quality Measure Performance

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

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

Alternative Payment Model Initiative – Performance Based Payments

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

Alternative Payment Model Initiative – Quality Measure Performance

The purpose of the APM Initiative – Quality Measure Performance incentive arrangement is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are

conducive to improved health outcomes and cost savings. Contractors are required to meet a targeted percentage of total expenses under an APM contract arrangement in order to participate in the APM Initiative – Quality Measure Performance incentive.

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

The total payments under the incentive arrangements for the ALTCS/EPD Program (i.e., capitation rate payments plus incentive payments) will not exceed 105% of the capitation payments to comply with 42 CFR § 438.6(b)(2).

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

Alternative Payment Model Initiative – Performance Based Payments

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 22 capitation rates for the ALTCS/EPD Program and had no effect on the development of the capitation rates for the ALTCS/EPD Program. The incentive payments will be paid by AHCCCS to the ALTCS/EPD Contractors through lump sum payments after the completion of the CYE 22 contract year.

Alternative Payment Model Initiative – Quality Measure Performance

Incentive payments for the APM Initiative – Quality Measure Performance incentive arrangement are not included in the CYE 22 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 performance measures, and after the withhold payments are distributed and the value of the incentive pool determined.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2022 Guide provides information on the definition and requirements of a withhold arrangement.

I.4.B.ii. Appropriate Documentation

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

The ALTCS/EPD Program includes a percentage of capitation withhold arrangement which the Contractor may earn back. Contractors are required to engage in a minimally set targeted percentage of total expenses under an APM purchasing arrangement in order to receive any payment from the 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) Enrollees, Services, and Providers Covered

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

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

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

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

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

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

It is 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)(vi) Description of Reasonableness of Withhold Arrangement

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

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

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

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

The CYE 22 capitation rates documented in this rate certification are actuarially sound even if none of the withhold is earned back.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2022 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 22 capitation rates for the ALTCS/EPD Program will include risk corridors. There is also a cost-settlement type arrangement for the administration of COVID-19 vaccines for the CYE 22 rating period.

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 22 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 2022 Guide. The ALTCS/EPD Contract refers to the risk corridor as reconciliation.

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

The share of cost (SOC) risk corridor will reconcile the actual member 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.

AHCCCS will use a tiered risk corridor to reconcile each Contractor's medical cost expenses to the net capitation paid to each Contractor. Net capitation is equal to the capitation rates paid less the case management component, the premium tax, 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 (excluding COVID-19 vaccine administration encounters for CYE 22) and sub-capitated/block purchase expenses as reported by the Contractor's financial statements with dates of service during the contract year. Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically computed no sooner than 15 months after the contract year. This risk corridor will limit each ALTCS/EPD Contractor's statewide profits and losses as follows:

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

The cost-settlement will reimburse the Contractor's for the administration of COVID-19 vaccines via a periodic cost-settlement based upon adjudicated/approved encounter data subject to the two-year claiming rule.

Additional information regarding the CYE 22 risk corridors can be found in the Compensation section of the ALTCS/EPD Program contract.

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

The risk corridor did not have any effect on the development of the CYE 22 capitation rates for the ALTCS/EPD Program.

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

The threshold amount for the risk corridor was 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) Remittance/Payment Requirements for Specified Medical Loss Ratio – Not Applicable

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

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

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

AHCCCS provides a reinsurance program to the 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 encounter data and reinsurance payments are used as the base for development of the reinsurance offset.

The AHCCCS reinsurance program has been in place since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the ALTCS/EPD Contractors for covered services incurred above the deductible. The deductible is the responsibility of the ALTCS/EPD Contractors.

The 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 reinsurance offsets by rate cell are developed from CYE 19 reinsurance payments to the ALTCS/EPD Contractors for Regular and Catastrophic reinsurance cases associated with services incurred during the base period. The data is "brought current" by way of completion factors specific to reinsurance payments, adjustments for historical and prospective program and reimbursement changes, and has the same trend factors applied as the gross medical expense for acute care services, since LTC services are not eligible for consideration in reinsurance.

Other changes to the reinsurance program from the reinsurance base period to CYE22 included adding several drugs to the list of drugs covered by the AHCCCS reinsurance program. The projected costs of the additional drugs covered by the reinsurance program was calculated by taking the projected costs for CYE 22 for those drugs and applying a zero-dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset. The combined dollar impact of the reinsurance offsets for the ALTCS/EPD Program is approximately $116,000.

I.4.D. State Directed Payments

I.4.D.i. State Directed Payments

This section of the 2022 Guide provides information on delivery system and provider payment initiatives (i.e., state directed payments) authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

The only pre-prints addressed in this certification are the ones related to ALTCS/EPD. Those pre-prints are DAP, APSI, PSI, HEALTHII, and NF-SP. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 18.5%, depending on the provider type.

Access to Professional Services Initiative

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

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

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

Pediatric Service Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Nursing Facility 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 dollar increase is based on available funds in the nursing facility assessment fund plus FMAP and is expected to fluctuate based on utilization and available funds for each quarter. The increase is intended to supplement, not supplant, payments to eligible providers.

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

DAP are the only directed payments incorporated in the capitation rates. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

All EPD rate cells are affected.

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

For DAP see Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell.

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

The qualifying providers receiving the payments include hospitals subject to APR-DRG reimbursement (eligible for up to 3.0% increase), Critical Access Hospitals (eligible for up to 10.5% increase), other hospitals and inpatient facilities (eligible for up to 5.0% increase), nursing facilities (eligible for up to 2.0% increase), integrated clinics (eligible for a 10.0% increase on a limited set of codes), behavioral health outpatient clinics (eligible for a 1.0% increase), behavioral health outpatient clinics and integrated

clinics (eligible for up to 8.5% increase on all services provided), physicians, physician assistants, and registered nurse practitioners (eligible for up to 3.5% increase), behavioral health providers (eligible for up to 1.0% increase), dental providers (eligible for up to 2.0% increase), and HCBS providers (eligible for up to 1.0% increase on specified services for some provider types, and all services for other provider types). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 20 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 22 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 22 (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

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

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

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

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

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

The APSI, PSI, HEALTHII, and NF-SP are not included in the ALTCS/EPD certified capitation rates and will be paid out via lump sum payments. The 2022 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $3.5M. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Service Initiative

Anticipated payments including premium tax for PSI are approximately $2.3M. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 22 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments including premium tax for HEALTHII are approximately $46.6 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 22 utilization will be used to redistribute the payments.

Nursing Facility Supplemental Payments

The anticipated total payments for NF-SP are approximately $93.8 million, inclusive of premium tax. Of that total, approximately $84.3 million will be paid through ALTCS/EPD Contractors, and the remainder is paid on a fee-for-service basis outside ALTCS/EPD. AHCCCS will distribute the enhanced payments in the form of quarterly lump sum payments to the Contractors. Quarterly lump sum payments will be based on the current available funds in the nursing facility assessment fund plus FMAP.

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

Access to Professional Services Initiative

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

Pediatric Service Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Nursing Facility Supplemental Payments

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

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

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

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Nursing Facility Supplemental Payments

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

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Nursing Facility Supplemental Payments

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

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

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

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

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

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

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

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2022 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 22 capitation rates for the EPD Program were administrative expense estimates submitted by Contractors for CYE 20, and CYE 21. In addition, Contractors were required to submit administrative expense estimates for CYE 22, which were reviewed to inform development of cost projections. Also reviewed were trends and forecasts for Consumer Price Index (CPI) and Employment Cost Index (ECI) data from IHS Markit and each contractor's quarterly financial statements.

ADMINISTRATIVE EXPENSES

The actuaries used FFY 20 administrative (Admin) expenses and member months reported in the MCOs' supplemental non-benefit cost data submission as the base experience for projecting CYE 22 Admin expenses.

The wage-driven portion of the FFY 20 Admin expenses was trended forward from the base period to the rating period by the projected CPI for wage earners. The trend factor was based on data from an external firm, IHS Markit, which was reviewed and determined to be reasonable. A trend factor was not applied to the non-wage-driven portion of the FFY 20 Admin expenses.

The CYE 22 projected wage-driven and non-wage driven and amounts, summed together, equal the projected CYE 22 Admin expenses prior to inclusion of several PMPM add-ons.

CASE MANAGEMENT EXPENSES

Similar to Admin, the actuaries used quarterly financials and supplemental data from the MCOs were reviewed for use as the basis of the projection, based on periods spanning CYE 19 through CalYr19. The actuaries also examined CYE 20 quarterly financials and supplemental data from the MCOs for reasonableness to make MCO-specific adjustments in developing the final case management expense.

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

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

The data, assumptions, and methodology used to develop the CYE 22 projected administrative and case management costs are similar to the previous rating period and have been documented above. The previous methodology is documented in the CYE 21 actuarial rate certification.

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

No other material adjustments were applied to the projected non-benefit expenses included in the capitation rate.

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

The projected non-benefit costs for each of the listed categories of costs in the 2022 Guide are shown in Appendix 7 for the CYE 22 capitation rates.

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

The administrative component of the CYE 22 ALTCS/EPD capitation rates is described above in Section I.5.B.i.(a). The PMPM amounts by rate cell, Contractor, and GSA are provided in Appendix 7.

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

The CYE 22 capitation rates for the ALTCS/EPD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 22 capitation rate for the ALTCS/EPD Program includes a provision of 1.0% for risk margin (i.e., underwriting gain).

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

No other material or non-material non-benefit costs are reflected in the CYE 22 capitation rates for the ALTCS/EPD Program.

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

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

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

Not applicable. The CYE 22 capitation rates for the ALTCS/EPD Program do not include risk adjustment or acuity adjustments.

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

Section II of the 2022 Guide is applicable to the ALTCS/EPD Program because the CYE 22 capitation rates for ALTCS/EPD are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 and the ALTCS/EPD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. CMS Expectations

The rate development standards and appropriate documentation described in Section I of the 2022 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 2022 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 – Not Applicable

Section III of the 2022 Guide is not applicable to the ALTCS/EPD Program. As noted in Section I.1.B.iii, all covered populations under the ALTCS/EPD Program receive the regular FMAP.

Appendix 1: Actuarial Certification

We, Wenzhang Du and Colby Schaeffer, are employees of Arizona Health Care Cost Containment System (AHCCCS). We are Members of the American Academy of Actuaries and Associates of the Society of Actuaries. We 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(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

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

- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
- § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

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

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

The data, assumptions, and methodologies used to develop the CYE 22 capitation rates for the ALTCS/EPD Program have been documented according to the guidelines established by CMS in the 2022 Guide. The CYE 22 capitation rates for the ALTCS/EPD Program are effective from October 1, 2021 through September 30, 2022.

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

SIGNATURE ON FILE	August 13, 2021
Wenzhang Du	Date

Associate, Society of Actuaries
Member, American Academy of Actuaries

SIGNATURE ON FILE	August 13, 2021
Colby Schaeffer	Date

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Appendix 2: Certified Capitation Rates

Rate Cell	Contractor	GSA	CYE 22 Capitation Rate (10/1/21)
Dual	UHC-LTC	North	$3,531.10
Dual	Banner-UFC	South	$4,154.29
Dual	Mercy Care	South	$4,059.84
Dual	UHC-LTC	Central	$3,505.61
Dual	Banner-UFC	Central	$4,405.27
Dual	Mercy Care	Central	$4,418.60
Non-Dual	UHC-LTC	North	$7,184.79
Non-Dual	Banner-UFC	South	$7,785.85
Non-Dual	Mercy Care	South	$7,806.89
Non-Dual	UHC-LTC	Central	$8,328.60
Non-Dual	Banner-UFC	Central	$9,463.04
Non-Dual	Mercy Care	Central	$9,082.97

Appendix 3a: Comparison of Capitation Rates

Rate Cell	Contractor	GSA	CYE 21 Capitation Rate (10/1/20)	CYE 22 Capitation Rate (10/1/21)	Pct Change
Dual	UHC-LTC	North	$3,206.27	$3,531.10	10.1%
Dual	Banner-UFC	South	$3,611.48	$4,154.29	15.0%
Dual	Mercy Care	South	$3,493.02	$4,059.84	16.2%
Dual	UHC-LTC	Central	$3,155.71	$3,505.61	11.1%
Dual	Banner-UFC	Central	$3,924.55	$4,405.27	12.2%
Dual	Mercy Care	Central	$3,858.49	$4,418.60	14.5%
Non-Dual	UHC-LTC	North	$6,598.01	$7,184.79	8.9%
Non-Dual	Banner-UFC	South	$7,164.14	$7,785.85	8.7%
Non-Dual	Mercy Care	South	$7,518.07	$7,806.89	3.8%
Non-Dual	UHC-LTC	Central	$7,869.24	$8,328.60	5.8%
Non-Dual	Banner-UFC	Central	$8,919.62	$9,463.04	6.1%
Non-Dual	Mercy Care	Central	$8,354.83	$9,082.97	8.7%

Appendix 3b: Fiscal Impact Summary

Rate Cell	Contractor	GSA	Proj MMs 10/1/21 - 9/30/22	Capitation Rates 10/1/21 - 9/30/22	Projected Expenditures CYE 22
Dual	UHC-LTC	North	27,034	$3,531.10	$95,460,786
Dual	Banner-UFC	South	39,610	$4,154.29	$164,550,869
Dual	Mercy Care	South	24,453	$4,059.84	$99,274,748
Dual	UHC-LTC	Central	65,927	$3,505.61	$231,114,796
Dual	Banner-UFC	Central	23,848	$4,405.27	$105,056,054
Dual	Mercy Care	Central	89,081	$4,418.60	$393,613,765
Non-Dual	UHC-LTC	North	3,786	$7,184.79	$27,198,249
Non-Dual	Banner-UFC	South	6,079	$7,785.85	$47,330,447
Non-Dual	Mercy Care	South	4,260	$7,806.89	$33,253,763
Non-Dual	UHC-LTC	Central	10,466	$8,328.60	$87,168,130
Non-Dual	Banner-UFC	Central	4,374	$9,463.04	$41,393,620
Non-Dual	Mercy Care	Central	23,210	$9,082.97	$210,819,915

Appendix 4: Unadjusted and Adjusted Base Data by Rate Cell

CYE 2022, Gross Nursing Facility (NF) Expenses PMPM								
Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	DAP Payments Removed	SOC Payments Added	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 22
Dual	UHC-LTC	North	$5,024.13	0.9973	$(55.09)	$876.53	1.0562	$6,188.72
Dual	Banner-UFC	South	$5,380.37	0.9811	$(57.39)	$729.32	1.0562	$6,502.34
Dual	Mercy Care	South	$4,926.75	0.9755	$(59.93)	$703.65	1.0562	$6,014.76
Dual	UHC-LTC	Central	$5,247.62	0.9973	$(41.89)	$747.83	1.0562	$6,303.41
Dual	Banner-UFC	Central	$5,422.92	0.9811	$(49.11)	$747.93	1.0562	$6,576.54
Dual	Mercy Care	Central	$5,445.34	0.9755	$(39.10)	$717.86	1.0562	$6,613.31
Non-Dual	UHC-LTC	North	$9,961.43	0.9999	$(77.63)	$241.55	1.0706	$10,841.71
Non-Dual	Banner-UFC	South	$7,376.66	0.9729	$(47.19)	$115.04	1.0706	$8,189.92
Non-Dual	Mercy Care	South	$6,131.21	0.9673	$(52.15)	$134.08	1.0706	$6,873.62
Non-Dual	UHC-LTC	Central	$7,743.93	0.9999	$(30.64)	$67.93	1.0706	$8,331.75
Non-Dual	Banner-UFC	Central	$8,470.13	0.9729	$(47.24)	$111.78	1.0706	$9,389.63
Non-Dual	Mercy Care	Central	$8,528.89	0.9673	$(43.16)	$108.67	1.0706	$9,509.74

CYE 2022, Gross Home-and-Community-Based Settings (HCBS) Expenses PMPM								
Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	DAP Payments Removed	SOC Payments Added	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 22
Dual	UHC-LTC	North	$1,422.54	0.9993	$(1.94)	$17.77	1.0733	$1,544.86
Dual	Banner-UFC	South	$1,791.61	0.9874	$(3.27)	$15.29	1.0733	$1,960.44
Dual	Mercy Care	South	$1,860.06	0.9754	$(2.71)	$22.14	1.0733	$2,067.78
Dual	UHC-LTC	Central	$1,637.18	0.9993	$(1.98)	$14.06	1.0733	$1,771.38
Dual	Banner-UFC	Central	$1,837.33	0.9874	$(2.10)	$10.77	1.0733	$2,006.55
Dual	Mercy Care	Central	$1,985.69	0.9754	$(3.06)	$15.89	1.0733	$2,198.93
Non-Dual	UHC-LTC	North	$1,377.19	0.9999	$(2.41)	$0.47	1.0166	$1,398.26
Non-Dual	Banner-UFC	South	$1,692.61	0.9889	$(3.44)	$1.89	1.0166	$1,738.40
Non-Dual	Mercy Care	South	$2,192.95	0.9820	$(3.78)	$6.47	1.0166	$2,272.98
Non-Dual	UHC-LTC	Central	$1,808.64	0.9999	$(2.51)	$2.43	1.0166	$1,838.82
Non-Dual	Banner-UFC	Central	$2,034.43	0.9889	$(2.63)	$0.07	1.0166	$2,088.75
Non-Dual	Mercy Care	Central	$2,139.43	0.9820	$(3.68)	$6.36	1.0166	$2,217.56

CYE 2022, Gross Acute Care Expenses PMPM										
Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	PBM Spread Removal	IMD Repricing	DAP Payments Removed	Retrospective Program Changes	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 22
Dual	UHC-LTC	North	$148.81	0.8785	0.9916	$0.07	$(1.29)	1.0011	1.1109	$185.43
Dual	Banner-UFC	South	$245.36	0.9512	1.0000	$0.02	$(1.88)	1.0015	1.1109	$284.89
Dual	Mercy Care	South	$241.74	0.9708	0.9960	$0.14	$(1.43)	1.0015	1.1109	$274.49
Dual	UHC-LTC	Central	$222.10	0.8785	0.9944	$0.14	$(1.31)	1.0045	1.1109	$279.20
Dual	Banner-UFC	Central	$376.34	0.9512	1.0000	$-	$(2.63)	1.0045	1.1109	$438.55
Dual	Mercy Care	Central	$419.86	0.9708	0.9967	$0.03	$(2.57)	1.0045	1.1109	$478.16
Non-Dual	UHC-LTC	North	$2,667.25	0.9729	0.9907	$0.57	$(35.41)	1.0006	1.1624	$3,118.25
Non-Dual	Banner-UFC	South	$3,072.59	0.9754	1.0000	$0.10	$(33.18)	1.0004	1.1624	$3,624.42
Non-Dual	Mercy Care	South	$2,999.60	0.9801	0.9960	$0.62	$(28.21)	1.0004	1.1624	$3,512.40
Non-Dual	UHC-LTC	Central	$3,665.82	0.9729	0.9937	$(0.90)	$(44.42)	1.0024	1.1624	$4,309.44
Non-Dual	Banner-UFC	Central	$3,454.26	0.9754	1.0000	$-	$(40.89)	1.0024	1.1624	$4,078.39
Non-Dual	Mercy Care	Central	$3,755.64	0.9801	0.9966	$(1.04)	$(39.60)	1.0024	1.1624	$4,402.13

Appendix 5: CYE 22 Projected Trends by Rate Cell and Category of Service

Rate Cell	COS	Pct of Costs in Base	Annual Utilization Trend Rate	Annual Unit Cost Trend Rate	Annual PMPM Trend Rate
Dual	Nursing Facility	29.6%	0.9%	1.1%	2.0%
Dual	HCBS	32.9%	0.3%	2.3%	2.6%
Dual	Acute Care	6.8%	3.4%	0.5%	3.9%
Non-Dual	Nursing Facility	8.3%	1.9%	0.6%	2.5%
Non-Dual	HCBS	6.8%	0.0%	0.6%	0.6%
Non-Dual	Acute Care	15.6%	1.5%	4.1%	5.6%

Appendix 6: CYE 22 Projected Gross and Net Medical Expenses PMPM by COS and Rate Cell

Nursing Facility (NF) Expenses PMPM

Rate Cell	Contractor	GSA	Gross NF Expense Amount PMPM	Prop 206 Adjustment Factor	Provider Fee Schedule	DAP PMPM Add-on	Pct of Members Receiving LTSS	Projected NF Mix Pct	Projected SOC Payments Removed	Net NF Expense Amount PMPM 10/1/21
Dual	UHC-LTC	North	$6,188.72	1.0397	1.0881	$105.33	98.3%	25.9%	$(247.74)	$1,561.19
Dual	Banner-UFC	South	$6,502.34	1.0392	1.0867	$104.14	99.0%	25.4%	$(200.33)	$1,669.93
Dual	Mercy Care	South	$6,014.76	1.0392	1.0887	$105.30	99.2%	25.6%	$(204.46)	$1,548.68
Dual	UHC-LTC	Central	$6,303.41	1.0392	1.0894	$108.23	98.3%	17.2%	$(132.43)	$1,092.34
Dual	Banner-UFC	Central	$6,576.54	1.0392	1.0880	$112.27	99.1%	24.8%	$(191.26)	$1,661.77
Dual	Mercy Care	Central	$6,613.31	1.0392	1.0894	$109.25	98.9%	22.3%	$(181.29)	$1,491.22
Non-Dual	UHC-LTC	North	$10,841.71	1.0396	1.0976	$205.83	95.8%	16.6%	$(39.44)	$1,957.99
Non-Dual	Banner-UFC	South	$8,189.92	1.0392	1.0979	$153.84	96.2%	24.9%	$(20.27)	$2,254.84
Non-Dual	Mercy Care	South	$6,873.62	1.0392	1.0945	$131.39	96.4%	26.3%	$(26.84)	$1,990.94
Non-Dual	UHC-LTC	Central	$8,331.75	1.0392	1.0997	$157.78	96.5%	22.8%	$(11.61)	$2,121.84
Non-Dual	Banner-UFC	Central	$9,389.63	1.0392	1.0871	$145.71	96.4%	28.6%	$(25.04)	$2,944.28
Non-Dual	Mercy Care	Central	$9,509.74	1.0392	1.0981	$172.40	96.4%	22.4%	$(19.28)	$2,365.43

HCBS Expenses PMPM

Rate Cell	Contractor	GSA	Gross HCBS Expense Amount PMPM	Prospective Program Changes	Prop 206 Adjustment Factor	Provider Fee Schedule	DAP PMPM Add-on	Pct of Members Receiving LTSS	Projected HCBS Mix Pct	Projected SOC Payments Removed	Net HCBS Expense Amount PMPM 10/1/21
Dual	UHC-LTC	North	$1,544.86	1.0056	1.0879	1.1116	$3.34	98.3%	74.1%	$(14.37)	$1,356.79
Dual	Banner-UFC	South	$1,960.44	1.0034	1.0853	1.1152	$5.50	99.0%	74.6%	$(12.37)	$1,751.86
Dual	Mercy Care	South	$2,067.78	1.0034	1.0829	1.1102	$5.55	99.2%	74.4%	$(18.73)	$1,828.03
Dual	UHC-LTC	Central	$1,771.38	1.0035	1.0849	1.1116	$4.07	98.3%	82.8%	$(11.98)	$1,735.18
Dual	Banner-UFC	Central	$2,006.55	1.0035	1.0846	1.1141	$4.72	99.1%	75.2%	$(8.36)	$1,808.95
Dual	Mercy Care	Central	$2,198.93	1.0035	1.0840	1.1121	$7.31	98.9%	77.7%	$(14.01)	$2,037.16
Non-Dual	UHC-LTC	North	$1,398.26	1.0115	1.0860	1.1164	$4.17	95.8%	83.4%	$(0.39)	$1,373.10
Non-Dual	Banner-UFC	South	$1,738.40	1.0173	1.0832	1.1189	$6.70	96.2%	75.1%	$(1.01)	$1,552.23
Non-Dual	Mercy Care	South	$2,272.98	1.0173	1.0811	1.1097	$8.54	96.4%	73.7%	$(3.62)	$1,973.21
Non-Dual	UHC-LTC	Central	$1,838.82	1.0170	1.0845	1.1129	$5.47	96.5%	77.2%	$(1.40)	$1,684.11
Non-Dual	Banner-UFC	Central	$2,088.75	1.0170	1.0827	1.1228	$5.57	96.4%	71.4%	$(0.04)	$1,779.67
Non-Dual	Mercy Care	Central	$2,217.56	1.0170	1.0814	1.1130	$9.49	96.4%	77.6%	$(3.90)	$2,031.76

Acute Expenses PMPM

Rate Cell	Contractor	GSA	Gross Acute Expense Amount PMPM	Pharmacy Savings	Rx Rebates	Prospective Program Changes	Provider Fee Schedule	DAP PMPM Add-on	Reinsurance Offset PMPM	Net Acute Expense Amount PMPM 10/1/21
Dual	UHC-LTC	North	$ 185.43	$ 0.00	$ (0.11)	1.2081	1.0025	$ 1.51	$ (3.46)	$ 222.49
Dual	Banner-UFC	South	$ 284.89	$ 0.00	$ (0.12)	1.1130	1.0017	$ 1.76	$ (9.48)	$ 309.78
Dual	Mercy Care	South	$ 274.49	$ 0.00	$ (0.15)	1.1130	1.0013	$ 1.08	$ (2.69)	$ 304.13
Dual	UHC-LTC	Central	$ 279.20	$ 0.00	$ (0.12)	1.1068	1.0026	$ 1.04	$ (22.49)	$ 288.25
Dual	Banner-UFC	Central	$ 438.55	$ 0.00	$ (0.10)	1.1068	1.0010	$ 1.84	$ (8.62)	$ 478.99
Dual	Mercy Care	Central	$ 478.16	$ 0.00	$ (0.25)	1.1068	1.0009	$ 2.28	$ (49.40)	$ 482.31
Non-Dual	UHC-LTC	North	$ 3,118.25	$ (42.55)	$ (13.66)	1.0418	1.0276	$ 35.26	$ (103.76)	$ 3,209.67
Non-Dual	Banner-UFC	South	$ 3,624.42	$ (66.06)	$ (27.76)	1.0108	1.0257	$ 32.75	$ (438.75)	$ 3,254.36
Non-Dual	Mercy Care	South	$ 3,512.40	$ (44.29)	$ (22.41)	1.0108	1.0269	$ 28.92	$ (353.63)	$ 3,251.83
Non-Dual	UHC-LTC	Central	$ 4,309.44	$ (47.04)	$ (21.72)	1.0181	1.0261	$ 42.51	$ (689.65)	$ 3,782.96
Non-Dual	Banner-UFC	Central	$ 4,078.39	$ (55.76)	$ (22.28)	1.0181	1.0255	$ 37.30	$ (311.65)	$ 3,902.29
Non-Dual	Mercy Care	Central	$ 4,402.13	$ (110.20)	$ (27.76)	1.0181	1.0328	$ 31.26	$ (496.85)	$ 4,018.11

Appendix 7: CYE 22 Projected Capitation Rates PMPM by Rate Cell, Contractor, and GSA

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	$1,561.19	$1,356.79	$222.49	$170.29	$115.43	$34.30	$70.62	$3,531.10
Dual	Banner-UFC	South	$1,669.93	$1,751.86	$309.78	$144.14	$155.09	$40.40	$83.09	$4,154.29
Dual	Mercy Care	South	$1,548.68	$1,828.03	$304.13	$176.54	$81.84	$39.42	$81.20	$4,059.84
Dual	UHC-LTC	Central	$1,092.34	$1,735.18	$288.25	$169.70	$115.78	$34.24	$70.11	$3,505.61
Dual	Banner-UFC	Central	$1,661.77	$1,808.95	$478.99	$160.26	$164.36	$42.83	$88.11	$4,405.27
Dual	Mercy Care	Central	$1,491.22	$2,037.16	$482.31	$186.26	$89.92	$43.36	$88.37	$4,418.60
Non-Dual	UHC-LTC	North	$1,957.99	$1,373.10	$3,209.67	$173.29	$256.31	$70.74	$143.70	$7,184.79
Non-Dual	Banner-UFC	South	$2,254.84	$1,552.23	$3,254.36	$163.09	$325.73	$79.89	$155.72	$7,785.85
Non-Dual	Mercy Care	South	$1,990.94	$1,973.21	$3,251.83	$179.94	$175.57	$79.25	$156.14	$7,806.89
Non-Dual	UHC-LTC	Central	$2,121.84	$1,684.11	$3,782.96	$166.49	$318.98	$87.64	$166.57	$8,328.60
Non-Dual	Banner-UFC	Central	$2,944.28	$1,779.67	$3,902.29	$161.91	$390.72	$94.91	$189.26	$9,463.04
Non-Dual	Mercy Care	Central	$2,365.43	$2,031.76	$4,018.11	$185.79	$207.17	$93.05	$181.66	$9,082.97

Appendix 8a: State Directed Payments, CMS Prescribed Tables

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

Control name of the state directed payment	Type of payment - Section I.4.D.ii.(a)(i)(A)	Brief description - Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.d.ii.(a)(iii)
AZ_Fee_IP.OP.PC_Renewal_20211001-20220931 (a.k.a. DAP)	Uniform Percentage Increase	Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.	Rate Adjustment
AZ_Fee_AMC_Renewal_20211001-20220930 (a.k.a. APSI)	Uniform Percentage Increase	62% increase to otherwise contracted rates for professional services provided by qualified practitioners affiliated with designated hospitals.	Separate Payment Term
AZ_Fee_IP.OP1_Renewal_20211001-20220930 (a.k.a. PSI)	Uniform Percentage Increase	Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_IP.OP2_Renewal_20211001-20220930 (a.k.a. HEALTHII)	Uniform Percentage Increase	Uniform percentage increase for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class' aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term
AZ_Fee_NF_Renewal_20211001-20220930 (a.k.a. NF Supplemental Payments)	Uniform Dollar Amount	Uniform dollar increase to be applied across all Contractor's reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund plus FMAP and is expected to fluctuate based on utilization and available funds for each quarter.	Separate Payment Term

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

Control name of the state directed payment	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Impact - Section I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
AZ_Fee_IP.OP.PC_Renewal_20211001-20220931 (a.k.a. DAP)	All EPD rate cells are affected.	See Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell.	The qualifying providers receiving the payments include: Hospitals subject to APR-DRG reimbursement (eligible for up to 3.0% increase), Critical Access Hospitals (eligible for up to 10.5% increase), Other Hospitals and Inpatient Facilities (eligible for up to 5.0% increase), Nursing Facilities (eligible for up to 2.0% increase), Integrated Clinics (eligible for a 10.0% increase on a limited set of codes), Behavioral Health Outpatient Clinics (eligible for a 1.0% increase), Behavioral Health Outpatient Clinics and Integrated Clinics (eligible for up to 8.5% increase on all services provided), Physicians, Physician Assistants, and Registered Nurse Practitioners (eligible for up to 3.5% increase), Behavioral Health Providers (eligible for up to 1.0% increase), Dental Providers (eligible for up to 2.0% increase), and HCBS Providers (eligible for up to 1.0% increase on specified services for some provider types, and all services for other provider types). The AHCCCS DHCM Rates & Reimbursement Team provided the AHCCCS DHCM Actuarial Team with data for the impact of DAP. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the DAP impacts was the CYE 20 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 22 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 22 (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).	AHCCCS has submitted the Differential Adjusted Payments (DAP) §438.6(c) pre-print to CMS but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the pre-print under CMS review.	Not applicable.

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

Control name of the state directed payment	Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20211001-20220930 (a.k.a. APSI)	$3,501,593	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b	AHCCCS has submitted the Access to Professional Services Initiative (APSI) §438.6(c) pre-print to CMS but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IP.OP1_Renewal_20211001-20220930 (a.k.a. PSI)	$2,331,671	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b	AHCCCS has submitted the Pediatric Service Initiative (PSI) §438.6(c) pre-print to CMS but has not yet received approval. The PSI payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IP.OP2_Renewal_20211001-20220930 (a.k.a. HEALTHII)	$46,637,059	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) §438.6(c) pre-print to CMS but has not yet received approval. The HEALTHII payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_NF_Renewal_20211001-20220930 (a.k.a. NF Supplemental Payments)	$84,268,468	The actuaries (or actuary) certify (certifies) to the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b	AHCCCS has submitted the Nursing Facility Supplemental Payments (NFSP) §438.6(c) pre-print to CMS but has not yet received approval. The NFSP payment arrangement is accounted for in a manner consistent with the pre-print under CMS review.	After the rating period is complete and the final NFSP is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NFSP into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment pre-print, and as if the payment information had been fully known when the rates were initially developed.

Appendix 8b: State Directed Payments, Estimated PMPMs

Rate Cell	Contractor	GSA	DAP	APSI	PSI	NF-SP	HEALTHII
Dual	UnitedHealthCare	North	$31.69	$0.09	$0.00	$319.71	$28.20
Dual	Banner-UFC	South	$32.95	$0.65	$0.00	$301.44	$36.76
Dual	Mercy	South	$32.87	$1.10	$0.00	$284.01	$32.87
Dual	UnitedHealthCare	Central	$23.35	$0.72	$0.00	$190.35	$24.40
Dual	Banner-UFC	Central	$33.93	$0.29	$0.00	$287.77	$56.06
Dual	Mercy	Central	$32.93	$0.46	$0.00	$247.28	$56.20
Non-Dual	UnitedHealthCare	North	$73.47	$34.35	$57.77	$314.89	$724.78
Non-Dual	Banner-UFC	South	$76.72	$71.04	$4.31	$304.00	$732.59
Non-Dual	Mercy	South	$70.43	$74.31	$3.46	$301.83	$650.70
Non-Dual	UnitedHealthCare	Central	$83.86	$71.15	$91.25	$271.69	$737.10
Non-Dual	Banner-UFC	Central	$83.86	$64.49	$36.89	$360.23	$782.15
Non-Dual	Mercy	Central	$77.96	$62.29	$41.17	$282.44	$627.23

Notes:

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