AHCCCS
Arizona Health Care Cost Containment System

Contract Year Ending 2020
Arizona Long Term Care System/ Elderly and Physical Disability Capitation Rate Certification

October 1, 2019 through September 30, 2020

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 of 81 FR 27497 (published May 6, 2016 and effective July 5, 2016). This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for Contract Year Ending 2020 (CYE 20) effective October 1, 2019 through September 30, 2020, for the Arizona Long Term Care System (ALTCS)/Elderly and Physical Disability (ALTCS/EPD) Program. Due to one programmatic change (Proposition 206 Minimum Wage Increase) that will be implemented with an effective date of January 1, 2020, this certification will cover two sets of capitation rates. One set will apply for the time frame from October 1, 2019 through December 31, 2019, and another set will apply from January 1, 2020 through September 30, 2020. The rate development process is the same for both sets of capitation rates except the latter set includes the impact of the Proposition 206 Minimum Wage Increase adjustment. All comparisons to prior rates in this certification refer to the capitation rates effective January 1, 2019, previously submitted within the actuarial memorandum as signed by Matthew C. Varitek dated August 21, 2018. This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

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

The 2020 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 2020 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

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

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
- § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
- § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
- § 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 page 2 of the 2020 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 2020 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Rating Period

The CYE 20 capitation rates for the ALTCS/EPD Program are effective for the twelve month time period from October 1, 2019 through September 30, 2020.

I.1.A.ii. Required Elements

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

The actuarial certification letter for the CYE 20 capitation rates for the ALTCS/EPD Program, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 at 81 FR 27854 provided below for reference.

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

Mr. Varitek certifies that the CYE 20 capitation rates for the ALTCS/EPD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438 of 81 FR 27497.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ALTCS/EPD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i) at 81 FR 27856. The ALTCS/EPD contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell to be consistent with the applicable provisions of 42 CFR Part 438 of 81 FR 27497 and the 2020 Guide.

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

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

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

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

Table 1: Managed Care Plan(s) by GSA

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

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

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

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

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

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

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

The CYE 20 capitation rates for ALTCS/EPD are effective for the three month time period from October 1, 2019 through December 31, 2019 and the nine month time period from January 1, 2020 through September 30, 2020.

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

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

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

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

experience used in the development of these rates only includes ALTCS/EPD Medicaid eligible expenses for ALTCS/EPD Medicaid eligible individuals.

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

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

There are no expected changes to the eligibility and enrollment criteria during CYE 20 that could have an impact on the populations to be covered under the ALTCS/EPD Program.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6 at 81 FR 27859. The special contract provisions related to payment included in the CYE 20 capitation rates are:

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

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

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

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

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

Proposed differences among the CYE 20 capitation rates for the ALTCS/EPD Program are based on valid rate development standards and are not based on the rate of Federal Financial Participation for the populations covered under the ALTCS/EPD Program.

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

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

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

The effective dates of changes to the ALTCS/EPD Program are consistent with the assumptions used to develop the CYE 20 capitation rates for the ALTCS/EPD Program.

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

The certified capitation rates allow each ALTCS/EPD Program Contractor to reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 20.

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

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

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

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

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 20 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 20 capitation rates for the ALTCS/EPD Program.

I.1.A.ix. Rate Certification Procedures

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

This rate certification documents that the ALTCS/EPD Program capitation rates will be changing effective October 1, 2019 and January 1, 2020.

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

Not applicable. This rate certification will prospectively change the ALTCS/EPD Program capitation rates effective October 1, 2019 and January 1, 2020.

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

This section of the 2020 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell, in accordance with 42 CFR § 438.7(c)(3), and applying risk scores to capitation rates paid to plans under a

risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

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

A contract amendment will be submitted to CMS to reflect the ALTCS/EPD Program capitation rates changing effective October 1, 2019 and January 1, 2020.

I.1.B. Appropriate Documentation

I.1.B.i. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 20 capitation rates for the ALTCS/EPD Program.

I.1.B.ii. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2020 Guide. Sections of the 2020 Guide that do not apply will be marked as "Not Applicable"; any section wherein all subsections are not applicable will be collapsed to the section heading.

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

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

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

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

The comparisons between the most recent certified CYE 19 ALTCS/EPD Program capitation rates and the CYE 20 capitation rates being certified in this actuarial rate certification are available in Appendix 3a.

The 2020 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 20 certified capitation rates, the actuary 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 2020 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 19 rates, but as shown in Appendix 3a, eight different rate cells reflect a change of more than 10% from the most recent certified CYE 19 capitation rates. The percentage change in capitation from the rates effective January 1, 2019 is predominantly attributable to three forces: provider reimbursement increases; removal of bid efficiency factors, described in more detail in Section I.3.B.(ii)(b); and PMPM expense trend assumptions. When aggregated across all rate cells, each Contractor's percentage change in capitation from the rates effective January 1, 2019 to the rates effective October 1, 2019 does not vary much from the statewide average. Variations by rate cell from the statewide average change are primarily due to the impact of rebasing. Unlike the three forces identified above, which produce similar impacts to each Contractor and GSA, the impact of rebasing by individual rate cell can fluctuate. The CYE 19 capitation rates were developed using FFY 17 expense data averaged by GSA for all MCOs active in each GSA

during FFY 17 (EPD MCOs changed from FFY 17 to FFY 18 due to the ALTCS/EPD RFP), and then applying risk adjustment calculated from more current data to attempt to reflect actual cost relativities among currently active MCOs, while the CYE 20 rates are developed using FFY 18 experience as the base for projection. The FFY 18 experience was incurred through the same MCOs active in each GSA as are active for CYE 20. Consequently, the update to the base period data now reflects the experience of each MCO active in any particular GSA.

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

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

I.2. Data

This section provides documentation for the Data section of the 2020 Guide.

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

Since AHCCCS employs their own actuaries, a formal data request was not needed between the AHCCCS Division of Health Care Management (DHCM) Actuarial Team and the State. The AHCCCS DHCM Actuarial Team worked with the appropriate teams at AHCCCS to obtain the primary sources of data in accordance with 42 CFR § 438.5(c) at 81 FR 27858.

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

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

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

The types of data that AHCCCS relied upon for developing the CYE 20 capitation rates for the ALTCS/EPD program were:

- Adjudicated and approved encounter data (October 1, 2015 through September 30, 2018 (Federal Fiscal Year (FFY) 16, FFY 17, and FFY 18)) submitted by ALTCS/EPD Contractors;
- Reinsurance payments for FFY 16, FFY 17, and FFY 18;
- Historical member month data for FFY 16, FFY 17, and FFY 18 from the PMMIS mainframe;
- Projected enrollment data provided by the AHCCCS Division of Business and Finance (DBF) Budget Team for CYE 20;
- Quarterly and annual financial statements submitted by the Contractors for FFY 16, FFY 17, FFY 18, and FFY 19 and reviewed by the AHCCCS DHCM Finance & Reinsurance Team;
- Supplemental historical and projected data associated with benefit and non-benefit costs for current rate cells provided by the Contractors.

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

The encounter data serving as the base experience in the capitation rate development process was incurred during FFY 18 (October 1, 2017 to September 30, 2018) and paid through February 2019. For the purposes of developing trend assumptions applied within the Contractor-specific CYE 20 capitation

rates, AHCCCS also reviewed encounter data from FFY 16 (October 1, 2015 through September 30, 2016), FFY 17 (October 1, 2016 through September 30, 2017), and the first six months of FFY 19 (October 1, 2018 through March 31, 2019, paid through May 2019).

The historical enrollment data for ALTCS/EPD members aligned with the encounter data time periods of FFY 16, FFY 17, and FFY 18. The projected enrollment data for CYE 20 was provided by the AHCCCS Division of Business and Finance (DBF).

The financial statement data reviewed as part of the rate development process included financial statements for the FFY 16, FFY 17, FFY 18, and FFY 19 time periods.

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

The enrollment and encounter data were provided from the AHCCCS PMMIS mainframe. The projected enrollment data for CYE 20 was provided by the AHCCCS DBF Budget Team. The financial statement data were submitted by the ALTCS/EPD Contractors and reviewed by the DHCM Finance & Reinsurance team. Information regarding Home and Community-Based Settings (HCBS) placement and member movement among Contractors was provided by the DHCM Operations Unit.

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

The ALTCS/EPD Contractors have sub-capitated/block purchasing arrangements. During FFY 18, the ALTCS/EPD Contractors paid approximately 0.6% of total medical expenditures through sub-capitated arrangements. The sub-capitated arrangements between the ALTCS/EPD Contractors and their providers still require that the providers submit claims, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there is a repricing methodology (i.e. formula) for those (CN1 code = 05, and health plan paid of zero (i.e. sub-capitated)) encounters to estimate a health plan valued amount for these encounters. The revised amounts from the repricing methodology were used in rate development.

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

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

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

The AHCCCS Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a PMPM basis looking for anomalous patterns in encounter, unit, or cost totals, such as incurred months where totals are unusually low or high. If any anomalies are found, the AHCCCS Actuarial Team reports the findings to the AHCCCS Data Analysis & Research (DAR) Team, which then

works with ALTCS/EPD Contractors to determine causal factors. In addition, the AHCCCS DAR Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

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

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

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

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

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

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

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

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

The AHCCCS DHCM Actuarial Team reviewed the encounter data for all services provided by ALTCS/EPD Contractors to the annual financial statement data for the same entities for CYE 18. After adjustments to the encounter data for completion, the comparisons showed that the financial statements and the encounter data were consistent.

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

As required by ASOP No. 23, 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 actuary notes additional reliance on data provided by the AHCCCS Rates & Reimbursement Team with regards to DAP and fee schedule impacts, on information and data provided by Mercer consultants with regards to mental health parity and pharmacy reimbursement savings, and on data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

AHCCCS has determined the FFY 18 encounter data to be appropriate for the purposes of developing the CYE 20 capitation rates for the ALTCS/EPD program. Additionally, the FFY 16 and FFY 17 encounter data was deemed appropriate for use in trends.

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

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

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

The FFY 18 encounter data was appropriate to use as the base data for developing the CYE 20 capitation rates for the ALTCS/EPD program.

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

As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 20 capitation rates for the ALTCS/EPD Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 20 capitation rates for the ALTCS/EPD Program.

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

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

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

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

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

No credibility adjustment was necessary.

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

An adjustment was made to the encounter data to reflect the level of completion. AHCCCS calculated completion factors using the development method with monthly encounter data from October 1, 2015 through September 30, 2018, paid through February 2019. The monthly completion factors were

applied to the encounter data on a monthly basis for purposes of trend development. However, the base CYE 18 gross medical expense amounts, for purposes of projection to CYE 20, were completed using annualized completion factors calculated to equate the encounter totals to those found in CYE 18 financial statements, revised for prior period adjustments. The aggregated CYE 18 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 (October 1, 2017 through September 30, 2018) are described below. Additional adjustments for program and fee schedule changes which occurred before April 1, 2019 are also included below. All program and fee schedule changes which occurred or are effective on or after April 1, 2019 are described in Section I.3.B.ii.(a).

Reimbursement and Program Changes

NF and HCBS Expenses

Provider Fee Schedule Changes

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding their fee schedules. Effective October 1, 2018, AHCCCS updated provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates.

Additionally, as part of the 2018 Legislative session, the Arizona Legislature passed SB 1520 which includes an appropriation to increase reimbursement by 3% for skilled nursing facilities (SNF) and assisted living facilities. AHCCCS covers nursing facility (NF) services provided in institutional settings and assisted living facility services provided in home and community based settings to ALTCS/EPD members. This reimbursement change was effective October 1, 2018.

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, AHCCCS also adjusted fee schedule rates for select HCBS procedure codes, all NF revenue codes, and all Alternative Living Facility (ALF) procedure codes. The fee schedule rates for NF services increased by 0.7% effective January 1, 2018, and by 0.7% effective January 1, 2019. The fee schedule rates for ALF

and select HCBS services increased by 1.4% effective January 1, 2018, and by 1.4% effective January 1, 2019.

The overall impact to the ALTCS/EPD Program is approximately $26.8M, or $73.01 PMPM on an annual basis. The aggregate impact of the base data adjustments for fee schedule changes described above are shown in Appendix 4 columns "Reimbursement Changes" in the NF and HCBS Expense tables, by rate cell. The aggregate impacts vary by rate cell, MCO, and GSA due to differences in service mix and/or timing of services throughout the base year.

Acute Expenses

If a base data adjustment change had an impact of 0.2% of less on the statewide capitation rate, that adjustment was deemed non-material and has been grouped in the combined reimbursement and program changes subset below, along with a brief description of the non-material items. All programmatic and fee schedule changes which only affected base data for the Acute Expenses component of the capitation rate are non-material. The overall impact to the ALTCS/EPD Program is approximately $793,000, or $2.16 PMPM on an annual basis. The combined impact for each of the base data adjustments described here is shown by rate cell in Appendix 4 column "Reimb/Pgm Changes" in the Acute Expense table. The combined impacts vary by rate cell, MCO, and GSA due to differences in service mix and/or timing of services throughout the base year.

Reimbursement and Programmatic Changes

DRG Rebase

AHCCCS transitioned from version 31 to version 34 of the All Patient Refined Diagnostic Related Groups (APR-DRG) payment classification system on January 1, 2018. To make the APR-DRG grouper fully ICD-10 code compliant, AHCCCS rebased the inpatient system by updating the DRG grouper version, relative weights and DRG base rates via payment simulation modeling using more recent data.

Provider Fee Schedules

AHCCCS typically makes annual updates to provider fee schedules that are used for AHCCCS fee-for-service programs. The AHCCCS DHCM Rates & Reimbursement Team and the AHCCCS DHCM Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DHCM Finance & Reinsurance Team regarding their fee schedules. Effective October 1, 2018, AHCCCS updated provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates.

Hepatitis C (HCV) Treatment

In 2017, the AHCCCS Pharmacy and Therapeutics (P&T) Committee reviewed the HCV Direct Acting Antiviral Agents (DAA) and recommended Mavyret as the sole preferred agent to treat HCV based on both clinical efficacy and cost effectiveness. AHCCCS accepted P&T's recommendation and also

removed fibrosis level requirements that were previously necessary in order to access treatment and removed a one treatment per lifetime limitation effective January 1, 2018.

Removal of DAP from Base Period

Acute and NF Expenses

CYE 18 capitation rates funded Differential Adjusted Payments (DAP) for Acute and NF expenses from October 1, 2017 through September 30, 2018 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, 2018, AHCCCS has removed the impact of CYE 18 DAP payments from the base period. The change reduced the statewide costs for the base period by approximately $6.8 million or $20.37 PMPM. The impact of removing DAP from the base data is shown by rate cell in Appendix 4 columns "DAP Payments Removed" in the NF, HCBS, and Acute Expense tables. The impact varies by rate cell, MCO, and GSA due to differences in service mix and/or timing of services throughout the base year.

See section I.4.D. below for information on adjustments included in CYE 20 rates for DAP that are effective from October 1, 2019 through September 30, 2020.

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 20 capitation rates.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2020 Guide.

I.3.A. Rate Development Standards

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

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

I.3.A.ii. Variations in Assumptions

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

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

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

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

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

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

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

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

The data used to determine the base data adjustment was the CYE 18 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 18 encounter data, the AHCCCS DHCM Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The list of IMDs was updated during the CYE 20 rate development in a collaborative effort between the health plans and the AHCCCS DHCM Actuarial Team. 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 $864.51 and was derived from the CYE 18 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 Fee-for-Service 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 Fee-for-Service fee schedule per diem rate. The costs associated with an institutional stay at an IMD that were repriced in the base data are displayed below in Table 2a. Totals may not add up due to rounding.

Table 2a: Reprice of Costs for all IMD Stays by Rate Cell, Contractor, and GSA

Rate Cell	Contractor	GSA	Repriced IMD Dollars Added	Repriced IMD PMPM Added
Dual	UHC-LTC	North	$13,458	$0.47
Dual	Banner-UFC	South	$1,762	$0.04
Dual	Mercy Care	South	$4,363	$0.17
Dual	UHC-LTC	Central	$9,330	$0.15
Dual	Banner-UFC	Central	$57	$0.00
Dual	Mercy Care	Central	$20,198	$0.21
Non-Dual	UHC-LTC	North	$1,215	$0.29
Non-Dual	Banner-UFC	South	$0	$0.00
Non-Dual	Mercy Care	South	$2,818	$0.57
Non-Dual	UHC-LTC	Central	$13,071	$1.29
Non-Dual	Banner-UFC	Central	$0	$0.00
Non-Dual	Mercy Care	Central	$19,875	$0.81
Totals			**$86,149**	**$0.23**

The AHCCCS DHCM Actuarial Team identified all members age 21 to 64 who had IMD stays which exceeded 15 cumulative days in a month, and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed below in Table 2b. Totals may not add up due to rounding.

Table 2b: Removal of Repriced Stays More Than 15 Days in a Month by Rate Cell, Contractor, and GSA

Rate Cell	Contractor	GSA	Repriced IMD Dollars Removed	Repriced IMD PMPM Removed
Dual	UHC-LTC	North	$8,985	$0.31
Dual	Banner-UFC	South	$0	$0.00
Dual	Mercy Care	South	$0	$0.00
Dual	UHC-LTC	Central	$0	$0.00
Dual	Banner-UFC	Central	$0	$0.00
Dual	Mercy Care	Central	$4,861	$0.05
Non-Dual	UHC-LTC	North	$0	$0.00
Non-Dual	Banner-UFC	South	$0	$0.00
Non-Dual	Mercy Care	South	$31,122	$6.30
Non-Dual	UHC-LTC	Central	$31,122	$3.07
Non-Dual	Banner-UFC	Central	$0	$0.00
Non-Dual	Mercy Care	Central	$29,393	$1.20
Totals			**$105,484**	**$0.29**

Once a member was identified as having an IMD stay(s) greater than 15 cumulative days in a month, all encounter data for the member was pulled for the timeframe(s) they were in the IMD in order to remove those additional medical service costs from rate development. The associated costs removed from the base data are displayed below in Table 2c. Totals may not add up due to rounding.

Table 2c: Removal of Related Costs for IMD Stays of More Than 15 Days in a Month by Rate Cell, Contractor, and GSA

Rate Cell	Contractor	GSA	Related Cost Dollars Removed	Related Cost PMPM Removed
Dual	UHC-LTC	North	$205	$0.01
Dual	Banner-UFC	South	$0	$0.00
Dual	Mercy Care	South	$0	$0.00
Dual	UHC-LTC	Central	$0	$0.00
Dual	Banner-UFC	Central	$0	$0.00
Dual	Mercy Care	Central	$6,499	$0.07
Non-Dual	UHC-LTC	North	$0	$0.00
Non-Dual	Banner-UFC	South	$0	$0.00
Non-Dual	Mercy Care	South	$7,020	$1.42
Non-Dual	UHC-LTC	Central	$3,054	$0.30
Non-Dual	Banner-UFC	Central	$0	$0.00
Non-Dual	Mercy Care	Central	$7,353	$0.30
Totals			**$24,131**	**$0.07**

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 20 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. The adjusted base data per-member-per-month (PMPM) expenditures for each category of service (COS) were trended forward 24 months, from the midpoint of the FFY 18 time period to the midpoint of the CYE 20 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 20 DAP, member share of cost offset, 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 financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the DHCM Clinical Quality Management Team and the Office of the Director's Chief Medical Officer. The actuary relied upon the professional judgment of the financial analysts with regards to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuary met with the AHCCCS financial analysts to understand at a high level how the estimated amounts were derived and the data used for the amounts. The actuary was unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

Reimbursement Changes

Proposition 206 Reimbursement Rate Changes

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

The data used to develop CYE 20 adjustments for the minimum wage increase was the CYE 18 encounter data for the HCBS procedure codes, NF revenue codes, and the ALF procedure codes. The changes are expected to increase statewide costs under the ALTCS/EPD Program by a combined $47.3 million, or $128.77 PMPM on an annual basis. Appendix 6, columns "Prop 206 Adjustment Factor 10/1/19" and "Prop 206 Adjustment Factor 1/1/20" in the NF and HCBS Expense tables include these fee schedule adjustments by rate cell.

Provider Fee Schedule Changes

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

Effective October 1, 2019, AHCCCS will be updating provider fee schedules for certain providers based either on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 20 capitation rates have been adjusted to reflect these fee schedule changes. The data used by the AHCCCS DHCM Rates & Reimbursement Team to develop the adjustment to CYE 20 capitation rates was the CYE 18 encounter data across all programs. The AHCCCS DHCM Rates & Reimbursement Team applied the AHCCCS provider fee schedule changes as a unit cost change to determine what the impacts would be for the CYE 20 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program. The overall impact to the ALTCS/EPD Program is approximately $42.5 million, or $115.87 PMPM on an annual basis. The impacts of this change by rate cell are included in Appendix 6, columns "Reimb Adjustment Factor 10/1/19" in the NF and HCBS Expense tables, and in the column "Prog/Reimb Adjustments PMPM" in the Acute Expense table.

Pharmacy Reimbursement Savings

Analysis of pharmacy claims for all AHCCCS managed care programs and the AHCCCS Fee-for-Service (FFS) program has 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 the lesser of Health Plan Paid amounts or AHCCCS FFS repriced amounts would result in an annual savings of $68.2 million or 5.6% of pharmacy spend for FFY 18 across all programs. AHCCCS Contractors should reasonably be able to achieve pharmacy pricing that is at or near that achieved by the AHCCCS FFS program. However, AHCCCS recognizes that the full savings amount may not be reasonably achievable in a single year, and is therefore adjusting the base pharmacy data of each program by 33% of the savings that could be achieved in that program by repricing to the lesser of current health plan pricing and AHCCCS FFS pricing. Based on continued analysis, further adjustments may be made to phase-in larger savings amounts in subsequent contract periods.

The overall impact to the ALTCS/EPD Program is a decrease of approximately $843,000, or -$2.30 PMPM on an annual basis. The impacts of this change by rate cell are included the column “Prog/Reimb Adjustments PMPM” in the Acute Expense table.

Rx Rebates Adjustment

An adjustment was made to the projected gross medical expense to reflect the impact of Rx Rebates because the base data does not include any adjustments for Rx Rebates reported within the Contractors’ financial statements. The actuary reviewed the CYE 18 annual financial statement reports and the CYE 19 Q1 and Q2 financial statement reports. From this review, the actuary determined that it would be reasonable to apply an adjustment to the projected gross medical expense to reflect a level of reported Rx Rebates. From the review of the above data, the actuary assumed that each MCO would be able to achieve an average rebate percent between that reported on CYE 18 and YTD 19 financial statements and applied that percent as a reduction to the projected CYE 20 Pharmacy category of service.

The overall impact to the ALTCS/EPD Program is a decrease of approximately $968,000, or -$2.64 PMPM on an annual basis. The impacts of this change by rate cell are included the column “Prog/Reimb Adjustments PMPM” in the Acute Expense table.

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 to the ALTCS/EPD Program is a decrease of approximately

$546,000, or -$1.49 PMPM on an annual basis. The impacts of these changes by rate cell are included the column "Prog/Reimb Adjustments PMPM" in the Acute Expense table. Brief descriptions of the individual program changes are provided below.

- ***Prenatal Syphilis Screening****
  In September 2018, the Arizona Department of Health Services (ADHS) declared a syphilis outbreak for women and babies in Arizona. In response to the outbreak, AHCCCS issued a joint position statement with ADHS on February 28, 2019 to clarify that AHCCCS covers 3 prenatal syphilis screens during a member's pregnancy. The statement aligns with screening recommendations from the Centers for Disease Control and Prevention (CDC) that all pregnant women receive a screen during their first prenatal visit, and again early in the third trimester and at the time of delivery if they are at high risk of syphilis.
- ***Bilateral Cochlear Implants****
  Effective March 1, 2019, AHCCCS revised policy to specify coverage of bilateral cochlear impacts for children 20 years of age or younger. The change recognizes the latest standard of care and a CMS decision memo regarding the appropriateness of bilateral cochlear implants. Prior to the change, policy specified coverage of unilateral cochlear implants for children.
- ***LISAC Mental Health Assessments ****
  Effective November 1, 2018, AHCCCS included Licensed Independent Substance Abuse Counselors (LISAC) among qualifying providers that will be reimbursed for non-physician mental health assessments. The scope of practice for LISAC includes evaluation and treatment of substance abuse disorders, which can require use of mental health assessments. After unintendedly removing the permission for LISAC to bill for these services during the period from July 1, 2017 to October 31, 2018, the change restored that billing authority.
- ***Naturopathic Physicians Providing EPSDT ****
  In CYE 2019, AHCCCS began accepting applications for Doctors of Naturopathic Medicine (ND) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children under 21 years of age. The AHCCCS Office of Administrative and Legal Services (OALS) has interpreted federal and state laws to require the State to cover "medical care, or any other type of remedial care recognized under State law" provided by an ND as EPSDT services to "correct or ameliorate" any physical or mental conditions of the member. Use of services provided by NDs to members will largely replace existing use of services provided by other registered physician provider types. State law, however, places some limitations on the medications NDs may prescribe while many of the practitioners use pharmacological interventions sparingly. As a result, a number of ND office visits will require additional follow-up visits to a prescribing provider, which will increase use of services.
- ***Behavioral Health Residential Facilities ****
  Effective October 1, 2019, the AHCCCS DHCM Rates & Reimbursement Team will establish a differentiated Fee For Service rate for Behavioral Health Residential Facilities (BHRF) that are licensed by ADHS to provide personal care services.
- ***Transportation Network Companies for NEMT ****

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. The expansion of providers that can deliver NEMT services to members is also expected to reduce missed medical appointments and thus increase medical utilization. The estimated cost reduction associated with lower priced NEMT services provided by TNCs exceeds the estimated cost increase of additional office visits and NEMT rides associated with additional office visits.

- ***3D Mammography ****
  Effective June 1, 2019, upon recommendation of the AHCCCS Quality Management Team, AHCCCS began covering digital breast tomosynthesis (3D mammograms) for preventive screening and diagnosis of adults 21 years of age and older. The AHCCCS Quality Management Team made the recommendation in recognition of studies that find use of 3D mammograms in addition to or in place of 2D services has at times improved detection of breast cancer in some populations. Contractors are permitted to use prior authorization criteria in evaluating medical necessity of 3D services for members.
- ***Pharmacy and Therapeutics Committee Recommendations ****
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE 2019 that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 2020. 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.
- ***Advanced Practice Nurse MAT ****
  The Federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) permits Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists to administer Buprenorphine for medication assisted treatment (MAT). The federal law is expected to increase use of MAT and costs to the program.
- ***Telehealth for Rural and Urban Access to Care ****
  Effective October 1, 2019, AHCCCS policy is revised to improve access to telehealth services. The revision to policy eliminates restrictions on service categories for which telehealth can be used, removes place of service requirements for the distant site provider, and clarifies that telehealth services may be used in urban and rural settings.

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

The methodology for developing the ALTCS/EPD capitation rate has changed since the CYE 19 capitation rate development process. The CYE 20 rates are developed using Contractor-specific experience incurred during CYE 18 as the primary source of data under the methods described throughout this certification, without consideration for bid amounts received during the most recent request for proposal (RFP). The CYE 19 rates were developed using encounter data incurred prior to the RFP, when different Contractors were active in the Central and South GSAs than are active today. The expense

projections for CYE 19 incorporated aspects of the bid gross medical expenses, case management expenses and administrative expense PMPMs from the most recent RFP, with adjustments by GSA and Contractor as described in the CYE 2019 ALTCS/EPD Program Capitation Rate Certification dated August 21, 2018.

The CYE 19 rates preserved the cost savings achieved within the most recent RFP through the application of bid efficiency factors to the gross medical expense component of the CYE 19 capitation rate. The gross medical expense component was developed from base period data outside of the RFP contract period, and so did not reflect any cost efficiencies achieved through the competitive bidding process. The bid efficiency factors were developed by rate cell, GSA, Contractor, and COS. Each factor reflects the percentage by which a Contractor's awarded PMPM expense from the RFP prior to acuity adjustments for a given rate cell, GSA, and COS was below the top of the bid range for that rate cell, GSA, and COS as shown in Appendix 4a of the CYE 2018 ALTCS/EPD Program Capitation Rate Certification dated October 1, 2017. The CYE 20 capitation rates do not incorporate the bid efficiency factors, since the CYE 18 base data is within the current RFP contract period.

The methodology for developing the reinsurance offset component of the ALTCS/EPD capitation rate has changed since the CYE 19 capitation rate development process. The development of the CYE 20 offset amounts is described in section I.4.C.ii.(c).(iv). The CYE 19 offset amounts were developed from historical reinsurance payments made for services incurred during FFY 17, adjusted for changes in CYE 18 and CYE 19 to the types of acute care services eligible to accumulate towards a reinsurance payment.

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

The ALTCS/EPD program Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuary to set the CYE 20 capitation rates therefore includes those adjustments.

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

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

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

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

Please see Section I.2.B.ii.(a) for the types of data that AHCCCS relied upon for developing the projected benefit cost trends for the CYE 20 capitation rates for the ALTCS/EPD Program.

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

Historical utilization, unit cost, and PMPM data from contract years 2016, 2017, and 2018 were organized by incurred year and month and category of service (COS). The three years of data were normalized for historical program and fee schedule changes. Trend rates were developed to adjust the base data (midpoint April 1, 2018) forward 24 months to the midpoint of the contract period (April 1, 2020). 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 20.

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

The 2020 Guide requires explanation of outlier or negative trends. For the purposes of this rate certification, the actuary defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. There are no outlier or negative trends in the CYE 20 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. 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. 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

The AHCCCS DHCM Medical Management Team, the AHCCCS Office of Administrative Legal Services (OALS) Legal Counsel Team, and the AHCCCS Office of the Director, in coordination with our managed care contractors and Mercer consultants, have completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis to determine if additional services are necessary to comply with parity standards. No additional services have been identified as necessary services to comply with MHPAEA. Updates to program analysis will be reviewed throughout the year for continued compliance.

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

Services in alternative inpatient settings licensed by ADHS/DLS can be provided in lieu of services in an inpatient hospital (distinct and disparate from in-lieu-of services provided in an IMD). These services are then included in the ALTCS/EPD CYE 20 capitation rate development COS. Encounters which are in-lieu-of-services are not identified separately in the data. Thus, the actuary cannot define the percentage of cost that in-lieu-of services represented in the capitation rate development categories of service. However, the in-lieu-of services are treated exactly the same as all other State Plan approved services in capitation rate development.

I.3.B.vi. Retrospective Eligibility Periods

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

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

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

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

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

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

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

To be consistent with the rate structure of all other AHCCCS managed care programs, a separate PPC capitation rate was not developed for the ALTCS/EPD CYE 20 rates. All covered expenses and member months are included in the Dual and Non-Dual CYE 20 capitation rate cells. See section I.1.B.iv.(b) for more information about changes to methodology in developing CYE 20 rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

Alternative Payment Model (APM) Initiative – Quality Measure Performance

The incentive arrangement for the Alternative Payment Model (APM) Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of AHCCCS quality measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement. The maximum incentive pool possible is approximately $15.1M, which is the amount that would be available if every Contractor earned exactly 0% of the withhold described below. This is not anticipated to happen, and thus the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

APM Initiative – Performance Based Payments

The CYE 20 capitation rates for the ALTCS/EPD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2) at 81 FR 27589, called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the ALTCS/EPD Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by ALTCS/EPD Contractors that are aimed at quality improvement, such as reducing costs, improving health outcomes or improving access to care. For reference, the CYE 18 APM Initiative – Performance Based Payment amounts were $1.5M for the ALTCS/EPD Program.

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

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

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

APM Initiative – Quality Measure Performance

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

APM Initiative – Performance Based Payments

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

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

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

APM Initiative – Quality Measure Performance

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

APM Initiative – Performance Based Payments

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

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

All ALTCS/EPD program incentive arrangements combined will not exceed 105% of the capitation payments to comply with 42 CFR § 438.6(b)(2).

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

APM Initiative – Quality Measure Performance

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

APM Initiative – Performance Based Payments

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 20 capitation rates for the ALTCS/EPD Program. Additionally, incentive payments for the APM Initiative – Performance Based Payments incentive arrangement had no impact on the development of the CYE 20 capitation rates for the ALTCS/EPD Program. The anticipated incentive payment amount will be paid by AHCCCS to the ALTCS/EPD Contractors through lump sum payments after the completion of the CYE 20 contract year.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2020 Guide provides information on the definition and requirements of a withhold arrangement.

I.4.B.ii. Appropriate Documentation

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

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

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

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

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

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

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

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

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

The actuary relied upon the AHCCCS DHCM Finance & Reinsurance Team's review. That review of the total withhold percentage of 1% of capitation revenue indicated that it is reasonable within the context of the capitation rate development, and that the magnitude of the withhold does not have a detrimental

impact on the Contractors' financial operation needs and capital reserves. The AHCCCS DHCM Finance & Reinsurance Team's interpretation of financial operating needs relates to cash flow needs for the Contractors to pay claims and administer benefits for its covered populations. The AHCCCS DHCM Finance & Reinsurance Team evaluated the reasonableness of the withhold within this context by reviewing the Contractors' cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by AHCCCS. To evaluate the reasonableness of the withhold in relation to capitalization levels, the AHCCCS DHCM Finance & Reinsurance Team reviewed the surplus above the equity per member requirement, the performance bond amounts, and financial stability of each Contractor to pay all obligations. The AHCCCS DHCM Finance & Reinsurance Team reviewed cash and cash equivalent levels in relation to the withhold arrangement and has indicated the withhold arrangement is reasonable based on current cash levels.

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

The capitation rates shown in this rate certification are illustrated before offset for the withhold amount. 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 20 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 2020 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 20 capitation rates for the ALTCS/EPD Program will include risk corridors.

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

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 20 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 2020 Guide. The ALTCS/EPD Contract refers to the risk corridor as reconciliation.

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

The share of cost (SOC) risk corridor will reconcile the actual member share of cost (SOC) payments received by each Contractor during each federal fiscal year against the PMPM amounts assumed in the capitation rates for that year. The SOC payments are reconciled to zero; that is, payments to, or

recoupments from, each Contractor are the arithmetic difference between the actual and assumed amounts, grossed up by 2% for premium tax.

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 and subcapitated/block purchase expenses as reported by the Contractor's financial statements with dates of service during the contract year. Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically computed no sooner than 15 months after the contract year. This risk corridor will limit each ALTCS/EPD Contractor's statewide profits and losses as follows:

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

Additional information regarding the CYE 20 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 20 capitation rates for the ALTCS/EPD Program.

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

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

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

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

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

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

AHCCCS provides a reinsurance program to the ALTCS/EPD Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the

majority of the reinsurance cases falling into the Regular reinsurance case type. Regular reinsurance cases cover partial reimbursement of inpatient facility medical services. Most of the other reinsurance cases fall under Catastrophic, including reinsurance for biotech drugs. Additionally, rather than the ALTCS/EPD Contractors paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical. One could view the reinsurance offset as a premium. Historical encounter data and reinsurance payments are used as the base for development of the reinsurance offset.

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

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

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

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

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical 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 FFY 18 inpatient encounter data for Regular reinsurance cases, and historical reinsurance payments to the ALTCS/EPD Contractors for Catastrophic reinsurance cases associated with services incurred during FFY 18. The data is “brought current” by way of completion factors specific to reinsurance payments, adjustments for historical and proposed program and reimbursement changes, and has the same trend factors applied as the gross medical expense for acute care services, since LTC services are not eligible for consideration in reinsurance. The calculated reinsurance payments for Regular reinsurance cases, which are limited to inpatient expenses and subject to a deductible, therefore reflect deductible leveraging since they are calculated on the actual FFY 18 inpatient costs trended forward to CYE 20. See Section I.3.B.ii.(b) for additional information about changes in the reinsurance program.

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

I.4.D.i. Rate Development Standards

This section of the 2020 Guide provides information on delivery system and provider payment initiatives authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

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

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

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

Differential Adjusted Payments

The Differential Adjusted Payment (DAP) initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health and reduce cost of care growth. The rate increase is intended to supplement, not supplant, payments to eligible providers. The rate increases range from 0.5% to 28.5%, depending on the provider type.

Access to Professional Services Initiative

The Access to Professional Services Initiative (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 85% 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 Pediatric Service Initiative (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. In 2014, as the Arizona legislature expanded coverage for adults, it authorized AHCCCS to make uncompensated care payments to the state's freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. CMS approved an extension of the Safety Net Care Pool (SNCP) for freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds, only, "in light of their critical role in Medicaid delivery and as a transition to reforming the current payment system" (CMS demonstration approval letter, Dec. 26, 2013). Independent evaluations of the SNCP confirmed the need for enhanced funding for freestanding children's hospitals or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds and recommended that AHCCCS "consider additional policy changes to direct funding to Phoenix Children's Hospital (PCH) and the recipients it serves" should PCH continue to experience uncompensated costs (*Evaluation of Safety Net Care Pool Payments for Phoenix Children's Hospital*, Navigant, March 29, 2018). The PSI is consistent with AHCCCS' and CMS' shared goals of ensuring financial support through payment rates rather than separate funding pools.

The PSI provides a uniform percentage increase of 36% to otherwise contracted rates 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 rate increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

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 increase is intended to supplement, not supplant, payments to eligible providers.

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

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

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

All EPD rate cells are affected. See Appendix 6 for medical impact by rate cell, and Appendix 8 for total impact by rate cell.

I.4.D.ii.(a)(ii)(B) 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 4.0% increase), Critical Access Hospitals (eligible for up to 28.5% increase), other hospitals and inpatient facilities (eligible for up to 4.0% 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 and integrated clinics (eligible for up to 7.0% increase on all services provided), physicians, physician assistants, registered nurse practitioners, dental providers (all eligible for a 1.0% increase), home and community based services providers (eligible for a 1.0% increase on specified services at specified places of service) and Federally Qualified Health Centers (FQHCs) (eligible for up to a 1.5% increase). All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.

The 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 18 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 20 time period. The AHCCCS DHCM Actuarial Team then reviewed the results and applied the impacts by program and rate cell (the data provided by the AHCCCS DHCM Rates & Reimbursement Team was at a detailed rate code level which the AHCCCS DHCM Actuarial Team then aggregated to the specific rate cells for each program).

The total amount of DAP payments, included as an adjustment to the capitation rates and inclusive of premium tax, is approximately $11.0 million in total, approximately $11.0 million for Non-FQHC DAP and approximately $12,000 for FQHC DAP.

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

AHCCCS has submitted the Differential Adjusted Payments § 438.6(c) pre-prints 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-prints under CMS review.

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

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

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

Access to Professional Services Initiative

Anticipated payments including premium tax for APSI are approximately $3.3M. AHCCCS will distribute the total payment via three quarterly lump sum payments to the Contractors, and a final lump sum

payment after the completion of the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Pediatric Service Initiative

Anticipated payments including premium tax for PSI are approximately $2.9M. AHCCCS will distribute the total payment via three quarterly lump sum payments to the Contractors, and a final lump sum payment after the completion of the contract year. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

Nursing Facility Enhanced Payments

The CYE 20 anticipated total payments for Nursing Facility Enhanced Payments are approximately $101.8 million, inclusive of premium tax. Of that total, approximately $92.2 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. The estimated PMPM amounts provided in the certification appendix are for informational purposes only.

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

Access to Professional Services Initiative

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

Pediatric Service Initiative

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

Nursing Facility Enhanced Payments

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

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

Access to Professional Services Initiative

The distribution methodology for the CYE 20 APSI payments will be based on members' utilization of services from APSI qualified providers. The 85 percent uniform percentage increase will be applied to eligible services performed by APSI qualified providers. Eligible services are those submitted on Form CMS-1500s and dental encounters, excluding any subcapitated/block purchase arrangements (identified by CN1 Code 05 on the encounter), and excluding services where AHCCCS is not the primary payer. The estimated amount for CYE 20 APSI was developed by applying the 85 percent uniform increase to CYE 18 utilization of eligible services based on encounters for the CYE 18 APSI qualified providers. The same

definition of eligible services was applied for the estimated amount. The APSI qualified providers were identified by Billing Provider Tax IDs in AHCCCS encounter system. The encounter data used to distribute the final payment amounts will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells. The CYE 18 utilization is used as the basis for where to distribute the first three quarterly lump sum payments. The final quarterly lump sum payment will use CYE 20 encounter data for APSI qualified providers. The CYE 20 encounter data used to distribute the final lump sum payment amount will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 18, and thus distribution used to make the three initial quarterly lump sum payments.

Pediatric Service Initiative

The distribution methodology for the CYE 20 PSI will be based on members' utilization of inpatient and outpatient services at freestanding children's hospitals, or pediatric units of a general acute care hospital with more than 100 beds, excluding nursery beds. The 36 percent uniform percentage increase will be applied to eligible services performed by providers eligible for the Pediatric Service Initiative. Eligible services are those submitted on UB-04 Inpatient Hospital and UB-04 Outpatient Hospital. The estimated amount for CYE 20 PSI was developed by applying the 36 percent uniform increase to CYE 18 utilization of eligible services based on encounters for the providers eligible for the Pediatric Services Initiative. The same definition of eligible services was applied for the estimated amount. The providers were identified by Servicing Provider Tax IDs in AHCCCS encounter system. The encounter data used to distribute the final payment amounts will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells. The CYE 18 utilization is used as the basis for where to distribute the first three quarterly lump sum payments. The final quarterly lump sum payments will use CYE 20 encounter data for eligible providers. The CYE 20 encounter data used to distribute the final lump sum payment amount will include relevant rate cell and program information to determine utilization, and thus distribution into the individual rate cells, and will adjust any change in utilization from CYE 18, and thus distribution used to make the three initial quarterly lump sum payments.

Nursing Facility Enhanced Payments

The distribution methodology for Nursing Facility Enhanced Payments (NF-EP) is based on each facility's proportion of Medicaid resident bed days to total nursing facility Medicaid resident bed days for the most recent and complete contract year (i.e. CYE 18 for CYE 20 NF-EP). The distribution methodology will use CYE 18 adjudicated and approved encounter data to allocate the CYE 20 NF-EP by capitation rate cell. The encounter data for this allocation will include: nursing facility providers that maintain eligibility for NF-EP, relevant claim health plan information, relevant rate cell information, and counts of accommodation days. The AHCCCS DHCM Actuarial Team will exclude Fee for Service (FFS) utilization from the development of the payments to ALTCS/EPD Program Contractors. After all exclusions, a payment for each ALTCS/EPD Program Contractor, including an adjustment for premium tax, will be developed.

The payments will be allocated by rate cells using the same encounter data listed above which had all relevant rate cell information included. The allocation of payments by Contractor will be driven by the percentage of total accommodation days that are assigned to each Contractor. The estimated amount for CYE 20 NF-EP was developed by using CYE 18 encounter data. Each quarterly payment will be paid based on the available funds in the nursing facility assessment fund plus FMAP.

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

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

I.4.D.ii.(a)(iii)(E) 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 pre-print will be amended and re-submitted to CMS to include the definition of eligible services listed above in the distribution methodology. The payment arrangement is accounted for in a manner consistent with the amended pre-print.

Pediatric Service 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.

Nursing Facility Enhanced Payments

AHCCCS has submitted the Nursing Facility Enhanced Payments § 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)(F) Future Documentation Requirements

Access to Professional Services Initiative

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

Pediatric Service Initiative

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

Nursing Facility Enhanced Payments

After the rating period is complete and the final NF-EP payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NF-EP payments into the rate

certification's rate cells, consistent with the distribution methodology described in Section I.4.D.ii.(a)(iii)(C), and as if the payment information had been fully known when the rates were initially developed.

I.4.E. Pass-Through Payments

Not applicable. There are no pass-through payments in the CYE 20 capitation rates for the ALTCS/EPD Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2020 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 20 capitation rates for the EPD Program were administrative expense estimates submitted by Contractors for CYE 18 and CYE 19. In addition, Contractors were required to submit administrative expense estimates for CYE 20, which were reviewed to inform development of cost projections. Also reviewed were trends and forecasts for Consumer Price Index (CPI) and Employment Cost Index (ECI) data from IHS Global Insight.

Reported CYE 18 administrative costs and CYE 19 expenditure projections were reviewed for each Contractor separately and trended forward to produce CYE 20 projected administrative expenses. The CYE 20 projections were developed by inflating the wage-driven portion of administrative expenses by the estimated change in CPI for wage earners for a one-year or two-year period as dictated by the base data. The actuary considered three options for base data to use in developing CYE 20 expenditure projections: each Contractor's projected CYE 19 administrative expenses as provided through a supplemental data request, converted to PMPM amounts using annualized estimates of their YTD CYE 19 enrollment; each Contractor's reported CYE 18 administrative expenses from the supplemental data request, converted to PMPM amounts using the CYE 18 member months by MCO as found in the rate setting databook; and each Contractor's reported CYE 18 administrative expenses from quarterly financial reporting, converted to PMPM amounts using the CYE 18 member months by MCO as found in the rate setting databook. The CYE 20 expenditure projections developed by the actuary were reviewed in comparison to CYE 18 actual expenses in the aggregate and on a PMPM basis, as well as compared to CYE 19 Q1 and Q2 financials, and judged to be reasonable and appropriate. Due to the actuary's assessment of the reasonability of the Contractors' submitted CYE 19 expense projections, the base data used to develop the non-benefit cost projection for one Contractor was their CYE 18 reported administrative expenses from quarterly financial reporting, while for the other two Contractors, the base data was their CYE 19 projected administrative expenditure from the supplemental data request.

The projected case management expenses were developed using reported case management expenses PMPM during CYE 18 for all Contractors, and actual HCBS mix percentages by rate cell during CYE 18, as a base for projection. The actuary estimated the wage-driven portion of the PMPM expenses, inflated the CYE 18 base by the two-year change in CPI-W, and adjusted for updated projections of each Contractor's HCBS mix percentage.

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

The data and methodology used for developing the ALTCS/EPD non-benefit component of the capitation rates has changed since the CYE 19 capitation rate development process. The CYE 20 non-benefit components of the capitation rates were developed with consideration of Contractor-specific experience and projected expenses, as discussed in section I.5.B.i.(a), while the CYE 19 non-benefit components were developed as adjustments to the awarded administrative and case management expenses PMPM from the most recent request for proposal as assumed in the CYE 18 capitation rates.

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

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

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

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

The projected non-benefit costs for each of the listed categories of costs in the 2020 Guide are shown in Appendix 7 for the CYE 20 capitation rates.

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

The administrative component of the CYE 20 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 20 capitation rates for the ALTCS/EPD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. The Health Insurance Providers Fee (HIPF) is discussed below in I.5.B.iii. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 20 capitation rate for the ALTCS/EPD Program includes a provision of 1% for risk margin (i.e. underwriting gain).

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

No other material or non-material non-benefit costs are reflected in the CYE 20 capitation rates for the ALTCS/EPD Program.

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

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

The capitation rates for the ALTCS/EPD Program reflected in this rate certification do not incorporate the Health Insurance Providers Fee (HIPF). AHCCCS will follow previous capitation rate methodologies for the HIPF in which capitation rates are amended to reflect the calculated HIPF and related tax impacts, except in years where there is a moratorium and no capitation rate adjustment happens.

AHCCCS intends to submit a new actuarial certification due to this update, except in years where there is a moratorium and no capitation rate adjustment happens.

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

Not applicable. The HIPF is not included in the CYE 20 capitation rates for the ALTCS/EPD Program.

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

Not applicable. The HIPF is not included in the CYE 20 capitation rates for the ALTCS/EPD Program.

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

The capitation rates in this certification do not include the fee because the rates will be adjusted to account for the fee at a later date, except in years where there is a moratorium and no capitation rate adjustment happens. If there is no moratorium, a new certification will be submitted with the rate impacts to CMS once the fees are known.

The PMPM capitation adjustments will be developed based on the HIPF liability reported to AHCCCS. The Contractors are notified of the HIPF liability for the entire corporate entity by the Treasury Department. The Contractors who receive multiple streams of revenue applicable to the HIPF calculation will be responsible for allocating an appropriate portion of their HIPF liability to AHCCCS, which will be verified by the AHCCCS DHCM Actuarial Team for reasonableness and appropriateness. To determine if the reported revenue and the HIPF liability allocations to AHCCCS from the Contractors is reasonable and appropriate, the AHCCCS DHCM Actuarial Team will review for each Contractor the HIPF liability allocated to AHCCCS as a percentage of the total HIPF liability from the IRS, and the revenue allocated to AHCCCS as a percentage of the total revenue reported to the IRS. Additionally, the AHCCCS DHCM Actuarial Team will compare the revenue allocated to each AHCCCS program from each Contractor against paid capitation data and determine if the revenue allocated by Contractor to each AHCCCS program is reasonable and appropriate.

As in previous years, the PMPM adjustments will be developed based on each corporate entity's actual member months within each applicable rate cell. The HIPF adjustment to the capitation rates is expected to be calculated late in the fee year.

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

The portion of the CYE 20 capitation rates effective October 1, 2019 for the ALTCS/EPD Program attributable to NF services, and related HCBS services, are located below in Table 3.

Table 3: Portion of the CYE 20 Capitation Rates for HCBS and NF

Rate Cell	CYE 20 MMs	LTC NF	LTC HCBS	LTC Total
Dual	307,770	$1,305.05	$1,524.01	$2,829.06
Non-Dual	59,382	$2,032.58	$1,682.12	$3,714.70
Total	367,153	$1,422.72	$1,549.58	$2,972.30

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

For any HIPF that has been paid in 2014, 2015, 2016, and/or 2018, the HIPF has been included in the capitation rates as a retroactive amendment to the initially certified capitation rates.

I.6. Risk Adjustment and Acuity Adjustments

Not applicable. The CYE 20 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 2020 Guide is applicable to the ALTCS/EPD Program because the CYE 20 capitation rates for ALTCS/EPD are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 at 81 FR 27858 and the ALTCS/EPD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. CMS Expectations

The rate development standards and appropriate documentation described in Section I of the 2020 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 2020 Guide provides the two most common approaches to structuring the rate cells.

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

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

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

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

II.1.C. Appropriate Documentation

II.1.C.i. Considerations

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

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

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

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

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

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

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

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

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

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

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

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

II.1.C.iii. Additional Information

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

Section III New Adult Group Capitation Rates

Section III of the 2020 Guide is not applicable to the ALTCS/EPD Program. As noted in Section I.1.B.iii, all covered populations under the ALTCS/EPD Program receive the regular FMAP.

Appendix 1: Actuarial Certification

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

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

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
- § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
- § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
- § 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 20 capitation rates for the ALTCS/EPD Program have been documented according to the guidelines established by CMS in the 2020 Guide. The CYE 20 capitation rates for the ALTCS/EPD Program are effective for the three month time period from October 1, 2019 through December 31, 2019 and the nine month time period from January 1, 2020 through September 30, 2020.

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

SIGNATURE ON FILE	August 15, 2019
Matthew C. Varitek	Date

Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Rate Cell	Contractor	GSA	CYE 20 Capitation Rate (10/1/19)	CYE 20 Capitation Rate (1/1/20)
Dual	UHC-LTC	North	$3,072.42	$3,125.28
Dual	Banner-UFC	South	$3,622.56	$3,685.05
Dual	Mercy Care	South	$3,378.06	$3,438.80
Dual	UHC-LTC	Central	$2,966.04	$3,020.21
Dual	Banner-UFC	Central	$3,823.61	$3,889.23
Dual	Mercy Care	Central	$3,745.32	$3,812.57
Non-Dual	UHC-LTC	North	$6,466.27	$6,525.80
Non-Dual	Banner-UFC	South	$6,452.05	$6,514.73
Non-Dual	Mercy Care	South	$7,141.60	$7,211.35
Non-Dual	UHC-LTC	Central	$7,046.94	$7,112.83
Non-Dual	Banner-UFC	Central	$7,792.47	$7,875.23
Non-Dual	Mercy Care	Central	$7,775.25	$7,855.05

Notes:

1. This filing certifies to Capitation Rates effective October 1, 2019 through December 31, 2019 and January 1, 2020 through September 30, 2020.

Appendix 3a: Comparison of Capitation Rates

Rate Cell	Contractor	GSA	CYE 19 Capitation Rate (1/1/19)	CYE 20 Capitation Rate (10/1/19)	Pct Change	CYE 20 Capitation Rate (1/1/20)	Pct Change
Dual	UHC-LTC	North	$2,904.09	$3,072.42	5.8%	$3,125.28	1.7%
Dual	Banner-UFC	South	$3,185.61	$3,622.56	13.7%	$3,685.05	1.7%
Dual	Mercy Care	South	$3,060.87	$3,378.06	10.4%	$3,438.80	1.8%
Dual	UHC-LTC	Central	$2,564.44	$2,966.04	15.7%	$3,020.21	1.8%
Dual	Banner-UFC	Central	$3,657.53	$3,823.61	4.5%	$3,889.23	1.7%
Dual	Mercy Care	Central	$3,428.35	$3,745.32	9.2%	$3,812.57	1.8%
Non-Dual	UHC-LTC	North	$5,543.97	$6,466.27	16.6%	$6,525.80	0.9%
Non-Dual	Banner-UFC	South	$5,560.64	$6,452.05	16.0%	$6,514.73	1.0%
Non-Dual	Mercy Care	South	$5,985.19	$7,141.60	19.3%	$7,211.35	1.0%
Non-Dual	UHC-LTC	Central	$6,024.69	$7,046.94	17.0%	$7,112.83	0.9%
Non-Dual	Banner-UFC	Central	$7,370.46	$7,792.47	5.7%	$7,875.23	1.1%
Non-Dual	Mercy Care	Central	$6,470.18	$7,775.25	20.2%	$7,855.05	1.0%

Appendix 3b: Fiscal Impact Summary

Rate Cell	Contractor	GSA	Proj MMs 10/1/19 - 12/31/19	Capitation Rates 10/1/19 - 12/31/19	Proj MMs 1/1/20 - 9/30/20	Capitation Rates 1/1/20 - 9/30/20	Projected Expenditures CYE 20
Dual	UHC-LTC	North	7,716	$3,072.42	23,564	$3,125.28	$97,352,381
Dual	Banner-UFC	South	11,054	$3,622.56	33,756	$3,685.05	$164,437,246
Dual	Mercy Care	South	6,926	$3,378.06	21,151	$3,438.80	$96,130,198
Dual	UHC-LTC	Central	17,995	$2,966.04	54,953	$3,020.21	$219,345,341
Dual	Banner-UFC	Central	6,634	$3,823.61	20,259	$3,889.23	$104,160,272
Dual	Mercy Care	Central	25,596	$3,745.32	78,164	$3,812.57	$393,872,426
Non-Dual	UHC-LTC	North	1,049	$6,466.27	3,204	$6,525.80	$27,689,779
Non-Dual	Banner-UFC	South	1,704	$6,452.05	5,203	$6,514.73	$44,890,162
Non-Dual	Mercy Care	South	1,240	$7,141.60	3,787	$7,211.35	$36,165,403
Non-Dual	UHC-LTC	Central	2,852	$7,046.94	8,710	$7,112.83	$82,052,082
Non-Dual	Banner-UFC	Central	1,199	$7,792.47	3,662	$7,875.23	$38,181,828
Non-Dual	Mercy Care	Central	6,604	$7,775.25	20,168	$7,855.05	$209,772,261

Appendix 4: Unadjusted and Adjusted Base Data by Rate Cell

CYE 20, Gross Nursing Facility (NF) Expenses PMPM										
Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	Reimbursement Changes	DAP Payments Removed	IMD Repricing	NF SOC Payments Added	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 20
Dual	UHC-LTC	North	$4,516.95	0.9980	1.0391	$67.31	$0.00	$776.68	0.70%	$5,488.39
Dual	Banner-UFC	South	$5,176.11	0.9912	1.0391	$77.85	$0.00	$673.89	0.70%	$6,107.22
Dual	Mercy Care	South	$4,677.71	0.9777	1.0390	$52.12	$0.00	$664.76	0.70%	$5,662.31
Dual	UHC-LTC	Central	$5,010.35	0.9980	1.0390	$77.15	$0.00	$732.78	0.70%	$5,954.61
Dual	Banner-UFC	Central	$5,260.99	0.9912	1.0390	$82.84	$0.00	$697.59	0.70%	$6,216.14
Dual	Mercy Care	Central	$5,243.27	0.9777	1.0391	$80.29	$0.00	$685.64	0.70%	$6,264.67
Non-Dual	UHC-LTC	North	$6,199.70	0.9980	1.0390	$91.94	$0.00	$105.97	4.55%	$7,070.39
Non-Dual	Banner-UFC	South	$6,154.96	0.9912	1.0391	$97.32	$0.00	$97.82	4.55%	$7,053.73
Non-Dual	Mercy Care	South	$5,877.46	0.9777	1.0390	$76.02	$0.00	$140.88	4.55%	$6,898.12
Non-Dual	UHC-LTC	Central	$8,002.73	0.9980	1.0389	$124.10	$0.00	$76.74	4.55%	$9,053.69
Non-Dual	Banner-UFC	Central	$8,065.38	0.9912	1.0390	$128.91	$0.00	$55.55	4.55%	$9,161.48
Non-Dual	Mercy Care	Central	$8,311.07	0.9777	1.0389	$124.04	$0.00	$82.77	4.55%	$9,607.94

CYE 20, Gross Home- and Community-Based Settings (HCBS) Expenses PMPM										
Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	Reimbursement Changes	DAP Payments Removed	IMD Repricing	NF SOC Payments Added	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 20
Dual	UHC-LTC	North	$1,337.34	0.9637	1.0173	$0.00	$0.00	$0.00	2.91%	$1,495.18
Dual	Banner-UFC	South	$1,661.80	0.9703	1.0172	$0.00	$0.00	$0.00	2.91%	$1,845.13
Dual	Mercy Care	South	$1,693.88	0.9880	1.0174	$0.00	$0.00	$0.00	2.91%	$1,847.28
Dual	UHC-LTC	Central	$1,486.40	0.9637	1.0172	$0.00	$0.00	$0.00	2.91%	$1,661.65
Dual	Banner-UFC	Central	$1,794.61	0.9703	1.0173	$0.00	$0.00	$0.00	2.91%	$1,992.69
Dual	Mercy Care	Central	$1,915.51	0.9880	1.0173	$0.00	$0.00	$0.00	2.91%	$2,088.82
Non-Dual	UHC-LTC	North	$1,466.32	0.9637	1.0158	$0.00	$0.00	$0.00	1.70%	$1,598.68
Non-Dual	Banner-UFC	South	$1,693.82	0.9703	1.0157	$0.00	$0.00	$0.00	1.70%	$1,833.93
Non-Dual	Mercy Care	South	$2,002.12	0.9880	1.0159	$0.00	$0.00	$0.00	1.70%	$2,129.23
Non-Dual	UHC-LTC	Central	$1,650.13	0.9637	1.0159	$0.00	$0.00	$0.00	1.70%	$1,799.15
Non-Dual	Banner-UFC	Central	$2,170.70	0.9703	1.0158	$0.00	$0.00	$0.00	1.70%	$2,350.42
Non-Dual	Mercy Care	Central	$2,262.55	0.9880	1.0157	$0.00	$0.00	$0.00	1.70%	$2,405.70

CYE 20, Gross Acute Care Expenses PMPM										
Rate Cell	Contractor	GSA	Unadjusted Base Data PMPMs	Completion Factors	Reimb/Pgm Changes	DAP Payments Removed	IMD Repricing	NF SOC Payments Added	PMPM Trend	Adjusted Base Data PMPMs, Trended to CYE 20
Dual	UHC-LTC	North	$136.82	0.8623	1.0045	$0.15	$0.15	$0.00	1.81%	$165.20
Dual	Banner-UFC	South	$220.39	0.9483	1.0045	$0.18	$0.04	$0.00	1.81%	$241.81
Dual	Mercy Care	South	$225.91	0.9447	1.0045	$0.16	$0.17	$0.00	1.81%	$248.96
Dual	UHC-LTC	Central	$189.41	0.8623	1.0045	$0.19	$0.15	$0.00	1.81%	$228.66
Dual	Banner-UFC	Central	$300.81	0.9483	1.0044	$0.30	$0.00	$0.00	1.81%	$329.93
Dual	Mercy Care	Central	$347.68	0.9447	1.0045	$0.40	$0.09	$0.00	1.81%	$382.83
Non-Dual	UHC-LTC	North	$2,349.99	0.8623	1.0023	$3.89	$0.29	$0.00	3.91%	$2,945.23
Non-Dual	Banner-UFC	South	$2,626.56	0.9483	1.0022	$2.55	$0.00	$0.00	3.91%	$2,994.42
Non-Dual	Mercy Care	South	$3,002.82	0.9447	1.0022	$2.37	-$7.15	$0.00	3.91%	$3,429.05
Non-Dual	UHC-LTC	Central	$2,736.47	0.8623	1.0022	$5.71	-$2.08	$0.00	3.91%	$3,425.51
Non-Dual	Banner-UFC	Central	$2,468.04	0.9483	1.0022	$4.31	$0.00	$0.00	3.91%	$2,811.53
Non-Dual	Mercy Care	Central	$3,172.59	0.9447	1.0022	$5.38	-$0.69	$0.00	3.91%	$3,627.17

Appendix 5: 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	30.9%	0.3%	0.4%	0.7%
Dual	HCBS	32.2%	2.3%	0.6%	2.9%
Dual	Acute Care	6.7%	0.6%	1.2%	1.8%
Non-Dual	Nursing Facility	8.3%	1.8%	2.7%	4.5%
Non-Dual	HCBS	7.1%	1.6%	0.1%	1.7%
Non-Dual	Acute Care	14.8%	3.7%	0.2%	3.9%

Appendix 6: CYE 20 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 10/1/19	Reimb Adjustment Factor 10/1/19	DAP PMPM 10/1/19	Pct of Members Receiving LTSS	Projected NF Mix Pct	Projected SOC PMPM	Net NF Expense Amount PMPM 10/1/19	Prop 206 Adjustment Factor 1/1/20	Net NF Expense Amount PMPM 1/1/20
Dual	UHC-LTC	North	$5,488.39	1.0185	1.0261	$16.70	98.92%	28.68%	-$237.30	$1,394.45	1.0131	$1,415.78
Dual	Banner-UFC	South	$6,107.22	1.0185	1.0261	$15.88	99.01%	27.46%	-$207.00	$1,532.59	1.0131	$1,555.38
Dual	Mercy Care	South	$5,662.31	1.0185	1.0261	$15.88	99.18%	26.68%	-$201.16	$1,369.19	1.0131	$1,389.77
Dual	UHC-LTC	Central	$5,954.61	1.0185	1.0261	$13.00	98.30%	17.45%	-$137.47	$932.30	1.0131	$946.31
Dual	Banner-UFC	Central	$6,216.14	1.0185	1.0261	$13.00	98.73%	26.64%	-$209.84	$1,502.12	1.0131	$1,524.54
Dual	Mercy Care	Central	$6,264.67	1.0185	1.0261	$13.00	98.86%	24.11%	-$189.90	$1,373.47	1.0131	$1,393.95
Non-Dual	UHC-LTC	North	$7,070.39	1.0185	1.0261	$18.87	96.21%	28.34%	-$24.30	$1,995.32	1.0131	$2,021.72
Non-Dual	Banner-UFC	South	$7,053.73	1.0185	1.0261	$16.08	95.49%	25.41%	-$20.59	$1,771.62	1.0131	$1,795.10
Non-Dual	Mercy Care	South	$6,898.12	1.0185	1.0261	$16.08	97.00%	26.46%	-$21.44	$1,832.82	1.0131	$1,857.11
Non-Dual	UHC-LTC	Central	$9,053.69	1.0185	1.0261	$20.18	97.41%	19.45%	-$11.43	$1,785.34	1.0131	$1,808.87
Non-Dual	Banner-UFC	Central	$9,161.48	1.0185	1.0261	$20.18	93.47%	31.98%	-$18.79	$2,849.36	1.0131	$2,886.93
Non-Dual	Mercy Care	Central	$9,607.94	1.0185	1.0261	$20.18	93.31%	22.53%	-$13.24	$2,101.82	1.0131	$2,129.52

HCBS Expenses PMPM

Rate Cell	Contractor	GSA	Gross HCBS Expense Amount PMPM	Prop 206 Adjustment Factor 10/1/19	Reimb Adjustment Factor 10/1/19	DAP PMPM 10/1/19	Pct of Members Receiving LTSS	Projected HCBS Mix Pct	Net HCBS Expense Amount PMPM 10/1/19	Prop 206 Adjustment Factor 1/1/20	Net HCBS Expense Amount PMPM 1/1/20
Dual	UHC-LTC	North	$1,495.18	1.0362	1.0496	$5.22	98.92%	71.32%	$1,151.00	1.0260	$1,180.96
Dual	Banner-UFC	South	$1,845.13	1.0362	1.0496	$6.39	99.01%	72.54%	$1,445.96	1.0262	$1,483.81
Dual	Mercy Care	South	$1,847.28	1.0362	1.0496	$6.39	99.18%	73.32%	$1,465.61	1.0262	$1,503.97
Dual	UHC-LTC	Central	$1,661.65	1.0362	1.0496	$6.75	98.30%	82.55%	$1,471.87	1.0262	$1,510.43
Dual	Banner-UFC	Central	$1,992.69	1.0362	1.0496	$6.75	98.73%	73.36%	$1,574.61	1.0262	$1,615.86
Dual	Mercy Care	Central	$2,088.82	1.0362	1.0496	$6.75	98.86%	75.89%	$1,709.49	1.0262	$1,754.27
Non-Dual	UHC-LTC	North	$1,598.68	1.0362	1.0496	$6.74	96.21%	71.66%	$1,203.43	1.0261	$1,234.79
Non-Dual	Banner-UFC	South	$1,833.93	1.0362	1.0496	$7.90	95.49%	74.59%	$1,426.34	1.0262	$1,463.68
Non-Dual	Mercy Care	South	$2,129.23	1.0362	1.0496	$7.90	97.00%	73.54%	$1,657.65	1.0262	$1,701.04
Non-Dual	UHC-LTC	Central	$1,799.15	1.0362	1.0496	$9.45	97.41%	80.55%	$1,542.65	1.0262	$1,583.06
Non-Dual	Banner-UFC	Central	$2,350.42	1.0362	1.0496	$9.45	93.47%	68.02%	$1,631.34	1.0262	$1,674.07
Non-Dual	Mercy Care	Central	$2,405.70	1.0362	1.0496	$9.45	93.31%	77.47%	$1,898.19	1.0262	$1,947.91

Acute Expenses PMPM

Rate Cell	Contractor	GSA	Gross Acute Expense Amount PMPM	Prog/Reimb Adjustments PMPM	DAP PMPM 10/1/19	Reinsurance Offset PMPM	Net Acute Expense Amount PMPM 10/1/19
Dual	UHC-LTC	North	$165.20	$0.32	$1.26	-$6.01	$160.77
Dual	Banner-UFC	South	$241.81	-$0.99	$1.62	-$9.89	$232.55
Dual	Mercy Care	South	$248.96	-$1.03	$1.62	-$8.82	$240.73
Dual	UHC-LTC	Central	$228.66	-$0.18	$2.09	-$28.48	$202.09
Dual	Banner-UFC	Central	$329.93	-$0.15	$2.09	-$12.60	$319.28
Dual	Mercy Care	Central	$382.83	-$0.26	$2.09	-$72.02	$312.64
Non-Dual	UHC-LTC	North	$2,945.23	-$14.13	$27.65	-$294.81	$2,663.94
Non-Dual	Banner-UFC	South	$2,994.42	-$28.10	$30.97	-$413.13	$2,584.16
Non-Dual	Mercy Care	South	$3,429.05	-$33.21	$30.97	-$286.54	$3,140.27
Non-Dual	UHC-LTC	Central	$3,425.51	-$36.34	$37.18	-$353.29	$3,073.06
Non-Dual	Banner-UFC	Central	$2,811.53	-$28.57	$37.18	-$278.50	$2,541.64
Non-Dual	Mercy Care	Central	$3,627.17	-$35.60	$37.18	-$425.92	$3,202.82

Appendix 7: CYE 20 Projected Capitation Rates PMPM by Rate Cell, Contractor, and GSA

October 1, 2019 Capitation Rates

Rate Cell	Contractor	GSA	Net NF Expense Amount PMPM	Net HCBS Expense Amount PMPM	Net Acute Expense Amount PMPM	Case Mgmt PMPM	Admin Exp PMPM	UW Gain PMPM	Premium Tax PMPM	Final Net Capitation PMPM
Dual	UHC-LTC	North	$1,394.45	$1,151.00	$160.77	$168.78	$106.09	$29.87	$61.45	$3,072.42
Dual	Banner-UFC	South	$1,532.59	$1,445.96	$232.55	$140.93	$162.82	$35.25	$72.45	$3,622.56
Dual	Mercy Care	South	$1,369.19	$1,465.61	$240.73	$131.45	$70.65	$32.86	$67.56	$3,378.06
Dual	UHC-LTC	Central	$932.30	$1,471.87	$202.09	$168.33	$103.06	$29.06	$59.32	$2,966.04
Dual	Banner-UFC	Central	$1,502.12	$1,574.61	$319.28	$141.60	$172.31	$37.23	$76.47	$3,823.61
Dual	Mercy Care	Central	$1,373.47	$1,709.49	$312.64	$158.32	$79.43	$37.05	$74.91	$3,745.32
Non-Dual	UHC-LTC	North	$1,995.32	$1,203.43	$2,663.94	$167.73	$240.86	$65.66	$129.33	$6,466.27
Non-Dual	Banner-UFC	South	$1,771.62	$1,426.34	$2,584.16	$161.03	$313.17	$66.69	$129.04	$6,452.05
Non-Dual	Mercy Care	South	$1,832.82	$1,657.65	$3,140.27	$137.44	$158.45	$72.13	$142.83	$7,141.60
Non-Dual	UHC-LTC	Central	$1,785.34	$1,542.65	$3,073.06	$168.87	$264.21	$71.87	$140.94	$7,046.94
Non-Dual	Banner-UFC	Central	$2,849.36	$1,631.34	$2,541.64	$166.86	$369.06	$78.37	$155.85	$7,792.47
Non-Dual	Mercy Care	Central	$2,101.82	$1,898.19	$3,202.82	$162.51	$174.75	$79.66	$155.51	$7,775.25

January 1, 2020 Capitation Rates

Rate Cell	Contractor	GSA	Net NF Expense Amount PMPM	Net HCBS Expense Amount PMPM	Net Acute Expense Amount PMPM	Case Mgmt PMPM	Admin Exp PMPM	UW Gain PMPM	Premium Tax PMPM	Final Net Capitation PMPM
Dual	UHC-LTC	North	$1,415.78	$1,180.96	$160.77	$168.78	$106.09	$30.38	$62.51	$3,125.28
Dual	Banner-UFC	South	$1,555.38	$1,483.81	$232.55	$140.93	$162.82	$35.85	$73.70	$3,685.05
Dual	Mercy Care	South	$1,389.77	$1,503.97	$240.73	$131.45	$70.65	$33.45	$68.78	$3,438.80
Dual	UHC-LTC	Central	$946.31	$1,510.43	$202.09	$168.33	$103.06	$29.59	$60.40	$3,020.21
Dual	Banner-UFC	Central	$1,524.54	$1,615.86	$319.28	$141.60	$172.31	$37.86	$77.78	$3,889.23
Dual	Mercy Care	Central	$1,393.95	$1,754.27	$312.64	$158.32	$79.43	$37.71	$76.25	$3,812.57
Non-Dual	UHC-LTC	North	$2,021.72	$1,234.79	$2,663.94	$167.73	$240.86	$66.24	$130.52	$6,525.80
Non-Dual	Banner-UFC	South	$1,795.10	$1,463.68	$2,584.16	$161.03	$313.17	$67.30	$130.29	$6,514.73
Non-Dual	Mercy Care	South	$1,857.11	$1,701.04	$3,140.27	$137.44	$158.45	$72.81	$144.23	$7,211.35
Non-Dual	UHC-LTC	Central	$1,808.87	$1,583.06	$3,073.06	$168.87	$264.21	$72.51	$142.26	$7,112.83
Non-Dual	Banner-UFC	Central	$2,886.93	$1,674.07	$2,541.64	$166.86	$369.06	$79.17	$157.50	$7,875.23
Non-Dual	Mercy Care	Central	$2,129.52	$1,947.91	$3,202.82	$162.51	$174.75	$80.43	$157.10	$7,855.05

Appendix 8: Projected Delivery System and Provider Payment Initiatives, PMPM

Rate Cell	Contractor	GSA	DAP Non-FQHC	DAP FQHC	APSI	PSI	Enhanced NF Payments
Dual	UHC-LTC	North	$23.87	$0.01	$0.06	$0.00	$266.23
Dual	Banner-UFC	South	$24.60	$0.02	$0.27	$0.00	$285.93
Dual	Mercy Care	South	$24.60	$0.02	$0.95	$0.00	$288.74
Dual	UHC-LTC	Central	$22.50	$0.01	$0.69	$0.08	$179.06
Dual	Banner-UFC	Central	$22.50	$0.01	$0.20	$0.00	$305.72
Dual	Mercy Care	Central	$22.50	$0.01	$1.07	$0.00	$256.41
Non-Dual	UHC-LTC	North	$54.76	$0.13	$28.53	$17.73	$171.84
Non-Dual	Banner-UFC	South	$56.38	$0.25	$77.66	$11.97	$202.75
Non-Dual	Mercy Care	South	$56.38	$0.25	$82.86	$3.00	$313.64
Non-Dual	UHC-LTC	Central	$68.72	$0.12	$42.84	$82.27	$237.66
Non-Dual	Banner-UFC	Central	$68.72	$0.12	$31.25	$72.06	$364.56
Non-Dual	Mercy Care	Central	$68.72	$0.12	$51.68	$53.42	$255.67

Note: All amounts shown include premium tax. DAP amounts also include underwriting gain.