ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Contract Year Ending 2027
Capitation Rate Certification
Arizona Long Term Care System
Developmental Disabilities Program

October 1, 2026 through September 30, 2027

Prepared for:

The Centers for Medicare & Medicaid Services

Prepared by:

AHCCCS Division of Business and Finance

July 30, 2026

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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for the Contract Year Ending 2027 (CYE 27) for the Arizona Long Term Care System (ALTCS) Developmental Disabilities (ALTCS-DD) Program contracted under the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD). Programs under AHCCCS and their respective contracts have been aligned with the federal fiscal year since October 1, 2018. All contract years referenced below cover the timeframe from October 1 of one year through September 30 of the following year (e.g., CYE 27 covers the timeframe between October 1, 2026, through September 30, 2027).

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

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2026-2027 Medicaid Managed Care Rate Development Guide (2027 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2027 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 2027 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(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

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

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

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

- Actuarial Standards of Practice (ASOPs) applicable to Medicaid managed care rate setting which were effective before the start date of the rating period:
  - ASOP No. 1 - Introductory Actuarial Standard of Practice,
  - ASOP No. 5 - Incurred Health and Disability Claims,
  - ASOP No. 12 - Risk Classification (for All Practice Areas),
  - ASOP No. 23 - Data Quality,
  - ASOP No. 25 - Credibility Procedures,
  - ASOP No. 41 - Actuarial Communications,
  - ASOP No. 45 - The Use of Health Status Based Risk Adjustment Methodologies,
  - ASOP No. 49 - Medicaid Managed Care Capitation Rate Development and Certification, and
  - ASOP No. 56 - Modeling.
- The 2016, 2020, and 2024 Medicaid and CHIP Managed Care Final Rules (CMS-2390-F, CMS-2408-F, and CMS-2408-F)
- FAQs related to payments to MCOs and PIHPs for IMD stays
- The 2026-2027 Medicaid Managed Care Rate Development Guide (2027 Guide) published by CMS

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

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

As stated on page 5 of the 2027 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 2027 Guide.

I.1.A. Rate Development Standards

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

This section of the 2027 Guide notes that standards and documentation expectations are not different for capitation rates and capitation rate ranges, except where otherwise stated.

I.1.A.ii. Rating Period

The CYE 27 capitation rates for the ALTCS-DD Program are effective for the 12-month time period from October 1, 2026, through September 30, 2027.

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 27 capitation rates for the ALTCS-DD Program, signed by Ethan Sheffield, ASA, MAAA is in Appendix 1. Mr. Sheffield meets the requirements for the definition of an Actuary described at 42 CFR § 438.2, 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. Sheffield certify that the CYE 27 capitation rates for the ALTCS-DD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

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

The final and certified capitation rates by rate cell are located in Appendix 2. Additionally, the ALTCS-DD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ALTCS-DD Program contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell when identifying a population at the certified capitation rate level (as shown in Appendix 3, Appendix 5, and Appendix 7) to be consistent with the applicable provisions of 42 CFR Part 438 and the 2026 Guide and will use the term risk group when identifying a population not at the certified capitation rate level, such as when discussing the development of impacts where modeling was done for multiple programs.

I.1.A.iii.(c) Portion of Capitation Attributable to SDPs

See Appendix 8b for the portion of capitation attributable to state directed payments (SDPs) that are incorporated into the capitation rates

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

This section of the rate certification provides a summary of information about the ALTCS-DD Program.

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

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

DES/DDD is the only managed care organization for this program. AHCCCS requires DES/DDD to offer a Dual Eligible Special Needs Plan (D-SNP). DES/DDD subcontracts with integrated subcontractors who operate D-SNPs contracted with AHCCCS to provide some of the services (as outlined in I.1.A.iii.(c)(i)(B) below) for the members enrolled in the ALTCS-DD Program. Mercy Care operates the Mercy Care D-SNP, and UnitedHealthcare Community Plan operates the Arizona Physicians IPA D-SNP.

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

This certification covers the ALTCS-DD Program which provides Long Term Services & Supports (LTSS) and physical and mental health services to its members, as well as Targeted Case Management (TCM) services -- a benefit provided by DES/DDD to AHCCCS members with qualifying intellectual and developmental disabilities who exceed the functional limitations necessary for eligibility under an ALTCS program and are therefore not eligible for ALTCS-DD. Additional information regarding covered services can be found in the ALTCS-DD Program contract.

Although most LTSS are covered directly by DES/DDD, the Division maintains contracts with two integrated subcontractors to cover the following services for the ALTCS-DD Program:

- LTSS provided in a nursing facility, and
- all integrated physical and mental health services, including but not limited to:
    - Children's Rehabilitative Services (CRS) specialty care,
    - Applied behavior analysis (ABA) services, and
    - Augmentative and alternative communication (AAC) services.

American Indians and Alaska Natives (AI/AN) enrolled in the ALTCS-DD Program can choose to receive their integrated physical and mental health services through managed care with one of the integrated subcontractors or on a fee-for-service (FFS) basis through the DDD Tribal Health Plan (DDD THP).

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

The ALTCS-DD Program operates on a statewide basis and has been the health plan for individuals with developmental disabilities since the late 1980s.

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

The rate certification for the CYE 27 capitation rates for the ALTCS-DD Program is effective for the 12-month time period from October 1, 2026, through September 30, 2027.

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

The populations covered under the ALTCS-DD Program are individuals with a qualifying developmental disability.

ALTCS-DD Program capitation rates are developed for two distinct rate cells.

The first rate cell (regular DDD capitation rate) includes the costs of providing covered long-term care, acute care, CRS specialty care for members with a CRS qualifying condition, and mental health services for all DD members.

The second rate cell is for Targeted Case Management and includes the costs of providing case management services for members who have a qualifying DD diagnosis and meet the financial eligibility of Title XIX or Title XXI programs, but do not meet the functional requirements of ALTCS.

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

DES/DDD determines eligibility primarily by diagnosis of a cognitive disability: cerebral palsy, epilepsy, Down syndrome, or autism. Cognitive disability, defined in statute, A.R.S. § 36-551(14), as "a condition that involves subaverage general intellectual functioning, that exists concurrently with deficits in adaptive behavior manifested before the age of eighteen and that is sometimes referred to as intellectual disability", is a covered diagnosis regardless of the origin of impairment. There are three types of DDD eligibility:

A. Members who are DDD State Only receive Support Coordination and direct services based on assessed need and availability of state funds. These members are not eligible for Targeted Case Management or ALTCS and are not considered in this rate certification.
B. Members who are Targeted Case Management are eligible for Title XIX or Title XXI acute care services including Early Periodic Screening Diagnosis and Treatment (EPSDT), but do not meet the functional requirements of ALTCS. Members in this category receive Support Coordination.
C. Members who are ALTCS eligible receive Support Coordination and direct services based on assessed need including medical necessity and cost effectiveness, and physical and mental health services including EPSDT. Members eligible for ALTCS under DES/DDD have choice with regard to which DES/DDD sub-contracted integrated health plan they wish to enroll in.

Additional information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the ALTCS-DD Program contract.

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6. The special contract provisions related to payment included in the CYE 27 capitation rates are:

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

- SDPs (42 CFR § 438.6(c))
    - Vaccines for Children (VFC) (42 CFR § 438.6(c)(1)(iii)(A))
    - Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(D))
    - Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(D))
    - Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(D))
    - Safety Net Services Initiative (SNSI) (42 CFR § 438.6(c)(1)(iii)(D))

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

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

All proposed differences among the CYE 27 capitation rates for the ALTCS-DD Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the ALTCS-DD Program.

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

The CYE 27 capitation rates were developed at the rate cell level. Payments from rate cells do not cross-subsidize payments of other rate cells.

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

The effective dates of changes to the ALTCS-DD Program are consistent with the assumptions used to develop the CYE 27 capitation rates for the ALTCS-DD Program.

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

The capitation rates were developed such that DES/DDD would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 27.

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

Not applicable. The actuary is not certifying capitation rate ranges.

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

Not applicable. The actuary is not certifying capitation rate ranges.

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

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

In the 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, there are no reasonable, appropriate, and attainable costs which have not been included in the rate certification.

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

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

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

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 27 capitation rates certified in this report represent the contracted rates by rate cell.

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

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 27 capitation rates for the ALTCS-DD Program.

I.1.A.xii. Evaluation Conducted, Assumptions Included or Not Included, Related to Changes in Federal Requirements

This section of the 2027 Guide requests description of evaluations conducted, and the rationale for any applicable assumptions included or not included in rate development related to changes in Federal requirements, such as in Public Law 119-21 (which CMS refers to as the "Working Families Tax Cut" (WFTC) legislation), within the rate certification.

No adjustments were made for the ALTCS-/DD Program related to the WFTC legislation. Less than two thousandths of one percent of ALTCS-/DD members are covered under expansion or expansion-like coverage under the 1115 waiver, and those few members are likely specified excluded individuals under the medically frail definitions; the functional and medical assessment used in pre-admission screening for determining eligibility for the ALTCS-DD program guarantees that eligible members are "at immediate risk of institutionalization" (Arizona Administrative Code R9-28-303 Section E) based on evaluations of behavioral impairments and limitations in performing activities of daily living (ADLs), which are the basis for medical frailty categories 3 ("disabling mental disorder") and 4 ("physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living").

I.1.A.xiii. Risk Mitigation Strategies

This section of the 2027 Guide includes CMS recommendations for risk mitigation strategies. See Section I.4.C. Risk-Sharing Mechanisms for AHCCCS risk mitigation strategies. AHCCCS reviews all risk mitigation strategies on an annual basis.

I.1.A.xiv. Rate Certification Procedures

I.1.A.xiv.(a) Timely Filing for Claiming FFP

This section of the 2027 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR Part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

I.1.A.xiv.(b) CMS Rate Certification Requirements for Retroactive Rate Adjustments – Not Applicable

Not applicable. This rate certification does not cover retroactive adjustments for previous capitation rates. This is a new rate certification that documents that the ALTCS-DD Program capitation rates are changing effective October 1, 2026.

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

Not applicable. This rate certification will change the ALTCS-DD Program capitation rates effective October 1, 2026.

I.1.A.xiv.(d) CMS Rate Certification Circumstances for Special Contract Provisions – Not Applicable

Not applicable. This is a new rate certification that documents that the ALTCS-DD Program capitation rates are changing effective October 1, 2026. In the event of any change to capitation rates due to special payment provisions under 42 CFR § 438.6, with the exception of risk-sharing mechanisms which cannot be added or modified after the start of the contract year, the state will submit a revised rate certification to CMS as required.

I.1.A.xiv.(e) CMS Rate Certification Requirements for Retroactive SDP Adjustments

This section of the 2027 Guide reminds states of the requirements associated with retroactive adjustments to capitation rates when those adjustments result from a state directed payment under 42 CFR § 438.6, as required under 42 CFR § 438.7(c)(5). A retroactive adjustment resulting from a state directed payment must be a result of adding or amending any state directed payment consistent with the requirements in 42 CFR § 438.6(c), or a material error in the data, assumptions, or methodologies used to develop the initial capitation rate adjustment such that modifications are necessary to correct the error.

I.1.A.xiv.(f) CMS Rate Certification Circumstances for Limited Payment Changes

This section of the 2027 Guide provides information on limited payment changes where CMS would not require a new rate certification. These limited payment changes include:

- for certified rates per rate cell, increasing or decreasing the most recently certified actuarially sound capitation rates per rate cell up to 1.5% during the rating period, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4),

- for certified rate ranges for the rate cell(s), increasing or decreasing capitation rates within the certified rate range up to 1% during the rating period, in accordance with 42 CFR § 438.4(c)(2), or
- applying an approved risk adjustment methodology specified in the contract and rate certification for that rating period, in accordance with 42 CFR § 438.7(b)(5)(iii).

I.1.A.xiv.(g) CMS Contract Amendment Requirement

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

I.1.A.xiv.(h) CMS Contract and Rate Amendment Requirement for Changes in Law

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

I.1.B. Appropriate Documentation

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

The actuary is certifying capitation rates for each rate cell.

I.1.B.ii. CMS as Intended User

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.

I.1.B.iii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 27 capitation rates for the ALTCS-DD Program.

I.1.B.iv. Rate Development Exhibits in Excel

All tables and appendices from the rate certification will be provided to CMS in Excel format.

I.1.B.v. Medical Loss Ratio

The capitation rates were developed so each Contractor would reasonably achieve a medical loss ratio (MLR) standard of at least 85 percent as required per 42 CFR § 438.4(b)(9). The ALTCS-DD actuary calculates a modified MLR where the only inclusion in the numerator is the projected gross medical expense component of the capitation rates (discounts related to pharmacy rebates are included in this calculation), ensuring the result of the calculation will be less than or equal to the actual MLR calculation because the modified MLR calculation does not include any considerations for the allowed additional

expenses under 42 CFR § 438.8(e)(3)-(4) in the numerator. For CYE 27 capitation rates, the modified MLR for DES/DDD was greater than 85 percent. Per 42 CFR § 438.5(b)(5) the actuary reviewed past MLR results focusing in on the MLR results that correspond to the base period, and for any Contractors performing below 85 percent the actuaries would make adjustments to assumptions in capitation rate setting where appropriate, however this was not necessary because all Contractors for all programs were above 85 percent MLR for the base period.

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

This section of the 2027 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell.

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

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

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

I.1.B.viii. 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 relevant section numbers from the 2027 Guide. Sections of the 2027 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.ix. Assurance Rate Assumptions Do Not Differ by FFP

All proposed differences in the assumptions, methodologies, or factors used to develop the certified CYE 27 capitation rates for the covered populations under the ALTCS-DD Program are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

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

The covered populations under the ALTCS-DD Program receive the regular Federal Medical Assistance Percentage. The ALTCS-DD Program is eligible to receive Children’s Health Insurance Program (CHIP) funding for Targeted Case Management for those acute enrolled members who are TXXI. There have not been any CHIP members provided Targeted Case Management services under the contract since 2015.

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

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

The 2027 Guide requests a comparison to the final certified rates in the previous rate certification. Comparisons between the most recently certified CYE 26 ALTCS-DD Program capitation rates effective October 1, 2025, and the CYE 27 capitation rates being certified in this actuarial rate certification are available in Appendix 3.

The 2027 Guide requires descriptions of what is leading to large or negative changes in rates from the previous rating period. As in past years, the AHCCCS Division of Business and Finance (DBF) Actuarial Team has 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 as a negative change in the rate. Neither the CYE 27 ALTCS-DD Program capitation rate nor the Targeted Case Management rate cell capitation rate for CYE 27 are increasing by more than 10% or are decreasing compared to the previous rating period.

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

For CYE 27, pharmaceutical costs were examined at a more granular level for the purpose of developing medical cost trend projections that are more responsive to new pharmaceuticals and potential changes in pricing. Costs were categorized into specialty, brand, and generic drugs to reflect significant differences in usage patterns and unit prices among these categories. In prior rate certifications, pharmacy costs were examined in aggregate, resulting in forecasts that were less responsive to the introduction of high-cost drugs with low expected utilization.

All other material changes since the last rate certification are described elsewhere in this certification.

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

The state adjusted the ALTCS-DD Program capitation rate in the previous rating period by 1.4% under the *de minimis* amount using the authority in 42 CFR § 438.7(c)(3).

I.1.B.xii. Future Rate Amendments

There will be an amendment related to the Access to Professional Services Initiative (APSI) no later than December 2026. AHCCCS is still finalizing the CYE 27 preprint for APSI for submission to CMS.

There may be changes to the SDPs due to AHCCCS submitted preprints with differing options for payment for some of its SDPs based on proposed changes to regulations in the current Notice of Proposed Rule Making (NPRM) and may need to submit revisions based on whatever provisions are finalized in the regulations. The potential submission date for this potential amendment would be after the NPRM becomes a final rule.

I.1.B.xiii. Summarizing Changes Accounted For in Rate Amendment

Any future rate amendments will include a summary of the changes being accounted for in that rate amendment and the documentation will be limited to the changes accounted for in the rate amendment.

I.1.B.xiv. Addressing Impacts of Unwinding the COVID-19 PHE

I.1.B.xiv.(a) Accounting for Direct and Indirect Impacts

The CYE 27 capitation rates use a base data experience period that reflects changes in service delivery that have continued beyond the unwinding of the PHE, including increased telehealth usage and attendant care, and decreased employment, day treatment, and transportation services.

I.1.B.xiv.(b) Risk Mitigation Strategies

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 27 contracts will continue AHCCCS' long-standing program policy and will include risk corridors. There are no risk mitigation strategies utilized specifically for COVID-19 costs for CYE 27.

I.2. Data

This section provides documentation for the Data section of the 2027 Guide.

I.2.A. Rate Development Standards

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

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

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

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

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

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

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

The primary data sources used or reviewed for the development of the CYE 27 capitation rates for the ALTCS-DD Program were:

- Adjudicated and approved encounter data submitted by all health plans with responsibility for services provided to ALTCS-DD members and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2019 through February 2026
  - Adjudicated and approved through the second February 2026 encounter cycle
  - Pended for DES/DDD from October 2024 through September 2025
- Reinsurance payments made to DES/DDD for services
  - Incurred from October 2019 through March 2026 paid through March 2026
- Historical and projected enrollment data for ALTCS-DD Program members and Targeted Case Management members, provided by DES/DDD
- Supplemental intermediate care facility (ICF), nursing facility (NF), and home and community based services (HCBS) expenses provided by DES/DDD for dates of service between October 2023 and February 2026
- Quarterly and annual financial statements submitted by DES/DDD, and other health plans with responsibility for services provided to ALTCS-DD members between October 2019 and the present, and reviewed by the AHCCCS DBF Finance & Reinsurance Team
- AHCCCS FFS fee schedules developed and maintained by the AHCCCS DBF Rates & Reimbursement Team

- Data from the AHCCCS DBF Rates & Reimbursement team related to DAP, see Section I.4.D.
- Data from AHCCCS DBF financial analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)
- Historical and projected Targeted Case Management expenses provided by DES/DDD
  - Historical expenses through February 2026
  - Projected expenses for March 2026 through September 2027
- Historical and projected administrative and case management expenses from DES/DDD
  - Historical expenses through February 2026
  - Projected expenses for March 2026 through September 2027
- Bid administrative expenses from a competitive bid process for ALTCS-DD Program integrated subcontractors updated for forecasted inflation

Additional sources of data used or reviewed were:

- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CYE 25
- Historical and projected enrollment data provided by the AHCCCS DBF Budget Team
  - Historical enrollment from mid CYE 26 and earlier
  - Projected enrollment through CYE 27
- Integrated subcontractors' membership for determining administrative expense thresholds related to the bids

Any additional data used and not identified here will be identified in their applicable sections below.

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

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

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

The sources of the data are listed above in Section 1.2.B.ii.(a)(i).

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

For LTSS provided in either an ICF or HCBS setting, DES/DDD does not use sub-capitated arrangements. DES/DDD utilizes staff models for some of these LTSS services. DES/DDD has staff models for State Operated Group Homes (SOGH) and State Operated Intermediate Care Facilities (SOICF) throughout the State and also for those located at the Arizona Training Program at Coolidge (ATPC) campus. Encounters are submitted for the LTSS services provided in staff models, with health plan paid amounts of zero. These encounters go through all of the same processes described below in Section I.2.B.ii.(b) and are available to the actuaries through the AHCCCS PMMIS mainframe. The units from the encounters are then matched up with the cost of those services reflected in the supplemental expense information provided by DES/DDD for purposes of rate development.

All services under the responsibility of DES/DDD's historically subcontracted health plans, and the current subcontracted integrated health plans are also submitted in the same manner as encounters from other health plans, under the DES/DDD health plan ID with a Transmission Submitter Number (TSN) to identify

the payer as one of the subcontracted health plans. These encounters go through all of the same processes described below in Section I.2.B.ii.(b) and are available to the actuaries through the AHCCCS PMMIS mainframe.

In addition to the staff model addressed above, AHCCCS Contractors, including DES/DDD's integrated subcontractors, sometimes use sub-capitation/block purchasing arrangements for some services. The sub-capitation and block purchasing arrangements between the Contractors and their providers require that the providers submit claims for services provided, 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/block purchased encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there are repricing methodologies (i.e., formulas) for sub-capitated/block purchased encounters to estimate a health plan valued amount in place of the health plan paid amount of zero. The units of service data from the sub-capitated encounters and the repriced amounts were used for the basis of calculating utilization and unit cost for all components, in conjunction with the regular encounters.

I.2.B.ii.(a)(v) Base Data Exception – Not Applicable

Not applicable. No exception to the base data requirements was necessary for capitation 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. This process occurs for both regular and sub-capitated/block purchased encounters.

The AHCCCS DBF Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a per member per month (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 DBF Actuarial Team reports the findings to the AHCCCS Information Services Division (ISD) Data Management and Oversight (DMO) Team, who then works with the health plan to identify causes. In addition, the AHCCCS ISD DMO Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

DES/DDD, and all other AHCCCS Contractors, know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides DES/DDD with the "Encounter Monthly

Data File" (aka the "magic" file) which contains the previous 36 months of encounter data. DES/DDD is responsible for providing the "magic" file to the integrated subcontractors. 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. This file, with its expanded view of encounter statuses, allows DES/DDD and its subcontractors to compare the data to their claim payments to identify discrepancies and evaluate the need for new or revised submissions. For purposes of CYE 27 rate development, AHCCCS relied primarily on adjudicated/approved encounters, but also included some pended encounters related to services paid for by DES/DDD but which were held in an unadjudicated status due to missing Electronic Visit Verification (EVV) information. The actuaries determined that these costs were not reflected anywhere else in the adjudicated/approved encounter data. Since the remaining pended encounters were not replaced in time to be adjudicated and represent service costs that DES/DDD will be at risk for in CYE 27, the actuaries determined that these costs should be included for purposes of rate development as they are representative of reasonable, appropriate, and attainable costs for the program.

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 ISD DMO Team performs encounter data validation studies to evaluate the completeness, accuracy, and timeliness of the collected encounter data.

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

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

The AHCCCS DBF Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe and ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 26 capitation rates for the ALTCS-DD Program. Additionally, the AHCCCS DBF Actuarial Team ensured that only services covered under the state plan were included.

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

The AHCCCS DBF Actuarial Team reviewed encounter data from all relevant Contractors providing services to ALTCS-DD Program members over the October 2019 through February 2026 time frame, along with supplemental cost data from DES/DDD for state operated facilities, for consistency by viewing month over month, and year over year changes. The AHCCCS DBF Actuarial Team also compared the aggregated encounter and supplemental cost data to financial statements for all relevant Contractors. The data was judged to be consistent across data sources.

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

As required by ASOP No. 23, the AHCCCS DBF Actuarial Team discloses that the rate development process has relied upon encounter data submitted by DES/DDD, DES/DDD integrated subcontractors, the prior CRS subcontractor, and the Regional Behavioral Health Authorities retrieved 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 same entities and reviewed by the AHCCCS DBF Finance & Reinsurance Team. The AHCCCS DBF Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuaries note additional reliance on the following:

- data provided by the AHCCCS DBF Rates & Reimbursement Team with regard to DAP and fee schedule impacts,
- the Public Notice of proposed fee schedule changes for CYE 27 posted by DES/DDD to its website,
- data provided by the AHCCCS DBF financial analysts with regard to some program changes,
- information and data provided by Milliman consultants with regard to the HEALTHII and SNSI SDPs,
- data provided by the integrated subcontractors with regard to administrative components, and
- data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

The actuaries have found the encounter data in total, after adjustments for data concerns, along with the supplemental cost data for state operated facilities to be appropriate for the purposes of developing the CYE 27 capitation rates for the ALTCS-DD Program.

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

As referenced in section I.2.B.ii.(b)(i), pended encounters reflecting EVV submission issues, but for otherwise allowable services representative of costs in the rating period, were included in the base data. There were no other material concerns identified with the availability or quality of the data.

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

The AHCCCS DBF Actuarial Team determined that the CYE 25 encounter data in total, after adjustments noted in I.2.B.ii.(b)(i), was appropriate to use as the base data for developing the CYE 27 capitation rates for the ALTCS-DD Program with the inclusion of supplemental cost data related to staff models for LTSS provided in state operated facilities, and pended encounters for services affected by EVV implementation that are representative of services that will be delivered and allowed in the rating period, as previously noted.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 27 capitation rates for the ALTCS-DD Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters are used in the development of the CYE 27 capitation rates for the ALTCS-DD Program.

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

Not applicable. The AHCCCS DBF Actuarial Team did not rely on a data book to develop the CYE 27 capitation rates.

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

This section describes adjustments made to the CYE 25 encounter data that was used as the base data for developing the CYE 27 capitation rates for the ALTCS-DD Program.

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

Not applicable. No credibility adjustments were made to the CYE 25 encounter data.

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 2019 through February 2026. The monthly completion factors were applied to the encounter data on a monthly basis. Aggregated CYE 25 completion factors by COS for the regular DDD rate cell can be found in Appendix 4. The aggregated CYE 25 completion factor impacts are shown in Table 1.

Table 1: Completion Factor Impacts

Rate Component	Before Completion	After Completion	Impact
LTSS	$5,318.94	$5,322.86	0.07%
Integrated Care Services	$1,250.00	$1,300.50	4.04%
Total	**$6,568.93**	**$6,623.36**	**0.83%**

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

CYE 25 base data was evaluated at the COS level for significant deviations from historical experience. No deviations were observed requiring adjustment to the base data.

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2024, through September 30, 2025) are described below, or in Section I.3.A.v. for base data adjustments required with respect to IMD in lieu of services. Adjustments to address the concerns noted by the actuaries in Section I.2.B.ii.(b)(iii) are also described in this section. All other program and fee schedule changes which occurred or are effective on or after October 1, 2025, are described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the rate for the regular DDD rate cell (base data adjustments do not impact the Targeted Case Management rate cell), that adjustment was deemed non-material and has been grouped in the Combined Miscellaneous Base Data Adjustment subset below.

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

Removal of Differential Adjusted Payments from Base Data

CYE 25 capitation rates funded DAP made from October 1, 2024, through September 30, 2025, 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, 2025, AHCCCS has removed the impact of DAP from the base period CYE 25. To remove the impact, the AHCCCS DBF Actuarial Team requested provider IDs for the qualifying providers for the CYE 25 DAP by specific measure from the AHCCCS DBF Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 25 were then adjusted downward by the appropriate percentage bump specific to the DAP measure. The impact of this adjustment is given in Table 2a.

Table 2a: CYE 25 DAP Removal

Rate Component	PMPM Impact	Dollar Impact
LTSS	($20.04)	($12,235,180)
Integrated Care Services	($8.33)	($5,084,388)
Total	**($28.37)**	**($17,319,568)**

Combined Miscellaneous Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component of the rate for the regular DDD rate cell, that program change was deemed non-material for the purpose of the actuarial rate certification. The impacts have been aggregated and are provided in Table 2b. Brief descriptions of the individual program changes requiring base data adjustment are provided below.

Pharmacy and Therapeutics Committee Recommendations *

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes that impacted utilization and unit costs of Contractors' pharmacy costs in the base period. The

P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.

Pharmacy Compounding Level of Effort *

Effective June 1, 2025, AHCCCS began reimbursing compounding pharmacies for compounded prescriptions based on the level of effort. Level of effort is an industry standard to identify the time and complexity involved in compounding a prescription, with more simple compounds having a lower level of effort and higher complexity involving the need for a sterile environment having the highest level of effort.

Table 2b: Combined Miscellaneous Base Data Adjustments

Rate Component	PMPM Impact	Dollar Impact
LTSS	$0.00	$0
Integrated Care Services	$0.15	$92,719
Total	**$0.15**	**$92,719**

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

The AHCCCS DBF Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 27 capitation rates.

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2027 Guide.

I.3.A. Rate Development Standards

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

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

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

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

I.3.A.iii. In Lieu Of Services or Settings (ILOS)

There are no in lieu of services or settings (ILOS) allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an IMD in lieu of services in an inpatient hospital. For enrollees aged 21-64, 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.iv. ILOS Cost Percentage – Not Applicable

Not applicable. There are no ILOS under the ALTCS-DD Program, except for short term stays in an IMD which are addressed in Section I.3.A.v. below.

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

The projected benefit costs include costs for members aged 21-64 that have a stay of no more than 15 cumulative days within a month in an IMD in accordance with 42 CFR § 438.3(e).

Costs Associated with an Institution for Mental Disease Stay

The AHCCCS DBF Actuarial Team adjusted the base data to reprice the costs associated with stays in an IMD for enrollees aged 21-64 in accordance with 42 CFR § 438.6(e). The AHCCCS DBF 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 DBF Actuarial Team then removed costs for members aged 21-64 for stays in an IMD exceeding 15 cumulative days in a month, whether through a single stay or multiple within the month. Additionally, the AHCCCS DBF 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 25 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 25 encounter data, the AHCCCS DBF Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the non-IMD price-per-day. The non-IMD price-per-day used in the analysis was $883.94 and was derived from the CYE 25 encounter data for similar IMD services that occurred within a non-IMD setting. The encounter data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a non-IMD setting which may not be fully captured within the AHCCCS FFS fee schedule per diem rate. The costs associated with institutional stays at an IMD that were repriced in the base data are displayed in Table 3a. Totals may not add up due to rounding.

Table 3a: IMD Repricing Impact

Rate Component	PMPM Impact	Dollar Impact
LTSS	$0.00	$0
Integrated Care Services	$0.48	$290,387
Total	**$0.48**	**$290,387**

The AHCCCS DBF Actuarial Team identified all members aged 21-64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4). The repriced costs removed from the base data are displayed in Table 3b. Totals may not add up due to rounding.

Table 3b: Removal of Repriced Stays Longer than 15 Cumulative Days in a Month

Rate Component	PMPM Impact	Dollar Impact
LTSS	$0.00	$0
Integrated Care Services	($1.06)	($648,757)
Total	**($1.06)**	**($648,757)**

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 in Table 3c. Totals may not add up due to rounding.

Table 3c: Removal of Other Costs Associated with Problematic IMD Stays

Rate Component	PMPM Impact	Dollar Impact
LTSS	($0.12)	($76,065)
Integrated Care Services	($0.19)	($114,838)
Total	**($0.31)**	**($190,903)**

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

The final projected benefit costs for the regular DDD rate cell are detailed in Appendix 6.

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

This section provides information on the projected benefit costs included in the CYE 27 capitation rates for the ALTCS-DD Program.

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

The base data described in Section I.2.B.ii. was adjusted to reflect completion and all base data adjustments described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in I.3.A.v. The adjusted base data PMPM expenditures were trended forward 24 months from the midpoint of the CYE 25 time period to the midpoint of the CYE 27 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below.

The CYE 27 capitation rates include an offset to account for ALTCS-DD Program members' projected share of cost (SOC) in CYE 27. Each member's SOC is determined based on their monthly income less certain allowable deductions based on the member's placement in either an Institutional or HCBS setting; the personal allowances for HCBS placements tend to exceed member income, so it is rare for SOC to be nonzero in these circumstances. Contrarily, personal allowance for members in Institutional settings is limited to 15% of the Federal Benefits Rate, so members in these settings often have a positive SOC amount. The SOC offset was developed based on base period (CYE 25) ALTCS-DD Program member SOC data. The SOC offset ensures that capitation rates only reflect DES/DDD's responsibility for costs, and not those of its members.

Appendix 4 contains the base data and base data adjustments, and Appendix 5 contains the projected benefit cost trends. Appendix 6 contains the development of the gross medical expense from the adjusted base data, including all prospective programmatic and fee schedule changes and the impact of DAP, and Appendix 7 contains the development of the certified capitation rates from the projected gross medical expense, including reinsurance offset, SOC offset, administrative expense, underwriting (UW) margin, and premium tax.

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

Some of the impacts for projected benefit costs described below (indicated by an asterisk *) were developed by AHCCCS DBF financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS OOD Chief Medical Officer and the OOD Medical Services CQM Team. The actuaries relied upon the professional judgment of the AHCCCS DBF financial analysts with regard to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the

estimated amounts. The actuaries met with the AHCCCS DBF financial analysts to understand at a high level how the estimated amounts were derived, and the data used for the amounts. The actuaries were unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

Legislative and Policy Restrictions to Limit Utilization Growth In the Paid Parental Caregiver (PPCG) Program

Since April 2022, attendant care services, and other individual habilitation services delivered in personal care settings, have experienced accelerated growth beyond even the effect observed due to lockdowns associated with the COVID-19 PHE. This acceleration in growth has largely been concentrated among minor children and can be attributed to persistent changes in service delivery preferences primarily brought on by constrained availability of congregate care settings in schools, and the availability of the PPCG initiative to expand the available care worker supply. Utilization growth has consistently exceeded expectations, leading to multiple mid-year capitation rate updates to address imminent financial and operational risk, and has resulted in increased pressure on the State's financial resources.

Faced with this increased budgetary pressure, the 57th Arizona Legislature passed HB2945 in April 2025 as an emergency appropriations resolution intended to provide needed funding to the ALTCS-DD program for the CYE25 contract year, while simultaneously placing limitations on service delivery and billing practices with the aim of slowing growth and prioritizing appropriate levels of care for the neediest members. All provisions mentioned in the certification for the ALTCS-DD CYE 26 capitation rate have been implemented and are being monitored for impact, save the item below:

- HB2945 36-2970.01(D) - Strengthened Assessment Tool (HCBS Needs Tool – HNT) to prioritize assignment of personal care services and clarify requirements and exceptions

AHCCCS developed a strengthened assessment tool to be effective October 1, 2025 consistent with ARS 36-2970.01. However, AHCCCS discontinued use of the revised tool as a result of the approval of an emergency HCBS Needs Tool (HNT) rulemaking effective October 15, 2025. AHCCCS suspended the strengthened standardized assessment tool required by Laws 2025, Chapter 93 and proceeded with emergency rulemaking due to the probability of imminent litigation and the possibility of an adverse court ruling that may have resulted in further delay in implementation of the new assessment tool and inability to achieve cost savings. The emergency HNT rulemaking includes an extraordinary care review (ECR) process with clinical review of the direct care and habilitation assessment for certain individuals. In the near future AHCCCS will proceed with exempt HNT/ECR rulemaking as authorized by Section 19 of Laws 2026, Chapter 132 which was approved during the 2026 Legislative Session. This exempt rulemaking authority becomes effective September 12, 2026, and the resulting exempt HNT/ECR rulemaking is anticipated to be implemented during CYE 27. As a result, cost reductions originally expected during CYE 26 are now expected to be realized during CYE 27. Table 4a on the following page provides a summary of the impact of the exempt rulemaking.

Table 4a: Legislative and Policy Restrictions on the PPCG Program

Rate Component	PMPM Impact	Dollar Impact
LTSS	($164.39)	($100,345,686)
Integrated Care Services	$0.00	$0
Total	**($164.39)**	**($100,345,686)**

ABA Policy Revisions

Effective October 1, 2026, AHCCCS will adopt revisions to its Applied Behavior Analysis (ABA) policy. To estimate the impact, the AHCCCS DBF Actuarial Team developed a claim-level policy model using CYE 25 ABA encounter data that applies each revised provision sequentially to derive adjusted service units, and then converted those units to cost impacts using category-specific baseline unit costs. In addition to the revisions to the policy, there have been contract terminations between Contractors and some ABA providers with higher-than-average authorizations and utilization on a per member basis. Members affected by these provider contract terminations are expected to transition to other ABA providers with lower (i.e., average) member-level authorizations and utilization patterns. To account for this member transition, the historical utilization of affected members was adjusted on an aggregate basis to align with patterns observed across other ABA providers. This adjustment was applied following the modeling of the policy revisions.

The overall impact attributable to the ABA policy revisions and member transitions is displayed in table 4b. Totals may not add up due to rounding.

Table 4b: ABA Policy Revisions

Rate Component	PMPM Impact	Dollar Impact
LTSS	$0.00	$0
Integrated Care Services	($102.22)	($62,397,681)
Total	**($102.22)**	**($62,397,681)**

AHCCCS FFS Fee Schedule Updates

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

Additionally, the contract has requirements that the Contractors reimburse FQHCs/RHCs at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates include adjustments to bring the base FQHC/RHC encounter data up to the projected CYE 27 FQHC/RHC PPS rates.

AHCCCS' contracts also require that the Contractor shall reimburse providers at no less than the regional maximum allowable rate as set by the Centers for Medicare and Medicaid, which is the fee schedule in the State Plan, for vaccines administered for the Vaccines for Children program.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative or regulatory mandates. Additionally, AHCCCS implemented quarterly rate adjustments for physician administered drugs (PADs) in alignment with updates to the State Plan. The CYE 27 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DBF Rates & Reimbursement Team used the CYE 25 encounter data to develop the impacts of fee schedule changes between the base year and the rating period. The AHCCCS DBF Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to calculate the adjustment to the CYE 25 base data. The AHCCCS DBF Actuarial Team then reviewed the results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting COS.

AHCCCS also increases some fee schedule rates effective January 1 of each year to recognize the annual minimum wage increase resulting from the passing of Proposition 206. The increased costs for this change have been included with the fee schedule changes already discussed.

The overall impact of the AHCCCS Fee-for-Service fee schedule updates is illustrated in Table 4c. Totals may not add up due to rounding.

Table 4c: Provider Fee Schedule Changes

Rate Component	PMPM Impact	Dollar Impact
LTSS	$69.50	$42,420,558
Integrated Care Services	$4.87	$2,971,756
Total	**$74.36**	**$45,392,314**

Combined Miscellaneous Program Changes

The rate development process includes every individual program and reimbursement change as a separate adjustment. However, as noted earlier in this section, if an individual program or reimbursement change had an impact of 0.2% or less on the gross medical component of the regular DDD rate cell capitation rate, that program change was deemed non-material for the purpose of the actuarial rate certification. The aggregated impacts of all non-material changes are shown in Table 4d. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

Cochlear Implants *

Pursuant to SB1741, AHCCCS covers cochlear implants for persons who are at least 21 years old, effective October 1, 2025.

Fingerstick Devices for Clozapine Patients *

Effective October 1, 2025, AHCCCS began coverage of fingerstick devices and testing strips that can be used in the monitoring of neutrophil blood levels for members taking clozapine. The devices may be used

in office by the physician or by the member in their own home to provide timely results and allow the physician to adjust the medication dosing for the member.

Pharmacy and Therapeutics Committee Recommendations *

On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 27. 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.

Traditional Healing *

Effective October 1, 2025, AHCCCS began covering traditional health care practices provided through Indian Health Service facilities or facilities operated by Tribes or Tribal organizations. Traditional health care practices, or traditional healing, encompasses a wide variety of therapies that reflect the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures.

AzEIP *

Effective January 1, 2026, administrators of the Arizona Early Intervention Program (AzEIP) revised their policies and billing practices to align with federal requirements to bill AHCCCS for the administration of developmental tests provided to AHCCCS members.

H2021 Community Based Wrap-around Services *

Effective August 1, 2026, AHCCCS will open procedure code H2021, Community Based Wrap-around Services, to be used by providers that have participated in training through the National Wrap-around Implementation Center and are eligible for the associated CYE 26 or CYE 27 DAP.

G-tube Feeding Nurse Training for Direct Care Workers *

Effective September 1, 2026, AHCCCS will allow direct care workers to be trained in the procedures for enteral feeding (G-tube feeding) for ALTCS members that need this service. A nurse will perform the training with each direct care worker serving each member.

340B Pharmacy Dispensing Fee *

Effective October 1, 2026, AHCCCS will revise the 340B pharmacy dispensing fee from $10.11 to $13.20 for FQHC pharmacies for medications which are identified on the 340B Drug Pricing File.

Diabetic Drug Class Utilization Changes

The AHCCCS DBF Actuarial Team reviewed all historical adjudicated and approved encounters for glucagon-like peptide-1 (GLP-1) receptor agonists, sodium-glucose co-transporter-2 inhibitors (SGLT2), and insulins, and determined that the changing utilization patterns of these drug classes was not fully accounted for by the projected trend assumptions and have included a separate, specific adjustment to these drug classes as part of the capitation rate development.

Oral Contraceptives: 12-month Supply *

Effective October 1, 2026, AHCCCS will allow members to receive a 12-month supply of oral contraceptives in a single prescription fill.

Rx Rebates Adjustment

An adjustment was made to reflect the impact of Rx Rebates reported within the integrated subcontractors' financial statements, as pharmacy encounter data does not include these adjustments.

SMART Asthma Therapy *

Effective October 1, 2026, AHCCCS will implement a guideline-aligned asthma management initiative ensuring access to Single Maintenance and Reliever Therapy (SMART) for members with moderate to severe persistent asthma.

Table 4d: Combined Miscellaneous Program Changes

Rate Component	PMPM Impact	Dollar Impact
LTSS	$0.35	$214,790
Integrated Care Services	($6.66)	($4,065,552)
Total	**($6.31)**	**($3,850,762)**

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

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

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

DES/DDD and its subcontractors 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 27 capitation rates therefore includes those adjustments.

I.3.B.ii.(d) Emerging High-Cost Drugs

AHCCCS has a longstanding reinsurance program that includes coverage for high-cost drugs (i.e., the biologic reinsurance case type). See Section I.4.C.ii.(c) for additional information on the reinsurance program. For CYE 27 capitation rate setting, the pharmacy category has been split into specialty, brand, and generic, with separate trend assumptions for each category to better support monitoring of high-cost drugs. Additionally, any high-cost drugs with a material impact on the capitation rates have been specifically addressed in Sections I.2.B.iii.(d) if they were introduced during the base data period or in I.3.B.ii.(a) if they were introduced after the base data period.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2019 through December 2025 and adjudicated and approved through the second February

2026 encounter cycle, as well as supplemental cost data provided by DES/DDD as described in Section I.2.B.ii.(a) for the staff model as noted in Section I.2.B.ii.(a)(iv).

All encounter and supplemental data used was specific to the ALTCS-DD Program population.

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

The encounter and supplemental data were summarized by month and COS, and by utilization per 1000, unit costs, and PMPM values. The encounter data was adjusted for completion and to normalize for previous program and reimbursement changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 25 (April 1, 2025) to the midpoint of the rating period for CYE 27 (April 1, 2027). The projected benefit cost trends were not based upon a formula-driven approach using historical benefit cost trends. Projected benefit cost trends were estimated based upon actuarial judgment after reviewing multiple moving averages and several linear regression lines for each of the utilization per 1000, unit cost, and resulting PMPM time series. Each COS was analyzed in the same manner.

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

All PMPM trend estimates were compared to similar estimates made in CYE 26 for ALTCS-DD Program capitation rates and judged reasonable to assume for projection to CYE 27, considering the change in the base data time period, the rating period, and the unwinding of the MOE, as well as changes to covered services.

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

The 2027 Guide requires explanation of outlier or negative trends.

The actuary assumed negative trends for state-operated facilities (e.g. ATPC, SOGH, and SOICF) and Intermediate Care Facilities (ICFs). State-operated facilities like the Arizona Training Program at Coolidge (ATPC) and various other state-operated group homes (SOGH) and state-operated ICFs (SOICF) have long operated under legislative constraints regarding member placement in those facilities. There is only one operating private ICF, serving some of the most vulnerable members in the ALTCS-DD population, but there has historically only been a need for a small number of these high-intensity institutional settings. The State's legislative constraints on new admissions to ATPC, the small availability among these other institutional settings, coupled with the program's very successful implementation of Home and Community Based Services places a considerable limit on the utilization growth potential for these services. As the membership at ATPC, in particular, continue to age, it is expected that these negative trends will only accelerate due to attrition and no possibility of admitting new members. Review of multiple moving averages and several linear regression lines show that services in these categories are likely to continue their decline throughout CYE 27.

As in recent years, the actuary identified Personal Care Services like Attendant Care and Habilitation services (both per 15 minutes and per diem) as well as Integrated Care Services (driven by Applied Behavioral Analysis) as outliers explaining most of the annualized growth rate in the ALTCS-DD capitation rate.

Personal Care Services

The growth in both Attendant Care and Habilitation Per 15 Minute services are consistent with trends observed in prior years related to substantial growth in utilization among minor children since April 2022. Habilitation Per Diem, while generally a smaller explanatory component on its own, is influenced by growth in the Habilitation Per 15 Minute category and so is considered an outlier this year to the extent that its growth is attributable to continued growth in the broader category of all habilitation services. As discussed in section I.3.B.ii.(b), legislation and policy have been enacted in an attempt to constrain utilization growth. While there remains uncertainty about the long-term effectiveness of either the already-enacted policies or the forthcoming changes, there has been a noticeable deceleration of growth since July 2025, which is either attributable to awareness of the policies or to a cooling effect on demand driven by messaging from the Agencies and policy makers that there will be continued scrutiny of policies regarding these services. Nevertheless, growth rates for these services remain elevated relative to the patterns observed pre-April 2022 and relative to other HCBS components. To avoid the possibility of double-counting the effect of the policy savings, assumptions have been developed without consideration of the impact of the upcoming policy actions. To the extent that previous actions and any other cooling effects are affecting growth, they have been considered through actuarial review and judgement of the moving averages and linear regression models of historical data for these services.

Integrated Care Services

This category represents services provided by the DES/DDD Integrated Care Subcontractors. The trend assumptions for this COS are driven primarily by continued observed utilization growth in Applied Behavioral Analysis (ABA) services. As above, the growth assumption for these services is set without consideration of the effects of the forthcoming ABA policy as described in I.3.B.ii.(b) in order to avoid double-counting those impacts.

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

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

The projected benefit cost trends by COS for utilization per 1000, unit cost, and PMPM values are included in Appendix 5. The aggregate projected benefit cost trends for the ALTCS-DD Program for utilization per 1000, unit cost, and PMPMs are included in Table 5.

Table 5: CYE 27 Trend Assumptions

Rate Component	Utilization per 1000	Unit Cost	PMPM
LTSS	4.04%	1.73%	5.84%
Integrated Care Services	12.29%	2.06%	14.61%
Total	**5.71%**	**1.80%**	**7.61%**

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

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

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

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

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

Projected benefit cost trends do not vary except by COS.

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

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

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

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

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS Division of Managed Care Medical Management Team reviews updated Contractor analyses to determine if additional services are necessary to comply with parity standards. As of July 30, 2026, no additional services have been identified as necessary services to comply with MHPAEA.

I.3.B.v. ILOS

There are no ILOS allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an IMD in lieu of services in an inpatient hospital. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the capitation rate development has complied with the requirements of 42 CFR § 438.3(e) described above in Section I.3.A.v.

I.3.B.vi. Retrospective Eligibility Periods

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

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

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

Encounter data related to prior period coverage is included with the base data and is included in the capitation rate development process.

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

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

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

No specific adjustments are made to the CYE 27 capitation rates for the ALTCS-DD Program for the prior period time frame, given that the encounter and enrollment data are already included within the base data used for rate development.

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

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

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

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

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

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

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

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

Adjustments related to provider payment requirements under SDPs, as defined in 42 CFR § 438.2, are discussed in Section I.4.D. of this rate certification. Additionally, provider payment requirements related to FQHCs/RHCs are described in Section I.3.B.ii.

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

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

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

There are no material changes related to covered benefits or services since the last rate certification related to litigation.

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

All material and non-material changes have been included in the rate development process and all requirements in this section of the 2027 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements – Not Applicable

Not applicable. No incentive arrangements exist with the ALTCS-DD Program.

I.4.B. Withhold Arrangements – Not Applicable

Not applicable. There are no withhold arrangements in the CYE 27 capitation rates for the ALTCS-DD Program.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2027 Guide provides information on the requirements for risk-sharing mechanisms. For information on the COVID-19 costs covered on a non-risk basis, see Section I.1.B.xi.(c).

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

I.4.C.ii. Appropriate Documentation

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

The CYE 27 contract for the ALTCS-DD Program will include risk corridors for the regular DDD rate cell.

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

AHCCCS has a long-standing program policy of including risk corridors within many of 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 27 contract will continue AHCCCS' long-standing program policy and will include risk corridors. This rate certification will use the term risk corridor to be consistent with the 2027 Guide. The ALTCS-DD Program Contract refers to the risk corridor as a reconciliation.

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

There are two risk corridor type arrangements in the ALTCS-DD Program. The first is DES/DDD reconciling its Subcontractor costs to reimbursement and the second is the LTSS and DDD-THP reconciliation of costs to reimbursement.

The Subcontractor costs to reimbursement risk corridor will reconcile Subcontractors medical expenses to medical capitation paid to the Subcontractor in accordance with the DES/DDD's contract with the

Subcontractor. The risk corridor with the Subcontractor provides for payment or recoupment outside a risk corridor as agreed to in the subcontract. DES/DDD will submit the reconciliation for AHCCCS approval and AHCCCS will reconcile with DES/DDD by reimbursing excess losses to be paid to the Subcontractor. The total amount of any excess profits to be recouped from the Subcontractor will be returned to AHCCCS.

The LTSS and DDD-THP costs risk corridor will reconcile DES/DDD's LTSS and DDD-THP medical cost expenses to the net retained capitation paid to DES/DDD. Net retained capitation is equal to the retained capitation rates paid less the administrative component, the case management component, and the premium tax plus any reinsurance payments. DES/DDD's medical cost expenses are equal to the fully adjudicated encounters, sub-cap/block payment medical expenses, and staff model expenses for LTSS and DDD-THP services as reported by DES/DDD with dates of service during the contract year. The risk corridor will limit DES/DDD profits to 6% and losses to 1%.

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.

Additional information regarding the risk corridors can be found in the Compensation section of the ALTCS-DD Program contract.

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

The risk corridors did not have any effect on the development of the CYE 27 capitation rates for the ALTCS-DD Program.

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

Risk-sharing mechanisms are developed in accordance with generally accepted actuarial principles and practices. The threshold amounts for the risk corridors were set using actuarial judgement with consideration of conversations and input between the AHCCCS DBF Actuarial Team, the AHCCCS DBF Finance & Reinsurance Team, the AHCCCS OOD, and the ALTCS-DD Program leadership.

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

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

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

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

If experience in the rating period aligns with pricing assumptions used in capitation rate development, there will be no remittance/payment between AHCCCS and the Contractors associated with the risk corridors. The risk corridors protect the State against excessive Contractor profits and protect

Contractors from excessive losses when experience in the rating period materially differs from the pricing assumptions.

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

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

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

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

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

AHCCCS provides a reinsurance program to AHCCCS Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types - with the majority of the reinsurance cases falling into the Regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under Catastrophic, including reinsurance for biologic drugs. Additionally, rather than the DES/DDD Contractor 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 which would trigger a reinsurance case based on the applicable reinsurance rules and service responsibility of DES/DDD in CYE 27 is the basis of the reinsurance offset.

The AHCCCS reinsurance program has been in place since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses DES/DDD for covered services incurred above the deductible. The deductible is the responsibility of DES/DDD. The deductible for CYE 26 Regular reinsurance cases is $150,000. The limit on High Dollar Catastrophic reinsurance is $1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

For additional information on the reinsurance program, refer to the Reinsurance section of the ALTCS-DD Program contract.

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

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical expense PMPM calculated for the rate setting period. It is a separate calculation and does not affect the methodologies for development of the gross medical expense component of the capitation 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 methodology for setting the reinsurance offset has not changed from the CYE 26 capitation rates. The capitation rates are adjusted by subtracting the reinsurance offset amounts from the gross medical expenses since DES/DDD will receive payment from AHCCCS for reinsurance cases. The data used to develop the reinsurance offset amounts are historical encounters incurred during CYE 25. Encounter data were adjusted in line with the changes outlined in sections I.2.B.iii., I.3.B.ii., and I.3.B.iii.

The projected costs of drugs added to the biologic reinsurance case type after the base period was calculated by taking the projected costs for CYE 27 for those drugs and applying a zero dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset.

Additionally, these data were adjusted for an expected contractor reporting factor, representing the rate at which the contractor reports reinsurance cases that merit reimbursement. The contractor reporting factor was developed from historical reinsurance payments as compared to the aggregated encounters for individual members which would have triggered reinsurance payments in each contract year. The historical average for this discrepancy is approximately 95% of “eligible reinsurance cases based on encounters” become “actual reinsurance cases submitted by the contractor”. Costs from the adjusted and trended encounter data were then evaluated for each member individually, repricing the total by reinsurance case type to a “reinsurance case value” using the deductibles and coinsurance percentages specific to each case type as outlined in the contract for CYE 27. The reinsurance offset was derived by taking the sum of the reinsurance case values and dividing by the CYE 27 projected member months.

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

This section of the 2027 Guide provides information on delivery system and provider payment initiatives (i.e., SDPs) authorized under 42 CFR §§ 438.2 and 438.6(c).

I.4.D.ii. Appropriate Documentation

I.4.D.ii.(a) Description of SDPs

The only SDPs addressed in this certification are the ones related to the ALTCS-DD Program. The contract requires the adoption of a minimum fee schedule for VFC providers, using State plan approved rates, as defined in 42 CFR § 438.6(a), as allowed under 42 CFR § 438.6(c)(1)(iii)(A). The SDP for VFC providers does not require written approval prior to implementation per 42 CFR § 438.6(c)(2)(i). The SDPs which require preprints for prior approval are DAP, PSI, HEALTHII, and SNSI. The 2027 Guide requires specifically formatted tables in addition to the information provided here. The CMS prescribed tables can be found in Appendices 8a and 8b.

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

Vaccines for Children

Through the VFC program, the Federal and State governments purchase, and make available at no cost, vaccines for AHCCCS children under age 19. A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(20)(C)(ii) of the Act. Contractors are required to adopt the payment rates in the Arizona Medicaid State plan, as described on Page 66b, as a minimum fee schedule for VFC providers.

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP. The potential rate increases range from 0.25% to 20%, depending on the provider type.

Pediatric Services Initiative

The PSI SDP provides a uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 licensed beds. The PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to Qualified Children's Hospitals.

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

The SNSI SDP provides a uniform percentage increase for inpatient and outpatient services provided by the eligible public safety net hospital. The SNSI uniform percentage increase is based on a fixed total

payment amount and is expected to fluctuate based on utilization in the contract year. This increase is intended to supplement, not supplant, payments to the eligible public safety net hospital.

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

The VFC minimum fee schedule and the DAP initiative are the only SDPs incorporated in the capitation rates. The 2027 Guide requires specifically formatted tables in addition to the information provided here. These CMS prescribed tables can be found in Appendices 8a and 8b.

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

Only the regular DDD rate cell is impacted by the VFC minimum fee schedule SDP and the DAP initiative. There is no impact to the Targeted Case Management rate cell.

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

The VFC minimum fee schedule impacts are included as part of the aggregate fee schedule changes shown in Appendix 6. See Appendix 8c for the total impact to the regular DDD rate cell for the VFC minimum fee schedules. For DAP, see Appendix 6 for the medical impact and Appendix 8c for the total impact to the regular DDD rate cell.

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

Vaccines for Children

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

Differential Adjusted Payments

The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 25 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DBF 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 27 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and risk group to the applicable COS to come to the final dollar impact for CYE 27 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and COS level which the AHCCCS DBF Actuarial Team then aggregated to the specific risk groups for each program).

I.4.D.ii.(a)(ii)(D) Preprint Acknowledgement

The actuary confirms that they have received and reviewed the DAP SDP preprint at the time of rate certification, and these payments are being made in a manner consistent with the preprint that will be submitted to CMS by September 15, 2026.

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

Not applicable. None of the SDPs for the ALTCS-DD Program are based on maximum fee schedules.

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

The PSI, HEALTHII, and SNSI SDPs are not included in the ALTCS-DD Program certified capitation rates and will be paid out via lump sum payments. The 2027 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a and 8b.

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

Pediatric Services Initiative

The aggregate amount of the separate payment term payment applicable to the ALTCS-DD Program for PSI is approximately $20.47 million, including premium tax.

Hospital Enhanced Access Leading to Health Improvements Initiative

The aggregate amount of the separate payment term payment applicable to the ALTCS-DD Program for HEALTHII is approximately $106.12 million, including premium tax.

Safety Net Services Initiative

The aggregate amount of the separate payment term payment applicable to the ALTCS-DD Program for SNSI is approximately $3.58 million, including premium tax.

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

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

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

Appendix 8c contains estimated PMPMs, including premium tax, for the regular DDD rate cell for informational purposes only; these payments are not made on a PMPM basis.

I.4.D.ii.(a)(iii)(D) Preprint Acknowledgement

Pediatric Services Initiative

AHCCCS has submitted the PSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each SDP preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Hospital Enhanced Access Leading to Health Improvements Initiative

AHCCCS has submitted the HEALTHII 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each SDP preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Safety Net Services Initiative

AHCCCS has submitted the SNSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each SDP preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

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

Pediatric Services Initiative

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

Hospital Enhanced Access Leading to Health Improvements Initiative

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

Safety Net Services Initiative

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

I.4.D.ii.(a)(iv) Portion of Capitation Rates and Aggregate Impact by Rate Cell

The 2027 Guide requires a new CMS prescribed table for SDPs that are incorporated in the capitation rates through rate adjustments and SDPs that are separate payments terms but are paid as part of the PMPM capitation rates. AHCCCS does not have any SDPs that are separate payments terms but are paid as part of the PMPM capitation rates. AHCCCS has two SDPs that are incorporated into the capitation rates which are: VFC program and DAP initiative.

I.4.D.ii.(a)(iv)(A) Incorporated in the Capitation Rates

See Appendix 8b for the specifically formatted table that documents the certified capitation rates, the projected enrollment in member months, the portion of the certified capitation rates that are attributable to each SDP, and the aggregate impact of the SDPs for each rate cell. The table incorporates footnotes which document assumptions made to develop estimates for each SDP, and descriptions of interactions between SDPs, as applicable.

I.4.D.ii.(a)(iv)(B) Not Incorporated in the Capitation Rates

See Appendix 8a for the aggregate magnitude of each SDP that is paid as a separate payment term and is not paid as part of the PMPM capitation rates and see Appendix 8c for the rate cell SDP PMPMs.

I.4.D.ii.(a)(v) Confirmation of No Other SDPs

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

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

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

I.4.D.ii.(a)(vii) SDP Page References

To the extent that an SDP is referenced in other sections of the rate certification beyond I.4.D., Appendix 8a identifies each page where the SDP is referenced.

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

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

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2027 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 projected ALTCS case management expense PMPM within the regular DDD capitation rate was informed by DES/DDD's expense projections for CYE 27. The projected PMPMs are derived from a case management expense model utilized by the AHCCCS DBF Actuarial Team incorporating membership projections from the AHCCCS DBF Budget Team, and salary information for case managers, case manager supervisors, and support staff provided by DES/DDD along with the contractual and legislative requirements for case management ratios. The projected PMPM associated with case management expenses for CYE 27 is denoted as 'Case Management' in Appendix 7.

The projected administrative expense PMPMs for LTSS were informed by DES/DDD's expense projections for CYE 27, actual expenses reported by DES/DDD for CYE 23, CYE 24, and CYE 25, and inflation forecasts provided in the S&P Global Market Intelligence Healthcare Cost Review First Quarter 2026 Healthcare Cost Report. The base data used for the administrative expense projection for LTSS was DES/DDD administrative expenses reported during CYE 25. The actuary used fixed and variable percentages reported by DES/DDD related to the administrative expenses reported over time and adjusted the variable portion of the administrative expenses with respect to membership growth. The actuary incorporated estimates for additional administrative requirements in the upcoming contract year to come up with a projected administrative expense amount for CYE 27. This projection was then compared to the CYE 27 expense projection from DES/DDD. The actuary's estimated projection of administrative expenses for CYE 27 was similar to the forecast provided by DES/DDD for CYE 27. The actuary's CYE 27 projection of administrative expenses for LTSS is denoted as 'Admin - LTSS' in Appendix 7.

The administrative expense PMPM for CYE 27 for the integrated subcontractors reflects inflation-adjusted administrative bid amounts from a Request for Proposal (RFP) competitive bid process which DES/DDD engaged in to subcontract the Integrated Care Services portion of their overall medical services responsibilities. One of the requirements of the RFP was to submit administrative bid amounts based on membership thresholds for the integrated contract. The original bid amounts took effect October 2019; to produce an estimate of the integrated subcontractor administrative cost, the actuary estimated the projected membership for each integrated subcontractor for CYE 27 to determine the appropriate bid threshold, based on reported integrated subcontractor enrollment as of February 2026. The actuary adjusted compensation-related components of the bid amounts using projected CPI-W inflation from the S&P Global Market Intelligence Healthcare Cost Review Healthcare Cost Report and added administrative

cost projections associated with the AAC transition to the bid threshold amounts. The CYE 27 administrative expense projection for the integrated subcontractors is denoted as 'Admin - ICS' in Appendix 7.

The Targeted Case Management capitation rate is updated in this certification and will be effective for the entire 12-month time period from October 1, 2026, through September 30, 2027. Similar to ALTCS case management, Targeted Case Management expenses were determined by incorporating case manager, case manager supervisor, and support staff salary information as well as supplemental staff model expenses provided by DES/DDD.

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

There were no other material changes not addressed elsewhere to the data, assumptions, or methodologies for projected 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

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

The administrative component of the CYE 27 capitation rates for the ALTCS-DD Program is described above in Section I.5.B.i.(a).

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

The CYE 27 capitation rates for the ALTCS-DD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

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

The CYE 27 capitation rates for the ALTCS-DD Program include a provision (denoted as underwriting (UW) margin and expressed as a percentage) for contributions to reserves, risk margin, and cost of capital.

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

No other material or non-material non-benefit costs not already addressed in previous sections are reflected in the CYE 27 capitation rates for the ALTCS-DD Program.

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

Historical non-benefit cost data is provided by the AHCCCS Contractors via financial statements and additional data requests. The audited financial statements can be found on the AHCCCS website at https://www.azahcccs.gov/Resources/OversightOfHealthPlans/contractedhealthplan.html. Historical

non-benefit cost data was considered and used in the non-benefit cost assumptions as described in section I.5.B.i.(a) above.

I.6. Risk Adjustment – Not Applicable

This section of the 2027 Guide is not applicable to the ALTCS-DD Program. The certified capitation rates paid to the ALTCS-DD Program do not include risk adjustment.

I.7. Acuity Adjustments – Not Applicable

This section of the 2027 Guide is not applicable to the ALTCS-DD Program. The certified capitation rates paid to the ALTCS-DD Program do not utilize acuity adjustments.

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

Section II of the 2027 Guide is applicable to the ALTCS-DD Program because the CYE 27 capitation rates for the ALTCS-DD Program are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 and the ALTCS-DD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. Applicability of Section I for MLTSS

The rate development standards and appropriate documentation described in Section I of the 2027 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 2027 Guide provides the two most common approaches to structuring the rate cells.

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

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

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

Not applicable. A member's individual 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-DD Program 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-DD 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-DD Program operates as managed care. No data is available that quantifies the effect that the management of this care is expected to have on the level of care within each care setting.

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

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

II.1.C.iii. Additional Information

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

Section III New Adult Group Capitation Rates – Not Applicable

Section III of the 2027 Guide is not applicable to the ALTCS-DD Program.

Appendix 1: Actuarial Certification

I, Ethan Sheffield, am an employee of AHCCCS. I am a Member of the American Academy of Actuaries and an Associate of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries, the Actuarial Standards Board, CMS, and federal regulations.

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

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

- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
- § 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 27 capitation rates for the ALTCS-DD Program have been documented according to the guidelines established by CMS in the 2027 Guide. The CYE 27 capitation rates for the ALTCS-DD Program are effective for the 12-month time period from October 1, 2026, through September 30, 2027.

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, DES/DDD, and the DES/DDD integrated subcontractors. I have relied upon AHCCCS, DES/DDD, and the DES/DDD integrated subcontractors for the accuracy of the data and I have accepted the data without audit, after checking the data for reasonableness and consistency.

SIGANATURE ON FILE — July 30, 2026

Ethan Sheffield — Date
Associate, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Appendix 2: Certified Capitation Rates

ALTCS-DD Capitation Rates Effective October 1, 2026, through September 30, 2027	
Regular DDD	$8,146.92
Targeted Case Management	$240.25

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

Appendix 3: Fiscal Impact Summary and Comparison to Prior Capitation Rates

ALTCS-DD Capitation Rates Effective October 1, 2026, through September 30, 2027					
Rate Cell	Rate Effective 10/1/2025	Rate Effective 10/1/2026	% Change	CYE 27 Projected MMs	CYE 27 Projected Expenses
Regular DDD	$7,952.35	$8,146.92	2.45%	610,406	$4,972,925,327
Targeted Case Management	$227.99	$240.25	5.38%	103,615	$24,893,870

Appendix 4: Base Data and Base Data Adjustments

Appendix 4: Base Data and Base Data Adjustments

Category of Service	Subtotal Base PMPM	I.2.B.iii.(b) Completion	Subtotal Completed Base PMPM	I.2.B.iii.(d) DAP Removal	I.2.B.iii.(d) Comb. Misc. Adjustment	I.3.A.v IMD (Reprice Stays of all Lengths)	I.3.A.v IMD (Remove Stays > 15)	I.3.A.v IMD (Remove Related Expenses > 15)	Subtotal Adjusted Base PMPM
ATPC	$39.58	1.0000	$39.58	0.00%	0.00%	0.00%	0.00%	0.00%	$39.58
Attendant Care	$1,362.79	0.9993	$1,363.80	(0.38%)	0.00%	0.00%	0.00%	(0.00%)	$1,358.56
Day Treatment	$410.01	0.9993	$410.32	(0.38%)	0.00%	0.00%	0.00%	(0.01%)	$408.69
Employment	$67.12	0.9993	$67.17	(0.38%)	0.00%	0.00%	0.00%	(0.01%)	$66.91
Hab - Per 15 Min	$888.90	0.9992	$889.58	(0.38%)	0.00%	0.00%	0.00%	(0.00%)	$886.17
Hab - Per Diem	$1,640.40	0.9993	$1,641.56	(0.38%)	0.00%	0.00%	0.00%	(0.00%)	$1,635.20
Misc. In Home Care	$3.90	0.9992	$3.91	(0.38%)	0.00%	0.00%	0.00%	0.00%	$3.89
Nursing	$174.74	0.9993	$174.87	(0.38%)	0.00%	0.00%	0.00%	0.00%	$174.20
Private ICF	$27.14	0.9948	$27.28	(0.00%)	0.00%	0.00%	0.00%	0.00%	$27.28
Respite	$387.67	0.9994	$387.91	(0.38%)	0.00%	0.00%	0.00%	(0.00%)	$386.43
SelfCare	$3.45	0.9998	$3.45	(0.38%)	0.00%	0.00%	0.00%	0.00%	$3.44
SOGH	$15.85	1.0000	$15.85	0.00%	0.00%	0.00%	0.00%	0.00%	$15.85
SOICF	$16.89	1.0000	$16.89	0.00%	0.00%	0.00%	0.00%	0.00%	$16.89
Therapies	$236.14	0.9993	$236.31	(0.38%)	0.00%	0.00%	0.00%	0.00%	$235.40
Transportation	$44.34	0.9993	$44.37	(0.38%)	0.00%	0.00%	0.00%	0.00%	$44.20
Integrated Care Services	$1,250.00	0.9612	$1,300.50	(0.64%)	0.01%	0.04%	(0.08%)	(0.01%)	$1,291.54
Gross Medical	**$6,568.93**		**$6,623.36**						**$6,594.24**

Appendix 5: Projected Benefit Cost Trends

Statewide				
Rate Cell	Trend COS	Utilization Per 1000	Unit Cost	PMPM
Regular DDD	ATPC	-10.00%	6.00%	-4.60%
Regular DDD	Attendant Care	8.90%	0.00%	8.90%
Regular DDD	Day Treatment	0.10%	0.00%	0.10%
Regular DDD	Employment	0.10%	0.00%	0.10%
Regular DDD	Hab - Per 15 Min	8.90%	0.00%	8.90%
Regular DDD	Hab - Per Diem	-1.30%	5.80%	4.42%
Regular DDD	Misc. In Home Care	6.80%	0.00%	6.80%
Regular DDD	Nursing	6.80%	0.00%	6.80%
Regular DDD	Private ICF	-10.00%	6.00%	-4.60%
Regular DDD	Respite	6.80%	0.00%	6.80%
Regular DDD	SelfCare	6.80%	0.00%	6.80%
Regular DDD	SOGH	-10.00%	6.00%	-4.60%
Regular DDD	SOICF	-10.00%	6.00%	-4.60%
Regular DDD	Therapies	0.00%	0.00%	0.00%
Regular DDD	Transportation	0.10%	0.00%	0.10%
Regular DDD	Integrated Care Services	12.29%	2.06%	14.61%

Appendix 6: Development of Gross Medical Component

Appendix 6: Development of Gross Medical Component

Category of Service	Subtotal Adjusted Base PMPM	I.3.B.iii.(b)(i) Trend Rates	Subtotal Trended PMPM	I.3.B.ii.(a) PPCG Restrictions HB2945	I.3.B.ii.(a) ABA Policy Revisions	I.3.B.ii.(a) Provider Fee Schedule Changes	I.3.B.ii.(a) Comb. Misc. Adjustment	Subtotal Gross Medical (10/1/2026 - 9/30/2027)
ATPC	$39.58	(4.60%)	$36.02	0.00%	0.00%	0.00%	0.00%	$36.02
Attendant Care	$1,358.56	8.90%	$1,611.15	(3.19%)	0.00%	1.20%	0.02%	$1,578.70
Day Treatment	$408.69	0.10%	$409.50	0.00%	0.00%	1.27%	0.00%	$414.70
Employment	$66.91	0.10%	$67.04	0.00%	0.00%	1.31%	0.00%	$67.92
Hab - Per 15 Min	$886.17	8.90%	$1,050.92	(10.75%)	0.00%	1.17%	0.00%	$948.90
Hab - Per Diem	$1,635.20	4.42%	$1,783.10	0.00%	0.00%	1.29%	0.00%	$1,806.03
Misc. In Home Care	$3.89	6.80%	$4.44	0.00%	0.00%	1.25%	0.00%	$4.49
Nursing	$174.20	6.80%	$198.70	0.00%	0.00%	1.18%	0.02%	$201.08
Private ICF	$27.28	(4.60%)	$24.83	0.00%	0.00%	0.00%	0.00%	$24.83
Respite	$386.43	6.80%	$440.77	0.00%	0.00%	1.18%	0.00%	$445.95
SelfCare	$3.44	6.80%	$3.93	0.00%	0.00%	1.20%	0.00%	$3.97
SOGH	$15.85	(4.60%)	$14.42	0.00%	0.00%	0.00%	0.00%	$14.42
SOICF	$16.89	(4.60%)	$15.37	0.00%	0.00%	0.00%	0.00%	$15.37
Therapies	$235.40	0.00%	$235.40	0.00%	0.00%	1.15%	0.00%	$238.11
Transportation	$44.20	0.10%	$44.29	0.00%	0.00%	1.25%	0.00%	$44.85
Integrated Care Services	$1,291.54	14.61%	$1,696.41	0.00%	(6.03%)	0.31%	(0.42%)	$1,592.40
Gross Medical	**$6,594.24**		**$7,636.31**					**$7,437.75**
SDP: DAP PMPM								$28.69
GME + SDP								**$7,466.43**

Appendix 7: Capitation Rate Development

Appendix 7: Capitation Rate Development

Rate Cell	Gross Medical plus SDP	RI Offset	Net Medical	Case Management	Admin - LTSS	Admin - ICS	UW Margin	Share of Cost	Premium Tax	Certified Capitation Rate
Regular DDD	$7,466.43	($97.37)	$7,369.06	$194.41	$265.87	$82.11	$79.91	($7.39)	$162.94	$8,146.92
Targeted Case Management	$0.00	$0.00	$0.00	$233.09	$0.00	$0.00	$2.35	$0.00	$4.81	$240.25

Appendix 8a: State Directed Payments – CMS Prescribed Tables

CMS Prescribed Table for I.4.D.ii.(a)(i)

Control name of the SDP	Type of payment - Section I.4.D.ii.(a)(i)(A)	Brief description - Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.D.ii.(a)(iii)	Page number(s) of other references to the SDP Section I.4.D.ii.(a)(vii)
Vaccines for Children (VFC)	Minimum Fee Schedule	Contractors are required to adopt the payment rates in the Arizona Medicaid State plan as a minimum fee schedule for VFC providers.	Rate Adjustment	8
Assumed preprint name to be assigned by CMS is AZ_Fee_IP.OP.PC.SP.NF.HCBS.BHI.BHO.D_Renewal_20261001-20270930 (DAP)	Uniform Percentage Increase	Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.	Rate Adjustment	8, 16, 19, 21, 25
AZ_Fee_IPH.OPH1_Renewal_20261001-20270930 (PSI)	Uniform Percentage Increase	Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 beds. The uniform percentage increase is based on a fixed total payment amount, and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term	8
AZ_Fee_IPH.OPH2_Renewal_20261001-20270930 (HEALTHII)	Uniform Percentage Increase	Uniform percentage increase for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class' aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term	8, 19
AZ_Fee_IPH.OPH3_Renewal_20261001-20270930 (SNSI)	Uniform Percentage Increase	Uniform percentage increase to the Contractor's rates for inpatient and outpatient services provided by the public safety net hospital. The uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term	8, 19

CMS Prescribed Table for I.4.D.ii.(a)(ii)

Control name of the SDP	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Magnitude of the Adjustment I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
Vaccines for Children (VFC)	Regular DDD	See Appendices 8b and 8c.	The impact of the minimum fee schedule requirement for VFC providers is addressed as part of the fee schedule updates. The impact of bringing vaccines administered for the VFC program to the minimum fee schedule using CYE 25 encounter data is equivalent to zero, given that the minimum fee schedule was in place for CYE 25 and there has been no change to the fee schedule in the intervening time period.	Not applicable.	Not applicable.
Assumed preprint name to be assigned by CMS is AZ_Fee_IP.OP.PC.SP.NF.HCBS.BHI.BHO.D_Renewal_20261001-20270930 (DAP)	Regular DDD	See Appendices 6, 8b, and 8c.	The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 25 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DBF 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 27 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 27 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DBF Actuarial Team then aggregated to the specific rate cells for each program).	AHCCCS has submitted the DAP §438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each SDP preprint at the time the rates were certified. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the preprint under CMS review.	Not applicable.

CMS Prescribed Table for I.4.D.ii.(a)(iii)

Control name of the SDP	Aggregate amount included in the certification - Sections I.4.D.ii.(a)(iii)(A) and I.4.D.ii.(a)(iv)(B)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_IPH.OPH1_Renewal_20261001-20270930 (PSI)	$20,470,285	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8c.	AHCCCS has submitted the PSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each SDP preprint at the time the rates were certified. The SDP is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved SDP preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH2_Renewal_20261001-20270930 (HEALTHII)	$106,117,109	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8c.	AHCCCS has submitted the HEALTHII 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each SDP preprint at the time the rates were certified. The SDP is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved SDP preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH3_Renewal_20261001-20270930 (SNSI)	$3,580,975	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8c.	AHCCCS has submitted the SNSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each SDP preprint at the time the rates were certified. The SDP is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final SNSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the SNSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved SDP preprint, and as if the payment information had been fully known when the rates were initially developed.
Total	**$130,168,369**				

Appendix 8b: State Directed Payments Portion of Capitation Rates

CMS Prescribed Table for I.4.D.ii.(a)(iv)

Rate Cell	Projected Enrollment (MM) - Section I.4.D.ii.(a)(iv)(A)(ii)	Certified Capitation Rate - Section I.4.D.ii.(a)(iv)(A)(i)	Portion of the rate attributable to VFC - Sections I.4.D.ii.(a)(iv)(A)(iii) and I.4.D.ii.(a)(iv)(A)(v)	Portion of the rate attributable to DAP - Sections I.4.D.ii.(a)(iv)(A)(iii) and I.4.D.ii.(a)(iv)(A)(v)	Aggregate impact of all SDPs - Section I.4.D.ii.(a)(iv)(A)(iv)
Regular DDD	610,406	$8,146.92	$0.00	$29.57	$29.57
Targeted Case Management	103,615	$240.25	$0.00	$0.00	$0.00

CMS Prescribed Table for I.4.D.ii.(a)(iv)(A)(iii-v) Description of Assumptions

SDP	Description
VFC	VFC - Contractors are required to adopt the payment rates specified in the Arizona Medicaid State Plan as the minimum fee schedule for VFC providers. The VFC minimum fee schedule has been in place since the start of CYE 25 and is fully reflected in the base data. There are no increases to the minimum fee schedule from the base period to the rating period; therefore, no incremental impact on the capitation rates is attributable to the VFC minimum fee schedule SDP.
DAP	DAP - DAP provides a uniform percentage increase to otherwise contracted rates, with the percentage varying by provider class and the qualifications met. Providers were notified of the qualifying criteria through both proposed and final Public Notices. The DAP has been in place for multiple years and base year encounters reflect past DAP percentages; the capitation rate development process therefore removes previous DAP amounts and the projected DAP requirements and associated payment impacts are then incorporated for the upcoming rating period.
Aggregate	Aggregate - There is no interaction between the DAP and VFC SDPs as they do not apply to overlapping services or procedure codes. Therefore, no adjustment is needed to account for interactions between the two SDPs.

Appendix 8c: State Directed Payments – Estimated PMPMs

Appendix 8c: State Directed Payments -- Estimated PMPMs

CYE 27 Estimated PMPM				
Directed Payment	Medical	Underwriting Margin	Premium Tax	Total
VFC	$0.00	$0.00	$0.00	$0.00
DAP	$28.69	$0.29	$0.59	$29.57
PSI	$32.86	$0.00	$0.67	$33.54
HEALTHII	$170.37	$0.00	$3.48	$173.85
SNSI	$5.75	$0.00	$0.12	$5.87