ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Contract Year Ending 2027
Capitation Rate Certification
Arizona Long Term Care System – Elderly and Physical Disability Program

October 1, 2026 through September 30, 2027

Prepared for:

The Centers for Medicare & Medicaid Services

Prepared by:

AHCCCS Division of Business and Finance

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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for Contract Year Ending 2027 (CYE 27) for the Arizona Long Term Care System (ALTCS) Elderly and Physical Disability (ALTCS-EPD) Program. Programs under the Arizona Health Care Cost Containment System (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 from 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 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 actuaries have followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), CMS, and federal regulations. In particular, the actuaries referenced the below during the development of the actuarially sound capitation rates:

- Actuarial Standards of Practice (ASOPs) applicable to Medicaid managed care rate setting which were effective before the start date of the rating period:
  - ASOP No. 1 – Introductory Actuarial Standard of Practice,
  - ASOP No. 5 – Incurred Health and Disability Claims,
  - ASOP No. 12 – Risk Classification (for All Practice Areas),
  - ASOP No. 23 – Data Quality,
  - ASOP No. 25 – Credibility Procedures,
  - ASOP No. 41 – Actuarial Communications,
  - ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies,
  - ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification, and
  - ASOP No. 56 – Modeling.
- The 2016, 2020, and 2024 Medicaid and CHIP Managed Care Final Rules (CMS-2390-F, CMS-2408-F, and CMS-2439-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-EPD 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-EPD Program, signed by Matthew C. Varitek, FSA, MAAA and Elizabeth Seaman, FSA, MAAA, is in Appendix 1. Mr. Varitek and Ms. Seaman meet the requirements for the definition of an Actuary described at 42 CFR § 438.2 which is provided below for reference.

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

Mr. Varitek and Ms. Seaman certify that the CYE 27 capitation rates for the ALTCS-EPD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

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

The final and certified capitation rates by rate cell are in Appendix 2. Additionally, the ALTCS-EPD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ALTCS-EPD 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 Appendices 2, 3, 4, 6, 7a, 7b, 8b, and 8c) to be consistent with the applicable provisions of 42 CFR Part 438 and the 2027 Guide and will use the term risk group when identifying a population not at the certified capitation rate level, e.g., the Duals risk group represents members who are dually eligible for Medicare and Medicaid in the ALTCS-EPD Program.

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-EPD Program.

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

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

The ALTCS-EPD Program contracts with three managed care organizations. The number of managed care organizations contracted with the Program varies by Geographical Service Area (GSA). Each ALTCS-EPD Program Contractor must have a dual eligible special needs plan (D-SNP) certified by either AHCCCS or Arizona Department of Insurance and Financial Institutions.

Table 1a provides the counties and zip codes covered in each GSA. Table 1b provides information about the GSAs each Contractor is responsible for, as well as the associated D-SNP for each Contractor.

Table 1a: GSA and Counties

GSA	Counties
North	Apache, Coconino, Mohave, Navajo, and Yavapai
Central	Gila, Maricopa, and Pinal (excluding zip codes 85542, 85192, and 85550)
South	Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma (including zip codes 85542, 85192, and 85550)

Table 1b: GSA and D-SNP Information by Contractor

Contractor	GSAs	D-SNP
Banner – University Family Care (Banner – UFC)	Central, South	Banner – University Care Advantage
Mercy Care	Central, South (Pima County Only)	Mercy Care
UnitedHealthcare Community Plan (UnitedHealthcare)	North, Central	Arizona Physicians IPA, Inc. d/b/a UnitedHealthcare Community Plan

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

This certification covers the ALTCS-EPD Program which provides Long-Term Services & Supports (LTSS), as well as physical and mental health services and case management services to eligible members who are elderly and/or have physical disabilities.

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

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

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

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

The rate certification for the CYE 27 capitation rates for the ALTCS-EPD 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 ALTCS-EPD Program are individuals who are elderly and/or have physical disabilities and have been deemed eligible to receive long-term care services through ALTCS.

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

The ALTCS-EPD Program has two risk groups: one group for members who are dually eligible for Medicare and Medicaid ("Duals") and another group for members who are not eligible for Medicare ("Non-Duals"). The capitation rates fund prospective and prior period coverage (PPC) of members for long-term, acute, mental health and case management services. The rates also include coverage of acute care only services for members that qualify for ALTCS but decline to receive long-term care services. Rates for the ALTCS-EPD population differ by GSA, risk group, and Contractor.

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

ALTCS determines eligibility for ALTCS-EPD services through eligibility offices located throughout the State. Further information is available in the "Eligibility" and "Enrollment and Disenrollment" sections of the ALTCS-EPD Contract.

There are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the population to be covered under the ALTCS-EPD Program during CYE 27.

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))
- Alternative Payment Model (APM) Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Withhold Arrangement) (42 CFR § 438.6(b)(3))

- 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))
    - Nursing Facility Supplemental Payments (NF-SP) (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 FFP

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

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

The CYE 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-EPD Program are consistent with the assumptions used to develop the CYE 27 capitation rates for the ALTCS-EPD Program.

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

The certified capitation rates were developed such that each ALTCS-EPD Contractor 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 actuaries are not certifying capitation rate ranges.

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

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

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

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

In the actuaries' judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To the actuaries' knowledge, 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-EPD 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-EPD Program related to the WFTC legislation. Less than three hundredths of one percent of ALTCS-EPD 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, given that eligibility for any ALTCS program is predicated upon needing nursing facility level of care (even if the member can be served in an HCBS setting).

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 Requirement 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-EPD 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-EPD 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-EPD 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 actuaries are certifying capitation rates for each rate cell.

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

This rate certification was prepared for 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-EPD 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-EPD Program actuaries calculate 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 each ALTCS-EPD Contractor was greater than 85 percent. Per 42 CFR § 438.5(b)(5) the actuaries reviewed past MLR results focusing in on the MLR results that correspond to the base period; for any ALTCS-EPD Contractors performing below 85 percent the actuaries would make adjustments to assumptions in capitation rate setting where appropriate, however this was not necessary for CYE 27 because all ALTCS-EPD Contractors 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. To the extent assumptions or adjustments underlying the capitation rates vary between managed care plans, the certification must also describe the basis for the variation.

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

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

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

All covered populations under the ALTCS-EPD Program receive the regular Federal Medical Assistance Percentage (FMAP).

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. The comparisons between the most recently certified CYE 26 ALTCS-EPD 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 also requires descriptions of what is leading to large or negative changes in rates from the previous rating period. As in past years, the AHCCCS 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. There are no large changes in the CYE 27 capitation rates as compared to the most recent certified CYE 26 capitation rates. Several rate cells have negative changes in the CYE 27 capitation rates as compared to the most recent certified CYE 26 capitation rates.

For the following combinations of GSA, Contractor, and risk group, the capitation rates reflect a negative change from the most recently certified CYE 26 capitation rates.

- **North GSA** – UnitedHealthcare – Duals
- **Central GSA** – UnitedHealthcare – Duals; Banner – UFC – Duals and Non-Duals
- **South GSA** – Banner – UFC – Duals

The primary driver for the negative rate changes is lower trend assumptions compared to the prior CYE 26 capitation rates. This is due primarily to reduced utilization growth across most categories of service (COS), compared to the utilization growth that was observed in development of the CYE 26 capitation rates.

An additional driver for the negative rate changes for the UnitedHealthcare Duals risk group in the North GSA and the Banner-UFC Non-Duals risk group in the Central GSA is that the base data PMPMs used to develop the CYE 27 capitation rates are lower than the base data PMPMs used in development of the CYE 26 capitation rates.

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

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

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

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

I.1.B.xii. Future Rate Amendments

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

Table 2: Future Rate Amendments

Possible Amendment	Potential Submission Date	Reason for Not Including in Current Certification
Access to Professional Services Initiative (APSI) SDP	No later than December 2026	AHCCCS is still finalizing the CYE 27 preprint for APSI for submission to CMS.
SDPs	After the Notice of Proposed Rule Making (NPRM) becomes a Final Rule	AHCCCS submitted preprints with differing options for payment for some SDPs based on proposed changes to regulations in the current NPRM. Revision may be needed based on provisions finalized in the regulations.

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 public health emergency (PHE), such as increased telehealth usage. No explicit adjustments were made as part of the capitation rate development for direct or indirect impacts of COVID-19, the PHE, or the related unwinding, given the uniqueness of the populations covered by the ALTCS-EPD Program.

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 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-EPD Program were:

- Adjudicated and approved encounter data submitted by the ALTCS-EPD Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2021 through February 2026
  - Adjudicated and approved through the second February 2026 encounter cycle
- Reinsurance payments made to the same ALTCS-EPD Contractors for services
  - Incurred from October 2021 through September 2025 paid through April 2026
- Enrollment data for the same ALTCS-EPD Contractors from the AHCCCS PMMIS mainframe
  - October 2021 through February 2026
- Annual and quarterly financial statements submitted by the same ALTCS-EPD Contractors and reviewed by the AHCCCS DBF Finance & Reinsurance Team
  - October 2021 through March 2026
- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DBF Rates & Reimbursement Team
- Data from 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)

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership provided by the Contractors, including additional detail on claims runout and prior period adjustments included in financial statements
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CYE 25
- Projected CYE 27 enrollment data provided by AHCCCS DBF Budget Team
- Nursing Facilities (NF) and Home and Community Based Services (HCBS) placement data for October 2020 through February 2026
- Member level share of cost data provided by AHCCCS for October 2021 through September 2025

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

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

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

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

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

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

AHCCCS Contractors 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/block purchased. 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 encounters and the repriced amounts were used as the basis for calculating utilization per 1000 and unit cost values.

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 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 Contractors 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.

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

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

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

The AHCCCS 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 categories of service (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 27 capitation rates for the ALTCS-EPD 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 compared the CYE 25 encounter data for all services provided by ALTCS-EPD Contractors to the financial statements data for the same entities for CYE 25. The actuaries also compared the CYE 25 encounter data to the yearly supplemental data request from the ALTCS-EPD Contractors. After adjustments to the AHCCCS encounter data for completion, the financial statements, the AHCCCS encounter data, and the Contractors' responses to the supplemental data request were judged to be consistent for capitation rate setting.

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

As required by ASOP No. 23, the AHCCCS DBF Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the ALTCS-EPD Contractors and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the ALTCS-EPD Contractors and reviewed by the AHCCCS 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,
- 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 ALTCS-EPD Contractors in the yearly supplemental data request with regards to administrative and case management components, and
- data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

The actuaries have found the encounter data in total to be appropriate for the purposes of developing the CYE 27 capitation rates for the ALTCS-EPD Program.

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

There were no 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 was appropriate to use as the base data for developing the CYE 27 capitation rates for the ALTCS-EPD Program.

There was a large member shift that occurred with the implementation of the Medicare/Medicaid dual alignment requirement as of January 1, 2025. This dual alignment requirement compels Medicaid plan enrollment to follow Medicare plan enrollment for dually-eligible individuals in the ALTCS-EPD Program.

The AHCCCS DBF Actuarial Team further reviewed and determined that it was appropriate to redistribute the first 3 months (October 1, 2024, through December 31, 2025) of the base data encounters and member months to align with the members' assignments to Contractors as of January and February 2025, due to the large member shift that occurred in January of 2025. This adjustment shifted the base data encounters and member months for individual Contractors but did not modify the CYE 25 base data in total.

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-EPD Program.

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

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

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-EPD 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

The AHCCCS DBF Actuarial Team developed completion factors to apply to the encounter data. Completion factors were calculated using the development method with monthly encounter data incurred from October 2021 through February 2026 and adjudicated and approved through the second encounter cycle for February 2026. The completion factors were developed by Contractor, GSA, major COS, and month of service, combining the experience of Duals and Non-Duals members. The major COS used in ALTCS-EPD completion factor development are primarily based upon the AHCCCS form type, with form A (CMS-1500 professional form type) being further subdivided into HCBS and acute services. Distinct completion factors are therefore developed for the following COS: Nursing Facility (LTSS, form type L), HCBS (LTSS, form type A), Acute-Inpatient (non-LTSS, form type I), Acute-Outpatient (non-LTSS, form type O), Acute-Pharmacy (non-LTSS, form type C), and Acute-Other (non-LTSS, form types A and D).

The monthly completion factors were applied to the encounter data on a monthly basis. Aggregate CYE 25 completion factors by Contractor, GSA, risk group, and COS can be found in Appendix 4. Table 3 displays the aggregate impact of completion by GSA.

Table 3: Impact of Completion Factors

GSA	Before Completion	After Completion	Impact
North	$4,057.35	$4,190.83	3.29%
Central	$5,216.63	$5,326.96	2.11%
South	$5,176.50	$5,235.28	1.14%
Total	**$5,109.92**	**$5,209.99**	**1.96%**

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

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

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 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. 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 every individual risk group at the GSA level, that adjustment was deemed non-material and has been grouped in the other base data adjustment subset below.

Some of the impacts for base data adjustment changes described below (indicated by an asterisk *) were developed by AHCCCS 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 regarding the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuaries met with the AHCCCS 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.

Member Share of Cost Add-on

An adjustment was made to add CYE 25 NF and HCBS share of cost (SOC) payments to the base data. This adjustment grosses up the base encounter data to reflect both the provider and member liabilities prior to the application of trend and other prospective adjustments described in Section I.3.B. After application of those adjustments, the projected CYE 27 SOC payments were removed as described in Section I.3.B.ii.(a).

The overall impacts by GSA for the ALTCS-EPD Program are displayed in Table 4. Totals may not add up due to rounding. Note that these impacts are after application of the percentages for members receiving LTSS and placement in the NF or HCBS settings.

Table 4: Member Share of Cost Add-on

GSA	Dollar Impact	PMPM Impact
North	$7,416,385	$281.57
Central	$36,498,707	$166.50
South	$17,680,392	$231.81
Total	**$61,595,484**	**$191.40**

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 CYE 25 DAP from the base period. 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 associated costs removed from the base data are displayed in Table 5. Totals may not add up due to rounding.

See Section I.4.D. for information on adjustments included in CYE 27 capitation rates for DAP that are effective from October 1, 2026, through September 30, 2027.

Table 5: Removal of DAP from Base Data

GSA	Dollar Impact	PMPM Impact
North	($1,001,464)	($38.02)
Central	($11,887,549)	($54.23)
South	($4,674,744)	($61.29)
Total	**($17,563,756)**	**($54.58)**

Other Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component of the rate for every individual rate cell, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated in Table 6. Totals may not add up due to rounding. 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 6: Other Base Data Adjustments

GSA	Dollar Impact	PMPM Impact
North	$3,695	$0.14
Central	$39,462	$0.18
South	$7,223	$0.09
Total	**$50,380**	**$0.16**

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-EPD 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 in a month in an IMD in accordance with 42 CFR § 438.6(e).

Costs Associated with an Institution for Mental Disease Stay

The AHCCCS 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 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).

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

The combined impacts of repricing all IMD stays to the cost of the same services through providers included under the State plan, removing IMD stays which exceeded 15 cumulative days in a month, and removing medical expenses related to problematic IMD stays by GSA for the ALTCS-EPD Program are displayed in Table 7. Totals may not add up due to rounding.

Table 7: IMD Repricing and Removal of All Costs for Repriced Stays > 15 Cumulative Days in a Month

GSA	Dollar Impact	PMPM Impact
North	$0	$0.00
Central	($133,292)	($0.61)
South	($9,642)	($0.13)
Total	**($142,933)**	**($0.44)**

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

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

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

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

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

The base data described in Section I.2.B.ii. was adjusted to reflect completion and all base data adjustments described in Section I.2.B.iii. Further base data adjustments for required IMD changes are

described in Section I.3.A.v. The adjusted base data PMPMs were trended forward 24 months, from the midpoint of the CYE 25 base 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.

Appendix 4 contains the base data and base data adjustments by COS and rate cell. Appendix 5 contains the projected benefit cost trends. Appendix 6 contains gross medical expenses by COS and rate cell after applying prospective program and reimbursement changes, and CYE 27 DAP. Appendix 7a contains projected percentages of members receiving LTSS and projected percentages of LTSS members placed in NF or HCBS settings at a rate cell level. Appendix 7b illustrates the capitation rate development, which includes the projected administrative expense, case management expense, underwriting (UW) margin, and premium tax by rate cell.

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 rate for every individual rate cell at the GSA level, 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 benefits 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 regards to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuaries met with the AHCCCS DBF financial analysts to understand at a high level how the estimated amounts were derived and what data was used for the amounts. The actuaries were unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

AHCCCS 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 by GSA is illustrated in Table 8. Totals may not add up due to rounding.

Table 8: Aggregate Fee Schedule Changes

GSA	Dollar Impact	PMPM Impact
North	$2,344,688	$89.02
Central	$21,931,987	$100.05
South	$7,880,323	$103.32
Total	**$32,156,998**	**$99.92**

Mix Percentage Change Impacts

The ALTCS-EPD Program has a long-standing practice of using mix percentages to create a blended capitation rate. The two percentages that are used to get to a blended rate are the percentage of members receiving LTSS services (LTSS %) and the percentage of members utilizing HCBS rather than NF services, which we call the HCBS mix percentage (HCBS %). The LTSS % is used to project the number of members out of the total ALTCS-EPD population who receive LTSS through the program, with the remainder of the members being those who opt out of receiving LTSS and choose to only have their acute services covered under the program. The HCBS % is used to project the number of LTSS members that will be utilizing HCBS rather than NF services; the HCBS % is applied to the HCBS component of the capitation rates, and the complement (1 minus HCBS %) is applied to the NF component of the capitation rates. To estimate projected CYE 27 LTSS utilization and HCBS mix percentages, the AHCCCS DBF Actuarial Team reviewed placement data from October 2020 through February 2026 to understand historical trends and reviewed results of several different forecasting techniques for setting the projected CYE 27 LTSS and HCBS mix percentages.

The impacts to the ALTCS-EPD Program accounting for the change in mix percentages from the base

period to the rating period, are displayed in Table 9. Totals may not add up due to rounding.

Table 9: Mix Percentage Change

GSA	Dollar Impact	PMPM Impact
North	$36,260	$1.38
Central	$5,247,004	$23.94
South	$1,629,151	$21.36
Total	**$6,912,415**	**$21.48**

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.

To estimate the impact of adopted P&T Committee changes, the AHCCCS DBF financial analysts largely relied on projections of drug utilization prepared by Magellan Rx Management, the agency's provider of drug rebate administrative services. Magellan has a nationwide vantage point that was drawn from in projecting how recommendations would impact drug utilization by AHCCCS members. For CYE 27 rate development, the aggregate impact of adopted changes was allocated across risk groups and GSAs using CYE 25 encounter data for the affected drug classes.

The actuaries also included other drug coverage decision impacts with the P&T Committee recommendations, including any drugs added to or removed from the covered drug list for AHCCCS' biologics reinsurance case type. These are included as part of the reinsurance offset development discussed in Section I.4.C.ii.(c)(iv).

The combined impacts of the adopted P&T Committee recommendations are displayed in Table 10. Totals may not add up due to rounding.

Table 10: P&T Committee Recommendations

GSA	Dollar Impact	PMPM Impact
North	($51,176)	($1.94)
Central	($372,382)	($1.70)
South	($83,367)	($1.09)
Total	**($506,925)**	**($1.58)**

Diabetic Drug Class Utilization Changes

Glucagon-like peptide-1 (GLP-1) receptor agonists and sodium-glucose co-transporter-2 inhibitors (SGLT2) play a key role in the treatment of type 2 diabetes mellitus. These drugs may also lead to weight loss and a reduced need for insulins. The AHCCCS DBF Actuarial Team reviewed all historical adjudicated and approved encounters for these drug classes as well as the projected pharmacy trend assumptions to determine if the changing utilization patterns of these drug classes was appropriately

accounted for by the trend assumptions, or if a specific adjustment would be more appropriate. After review, the AHCCCS actuaries judged a separate, specific adjustment to be appropriate, except for specific rate cells made up of only Dual eligible members. The overall impacts for CYE 27 are driven more by the increased utilization of the GLP-1 and SGLT2 drugs beyond the included pharmacy trend assumptions than by the reduced utilization of insulin products.

The overall impact of the separate, specific adjustments accounting for the changing utilization patterns of the three diabetic drug classes by GSA is displayed in Table 11. Totals may not add up due to rounding.

Table 11: Diabetic Drug Class Utilization Changes

GSA	Dollar Impact	PMPM Impact
North	$729	$0.03
Central	$83,026	$0.38
South	$92,258	$1.21
Total	**$176,014**	**$0.55**

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 rate for every individual risk group at the GSA level, that program or reimbursement change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across risk groups within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated in Table 12. Totals may not add up due to rounding. Brief descriptions of the individual program or reimbursement 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.
- ***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.

- ***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.
- ***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.
- ***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 12: Combined Miscellaneous Program Changes

GSA	Dollar Impact	PMPM Impact
North	($46,990)	($1.78)
Central	($182,844)	($0.83)
South	($9,935)	($0.13)
Total	**($239,769)**	**($0.75)**

Projected Member Share of Cost Removal

After application of trend and other prospective adjustments to the base period data described above, the actuaries removed projected CYE 27 member SOC payments from the NF and HCBS service categories to reflect only Contractor liability in the capitation rates. The CYE 27 projection for SOC payments was developed by reviewing historical SOC experience (CYE 21 through CYE 25) for consistency in year-over-year increases at the rate cell level, using projected Consumer Price Index (CPI) for wage earners to trend the CYE 25 base amount PMPM for SOC forward to CYE 27, and adjusting for any outlier trends. The trend factor was based on data from an external firm, S&P Global Market Intelligence Healthcare Cost Review, which was reviewed and determined to be reasonable.

The overall impact by GSA for the ALTCS-EPD Program is displayed in Table 13. Totals may not add up due to rounding. Note that these impacts are after application of the percentages for members receiving LTSS and placement in the NF or HCBS settings.

Table 13: Projected Member Share of Cost Removal

GSA	Dollar Impact	PMPM Impact
North	($7,615,358)	($289.13)
Central	($37,648,840)	($171.75)
South	($18,149,956)	($237.96)
Total	**($63,414,154)**	**($197.05)**

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

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

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

The ALTCS-EPD Program Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuaries to set the CYE 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 2021 through early January 2026 and adjudicated and approved through the second February 2026 encounter cycle. The trends were developed primarily with actual experience from the Medicaid population.

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

Historical utilization, unit cost, and PMPM data from October 2021 through January 2026 were organized by incurred year and month, COS, and region (Central GSA or North/South GSAs). The historical experience was adjusted for completion and normalized for historical program and fee schedule changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 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 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 trend assumptions. Each COS and region were analyzed in the same manner.

For the EPD Program, four of the rate setting COS were aggregated with one or more other rate setting COS for the purposes of developing projected benefit cost trends. The aggregated trend COS are as follows: Acute - Inpatient and Acute - Outpatient, Acute - Physician and Acute - Other. The remaining rate setting COS were analyzed without further aggregation for projected benefit cost trend development.

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

All COS PMPM trend assumptions were compared to similar assumptions made in prior years for ALTCS-EPD capitation rates and judged reasonable to assume for projection to CYE 27.

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

The 2027 Guide requires explanation of outlier or negative trends. There are no negative PMPM trend assumptions included in the CYE 27 ALTCS-EPD Program capitation rate development. The actuaries note outlier PMPM trends for the Acute - Pharmacy - Specialty COS.

The high trends for the Acute - Pharmacy - Specialty COS are primarily driven by increases in the average unit cost of specialty drugs. The actuaries judged the trends assumed herein to be reasonable and appropriate after reviewing all of the data, reviewing multiple moving averages, and reviewing several linear regression lines across different timeframes.

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

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

The trend assumptions were developed by unit cost and utilization. Appendix 5 contains the components of the projected benefit cost trend by COS and region. For purposes of developing trend estimates, the North and South GSAs as defined in Table 1a were combined in order to smooth variance and enhance credibility.

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

The projected benefit cost trends were developed by region, implicitly addressing regional differences in utilization and unit cost data.

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

Projected benefit cost trends do not vary except by COS and region.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 were no material adjustments made related to litigation.

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

All material and non-material changes have been included in the capitation rate development process and all requirements in this section of the 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

I.4.A.i. Rate Development Standards

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

I.4.A.ii. Appropriate Documentation

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

Alternative Payment Model Initiative – Performance Based Payments
The CYE 27 capitation rates for the ALTCS-EPD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2), called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractors that are aimed at quality improvement such as reducing costs, improving health outcomes, or improving access to care.

Alternative Payment Model Initiative – Quality Measure Performance
The incentive arrangement for the APM Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of performance measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement, as described below in Section I.4.B. The incentive arrangement uses a ranked score to distribute available incentive dollars by performance measure, but Contractors will not be ranked if they did not earn either a performance achievement score or a performance improvement score for a given measure. The maximum incentive pool possible is approximately $18.9 million, which is the amount that would be available if every Contractor earned exactly 0% of the withhold described below. This is not anticipated to happen; thus, the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

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

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

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

Alternative Payment Model Initiative – Performance Based Payments
All enrollees, children and adults, may be covered by this incentive arrangement. Likewise, all network providers have the opportunity to participate in the APM arrangements and all covered services are

eligible for inclusion. The Contractors' provider contracts must include performance measures for quality and/or cost effectiveness. The Contractors are mandated to utilize the APM strategies in the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 as defined at https://hcp-lan.org/workproducts/apm-whitepaper.pdf.

Alternative Payment Model Initiative – Quality Measure Performance
The incentive arrangement includes performance measures addressing initiation and engagement of substance use disorder treatment, cervical cancer screening, and breast cancer screening. All adult and child enrollees and providers utilizing or providing these services, respectively, are covered by the incentive arrangement, unless specifically stated otherwise.

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

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

Alternative Payment Model Initiative – Quality Measure Performance
The purpose of the APM Initiative – Quality Measure Performance incentive arrangement is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through APM strategies.

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

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

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

Alternative Payment Model Initiative – Performance Based Payments
Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 27 capitation rates and had no effect on the development of the capitation rates for the ALTCS-EPD Program. The incentive payments will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the CYE 27 contract year.

Alternative Payment Model Initiative – Quality Measure Performance
Incentive payments for the APM Initiative – Quality Measure Performance incentive arrangement are not included in the CYE 27 capitation rates and had no effect on the development of the capitation rates for the ALTCS-EPD Program. Incentive payments will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the contract year and the computation of the performance measures, and after the withhold payments are distributed and the value of the incentive pool determined.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2027 Guide provides information on the definition and requirements of a withhold arrangement.

I.4.B.ii. Appropriate Documentation

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

The ALTCS-EPD Program includes a percentage of capitation withhold arrangement which the Contractor may earn back. Each Contractor's earnings are based on their performance achievement score, using a threshold benchmark and a high-performance benchmark, and/or performance improvement score by measure.

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

The time period of the withhold arrangement described herein is twelve months.

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

All enrollees, services, and providers are covered by this withhold arrangement unless specifically stated otherwise in contract or policy.

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

The purpose of the ALTCS-EPD Program withhold is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings by aligning the incentives of the Contractor and provider through APM strategies.

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

AHCCCS has established a quality withhold of 1% of the Contractor's capitation and a percentage (up to 100%) of the withheld amount will be paid to the Contractor for performance on select performance measures.

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

A new policy governing the performance measure results became effective October 1, 2022, for CYE 23 and forward. However, the EPD withhold initiative for CYE 24 and CYE 25 were canceled due to the protest of the EPD procurement awards, with the withhold amounts returned to the Contractors, so the most recent available results are from CYE 23. After reviewing results from both the withhold and the incentive arrangements for CYE 23 for the ALTCS-EPD Program, when only the withhold amounts were considered, the median amount of the withhold earned back in the first year was approximately 83.5% across all Contractors. The amounts that were not earned back from the withhold were combined into the incentive pool and redistributed among the Contractors according to the results of the performance measures, as described above in Section I.4.A. When considering both the withhold and the incentive

dollars earned, restricted to the lesser of what the individual Contractors actually earned back and 100% of the original withhold amount by Contractor, the median amount earned rose to 94.8%. Some Contractors earned back more in total than what was originally withheld based on the inclusion of their payments from the incentive pool, as was expected. Using averages, rather than medians, across all Contractors was 89.0% and 96.4%, respectively, for the same metrics. Given this information, the AHCCCS DBF Actuarial Team estimates approximately 3.5% to 5.0% of the withhold is not reasonably achievable through the combination of the withhold and the incentive arrangements. The AHCCCS DBF Actuarial Team estimates approximately 11.0% to 16.5% of the withhold is not reasonably achievable prior to taking into consideration the incentive arrangement tied to the withhold.

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

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

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

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

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

The CYE 27 capitation rates documented in this rate certification are actuarially sound even if none of the withhold is earned back.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2027 Guide provides information on the requirements for risk-sharing mechanisms.

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 contracts and capitation rate certification for the rating period which will be submitted to CMS before 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-EPD Program will include risk corridors.

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

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

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

There are two risk corridor type arrangements in the ALTCS-EPD Program. The first is a SOC reconciliation, and the second is a reconciliation of medical costs to medical reimbursement (tiered reconciliation).

The SOC risk corridor will reconcile the Contractor's "actual SOC PMPM" against the SOC PMPM amounts assumed in the capitation rates for that year plus or minus 2% (i.e. a risk band). The Contractor's "actual SOC PMPM" for the contract year will be calculated as the Contractor's total actual SOC payments divided by the Contractor's total paid member months. Differences between the Contractor's total actual share of cost payments and the Contractor's total assumed share of cost dollars that fall within the risk band are the responsibility of the Contractor. For differences that fall outside the risk band, AHCCCS shall recoup or reimburse the differences between the risk band threshold and the Contractor's total actual share of cost payments.

The tiered risk corridor will reconcile each Contractor's net medical expenses to the net capitation paid to each Contractor. Net capitation is equal to the capitation rates paid less the administrative component, the case management component, and the premium tax, plus any reinsurance payments. Each Contractor's net medical expenses are equal to the Contractor's fully adjudicated and approved encounters and sub-capitated/block purchase medical expenses as reported by the Contractor's financial statements with dates of service during the contract year. Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically computed no sooner than 15 months after the contract year. This risk corridor will limit each Contractor's statewide profits and losses as listed in Table 14.

Table 14: Tiered Risk Corridor Risk Bands

Profit	Contractor Share	State Share	Max Contractor Profit	Cumulative Contractor Profit
<= 2%	100%	0%	2.00%	2.00%
2% < Profit <= 4%	75%	25%	1.50%	3.50%
4% < Profit <= 7%	25%	75%	0.75%	4.25%
> 7%	0%	100%	0.00%	4.25%
Loss	**Contractor Share**	**State Share**	**Max Contractor Loss**	**Cumulative Contractor Loss**
<= 1%	100%	0%	1.00%	1.00%
1% < Loss <= 2%	75%	25%	0.75%	1.75%
2% < Loss <= 3%	50%	50%	0.50%	2.25%
3% < Loss <= 4%	25%	75%	0.25%	2.50%
> 4%	0%	100%	0.00%	2.50%

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-EPD 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 judgment with consideration of conversations between the AHCCCS DBF Actuarial Team, the AHCCCS DBF Finance & Reinsurance Team, and the AHCCCS OOD.

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. Additional information regarding the risk corridors can be found in the contract as well as in the AHCCCS Contractors Operations Manual (ACOM) 301.

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

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

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

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

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

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

The AHCCCS reinsurance program has been in place since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the ALTCS-EPD Contractors for covered services incurred above the deductible. The deductible is the responsibility of the ALTCS-EPD Contractors. The deductible for CYE 27 Regular reinsurance cases is $150,000, which is unchanged from the CYE 26 deductible. The limit on High Dollar Catastrophic reinsurance is $1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

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

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

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

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical PMPM calculated for the rate setting period. It is a separate calculation and does not affect the methodologies for development of the gross medical expense component of the capitation rates.

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 reinsurance offsets by risk group are developed from CYE 25 reinsurance payments to the ALTCS-EPD Contractors for Regular, Biologic, and Catastrophic reinsurance cases associated with services incurred during the base period. The data is "brought current" by way of completion factors specific to reinsurance payments, adjustments for historical and prospective program and reimbursement changes, and has the same trend factors applied as the gross medical expense for acute care services, since LTSS expenses are not eligible for consideration in reinsurance. The PMPM expense trend assumed for the Acute – Inpatient COS is applied to payments for Regular reinsurance cases; the Acute – Pharmacy PMPM expense trend is applied to payments for the biologic case type; and the aggregate PMPM expense trend for all Acute services is applied to payments for Catastrophic reinsurance cases.

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-EPD 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, SNSI, and NF-SP. 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 20.0%, 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.

Nursing Facility Supplemental Payments

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

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

The VFC minimum fee schedule SDP impacts all ALTCS-EPD rate cells. The DAP initiative impacts all ALTCS-EPD rate cells.

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. For the total impact by rate cell for the VFC minimum fee schedules see Appendix 8c. For DAP, see Appendix 6 for medical impact by risk group and Appendix 8c for total impact by 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 actuaries confirm 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-EPD Program are based on maximum fee schedules.

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

The PSI, HEALTHII, SNSI and NF-SP are not included in the ALTCS-EPD certified capitation rates and will be paid out via lump sum payments. 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)(iii)(A) Aggregate Amount

Pediatric Services Initiative

The aggregate amount of the separate payment term payment applicable to the ALTCS-EPD Program for PSI is approximately $2.4 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-EPD Program for HEALTHII is approximately $106.6 million, including premium tax.

Safety Net Services Initiative

The aggregate amount of the separate payment term payment applicable to the ALTCS-EPD Program for SNSI is approximately $5.76 million, including premium tax.

Nursing Facility Supplemental Payments

The aggregate amount of the separate payment term payment applicable to the ALTCS-EPD Program for NF-SP is approximately $95.4 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 actuaries certify 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 actuaries certify 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 actuaries certify 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.

Nursing Facility Supplemental Payments

The actuaries certify 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 by 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 actuaries 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 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 actuaries 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 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 actuaries 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 that is under CMS review.

Nursing Facility Supplemental Payments
AHCCCS has submitted the NF-SP 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuaries 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 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 payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Nursing Facility Supplemental Payments
After the rating period is complete and the final NF-SP payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NF-SP payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved 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 an 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-EPD 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 primary data sources used to develop the administrative component of the CYE 27 capitation rates for the ALTCS-EPD Program were the CYE 25 quarterly financial statements submitted by the Contractors, and historical and projected administrative expense data submitted by the Contractors per a supplemental data request. The ALTCS-EPD Contractors' supplemental data request included actual CYE 25 amounts, actual CYE 26 Q1 (through December 31, 2025) amounts, and actual/projected amounts for CYE 26. This data request included breakouts into different administrative categories for each time frame. The actuaries also reviewed Consumer Price Index (CPI) data from S&P Global Market Intelligence Healthcare Cost Review.

Administrative Expenses

The actuaries used CYE 25 administrative (Admin) expenses reported in the Contractors' quarterly financial statements as the base experience for projecting CYE 27 Admin expenses. The actuaries also evaluated each Contractor's supplemental data submission for reasonableness to make Contractor-specific adjustments in developing the final projected Admin expenses.

The wage-driven portion of the CYE 25 Admin expenses was trended forward from the base period to the rating period by the projected CPI for wage earners. The trend factor was based on data from an external firm, S&P Global Market Intelligence Healthcare Cost Review, which was reviewed and determined to be reasonable. A trend factor was not applied to the non-wage-driven portion of the CYE 25 Admin expenses. The CYE 27 projected wage-driven and non-wage-driven amounts were summed together to equal the projected CYE 27 Admin expenses. The administrative expenses are set as a percentage of statewide projected gross medical expenses by Contractor, and then the percentage by Contractor is applied to the projected gross medical expense by GSA and risk group (Duals or Non-Duals) to develop the projected CYE 27 Admin expense by rate cell.

Case Management Expenses

The actuaries used CYE 25 case management expenses by GSA and risk group, as reported in the Contractors' quarterly financial statements, as the base experience for projecting CYE 27 Case Management expenses. Adjustments were made for the change in HCBS mix percentage from the base experience period to the rating period, and to increase the wage-driven portion of the base case management expenses by the projected CPI for wage earners (as described in the Admin section above).

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

The data, assumptions, and methodology used to develop the CYE 27 projected administrative and case management costs are similar to the previous rating period and have been documented above.

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

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

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

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

The administrative component of the CYE 27 ALTCS-EPD capitation rates is described above in Section I.5.B.i.(a). The PMPM amounts by rate cell are provided in Appendix 7b.

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

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

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

The CYE 27 capitation rates for the ALTCS-EPD Program include a provision (denoted as UW margin and expressed as a percentage) for contributions to reserves, risk margin, and cost of capital of 1.15%, unchanged from the most recently certified CYE 26 capitation rates.

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

No other material or non-material non-benefit costs are reflected in the CYE 27 capitation rates for the ALTCS-EPD Program.

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

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

I.6. Risk Adjustment – Not Applicable

Not applicable. The CYE 27 capitation rates for the ALTCS-EPD Program do not include risk adjustment.

I.7. Acuity Adjustments – Not Applicable

Not applicable. The CYE 27 capitation rates for the ALTCS-EPD 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-EPD Program because the CYE 27 capitation rates for the ALTCS-EPD Program are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 and the ALTCS-EPD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. 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 long-term care setting does not determine the capitation paid for that member.

II.1.C. Appropriate Documentation

II.1.C.i. Considerations

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

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

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

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

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

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

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

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

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

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

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

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

II.1.C.iii. Additional Information

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

Section III New Adult Group Capitation Rates – Not Applicable

Section III of the 2027 Guide is not applicable to the ALTCS-EPD Program. As noted in Section I.1.B.x, all covered populations under the ALTCS-EPD Program receive the regular FMAP.

Appendix 1: Actuarial Certification

We, Matthew C. Varitek, FSA, MAAA and Elizabeth Seaman, FSA, MAAA, are employees of AHCCCS. We meet the qualification standards established by the American Academy of Actuaries and have followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries, the Actuarial Standards Board, CMS, and federal regulations.

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

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

- § 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-EPD Program have been documented according to the guidelines established by CMS in the 2027 Guide. The CYE 27 capitation rates for the ALTCS-EPD Program are effective 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, we have relied upon data and information provided by AHCCCS and ALTCS-EPD Contractors. We have relied upon AHCCCS and ALTCS-EPD Contractors for the accuracy of the data and we have accepted the data without audit, after checking the data for reasonableness and consistency unless stated otherwise.

SIGNATURE ON FILE	July 30, 2026
Matthew C. Varitek Fellow, Society of Actuaries Member, American Academy of Actuaries	Date

SIGNATURE ON FILE	July 30, 2026
Elizabeth Seaman Fellow, Society of Actuaries Member, American Academy of Actuaries	Date

Appendix 2: Certified Capitation Rates

Appendix 2: Certified Capitation Rates

GSA	Contractor	Duals	Non-Duals
North	UnitedHealthcare Community Plan	$4,145.28	$8,928.40
Central	Banner – University Family Care	$5,362.01	$11,016.16
Central	Mercy Care	$5,847.52	$11,910.37
Central	UnitedHealthcare Community Plan	$4,157.67	$9,725.37
South	Banner – University Family Care	$5,317.43	$10,309.24
South	Mercy Care (Pima County Only)	$5,521.97	$10,309.35

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

GSA	Contractor	Risk Group	CYE 27 Projected MMs	CYE 26 Capitation Rate	CYE 27 Capitation Rate	CYE 26 Projected Expenditures	CYE 27 Projected Expenditures	Percentage Change
North	UnitedHealthcare Community Plan	Duals	22,640	$4,284.02	$4,145.28	$ 96,992,106	$ 93,850,899	(3.24%)
Central	Banner – University Family Care	Duals	21,582	$5,420.17	$5,362.01	$ 116,980,471	$ 115,725,220	(1.07%)
Central	Mercy Care	Duals	60,085	$5,753.13	$5,847.52	$ 345,674,380	$ 351,345,716	1.64%
Central	UnitedHealthcare Community Plan	Duals	95,404	$4,169.87	$4,157.67	$ 397,821,198	$ 396,656,942	(0.29%)
South	Banner – University Family Care	Duals	47,524	$5,484.67	$5,317.43	$ 260,650,917	$ 252,702,898	(3.05%)
South	Mercy Care (Pima County Only)	Duals	16,578	$5,434.71	$5,521.97	$ 90,095,500	$ 91,542,191	1.61%
North	UnitedHealthcare Community Plan	Non-Duals	3,698	$8,827.65	$8,928.40	$ 32,648,970	$ 33,021,611	1.14%
Central	Banner – University Family Care	Non-Duals	6,075	$11,194.09	$11,016.16	$ 68,002,119	$ 66,921,229	(1.59%)
Central	Mercy Care	Non-Duals	23,435	$11,524.00	$11,910.37	$ 270,063,867	$ 279,118,556	3.35%
Central	UnitedHealthcare Community Plan	Non-Duals	12,630	$9,658.34	$9,725.37	$ 121,987,042	$ 122,833,650	0.69%
South	Banner – University Family Care	Non-Duals	8,820	$9,903.27	$10,309.24	$ 87,347,291	$ 90,928,014	4.10%
South	Mercy Care (Pima County Only)	Non-Duals	3,351	$9,653.00	$10,309.35	$ 32,344,238	$ 34,543,458	6.80%
Composite		**Duals**	**263,812**	**$4,958.88**	**$4,934.66**	**$ 1,308,214,572**	**$ 1,301,823,867**	**(0.49%)**
Composite		**Non-Duals**	**58,009**	**$10,556.84**	**$10,814.95**	**$ 612,393,527**	**$ 627,366,518**	**2.44%**
Composite		**Total**	**321,822**	**$5,967.93**	**$5,994.60**	**$ 1,920,608,099**	**$ 1,929,190,384**	**0.45%**

Appendix 4: Base Data and Base Data Adjustments

Appendix 4: Base Data and Base Data Adjustments

Contractor | UnitedHealthcare Community Plan
GSA | North
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 22,988 | LTSS %: 98.09% | HCBS Mix %: 70.72%
Projection Period | Member Months: 22,640 | LTSS %: 98.06% | HCBS Mix %: 71.44%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$6,053.19	0.95742	$6,322.43	$1,054.23	$7,376.66	(1.17%)	0.00%	0.00%	$7,290.08
HCBS - Assisted Living	$1,188.32	0.97296	$1,221.34	$26.36	$1,247.70	(0.43%)	0.00%	0.00%	$1,242.31
HCBS - Attendant Care	$810.57	0.97296	$833.09	$7.83	$840.92	(0.71%)	0.00%	0.00%	$834.97
HCBS - Other	$129.50	0.97296	$133.10	$0.00	$133.10	(0.43%)	0.00%	0.00%	$132.52
Acute - Inpatient	$13.57	0.98924	$13.72	$0.00	$13.72	(2.17%)	0.00%	0.00%	$13.42
Acute - Other	$106.70	0.98207	$108.65	$0.00	$108.65	(0.10%)	0.00%	0.00%	$108.54
Acute - Outpatient	$16.69	0.95663	$17.45	$0.00	$17.45	(1.91%)	0.00%	0.00%	$17.11
Acute - Pharmacy - Specialty	$0.00	0.99768	$0.00	$0.00	$0.00	0.00%	0.00%	0.00%	$0.00
Acute - Pharmacy - Brand	$0.89	0.99768	$0.89	$0.00	$0.89	0.00%	0.00%	0.00%	$0.89
Acute - Pharmacy - Generic	$3.18	0.99768	$3.19	$0.00	$3.19	0.00%	0.00%	0.00%	$3.19
Acute - Physician	$41.41	0.98207	$42.16	$0.00	$42.16	(0.00%)	0.00%	0.00%	$42.16
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$1,738.67	0.95742	$1,816.00	$302.81	$2,118.81	(1.17%)	0.00%	0.00%	$2,093.94
HCBS Component PMPM[4]	$1,476.47	0.97296	$1,517.50	$23.72	$1,541.22	(0.54%)	0.00%	0.00%	$1,532.94
Acute Component PMPM[5]	$182.45	0.98056	$186.06	$0.00	$186.06	(0.40%)	0.00%	0.00%	$185.32
Total Medical PMPM	**$3,397.59**	**0.96534**	**$3,519.56**	**$326.53**	**$3,846.09**	**(0.88%)**	**0.00%**	**0.00%**	**$3,812.21**

Percent Members Receiving LTSS	98.09%
HCBS Mix Percent	70.72%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | UnitedHealthcare Community Plan
GSA | North
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 3,661 | LTSS %: 96.84% | HCBS Mix %: 72.09%
Projection Period | Member Months: 3,698 | LTSS %: 97.11% | HCBS Mix %: 69.30%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$8,905.16	0.95742	$9,301.25	$160.23	$9,461.48	(1.38%)	0.00%	0.00%	$9,330.87
HCBS - Assisted Living	$805.59	0.97296	$827.98	$2.10	$830.08	(0.43%)	0.00%	0.00%	$826.50
HCBS - Attendant Care	$1,364.52	0.97296	$1,402.43	$3.04	$1,405.47	(0.70%)	0.00%	0.00%	$1,395.64
HCBS - Other	$284.43	0.97296	$292.34	$0.00	$292.34	(0.28%)	0.00%	0.00%	$291.52
Acute - Inpatient	$448.30	0.98924	$453.17	$0.00	$453.17	(2.11%)	0.00%	0.00%	$443.62
Acute - Other	$650.03	0.98207	$661.90	$0.00	$661.90	(0.04%)	0.00%	0.00%	$661.65
Acute - Outpatient	$452.05	0.95663	$472.54	$0.00	$472.54	(1.76%)	0.00%	0.00%	$464.20
Acute - Pharmacy - Specialty	$1,554.14	0.99768	$1,557.75	$0.00	$1,557.75	0.00%	0.00%	0.00%	$1,557.75
Acute - Pharmacy - Brand	$349.45	0.99768	$350.26	$0.00	$350.26	0.00%	0.12%	0.00%	$350.69
Acute - Pharmacy - Generic	$128.97	0.99768	$129.27	$0.00	$129.27	0.00%	0.44%	0.00%	$129.84
Acute - Physician	$497.13	0.98207	$506.20	$0.00	$506.20	(0.00%)	0.00%	0.00%	$506.20
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$2,406.61	0.95742	$2,513.65	$43.30	$2,556.95	(1.38%)	0.00%	0.00%	$2,521.65
HCBS Component PMPM[4]	$1,713.70	0.97296	$1,761.32	$3.59	$1,764.91	(0.56%)	0.00%	0.00%	$1,754.98
Acute Component PMPM[5]	$4,080.07	0.98765	$4,131.10	$0.00	$4,131.10	(0.44%)	0.02%	0.00%	$4,113.94
Total Medical PMPM	**$8,200.38**	**0.97553**	**$8,406.07**	**$46.89**	**$8,452.96**	**(0.75%)**	**0.01%**	**0.00%**	**$8,390.58**

Percent Members Receiving LTSS	96.84%
HCBS Mix Percent	72.09%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Banner – University Family Care
GSA | Central
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 21,335 | LTSS %: 98.59% | HCBS Mix %: 74.98%
Projection Period | Member Months: 21,582 | LTSS %: 98.39% | HCBS Mix %: 74.03%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$7,612.83	0.99714	$7,634.70	$977.69	$8,612.39	(1.33%)	0.00%	(0.02%)	$8,496.26
HCBS - Assisted Living	$1,704.11	0.98284	$1,733.87	$17.94	$1,751.81	(0.46%)	0.00%	0.00%	$1,743.74
HCBS - Attendant Care	$1,058.36	0.98284	$1,076.84	$12.54	$1,089.39	(1.24%)	0.00%	0.00%	$1,075.89
HCBS - Other	$134.65	0.98284	$137.01	$0.00	$137.01	(1.00%)	0.00%	0.00%	$135.63
Acute - Inpatient	$44.86	0.98617	$45.49	$0.00	$45.49	(2.65%)	0.00%	(1.41%)	$43.66
Acute - Other	$200.81	0.98145	$204.61	$0.00	$204.61	(0.05%)	0.00%	0.00%	$204.51
Acute - Outpatient	$43.23	0.98467	$43.90	$0.00	$43.90	(1.70%)	0.00%	0.00%	$43.15
Acute - Pharmacy - Specialty	$0.13	0.99863	$0.13	$0.00	$0.13	0.00%	0.00%	0.00%	$0.13
Acute - Pharmacy - Brand	$1.76	0.99863	$1.76	$0.00	$1.76	0.00%	0.07%	0.00%	$1.76
Acute - Pharmacy - Generic	$1.56	0.99863	$1.56	$0.00	$1.56	0.00%	0.05%	0.00%	$1.56
Acute - Physician	$68.93	0.98145	$70.23	$0.00	$70.23	(0.02%)	0.00%	0.00%	$70.22
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$1,877.72	0.99714	$1,883.11	$241.15	$2,124.26	(1.33%)	0.00%	(0.02%)	$2,095.62
HCBS Component PMPM[4]	$2,141.75	0.98284	$2,179.15	$22.53	$2,201.69	(0.77%)	0.00%	0.00%	$2,184.73
Acute Component PMPM[5]	$361.26	0.98258	$367.67	$0.00	$367.67	(0.56%)	0.00%	(0.17%)	$364.99
Total Medical PMPM	**$4,380.73**	**0.98889**	**$4,429.94**	**$263.68**	**$4,693.62**	**(1.01%)**	**0.00%**	**(0.02%)**	**$4,645.33**

Percent Members Receiving LTSS	98.59%
HCBS Mix Percent	74.98%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Banner – University Family Care
GSA | Central
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 5,730 | LTSS %: 95.48% | HCBS Mix %: 67.19%
Projection Period | Member Months: 6,075 | LTSS %: 95.34% | HCBS Mix %: 66.50%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$11,260.81	0.99714	$11,293.17	$136.40	$11,429.57	(1.47%)	0.00%	0.00%	$11,261.26
HCBS - Assisted Living	$1,226.55	0.98284	$1,247.97	$3.42	$1,251.39	(0.52%)	0.00%	0.00%	$1,244.88
HCBS - Attendant Care	$1,325.24	0.98284	$1,348.38	$10.32	$1,358.71	(1.08%)	0.00%	0.00%	$1,344.09
HCBS - Other	$367.71	0.98284	$374.14	$0.00	$374.14	(0.72%)	0.00%	0.00%	$371.44
Acute - Inpatient	$887.66	0.98617	$900.11	$0.00	$900.11	(2.42%)	0.00%	0.03%	$878.60
Acute - Other	$842.07	0.98145	$857.99	$0.00	$857.99	(0.05%)	0.00%	0.00%	$857.53
Acute - Outpatient	$407.97	0.98467	$414.32	$0.00	$414.32	(2.08%)	0.00%	0.00%	$405.68
Acute - Pharmacy - Specialty	$881.41	0.99863	$882.62	$0.00	$882.62	0.00%	(0.01%)	0.00%	$882.57
Acute - Pharmacy - Brand	$340.44	0.99863	$340.91	$0.00	$340.91	0.00%	0.12%	0.00%	$341.33
Acute - Pharmacy - Generic	$89.96	0.99863	$90.08	$0.00	$90.08	0.00%	0.37%	0.00%	$90.42
Acute - Physician	$641.76	0.98145	$653.89	$0.00	$653.89	(0.01%)	0.00%	0.00%	$653.80
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$3,527.32	0.99714	$3,537.46	$42.73	$3,580.18	(1.47%)	0.00%	0.00%	$3,527.46
HCBS Component PMPM[4]	$1,873.01	0.98284	$1,905.72	$8.82	$1,914.54	(0.80%)	0.00%	0.00%	$1,899.26
Acute Component PMPM[5]	$4,091.27	0.98825	$4,139.92	$0.00	$4,139.92	(0.75%)	0.02%	0.01%	$4,109.92
Total Medical PMPM	**$9,491.60**	**0.99045**	**$9,583.10**	**$51.54**	**$9,634.65**	**(1.03%)**	**0.01%**	**0.00%**	**$9,536.65**

Percent Members Receiving LTSS	95.48%
HCBS Mix Percent	67.19%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Mercy Care
GSA | Central
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 62,209 | LTSS %: 98.66% | HCBS Mix %: 78.58%
Projection Period | Member Months: 60,085 | LTSS %: 98.85% | HCBS Mix %: 78.53%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$8,857.23	0.99303	$8,919.36	$955.42	$9,874.78	(1.43%)	0.00%	0.00%	$9,733.72
HCBS - Assisted Living	$1,137.82	0.98503	$1,155.12	$16.22	$1,171.34	(0.48%)	0.00%	0.00%	$1,165.73
HCBS - Attendant Care	$1,951.31	0.98503	$1,980.97	$10.69	$1,991.66	(1.51%)	0.00%	0.00%	$1,961.52
HCBS - Other	$225.86	0.98503	$229.29	$0.00	$229.29	(1.03%)	0.00%	0.00%	$226.93
Acute - Inpatient	$75.36	0.85719	$87.92	$0.00	$87.92	(2.49%)	0.00%	(0.67%)	$85.16
Acute - Other	$276.00	0.99512	$277.35	$0.00	$277.35	(0.05%)	0.00%	(0.00%)	$277.20
Acute - Outpatient	$63.71	0.98356	$64.77	$0.00	$64.77	(1.26%)	0.00%	0.00%	$63.96
Acute - Pharmacy - Specialty	$0.59	0.99995	$0.59	$0.00	$0.59	0.00%	0.00%	0.00%	$0.59
Acute - Pharmacy - Brand	$3.82	0.99995	$3.82	$0.00	$3.82	0.00%	0.07%	0.00%	$3.83
Acute - Pharmacy - Generic	$5.92	0.99995	$5.92	$0.00	$5.92	0.00%	0.05%	0.00%	$5.93
Acute - Physician	$98.78	0.99512	$99.26	$0.00	$99.26	(0.00%)	0.00%	0.00%	$99.26
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$1,871.78	0.99303	$1,884.91	$201.91	$2,086.82	(1.43%)	0.00%	0.00%	$2,057.01
HCBS Component PMPM[4]	$2,569.91	0.98503	$2,608.97	$20.86	$2,629.83	(1.12%)	0.00%	0.00%	$2,600.29
Acute Component PMPM[5]	$524.17	0.97135	$539.63	$0.00	$539.63	(0.58%)	0.00%	(0.11%)	$535.91
Total Medical PMPM	**$4,965.86**	**0.98656**	**$5,033.52**	**$222.77**	**$5,256.28**	**(1.19%)**	**0.00%**	**(0.01%)**	**$5,193.21**

Percent Members Receiving LTSS	98.66%
HCBS Mix Percent	78.58%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Mercy Care
GSA | Central
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 23,429 | LTSS %: 96.77% | HCBS Mix %: 71.06%
Projection Period | Member Months: 23,435 | LTSS %: 97.17% | HCBS Mix %: 70.15%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$13,487.86	0.99303	$13,582.48	$78.04	$13,660.52	(1.67%)	0.00%	0.00%	$13,432.38
HCBS - Assisted Living	$635.27	0.98503	$644.92	$0.35	$645.27	(0.46%)	0.00%	(0.02%)	$642.18
HCBS - Attendant Care	$2,418.99	0.98503	$2,455.76	$2.37	$2,458.13	(1.33%)	0.00%	0.00%	$2,425.52
HCBS - Other	$709.79	0.98503	$720.58	$0.00	$720.58	(0.55%)	0.00%	0.00%	$716.64
Acute - Inpatient	$816.22	0.85719	$952.21	$0.00	$952.21	(2.15%)	0.00%	(0.13%)	$930.52
Acute - Other	$1,026.48	0.99512	$1,031.51	$0.00	$1,031.51	(0.04%)	0.00%	(0.00%)	$1,031.02
Acute - Outpatient	$334.83	0.98356	$340.43	$0.00	$340.43	(1.43%)	0.00%	0.00%	$335.55
Acute - Pharmacy - Specialty	$948.33	0.99995	$948.38	$0.00	$948.38	0.00%	(0.01%)	0.00%	$948.32
Acute - Pharmacy - Brand	$377.14	0.99995	$377.16	$0.00	$377.16	0.00%	0.12%	0.00%	$377.62
Acute - Pharmacy - Generic	$147.40	0.99995	$147.41	$0.00	$147.41	0.00%	0.37%	(0.01%)	$147.94
Acute - Physician	$732.38	0.99512	$735.98	$0.00	$735.98	(0.00%)	0.00%	(0.02%)	$735.82
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$3,777.36	0.99303	$3,803.86	$21.86	$3,825.72	(1.67%)	0.00%	0.00%	$3,761.83
HCBS Component PMPM[4]	$2,588.23	0.98503	$2,627.57	$1.87	$2,629.44	(1.03%)	0.00%	(0.00%)	$2,602.17
Acute Component PMPM[5]	$4,382.78	0.96685	$4,533.07	$0.00	$4,533.07	(0.57%)	0.02%	(0.03%)	$4,506.81
Total Medical PMPM	**$10,748.38**	**0.98029**	**$10,964.50**	**$23.72**	**$10,988.22**	**(1.06%)**	**0.01%**	**(0.01%)**	**$10,870.81**

Percent Members Receiving LTSS	96.77%
HCBS Mix Percent	71.06%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | UnitedHealthcare Community Plan
GSA | Central
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 91,171 | LTSS %: 97.88% | HCBS Mix %: 83.93%
Projection Period | Member Months: 95,404 | LTSS %: 98.10% | HCBS Mix %: 84.16%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$7,186.61	0.95742	$7,506.25	$980.17	$8,486.42	(1.18%)	0.00%	(0.00%)	$8,385.87
HCBS - Assisted Living	$1,361.86	0.97296	$1,399.70	$12.87	$1,412.57	(0.35%)	0.00%	0.00%	$1,407.63
HCBS - Attendant Care	$960.41	0.97296	$987.10	$5.29	$992.38	(0.85%)	0.00%	0.00%	$984.00
HCBS - Other	$181.94	0.97296	$187.00	$0.00	$187.00	(0.72%)	0.00%	0.00%	$185.65
Acute - Inpatient	$20.53	0.98924	$20.75	$0.00	$20.75	(2.24%)	0.00%	(1.90%)	$19.90
Acute - Other	$152.52	0.98207	$155.30	$0.00	$155.30	(0.06%)	0.00%	(0.00%)	$155.20
Acute - Outpatient	$13.85	0.95663	$14.48	$0.00	$14.48	(1.67%)	0.00%	0.00%	$14.24
Acute - Pharmacy - Specialty	$0.57	0.99768	$0.57	$0.00	$0.57	0.00%	0.00%	0.00%	$0.57
Acute - Pharmacy - Brand	$1.11	0.99768	$1.12	$0.00	$1.12	0.00%	0.07%	0.00%	$1.12
Acute - Pharmacy - Generic	$4.67	0.99768	$4.69	$0.00	$4.69	0.00%	0.05%	0.00%	$4.69
Acute - Physician	$57.55	0.98207	$58.60	$0.00	$58.60	(0.01%)	0.00%	(0.01%)	$58.59
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$1,130.35	0.95742	$1,180.62	$154.17	$1,334.79	(1.18%)	0.00%	(0.00%)	$1,318.97
HCBS Component PMPM[4]	$2,057.24	0.97296	$2,114.41	$14.92	$2,129.33	(0.57%)	0.00%	0.00%	$2,117.27
Acute Component PMPM[5]	$250.81	0.98160	$255.51	$0.00	$255.51	(0.32%)	0.00%	(0.16%)	$254.32
Total Medical PMPM	**$3,438.40**	**0.96842**	**$3,550.55**	**$169.08**	**$3,719.63**	**(0.77%)**	**0.00%**	**(0.01%)**	**$3,690.56**

Percent Members Receiving LTSS	97.88%
HCBS Mix Percent	83.93%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | UnitedHealthcare Community Plan
GSA | Central
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 12,058 | LTSS %: 96.40% | HCBS Mix %: 72.88%
Projection Period | Member Months: 12,630 | LTSS %: 97.17% | HCBS Mix %: 72.09%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$10,180.99	0.95742	$10,633.82	$85.35	$10,719.17	(1.45%)	0.00%	0.00%	$10,564.23
HCBS - Assisted Living	$1,115.49	0.97296	$1,146.49	$1.81	$1,148.29	(0.39%)	0.00%	0.00%	$1,143.84
HCBS - Attendant Care	$1,374.31	0.97296	$1,412.49	$3.45	$1,415.94	(0.83%)	0.00%	0.00%	$1,404.18
HCBS - Other	$430.95	0.97296	$442.92	$0.00	$442.92	(0.49%)	0.00%	0.00%	$440.76
Acute - Inpatient	$650.57	0.98924	$657.65	$0.00	$657.65	(2.34%)	0.00%	0.04%	$642.55
Acute - Other	$690.56	0.98207	$703.17	$0.00	$703.17	(0.04%)	0.00%	0.00%	$702.87
Acute - Outpatient	$356.97	0.95663	$373.15	$0.00	$373.15	(1.82%)	0.00%	0.00%	$366.36
Acute - Pharmacy - Specialty	$986.32	0.99768	$988.61	$0.00	$988.61	0.00%	(0.01%)	0.00%	$988.55
Acute - Pharmacy - Brand	$368.14	0.99768	$369.00	$0.00	$369.00	0.00%	0.12%	0.00%	$369.45
Acute - Pharmacy - Generic	$150.66	0.99768	$151.01	$0.00	$151.01	0.00%	0.37%	0.00%	$151.58
Acute - Physician	$737.70	0.98207	$751.16	$0.00	$751.16	(0.01%)	0.00%	0.00%	$751.11
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$2,662.11	0.95742	$2,780.52	$22.32	$2,802.84	(1.45%)	0.00%	0.00%	$2,762.32
HCBS Component PMPM[4]	$2,051.96	0.97296	$2,108.98	$3.69	$2,112.67	(0.61%)	0.00%	0.00%	$2,099.76
Acute Component PMPM[5]	$3,940.93	0.98677	$3,993.75	$0.00	$3,993.75	(0.56%)	0.02%	0.01%	$3,972.47
Total Medical PMPM	**$8,655.00**	**0.97431**	**$8,883.24**	**$26.01**	**$8,909.25**	**(0.85%)**	**0.01%**	**0.00%**	**$8,834.55**

Percent Members Receiving LTSS	96.40%
HCBS Mix Percent	72.88%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Banner – University Family Care
GSA | South
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 46,517 | LTSS %: 98.50% | HCBS Mix %: 72.76%
Projection Period | Member Months: 47,524 | LTSS %: 98.67% | HCBS Mix %: 72.78%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$7,636.45	0.99714	$7,658.39	$940.80	$8,599.19	(1.14%)	0.00%	0.00%	$8,501.13
HCBS - Assisted Living	$1,166.19	0.98284	$1,186.56	$11.56	$1,198.11	(0.31%)	0.00%	0.00%	$1,194.35
HCBS - Attendant Care	$1,506.28	0.98284	$1,532.59	$6.16	$1,538.75	(1.76%)	0.00%	0.00%	$1,511.73
HCBS - Other	$237.30	0.98284	$241.45	$0.00	$241.45	(1.52%)	0.00%	0.00%	$237.77
Acute - Inpatient	$18.27	0.98617	$18.53	$0.00	$18.53	(2.44%)	0.00%	0.10%	$18.09
Acute - Other	$89.24	0.98145	$90.93	$0.00	$90.93	(0.11%)	0.00%	0.00%	$90.83
Acute - Outpatient	$46.91	0.98467	$47.64	$0.00	$47.64	(1.05%)	0.00%	0.00%	$47.13
Acute - Pharmacy - Specialty	$0.00	0.99863	$0.00	$0.00	$0.00	0.00%	0.00%	0.00%	$0.00
Acute - Pharmacy - Brand	$2.76	0.99863	$2.76	$0.00	$2.76	0.00%	0.00%	0.00%	$2.76
Acute - Pharmacy - Generic	$2.12	0.99863	$2.12	$0.00	$2.12	0.00%	0.01%	0.00%	$2.12
Acute - Physician	$80.59	0.98145	$82.12	$0.00	$82.12	(0.01%)	0.00%	0.00%	$82.11
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$2,048.58	0.99714	$2,054.46	$252.38	$2,306.85	(1.14%)	0.00%	0.00%	$2,280.54
HCBS Component PMPM[4]	$2,085.41	0.98284	$2,121.83	$12.70	$2,134.53	(1.16%)	0.00%	0.00%	$2,109.83
Acute Component PMPM[5]	$239.88	0.98278	$244.09	$0.00	$244.09	(0.43%)	0.00%	0.01%	$243.05
Total Medical PMPM	**$4,373.87**	**0.98948**	**$4,420.38**	**$265.08**	**$4,685.46**	**(1.11%)**	**0.00%**	**0.00%**	**$4,633.41**

Percent Members Receiving LTSS	98.50%
HCBS Mix Percent	72.76%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Banner – University Family Care
GSA | South
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 8,487 | LTSS %: 97.57% | HCBS Mix %: 70.55%
Projection Period | Member Months: 8,820 | LTSS %: 97.92% | HCBS Mix %: 69.33%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$10,819.85	0.99714	$10,850.94	$93.52	$10,944.45	(1.33%)	0.00%	0.00%	$10,798.45
HCBS - Assisted Living	$633.93	0.98284	$645.01	$1.74	$646.74	(0.43%)	0.00%	0.00%	$643.97
HCBS - Attendant Care	$1,763.84	0.98284	$1,794.64	$2.20	$1,796.85	(1.73%)	0.00%	0.00%	$1,765.81
HCBS - Other	$447.77	0.98284	$455.59	$0.00	$455.59	(1.26%)	0.00%	0.00%	$449.84
Acute - Inpatient	$900.04	0.98617	$912.66	$0.00	$912.66	(2.41%)	0.00%	0.00%	$890.65
Acute - Other	$690.23	0.98145	$703.28	$0.00	$703.28	(0.15%)	0.00%	0.00%	$702.25
Acute - Outpatient	$581.54	0.98467	$590.59	$0.00	$590.59	(1.79%)	0.00%	0.00%	$580.01
Acute - Pharmacy - Specialty	$720.07	0.99863	$721.06	$0.00	$721.06	0.00%	(0.00%)	0.00%	$721.06
Acute - Pharmacy - Brand	$286.91	0.99863	$287.31	$0.00	$287.31	0.00%	0.09%	0.00%	$287.56
Acute - Pharmacy - Generic	$75.57	0.99863	$75.67	$0.00	$75.67	0.00%	0.46%	0.00%	$76.02
Acute - Physician	$570.79	0.98145	$581.58	$0.00	$581.58	(0.04%)	0.00%	0.00%	$581.35
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$3,109.33	0.99714	$3,118.26	$26.87	$3,145.14	(1.33%)	0.00%	0.00%	$3,103.18
HCBS Component PMPM[4]	$1,958.80	0.98284	$1,993.01	$2.71	$1,995.72	(1.36%)	0.00%	0.00%	$1,968.49
Acute Component PMPM[5]	$3,825.16	0.98786	$3,872.16	$0.00	$3,872.16	(0.87%)	0.02%	0.00%	$3,838.89
Total Medical PMPM	**$8,893.29**	**0.98997**	**$8,983.43**	**$29.59**	**$9,013.02**	**(1.14%)**	**0.01%**	**0.00%**	**$8,910.56**

Percent Members Receiving LTSS	97.57%
HCBS Mix Percent	70.55%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Mercy Care
GSA | South
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 16,843 | LTSS %: 98.86% | HCBS Mix %: 72.41%
Projection Period | Member Months: 16,578 | LTSS %: 99.11% | HCBS Mix %: 71.72%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$7,109.34	0.99303	$7,159.21	$936.86	$8,096.07	(1.07%)	0.00%	0.00%	$8,009.52
HCBS - Assisted Living	$1,162.01	0.98503	$1,179.67	$16.88	$1,196.55	(0.33%)	0.00%	0.00%	$1,192.55
HCBS - Attendant Care	$1,812.05	0.98503	$1,839.59	$10.04	$1,849.63	(1.93%)	0.00%	0.00%	$1,814.01
HCBS - Other	$302.50	0.98503	$307.10	$0.00	$307.10	(0.99%)	0.00%	0.00%	$304.06
Acute - Inpatient	$39.65	0.85719	$46.25	$0.00	$46.25	(2.53%)	0.00%	(1.52%)	$44.39
Acute - Other	$159.52	0.99512	$160.30	$0.00	$160.30	(0.07%)	0.00%	0.00%	$160.18
Acute - Outpatient	$32.00	0.98356	$32.53	$0.00	$32.53	(1.17%)	0.00%	0.00%	$32.15
Acute - Pharmacy - Specialty	$0.18	0.99995	$0.18	$0.00	$0.18	0.00%	0.00%	0.00%	$0.18
Acute - Pharmacy - Brand	$1.94	0.99995	$1.94	$0.00	$1.94	0.00%	0.00%	0.00%	$1.94
Acute - Pharmacy - Generic	$2.76	0.99995	$2.76	$0.00	$2.76	0.00%	0.01%	0.00%	$2.76
Acute - Physician	$98.23	0.99512	$98.71	$0.00	$98.71	(0.00%)	0.00%	0.00%	$98.71
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$1,939.21	0.99303	$1,952.82	$255.55	$2,208.36	(1.07%)	0.00%	0.00%	$2,184.76
HCBS Component PMPM[4]	$2,345.42	0.98503	$2,381.07	$19.27	$2,400.34	(1.27%)	0.00%	0.00%	$2,369.80
Acute Component PMPM[5]	$334.26	0.97547	$342.67	$0.00	$342.67	(0.49%)	0.00%	(0.21%)	$340.31
Total Medical PMPM	**$4,618.90**	**0.98767**	**$4,676.55**	**$274.82**	**$4,951.38**	**(1.13%)**	**0.00%**	**(0.01%)**	**$4,894.87**

Percent Members Receiving LTSS	98.86%
HCBS Mix Percent	72.41%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 4: Base Data and Base Data Adjustments

Contractor | Mercy Care
GSA | South
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 3,371 | LTSS %: 96.95% | HCBS Mix %: 69.58%
Projection Period | Member Months: 3,351 | LTSS %: 97.19% | HCBS Mix %: 71.02%

	I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Category of Service	Base Medical	Completion Factors	Completed Base Medical	SOC Payments Added	Subtotal	DAP Payments Removed	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]									
Nursing Facility (NF)	$10,984.48	0.99303	$11,061.54	$127.85	$11,189.39	(1.32%)	0.00%	0.00%	$11,041.18
HCBS - Assisted Living	$398.04	0.98503	$404.09	$0.00	$404.09	(0.27%)	0.00%	0.00%	$403.01
HCBS - Attendant Care	$2,500.35	0.98503	$2,538.35	$2.71	$2,541.06	(2.06%)	0.00%	0.00%	$2,488.68
HCBS - Other	$899.39	0.98503	$913.06	$0.00	$913.06	(0.74%)	0.00%	0.00%	$906.27
Acute - Inpatient	$493.86	0.85719	$576.14	$0.00	$576.14	(2.32%)	0.00%	0.06%	$563.12
Acute - Other	$748.01	0.99512	$751.68	$0.00	$751.68	(0.15%)	0.00%	0.00%	$750.53
Acute - Outpatient	$252.55	0.98356	$256.77	$0.00	$256.77	(1.56%)	0.00%	0.00%	$252.77
Acute - Pharmacy - Specialty	$1,458.75	0.99995	$1,458.83	$0.00	$1,458.83	0.00%	(0.00%)	0.00%	$1,458.82
Acute - Pharmacy - Brand	$292.98	0.99995	$292.99	$0.00	$292.99	0.00%	0.09%	0.00%	$293.25
Acute - Pharmacy - Generic	$70.95	0.99995	$70.95	$0.00	$70.95	0.00%	0.46%	0.00%	$71.28
Acute - Physician	$561.92	0.99512	$564.68	$0.00	$564.68	(0.04%)	0.00%	0.00%	$564.47
PMPMs based on All Members in Risk Group[2]									
NF Component PMPM[3]	$3,239.88	0.99303	$3,262.61	$37.71	$3,300.32	(1.32%)	0.00%	0.00%	$3,256.61
HCBS Component PMPM[4]	$2,561.78	0.98503	$2,600.71	$1.83	$2,602.54	(1.56%)	0.00%	0.00%	$2,561.90
Acute Component PMPM[5]	$3,879.02	0.97658	$3,972.03	$0.00	$3,972.03	(0.47%)	0.01%	0.01%	$3,954.24
Total Medical PMPM	**$9,680.68**	**0.98427**	**$9,835.36**	**$39.54**	**$9,874.90**	**(1.04%)**	**0.01%**	**0.00%**	**$9,772.74**

Percent Members Receiving LTSS	96.95%
HCBS Mix Percent	69.58%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 5: Projected Benefit Cost Trends

Appendix 5: Projected Benefit Cost Trends

		I.3.B.iii.	I.3.B.iii.	I.3.B.iii.
GSA	COS	Utilization per 1000	Unit Cost	PMPM
Central	NF	0.6%	1.4%	2.0%
Central	HCBS - Assisted Living	1.5%	0.5%	2.0%
Central	HCBS - Attendant Care	1.5%	0.0%	1.5%
Central	HCBS - Other	1.5%	0.0%	1.5%
Central	Acute - Inpatient	0.0%	0.0%	0.0%
Central	Acute - Other	2.0%	0.5%	2.5%
Central	Acute - Outpatient	0.0%	0.0%	0.0%
Central	Acute - Pharmacy - Specialty	3.0%	7.0%	10.2%
Central	Acute - Pharmacy - Brand	0.0%	3.0%	3.0%
Central	Acute - Pharmacy - Generic	1.0%	1.5%	2.5%
Central	Acute - Physician	2.0%	0.5%	2.5%
North/South	NF	0.0%	2.0%	2.0%
North/South	HCBS - Assisted Living	2.0%	1.0%	3.0%
North/South	HCBS - Attendant Care	1.0%	0.5%	1.5%
North/South	HCBS - Other	1.5%	0.0%	1.5%
North/South	Acute - Inpatient	0.5%	1.0%	1.5%
North/South	Acute - Other	1.0%	1.0%	2.0%
North/South	Acute - Outpatient	0.5%	1.0%	1.5%
North/South	Acute - Pharmacy - Specialty	3.0%	12.0%	15.4%
North/South	Acute - Pharmacy - Brand	0.5%	1.5%	2.0%
North/South	Acute - Pharmacy - Generic	1.5%	0.0%	1.5%
North/South	Acute - Physician	1.0%	1.0%	2.0%

Appendix 6: Development of Gross Medical Component

Appendix 6: Development of Gross Medical Component

Contractor | UnitedHealthcare Community Plan
GSA | North
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 22,988 | LTSS %: 98.09% | HCBS Mix %: 70.72%
Projection Period | Member Months: 22,640 | LTSS %: 98.06% | HCBS Mix %: 71.44%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$7,290.08	2.00%	1.40%	0.00%	0.00%	0.00%	$7,690.65	$126.27	$7,816.92		$7,816.92
HCBS - Assisted Living	$1,242.31	3.02%	3.67%	0.00%	0.00%	0.00%	$1,366.86	$4.68	$1,371.54		$1,371.54
HCBS - Attendant Care	$834.97	1.51%	3.57%	0.00%	0.00%	0.00%	$891.04	$2.71	$893.75		$893.75
HCBS - Other	$132.52	1.50%	1.22%	0.00%	0.00%	0.00%	$138.20	$0.03	$138.22		$138.22
Acute - Inpatient	$13.42	1.51%	0.00%	0.00%	0.00%	0.00%	$13.83	$0.00	$13.83		$13.83
Acute - Other	$108.54	2.01%	0.11%	0.00%	0.00%	0.02%	$113.10	$0.00	$113.10		$113.10
Acute - Outpatient	$17.11	1.51%	0.00%	0.00%	0.00%	0.00%	$17.63	$0.00	$17.63		$17.63
Acute - Pharmacy - Specialty	$0.00	15.36%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00	$0.00		$0.00
Acute - Pharmacy - Brand	$0.89	2.01%	0.00%	0.00%	0.00%	(0.51%)	$0.93	$0.00	$0.93		$0.93
Acute - Pharmacy - Generic	$3.19	1.50%	0.00%	(0.00%)	0.00%	(0.42%)	$3.27	$0.00	$3.27		$3.27
Acute - Physician	$42.16	2.01%	0.00%	0.00%	0.00%	0.00%	$43.87	$0.00	$43.87		$43.87
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$2,093.94	2.00%	1.40%	0.00%	0.00%	0.00%	$2,209.00	$36.27	$2,245.27	(2.50%)	$2,189.23
HCBS Component PMPM[4]	$1,532.94	2.37%	3.49%	0.00%	0.00%	0.00%	$1,662.18	$5.15	$1,667.33	0.99%	$1,683.81
Acute Component PMPM[5]	$185.32	1.92%	0.07%	(0.00%)	0.00%	0.00%	$192.64	$0.00	$192.64	0.00%	$192.64
Total Medical PMPM	**$3,812.21**	**2.15%**	**2.20%**	**(0.00%)**	**0.00%**	**0.00%**	**$4,063.82**	**$41.42**	**$4,105.23**	**(0.96%)**	**$4,065.68**

Percent Members Receiving LTSS	98.09%	(0.03%)	98.06%
HCBS Mix Percent	70.72%	1.02%	71.44%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | UnitedHealthcare Community Plan
GSA | North
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 3,661 | LTSS %: 96.84% | HCBS Mix %: 72.09%
Projection Period | Member Months: 3,698 | LTSS %: 97.11% | HCBS Mix %: 69.30%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$9,330.87	2.00%	1.40%	0.00%	0.00%	0.00%	$9,843.80	$169.64	$10,013.44		$10,013.44
HCBS - Assisted Living	$826.50	3.02%	3.65%	0.00%	0.00%	0.00%	$909.15	$3.53	$912.69		$912.69
HCBS - Attendant Care	$1,395.64	1.51%	3.57%	0.00%	0.00%	0.00%	$1,489.30	$4.96	$1,494.26		$1,494.26
HCBS - Other	$291.52	1.50%	(0.59%)	0.00%	0.00%	0.07%	$298.77	$0.40	$299.17		$299.17
Acute - Inpatient	$443.62	1.51%	0.09%	0.00%	0.00%	0.00%	$457.49	$7.72	$465.21		$465.21
Acute - Other	$661.65	2.01%	1.60%	0.00%	0.00%	0.01%	$699.60	$0.48	$700.07		$700.07
Acute - Outpatient	$464.20	1.51%	0.87%	0.00%	0.00%	0.00%	$482.46	$7.07	$489.53		$489.53
Acute - Pharmacy - Specialty	$1,557.75	15.36%	0.00%	(0.26%)	0.00%	(0.52%)	$2,057.00	$0.00	$2,057.00		$2,057.00
Acute - Pharmacy - Brand	$350.69	2.01%	0.00%	(2.20%)	0.06%	(0.48%)	$355.35	$0.00	$355.35		$355.35
Acute - Pharmacy - Generic	$129.84	1.50%	0.00%	(0.31%)	0.00%	(0.46%)	$132.73	$0.00	$132.73		$132.73
Acute - Physician	$506.20	2.01%	(1.17%)	0.00%	0.00%	0.00%	$520.57	$0.05	$520.62		$520.62
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$2,521.65	2.00%	1.40%	0.00%	0.00%	0.00%	$2,660.27	$45.84	$2,706.12	10.30%	$2,984.85
HCBS Component PMPM[4]	$1,754.98	2.02%	3.14%	0.00%	0.00%	0.01%	$1,883.14	$6.21	$1,889.35	(3.60%)	$1,821.25
Acute Component PMPM[5]	$4,113.94	7.71%	0.21%	(0.29%)	0.00%	(0.27%)	$4,705.20	$15.32	$4,720.52	0.00%	$4,720.52
Total Medical PMPM	**$8,390.58**	**4.83%**	**1.14%**	**(0.14%)**	**0.00%**	**(0.13%)**	**$9,248.62**	**$67.37**	**$9,315.99**	**2.26%**	**$9,526.62**

Percent Members Receiving LTSS	96.84%	0.28%	97.11%
HCBS Mix Percent	72.09%	(3.87%)	69.30%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Banner – University Family Care
GSA | Central
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 21,335 | LTSS %: 98.59% | HCBS Mix %: 74.98%
Projection Period | Member Months: 21,582 | LTSS %: 98.39% | HCBS Mix %: 74.03%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$8,496.26	2.01%	1.40%	0.00%	0.00%	0.00%	$8,964.81	$144.16	$9,108.96		$9,108.96
HCBS - Assisted Living	$1,743.74	2.01%	3.64%	0.00%	0.00%	0.00%	$1,880.47	$8.09	$1,888.56		$1,888.56
HCBS - Attendant Care	$1,075.89	1.50%	3.57%	0.00%	0.00%	0.00%	$1,147.95	$10.87	$1,158.81		$1,158.81
HCBS - Other	$135.63	1.50%	(0.05%)	0.00%	0.00%	0.02%	$139.68	$0.10	$139.79		$139.79
Acute - Inpatient	$43.66	0.00%	0.00%	0.00%	0.00%	0.00%	$43.66	$0.00	$43.66		$43.66
Acute - Other	$204.51	2.51%	0.06%	0.00%	0.00%	0.02%	$215.09	$0.00	$215.09		$215.09
Acute - Outpatient	$43.15	0.00%	0.00%	0.00%	0.00%	0.00%	$43.15	$0.00	$43.15		$43.15
Acute - Pharmacy - Specialty	$0.13	10.21%	0.00%	(2.13%)	0.00%	(0.28%)	$0.15	$0.00	$0.15		$0.15
Acute - Pharmacy - Brand	$1.76	3.00%	0.00%	(0.00%)	0.00%	(0.23%)	$1.86	$0.00	$1.86		$1.86
Acute - Pharmacy - Generic	$1.56	2.52%	0.00%	(0.00%)	0.00%	(0.17%)	$1.63	$0.00	$1.63		$1.63
Acute - Physician	$70.22	2.51%	0.00%	0.00%	0.00%	0.00%	$73.79	$0.00	$73.79		$73.79
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$2,095.62	2.01%	1.40%	0.00%	0.00%	0.00%	$2,211.18	$35.56	$2,246.74	3.58%	$2,327.15
HCBS Component PMPM[4]	$2,184.73	1.80%	3.45%	0.00%	0.00%	0.00%	$2,342.07	$14.09	$2,356.16	(1.47%)	$2,321.46
Acute Component PMPM[5]	$364.99	1.94%	0.04%	(0.00%)	0.00%	0.01%	$379.34	$0.00	$379.34	0.00%	$379.34
Total Medical PMPM	**$4,645.33**	**1.91%**	**2.24%**	**(0.00%)**	**0.00%**	**0.00%**	**$4,932.59**	**$49.65**	**$4,982.24**	**0.92%**	**$5,027.95**

Percent Members Receiving LTSS	98.59%	(0.21%)	98.39%
HCBS Mix Percent	74.98%	(1.27%)	74.03%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Banner – University Family Care
GSA | Central
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 5,730 | LTSS %: 95.48% | HCBS Mix %: 67.19%
Projection Period | Member Months: 6,075 | LTSS %: 95.34% | HCBS Mix %: 66.50%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$11,261.26	2.01%	1.40%	0.00%	0.00%	0.00%	$11,882.19	$198.22	$12,080.41		$12,080.41
HCBS - Assisted Living	$1,244.88	2.01%	3.64%	0.00%	0.00%	0.00%	$1,342.50	$6.95	$1,349.46		$1,349.46
HCBS - Attendant Care	$1,344.09	1.50%	3.57%	0.00%	0.00%	0.00%	$1,434.16	$13.39	$1,447.55		$1,447.55
HCBS - Other	$371.44	1.50%	(1.55%)	0.00%	0.00%	0.10%	$377.12	$1.40	$378.52		$378.52
Acute - Inpatient	$878.60	0.00%	0.08%	0.00%	0.00%	0.00%	$879.29	$14.82	$894.11		$894.11
Acute - Other	$857.53	2.51%	(1.13%)	0.00%	0.00%	0.07%	$891.57	$0.35	$891.93		$891.93
Acute - Outpatient	$405.68	0.00%	0.74%	0.00%	0.00%	0.00%	$408.70	$6.65	$415.35		$415.35
Acute - Pharmacy - Specialty	$882.57	10.21%	0.00%	(0.30%)	0.00%	(0.27%)	$1,065.90	$0.00	$1,065.90		$1,065.90
Acute - Pharmacy - Brand	$341.33	3.00%	0.00%	(1.22%)	2.16%	(0.24%)	$364.58	$0.00	$364.58		$364.58
Acute - Pharmacy - Generic	$90.42	2.52%	0.00%	(0.39%)	(0.15%)	(0.20%)	$94.33	$0.00	$94.33		$94.33
Acute - Physician	$653.80	2.51%	(1.66%)	0.00%	0.00%	0.00%	$675.67	$0.06	$675.73		$675.73
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$3,527.46	2.01%	1.40%	0.00%	0.00%	0.00%	$3,721.96	$62.09	$3,784.05	1.97%	$3,858.51
HCBS Component PMPM[4]	$1,899.26	1.72%	2.99%	0.00%	0.00%	0.01%	$2,023.32	$13.95	$2,037.26	(1.18%)	$2,013.14
Acute Component PMPM[5]	$4,109.92	3.67%	(0.40%)	(0.18%)	0.18%	(0.07%)	$4,380.03	$21.88	$4,401.91	0.00%	$4,401.91
Total Medical PMPM	**$9,536.65**	**2.66%**	**0.94%**	**(0.08%)**	**0.08%**	**(0.03%)**	**$10,125.30**	**$97.92**	**$10,223.22**	**0.49%**	**$10,273.56**

Percent Members Receiving LTSS	95.48%	(0.15%)	95.34%
HCBS Mix Percent	67.19%	(1.04%)	66.50%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Mercy Care
GSA | Central
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 62,209 | LTSS %: 98.66% | HCBS Mix %: 78.58%
Projection Period | Member Months: 60,085 | LTSS %: 98.85% | HCBS Mix %: 78.53%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$9,733.72	2.01%	1.40%	0.00%	0.00%	0.00%	$10,270.63	$171.66	$10,442.29		$10,442.29
HCBS - Assisted Living	$1,165.73	2.01%	3.64%	0.00%	0.00%	0.00%	$1,257.14	$4.57	$1,261.71		$1,261.71
HCBS - Attendant Care	$1,961.52	1.50%	3.56%	0.00%	0.00%	0.00%	$2,092.72	$18.11	$2,110.83		$2,110.83
HCBS - Other	$226.93	1.50%	(0.59%)	0.00%	0.00%	0.02%	$232.45	$1.18	$233.62		$233.62
Acute - Inpatient	$85.16	0.00%	0.00%	0.00%	0.00%	0.00%	$85.16	$0.00	$85.16		$85.16
Acute - Other	$277.20	2.51%	(0.05%)	0.00%	0.00%	0.02%	$291.21	$0.01	$291.22		$291.22
Acute - Outpatient	$63.96	0.00%	0.00%	0.00%	0.00%	0.00%	$63.96	$0.00	$63.96		$63.96
Acute - Pharmacy - Specialty	$0.59	10.21%	0.00%	(2.13%)	0.00%	(0.27%)	$0.70	$0.00	$0.70		$0.70
Acute - Pharmacy - Brand	$3.83	3.00%	0.00%	(0.00%)	0.00%	(0.23%)	$4.05	$0.00	$4.05		$4.05
Acute - Pharmacy - Generic	$5.93	2.52%	0.00%	(0.00%)	0.00%	(0.17%)	$6.22	$0.00	$6.22		$6.22
Acute - Physician	$99.26	2.51%	0.00%	0.00%	0.00%	0.00%	$104.30	$0.00	$104.30		$104.30
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$2,057.01	2.01%	1.40%	0.00%	0.00%	0.00%	$2,170.47	$36.28	$2,206.75	0.44%	$2,216.47
HCBS Component PMPM[4]	$2,600.29	1.68%	3.32%	0.00%	0.00%	0.00%	$2,777.14	$18.50	$2,795.63	0.12%	$2,799.11
Acute Component PMPM[5]	$535.91	1.85%	(0.03%)	(0.00%)	0.00%	0.01%	$555.59	$0.01	$555.60	0.00%	$555.60
Total Medical PMPM	**$5,193.21**	**1.83%**	**2.22%**	**(0.00%)**	**0.00%**	**0.00%**	**$5,503.20**	**$54.78**	**$5,557.98**	**0.24%**	**$5,571.18**

Percent Members Receiving LTSS	98.66%	0.19%	98.85%
HCBS Mix Percent	78.58%	(0.07%)	78.53%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Mercy Care
GSA | Central
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 23,429 | LTSS %: 96.77% | HCBS Mix %: 71.06%
Projection Period | Member Months: 23,435 | LTSS %: 97.17% | HCBS Mix %: 70.15%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$13,432.38	2.01%	1.40%	0.00%	0.00%	0.00%	$14,173.31	$239.63	$14,412.94		$14,412.94
HCBS - Assisted Living	$642.18	2.01%	3.64%	0.00%	0.00%	0.00%	$692.53	$2.89	$695.42		$695.42
HCBS - Attendant Care	$2,425.52	1.50%	3.55%	0.00%	0.00%	0.00%	$2,587.66	$27.01	$2,614.67		$2,614.67
HCBS - Other	$716.64	1.50%	(1.08%)	0.00%	0.00%	0.10%	$731.07	$5.39	$736.46		$736.46
Acute - Inpatient	$930.52	0.00%	0.11%	0.00%	0.00%	0.00%	$931.58	$15.90	$947.48		$947.48
Acute - Other	$1,031.02	2.51%	(4.30%)	0.00%	0.00%	0.07%	$1,037.64	$0.20	$1,037.84		$1,037.84
Acute - Outpatient	$335.55	0.00%	1.60%	0.00%	0.00%	0.00%	$340.91	$4.94	$345.85		$345.85
Acute - Pharmacy - Specialty	$948.32	10.21%	0.00%	(0.30%)	0.00%	(0.27%)	$1,145.34	$0.00	$1,145.34		$1,145.34
Acute - Pharmacy - Brand	$377.62	3.00%	0.00%	(1.22%)	0.67%	(0.24%)	$397.46	$0.00	$397.46		$397.46
Acute - Pharmacy - Generic	$147.94	2.52%	0.00%	(0.39%)	(0.65%)	(0.19%)	$153.58	$0.00	$153.58		$153.58
Acute - Physician	$735.82	2.51%	(1.02%)	0.00%	0.00%	0.00%	$765.33	$0.05	$765.38		$765.38
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$3,761.83	2.01%	1.40%	0.00%	0.00%	0.00%	$3,969.33	$67.11	$4,036.44	3.58%	$4,180.90
HCBS Component PMPM[4]	$2,602.17	1.59%	2.73%	0.00%	0.00%	0.02%	$2,758.21	$24.27	$2,782.47	(0.87%)	$2,758.15
Acute Component PMPM[5]	$4,506.81	3.71%	(0.96%)	(0.18%)	0.04%	(0.07%)	$4,771.84	$21.09	$4,792.92	0.00%	$4,792.92
Total Medical PMPM	**$10,870.81**	**2.61%**	**0.75%**	**(0.08%)**	**0.01%**	**(0.03%)**	**$11,499.37**	**$112.46**	**$11,611.83**	**1.03%**	**$11,731.97**

Percent Members Receiving LTSS	96.77%	0.41%	97.17%
HCBS Mix Percent	71.06%	(1.28%)	70.15%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | UnitedHealthcare Community Plan
GSA | Central
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 91,171 | LTSS %: 97.88% | HCBS Mix %: 83.93%
Projection Period | Member Months: 95,404 | LTSS %: 98.10% | HCBS Mix %: 84.16%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$8,385.87	2.01%	1.40%	0.00%	0.00%	0.00%	$8,848.41	$143.05	$8,991.46		$8,991.46
HCBS - Assisted Living	$1,407.63	2.01%	3.64%	0.00%	0.00%	0.00%	$1,518.01	$4.67	$1,522.68		$1,522.68
HCBS - Attendant Care	$984.00	1.50%	3.60%	0.00%	0.00%	0.00%	$1,050.20	$6.51	$1,056.71		$1,056.71
HCBS - Other	$185.65	1.50%	0.05%	0.00%	0.00%	0.02%	$191.39	$0.31	$191.70		$191.70
Acute - Inpatient	$19.90	0.00%	0.00%	0.00%	0.00%	0.00%	$19.90	$0.00	$19.90		$19.90
Acute - Other	$155.20	2.51%	0.06%	0.00%	0.00%	0.02%	$163.23	$0.01	$163.24		$163.24
Acute - Outpatient	$14.24	0.00%	0.00%	0.00%	0.00%	0.00%	$14.24	$0.00	$14.24		$14.24
Acute - Pharmacy - Specialty	$0.57	10.21%	0.00%	(2.13%)	0.00%	(0.53%)	$0.68	$0.00	$0.68		$0.68
Acute - Pharmacy - Brand	$1.12	3.00%	0.00%	(0.00%)	0.00%	(0.47%)	$1.18	$0.00	$1.18		$1.18
Acute - Pharmacy - Generic	$4.69	2.52%	0.00%	(0.00%)	0.00%	(0.41%)	$4.91	$0.00	$4.91		$4.91
Acute - Physician	$58.59	2.51%	0.00%	0.00%	0.00%	0.00%	$61.57	$0.00	$61.57		$61.57
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$1,318.97	2.01%	1.40%	0.00%	0.00%	0.00%	$1,391.72	$22.50	$1,414.22	(1.22%)	$1,396.95
HCBS Component PMPM[4]	$2,117.27	1.78%	3.37%	0.00%	0.00%	0.00%	$2,267.06	$9.44	$2,276.50	0.50%	$2,287.80
Acute Component PMPM[5]	$254.32	2.21%	0.04%	(0.01%)	0.00%	0.00%	$265.71	$0.01	$265.72	0.00%	$265.72
Total Medical PMPM	**$3,690.56**	**1.89%**	**2.45%**	**(0.00%)**	**0.00%**	**0.00%**	**$3,924.49**	**$31.95**	**$3,956.44**	**(0.15%)**	**$3,950.47**

Percent Members Receiving LTSS	97.88%	0.22%	98.10%
HCBS Mix Percent	83.93%	0.28%	84.16%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | UnitedHealthcare Community Plan
GSA | Central
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 12,058 | LTSS %: 96.40% | HCBS Mix %: 72.88%
Projection Period | Member Months: 12,630 | LTSS %: 97.17% | HCBS Mix %: 72.09%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$10,564.23	2.01%	1.40%	0.00%	0.00%	0.00%	$11,146.96	$190.66	$11,337.62		$11,337.62
HCBS - Assisted Living	$1,143.84	2.01%	3.64%	0.00%	0.00%	0.00%	$1,233.53	$4.30	$1,237.83		$1,237.83
HCBS - Attendant Care	$1,404.18	1.50%	3.60%	0.00%	0.00%	0.00%	$1,498.75	$7.72	$1,506.46		$1,506.46
HCBS - Other	$440.76	1.50%	(4.08%)	0.00%	0.00%	0.10%	$436.01	$1.49	$437.50		$437.50
Acute - Inpatient	$642.55	0.00%	0.09%	0.00%	0.00%	0.00%	$643.15	$12.22	$655.38		$655.38
Acute - Other	$702.87	2.51%	(0.21%)	0.00%	0.00%	0.07%	$737.54	$0.21	$737.75		$737.75
Acute - Outpatient	$366.36	0.00%	0.84%	0.00%	0.00%	0.00%	$369.45	$6.08	$375.53		$375.53
Acute - Pharmacy - Specialty	$988.55	10.21%	0.00%	(0.30%)	0.00%	(0.52%)	$1,190.98	$0.00	$1,190.98		$1,190.98
Acute - Pharmacy - Brand	$369.45	3.00%	0.00%	(1.21%)	0.00%	(0.49%)	$385.29	$0.00	$385.29		$385.29
Acute - Pharmacy - Generic	$151.58	2.52%	0.00%	(0.39%)	(0.11%)	(0.44%)	$157.82	$0.00	$157.82		$157.82
Acute - Physician	$751.11	2.51%	(1.44%)	0.00%	0.00%	0.00%	$777.95	$0.02	$777.97		$777.97
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$2,762.32	2.01%	1.40%	0.00%	0.00%	0.00%	$2,914.69	$49.85	$2,964.55	3.71%	$3,074.52
HCBS Component PMPM[4]	$2,099.76	1.70%	2.56%	0.00%	0.00%	0.01%	$2,225.87	$9.49	$2,235.36	(0.28%)	$2,229.05
Acute Component PMPM[5]	$3,972.47	4.09%	(0.21%)	(0.21%)	(0.00%)	(0.19%)	$4,262.18	$18.53	$4,280.71	0.00%	$4,280.71
Total Medical PMPM	**$8,834.55**	**2.87%**	**0.95%**	**(0.09%)**	**(0.00%)**	**(0.08%)**	**$9,402.74**	**$77.88**	**$9,480.62**	**1.09%**	**$9,584.28**

Percent Members Receiving LTSS	96.40%	0.80%	97.17%
HCBS Mix Percent	72.88%	(1.07%)	72.09%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Banner – University Family Care
GSA | South
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 46,517 | LTSS %: 98.50% | HCBS Mix %: 72.76%
Projection Period | Member Months: 47,524 | LTSS %: 98.67% | HCBS Mix %: 72.78%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$8,501.13	2.00%	1.38%	0.00%	0.00%	0.00%	$8,966.67	$132.48	$9,099.15		$9,099.15
HCBS - Assisted Living	$1,194.35	3.02%	3.64%	0.00%	0.00%	0.00%	$1,313.67	$4.29	$1,317.96		$1,317.96
HCBS - Attendant Care	$1,511.73	1.51%	3.55%	0.00%	0.00%	0.00%	$1,612.82	$18.88	$1,631.70		$1,631.70
HCBS - Other	$237.77	1.50%	(0.43%)	0.00%	0.00%	0.01%	$243.93	$0.31	$244.25		$244.25
Acute - Inpatient	$18.09	1.51%	0.00%	0.00%	0.00%	0.00%	$18.64	$0.00	$18.64		$18.64
Acute - Other	$90.83	2.01%	0.13%	0.00%	0.00%	0.03%	$94.66	$0.00	$94.67		$94.67
Acute - Outpatient	$47.13	1.51%	0.00%	0.00%	0.00%	0.00%	$48.56	$0.00	$48.56		$48.56
Acute - Pharmacy - Specialty	$0.00	15.36%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00	$0.00		$0.00
Acute - Pharmacy - Brand	$2.76	2.01%	0.00%	(0.00%)	0.00%	1.65%	$2.92	$0.00	$2.92		$2.92
Acute - Pharmacy - Generic	$2.12	1.50%	0.00%	(0.00%)	0.00%	5.92%	$2.32	$0.00	$2.32		$2.32
Acute - Physician	$82.11	2.01%	0.00%	0.00%	0.00%	0.00%	$85.45	$0.00	$85.45		$85.45
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$2,280.54	2.00%	1.38%	0.00%	0.00%	0.00%	$2,405.43	$35.54	$2,440.96	0.11%	$2,443.56
HCBS Component PMPM[4]	$2,109.83	2.13%	3.28%	0.00%	0.00%	0.00%	$2,272.21	$16.83	$2,289.05	0.20%	$2,293.62
Acute Component PMPM[5]	$243.05	1.87%	0.05%	(0.00%)	0.00%	0.08%	$252.55	$0.00	$252.55	0.00%	$252.55
Total Medical PMPM	**$4,633.41**	**2.05%**	**2.19%**	**(0.00%)**	**0.00%**	**0.00%**	**$4,930.19**	**$52.37**	**$4,982.56**	**0.14%**	**$4,989.73**

Percent Members Receiving LTSS	98.50%	0.17%	98.67%
HCBS Mix Percent	72.76%	0.03%	72.78%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Banner – University Family Care
GSA | South
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 8,487 | LTSS %: 97.57% | HCBS Mix %: 70.55%
Projection Period | Member Months: 8,820 | LTSS %: 97.92% | HCBS Mix %: 69.33%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$10,798.45	2.00%	1.37%	0.00%	0.00%	0.00%	$11,389.16	$166.71	$11,555.87		$11,555.87
HCBS - Assisted Living	$643.97	3.02%	3.64%	0.00%	0.00%	0.00%	$708.31	$3.12	$711.43		$711.43
HCBS - Attendant Care	$1,765.81	1.51%	3.54%	0.00%	0.00%	0.00%	$1,883.78	$21.85	$1,905.63		$1,905.63
HCBS - Other	$449.84	1.50%	(5.18%)	0.00%	0.00%	0.07%	$439.75	$1.75	$441.51		$441.51
Acute - Inpatient	$890.65	1.51%	0.12%	0.00%	0.00%	0.00%	$918.80	$16.22	$935.02		$935.02
Acute - Other	$702.25	2.01%	(1.81%)	0.00%	0.00%	0.05%	$717.88	$0.55	$718.43		$718.43
Acute - Outpatient	$580.01	1.51%	1.31%	0.00%	0.00%	0.00%	$605.45	$7.21	$612.66		$612.66
Acute - Pharmacy - Specialty	$721.06	15.36%	0.00%	(0.18%)	0.00%	(0.27%)	$955.27	$0.00	$955.27		$955.27
Acute - Pharmacy - Brand	$287.56	2.01%	0.00%	(1.46%)	0.00%	(0.14%)	$294.43	$0.00	$294.43		$294.43
Acute - Pharmacy - Generic	$76.02	1.50%	0.00%	(0.35%)	0.00%	1.27%	$79.04	$0.00	$79.04		$79.04
Acute - Physician	$581.35	2.01%	(0.35%)	0.00%	0.00%	0.00%	$602.84	$0.11	$602.94		$602.94
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$3,103.18	2.00%	1.37%	0.00%	0.00%	0.00%	$3,272.93	$47.91	$3,320.84	4.51%	$3,470.55
HCBS Component PMPM[4]	$1,968.49	1.86%	2.30%	0.00%	0.00%	0.01%	$2,087.04	$18.40	$2,105.44	(1.37%)	$2,076.52
Acute Component PMPM[5]	$3,838.89	4.85%	(0.14%)	(0.15%)	0.00%	(0.04%)	$4,173.71	$24.08	$4,197.79	0.00%	$4,197.79
Total Medical PMPM	**$8,910.56**	**3.20%**	**0.92%**	**(0.06%)**	**0.00%**	**(0.01%)**	**$9,533.69**	**$90.38**	**$9,624.07**	**1.26%**	**$9,744.87**

Percent Members Receiving LTSS	97.57%	0.36%	97.92%
HCBS Mix Percent	70.55%	(1.73%)	69.33%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Mercy Care
GSA | South
Risk Group | Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 16,843 | LTSS %: 98.86% | HCBS Mix %: 72.41%
Projection Period | Member Months: 16,578 | LTSS %: 99.11% | HCBS Mix %: 71.72%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$8,009.52	2.00%	1.37%	0.00%	0.00%	0.00%	$8,447.27	$122.92	$8,570.19		$8,570.19
HCBS - Assisted Living	$1,192.55	3.02%	3.64%	0.00%	0.00%	0.00%	$1,311.69	$4.55	$1,316.24		$1,316.24
HCBS - Attendant Care	$1,814.01	1.51%	3.52%	0.00%	0.00%	0.00%	$1,934.76	$24.41	$1,959.18		$1,959.18
HCBS - Other	$304.06	1.50%	(0.40%)	0.00%	0.00%	0.01%	$312.05	$2.05	$314.10		$314.10
Acute - Inpatient	$44.39	1.51%	0.00%	0.00%	0.00%	0.00%	$45.74	$0.00	$45.74		$45.74
Acute - Other	$160.18	2.01%	(0.05%)	0.00%	0.00%	0.03%	$166.66	$0.01	$166.67		$166.67
Acute - Outpatient	$32.15	1.51%	0.00%	0.00%	0.00%	0.00%	$33.13	$0.00	$33.13		$33.13
Acute - Pharmacy - Specialty	$0.18	15.36%	0.00%	0.00%	0.00%	(0.27%)	$0.23	$0.00	$0.23		$0.23
Acute - Pharmacy - Brand	$1.94	2.01%	0.00%	(0.00%)	0.00%	1.65%	$2.05	$0.00	$2.05		$2.05
Acute - Pharmacy - Generic	$2.76	1.50%	0.00%	(0.00%)	0.00%	5.93%	$3.01	$0.00	$3.01		$3.01
Acute - Physician	$98.71	2.01%	0.00%	0.00%	0.00%	0.00%	$102.72	$0.00	$102.72		$102.72
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$2,184.76	2.00%	1.37%	0.00%	0.00%	0.00%	$2,304.16	$33.53	$2,337.69	2.76%	$2,402.18
HCBS Component PMPM[4]	$2,369.80	2.06%	3.22%	0.00%	0.00%	0.00%	$2,547.24	$22.20	$2,569.44	(0.70%)	$2,551.38
Acute Component PMPM[5]	$340.31	1.90%	(0.02%)	(0.00%)	0.00%	0.07%	$353.54	$0.01	$353.55	0.00%	$353.55
Total Medical PMPM	**$4,894.87**	**2.02%**	**2.17%**	**(0.00%)**	**0.00%**	**0.01%**	**$5,204.94**	**$55.73**	**$5,260.67**	**0.88%**	**$5,307.12**

Percent Members Receiving LTSS	98.86%	0.25%	99.11%
HCBS Mix Percent	72.41%	(0.95%)	71.72%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 6: Development of Gross Medical Component

Contractor | Mercy Care
GSA | South
Risk Group | Non-Duals
Base Period | October 1, 2024 through September 30, 2025
Projection Period | October 1, 2026 through September 30, 2027
Base Period | Member Months: 3,371 | LTSS %: 96.95% | HCBS Mix %: 69.58%
Projection Period | Member Months: 3,351 | LTSS %: 97.19% | HCBS Mix %: 71.02%

	Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal	I.4.D	Subtotal	I.3.B.ii.(a)	Change
Category of Service	Adjusted Base Gross Medical	Trend	Aggregate Fee Schedule Changes	P&T Committee	Diabetes Drugs	Other Projected Program Changes	Subtotal	DAP Add In	Subtotal	Mix Change	Projected Gross Medical
LTSS PMPMs based on Subset of Members in Risk Group[1]											
Nursing Facility (NF)	$11,041.18	2.00%	1.37%	0.00%	0.00%	0.00%	$11,644.41	$167.14	$11,811.55		$11,811.55
HCBS - Assisted Living	$403.01	3.02%	3.64%	0.00%	0.00%	0.00%	$443.29	$1.30	$444.59		$444.59
HCBS - Attendant Care	$2,488.68	1.51%	3.52%	0.00%	0.00%	0.00%	$2,654.35	$39.99	$2,694.35		$2,694.35
HCBS - Other	$906.27	1.50%	(0.03%)	0.00%	0.00%	0.07%	$934.04	$11.59	$945.63		$945.63
Acute - Inpatient	$563.12	1.51%	0.13%	0.00%	0.00%	0.00%	$580.94	$11.04	$591.98		$591.98
Acute - Other	$750.53	2.01%	(2.93%)	0.00%	0.00%	0.05%	$758.50	$0.15	$758.65		$758.65
Acute - Outpatient	$252.77	1.51%	1.15%	0.00%	0.00%	0.00%	$263.43	$4.00	$267.43		$267.43
Acute - Pharmacy - Specialty	$1,458.82	15.36%	0.00%	(0.18%)	0.00%	(0.27%)	$1,932.74	$0.00	$1,932.74		$1,932.74
Acute - Pharmacy - Brand	$293.25	2.01%	0.00%	(1.46%)	9.16%	(0.13%)	$327.80	$0.00	$327.80		$327.80
Acute - Pharmacy - Generic	$71.28	1.50%	0.00%	(0.35%)	0.00%	1.27%	$74.11	$0.00	$74.11		$74.11
Acute - Physician	$564.47	2.01%	(0.48%)	0.00%	0.00%	0.00%	$584.57	$0.05	$584.63		$584.63
PMPMs based on All Members in Risk Group[2]											
NF Component PMPM[3]	$3,256.61	2.00%	1.37%	0.00%	0.00%	0.00%	$3,434.53	$49.30	$3,483.83	(4.51%)	$3,326.81
HCBS Component PMPM[4]	$2,561.90	1.67%	2.71%	0.00%	0.00%	0.02%	$2,719.55	$35.67	$2,755.23	2.32%	$2,819.20
Acute Component PMPM[5]	$3,954.24	7.59%	(0.47%)	(0.19%)	0.66%	(0.09%)	$4,522.08	$15.24	$4,537.32	0.00%	$4,537.32
Total Medical PMPM	**$9,772.74**	**4.29%**	**0.94%**	**(0.08%)**	**0.28%**	**(0.04%)**	**$10,676.17**	**$100.21**	**$10,776.38**	**(0.86%)**	**$10,683.33**

Percent Members Receiving LTSS	96.95%	0.24%	97.19%
HCBS Mix Percent	69.58%	2.07%	71.02%

Footnotes

1. LTSS COS (NF/HCBS) PMPMs are calculated by dividing gross dollars by member months for members in those settings, Acute PMPMs use all member months as the denominator
2. PMPMs are calculated based on gross dollars and all member months for the denominator and are for informational purposes only
3. NF component is calculated using the sum of the NF COS multiplied by the percentage of members using LTSS multiplied by the NF mix percentage which is equal to 1 minus the HCBS percentage; NF component = (sum of NF)*LTSS %*(1-HCBS %)
4. HCBS component is calculated using the sum of the HCBS COS multiplied by the percentage of members using LTSS multiplied by the HCBS mix percentage; HCBS component = (sum of HCBS) * (LTSS %) * (HCBS %)
5. Acute component is calculated using the sum of the Acute COS; Acute component = (sum of Acute)

Appendix 7a: Capitation Rate Development – Medical Component

Appendix 7a: Dual Capitation Rate Development

				Appendix 6	I.3.B.ii.(a)	I.4.C.ii.(c)	Subtotal	I.3.B.ii.(a)	I.3.B.ii.(a)	Product	Total
GSA	Contractor	Risk Group	Category of Service	Projected Gross Medical	Projected SOC	RI Offset	Projected Net Medical	Projected Percent Members Receiving LTSS	Projected Mix	Net Medical After LTSS and HCBS Mix	Total Net Medical
North	UnitedHealthcare Community Plan	Duals	Nursing Facility	$7,816.92	($1,091.71)	$0.00	$6,725.20	98.06%	28.56%	$1,883.49	
			Home and Community Based Services	$2,403.52	($32.38)	$0.00	$2,371.13	98.06%	71.44%	$1,661.12	**$3,734.78**
			Acute	$192.64	$0.00	($2.47)	$190.17			$190.17	
Central	Banner – University Family Care	Duals	Nursing Facility	$9,108.96	($1,024.79)	$0.00	$8,084.17	98.39%	25.97%	$2,065.33	
			Home and Community Based Services	$3,187.16	($28.34)	$0.00	$3,158.82	98.39%	74.03%	$2,300.82	**$4,742.79**
			Acute	$379.34	$0.00	($2.71)	$376.63			$376.63	
Central	Mercy Care	Duals	Nursing Facility	$10,442.29	($963.82)	$0.00	$9,478.47	98.85%	21.47%	$2,011.89	
			Home and Community Based Services	$3,606.16	($25.81)	$0.00	$3,580.35	98.85%	78.53%	$2,779.07	**$5,328.27**
			Acute	$555.60	$0.00	($18.29)	$537.31			$537.31	
Central	UnitedHealthcare Community Plan	Duals	Nursing Facility	$8,991.46	($1,030.10)	$0.00	$7,961.36	98.10%	15.84%	$1,236.91	
			Home and Community Based Services	$2,771.10	($18.32)	$0.00	$2,752.78	98.10%	84.16%	$2,272.67	**$3,757.43**
			Acute	$265.72	$0.00	($17.87)	$247.85			$247.85	
South	Banner – University Family Care	Duals	Nursing Facility	$9,099.15	($954.60)	$0.00	$8,144.55	98.67%	27.22%	$2,187.20	
			Home and Community Based Services	$3,193.91	($19.81)	$0.00	$3,174.11	98.67%	72.78%	$2,279.40	**$4,716.38**
			Acute	$252.55	$0.00	($2.77)	$249.78			$249.78	
South	Mercy Care (Pima County Only)	Duals	Nursing Facility	$8,570.19	($949.77)	$0.00	$7,620.42	99.11%	28.28%	$2,135.97	
			Home and Community Based Services	$3,589.51	($31.11)	$0.00	$3,558.40	99.11%	71.72%	$2,529.27	**$5,018.79**
			Acute	$353.55	$0.00	$0.00	$353.55			$353.55	

Appendix 7a: Non-Dual Capitation Rate Development

				Appendix 6	I.3.B.ii.(a)	I.4.C.ii.(c)	Subtotal	I.3.B.ii.(a)	I.3.B.ii.(a)	Product	Total
GSA	Contractor	Risk Group	Category of Service	Projected Gross Medical	Projected SOC	RI Offset	Projected Net Medical	Projected Percent Members Receiving LTSS	Projected Mix	Net Medical After LTSS and HCBS Mix	Total Net Medical
North	UnitedHealthcare Community Plan	Non-Duals	Nursing Facility	$10,013.44	($147.08)	$0.00	$9,866.35	97.11%	30.70%	$2,941.00	
			Home and Community Based Services	$2,706.12	($6.93)	$0.00	$2,699.19	97.11%	69.30%	$1,816.59	**$8,075.15**
			Acute	$4,720.52	$0.00	($1,402.96)	$3,317.56			$3,317.56	
Central	Banner – University Family Care	Non-Duals	Nursing Facility	$12,080.41	($116.77)	$0.00	$11,963.64	95.34%	33.50%	$3,821.21	
			Home and Community Based Services	$3,175.52	($7.19)	$0.00	$3,168.33	95.34%	66.50%	$2,008.59	**$9,710.33**
			Acute	$4,401.91	$0.00	($521.38)	$3,880.53			$3,880.53	
Central	Mercy Care	Non-Duals	Nursing Facility	$14,412.94	($95.86)	$0.00	$14,317.09	97.17%	29.85%	$4,153.10	
			Home and Community Based Services	$4,046.54	($5.45)	$0.00	$4,041.09	97.17%	70.15%	$2,754.43	**$11,058.61**
			Acute	$4,792.92	$0.00	($641.84)	$4,151.08			$4,151.08	
Central	UnitedHealthcare Community Plan	Non-Duals	Nursing Facility	$11,337.62	($90.89)	$0.00	$11,246.73	97.17%	27.91%	$3,049.87	
			Home and Community Based Services	$3,181.79	($4.62)	$0.00	$3,177.17	97.17%	72.09%	$2,225.81	**$8,803.46**
			Acute	$4,280.71	$0.00	($752.94)	$3,527.77			$3,527.77	
South	Banner – University Family Care	Non-Duals	Nursing Facility	$11,555.87	($107.60)	$0.00	$11,448.27	97.92%	30.67%	$3,438.24	
			Home and Community Based Services	$3,058.57	($6.62)	$0.00	$3,051.95	97.92%	69.33%	$2,072.02	**$9,168.60**
			Acute	$4,197.79	$0.00	($539.46)	$3,658.33			$3,658.33	
South	Mercy Care (Pima County Only)	Non-Duals	Nursing Facility	$11,811.55	($173.84)	$0.00	$11,637.71	97.19%	28.98%	$3,277.85	
			Home and Community Based Services	$4,084.56	($9.76)	$0.00	$4,074.80	97.19%	71.02%	$2,812.46	**$9,528.81**
			Acute	$4,537.32	$0.00	($1,098.82)	$3,438.50			$3,438.50	

Appendix 7b: Capitation Rate Development – Final Capitation Rate

Appendix 7b: Capitation Rate Development

Duals								
		Appendix 7a	I.5.B.i.	I.5.B.i.	I.5.B.ii.(c)	Calculation	I.5.B.ii.(b)	Total
GSA	Contractor	Net Medical	Case Management	Admin	UW Margin Percent	UW Margin	Premium Tax	Capitation Rate
North	UnitedHealthcare Community Plan	$3,734.78	$ 186.50	$ 94.38	1.15%	$46.72	$82.91	$4,145.28
Central	Banner - University Family Care	$4,742.79	$ 173.19	$ 278.37	1.15%	$60.43	$107.24	$5,362.01
Central	Mercy Care	$5,328.27	$ 203.53	$ 132.86	1.15%	$65.90	$116.95	$5,847.52
Central	UnitedHealthcare Community Plan	$3,757.43	$ 178.52	$ 91.71	1.15%	$46.86	$83.15	$4,157.67
South	Banner - University Family Care	$4,716.38	$ 158.52	$ 276.25	1.15%	$59.93	$106.35	$5,317.43
South	Mercy Care (Pima County Only)	$5,018.79	$ 203.95	$ 126.57	1.15%	$62.23	$110.44	$5,521.97

Non-Duals								
		Appendix 7a	I.5.B.i.	I.5.B.i.	I.5.B.ii.(c)	Calculation	I.5.B.ii.(b)	Total
GSA	Contractor	Net Medical	Case Management	Admin	UW Margin Percent	UW Margin	Premium Tax	Capitation Rate
North	UnitedHealthcare Community Plan	$8,075.15	$ 352.91	$ 221.15	1.15%	$100.62	$178.57	$8,928.40
Central	Banner - University Family Care	$9,710.33	$ 392.58	$ 568.78	1.15%	$124.15	$220.32	$11,016.16
Central	Mercy Care	$11,058.61	$ 199.53	$ 279.79	1.15%	$134.23	$238.21	$11,910.37
Central	UnitedHealthcare Community Plan	$8,803.46	$ 395.32	$ 222.49	1.15%	$109.60	$194.51	$9,725.37
South	Banner - University Family Care	$9,168.60	$ 278.76	$ 539.51	1.15%	$116.19	$206.18	$10,309.24
South	Mercy Care (Pima County Only)	$9,528.81	$ 203.38	$ 254.78	1.15%	$116.19	$206.19	$10,309.35

Appendix 8a: State Directed Payments – Descriptive Exhibits

Appendix 8a: State Directed Payments – Descriptive Exhibits

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, 26
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, 15, 18, 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, 18
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, 18
AZ_Fee_NF_Renewal_20261001-20270930 (NF-SP)	Uniform Dollar Amount	Uniform dollar increase across all Contractor's reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund, plus FMAP, and is expected to fluctuate based on utilization and available funds for each quarter.	Separate Payment Term	8

Appendix 8a: State Directed Payments – Descriptive Exhibits

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)	All EPD rate cells are affected.	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)	All EPD rate cells are affected.	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).	The actuaries confirm 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.	Not applicable.

Appendix 8a: State Directed Payments – Descriptive Exhibits

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

Control name of the SDP	Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_IPH.OPH1_Renewal_20261001-20270930 (PSI)	$2,393,241	The actuaries certify 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 actuaries 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)	$96,576,140	The actuaries certify 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 actuaries 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)	$5,751,858	The actuaries certify 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 actuaries 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.
AZ_Fee_NF_Renewal_20261001-20270930 (NF-SP)	$95,400,000	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8c.	AHCCCS has submitted the NF-SP 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuaries 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 NF-SP is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NF-SP 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	**$200,121,240**				

Appendix 8b: State Directed Payments – Portion of Capitation Rates

Appendix 8b State Directed Payments - Portion of Capitation Rates

GSA	Contractor	Risk Group	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 [1] - 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 [2] - Sections I.4.D.ii.(a)(iv)(A)(iii) and I.4.D.ii.(a)(iv)(A)(v)	Aggregate impact of all SDPs [3] - Section I.4.D.ii.(a)(iv)(A)(iv)
North	UnitedHealthcare Community Plan	Duals	22,640	$4,145.28	$0.00	$42.74	$42.74
Central	Banner - University Family Care	Duals	21,582	$5,362.01	$0.00	$51.24	$51.24
Central	Mercy Care	Duals	60,085	$5,847.52	$0.00	$56.54	$56.54
Central	UnitedHealthcare Community Plan	Duals	95,404	$4,157.67	$0.00	$32.97	$32.97
South	Banner - University Family Care	Duals	47,524	$5,317.43	$0.00	$54.05	$54.05
South	Mercy Care (Pima County Only)	Duals	16,578	$5,521.97	$0.00	$57.52	$57.52
North	UnitedHealthcare Community Plan	Non-Duals	3,698	$8,928.40	$0.00	$69.53	$69.53
Central	Banner - University Family Care	Non-Duals	6,075	$11,016.16	$0.00	$101.06	$101.06
Central	Mercy Care	Non-Duals	23,435	$11,910.37	$0.00	$116.07	$116.07
Central	UnitedHealthcare Community Plan	Non-Duals	12,630	$9,725.37	$0.00	$80.37	$80.37
South	Banner - University Family Care	Non-Duals	8,820	$10,309.24	$0.00	$93.28	$93.28
South	Mercy Care (Pima County Only)	Non-Duals	3,351	$10,309.35	$0.00	$103.42	$103.42

Footnotes

1. 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.
2. 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.
3. 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

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Appendix 8c: State Directed Payments - Estimated PMPMs

SDP: VFC

GSA	Contractor	Risk Group	Medical PMPM	UW Margin	Premium Tax	Total PMPM
North	UnitedHealthcare Community Plan	Duals	$0.00	$0.00	$0.00	$0.00
Central	Banner - University Family Care	Duals	$0.00	$0.00	$0.00	$0.00
Central	Mercy Care	Duals	$0.00	$0.00	$0.00	$0.00
Central	UnitedHealthcare Community Plan	Duals	$0.00	$0.00	$0.00	$0.00
South	Banner - University Family Care	Duals	$0.00	$0.00	$0.00	$0.00
South	Mercy Care (Pima County Only)	Duals	$0.00	$0.00	$0.00	$0.00
North	UnitedHealthcare Community Plan	Non-Duals	$0.00	$0.00	$0.00	$0.00
Central	Banner - University Family Care	Non-Duals	$0.00	$0.00	$0.00	$0.00
Central	Mercy Care	Non-Duals	$0.00	$0.00	$0.00	$0.00
Central	UnitedHealthcare Community Plan	Non-Duals	$0.00	$0.00	$0.00	$0.00
South	Banner - University Family Care	Non-Duals	$0.00	$0.00	$0.00	$0.00
South	Mercy Care (Pima County Only)	Non-Duals	$0.00	$0.00	$0.00	$0.00

Appendix 8c: State Directed Payments - Estimated PMPMs

SDP: DAP

GSA	Contractor	Risk Group	Medical PMPM	UW Margin	Premium Tax	Total PMPM
North	UnitedHealthcare Community Plan	Duals	$41.42	$0.48	$0.85	$42.74
Central	Banner - University Family Care	Duals	$49.65	$0.58	$1.01	$51.24
Central	Mercy Care	Duals	$54.78	$0.64	$1.12	$56.54
Central	UnitedHealthcare Community Plan	Duals	$31.95	$0.37	$0.65	$32.97
South	Banner - University Family Care	Duals	$52.37	$0.61	$1.07	$54.05
South	Mercy Care (Pima County Only)	Duals	$55.73	$0.65	$1.14	$57.52
North	UnitedHealthcare Community Plan	Non-Duals	$67.37	$0.78	$1.37	$69.53
Central	Banner - University Family Care	Non-Duals	$97.92	$1.14	$2.00	$101.06
Central	Mercy Care	Non-Duals	$112.46	$1.31	$2.30	$116.07
Central	UnitedHealthcare Community Plan	Non-Duals	$77.88	$0.91	$1.59	$80.37
South	Banner - University Family Care	Non-Duals	$90.38	$1.05	$1.84	$93.28
South	Mercy Care (Pima County Only)	Non-Duals	$100.21	$1.17	$2.05	$103.42

Appendix 8c: State Directed Payments - Estimated PMPMs

SDP: PSI

GSA	Contractor	Risk Group	Medical PMPM	UW Margin	Premium Tax	Total PMPM
North	UnitedHealthcare Community Plan	Duals	$0.00	$0.00	$0.00	$0.00
Central	Banner - University Family Care	Duals	$0.00	$0.00	$0.00	$0.00
Central	Mercy Care	Duals	$0.00	$0.00	$0.00	$0.00
Central	UnitedHealthcare Community Plan	Duals	$0.00	$0.00	$0.00	$0.00
South	Banner - University Family Care	Duals	$0.00	$0.00	$0.00	$0.00
South	Mercy Care (Pima County Only)	Duals	$0.00	$0.00	$0.00	$0.00
North	UnitedHealthcare Community Plan	Non-Duals	$125.05	$0.00	$2.55	$127.60
Central	Banner - University Family Care	Non-Duals	$55.41	$0.00	$1.13	$56.54
Central	Mercy Care	Non-Duals	$37.50	$0.00	$0.77	$38.26
Central	UnitedHealthcare Community Plan	Non-Duals	$37.51	$0.00	$0.77	$38.28
South	Banner - University Family Care	Non-Duals	$20.37	$0.00	$0.42	$20.78
South	Mercy Care (Pima County Only)	Non-Duals	$4.10	$0.00	$0.08	$4.19

Appendix 8c: State Directed Payments - Estimated PMPMs

SDP: HEALTHII

GSA	Contractor	Risk Group	Medical PMPM	UW Margin	Premium Tax	Total PMPM
North	UnitedHealthcare Community Plan	Duals	$0.00	$0.00	$0.00	$0.00
Central	Banner - University Family Care	Duals	$0.00	$0.00	$0.00	$0.00
Central	Mercy Care	Duals	$0.00	$0.00	$0.00	$0.00
Central	UnitedHealthcare Community Plan	Duals	$0.00	$0.00	$0.00	$0.00
South	Banner - University Family Care	Duals	$0.00	$0.00	$0.00	$0.00
South	Mercy Care (Pima County Only)	Duals	$0.00	$0.00	$0.00	$0.00
North	UnitedHealthcare Community Plan	Non-Duals	$1,522.54	$0.00	$31.07	$1,553.62
Central	Banner - University Family Care	Non-Duals	$1,929.11	$0.00	$39.37	$1,968.48
Central	Mercy Care	Non-Duals	$1,737.12	$0.00	$35.45	$1,772.57
Central	UnitedHealthcare Community Plan	Non-Duals	$1,584.00	$0.00	$32.33	$1,616.33
South	Banner - University Family Care	Non-Duals	$2,465.31	$0.00	$50.31	$2,515.62
South	Mercy Care (Pima County Only)	Non-Duals	$1,375.55	$0.00	$28.07	$1,403.62

Appendix 8c: State Directed Payments - Estimated PMPMs

SDP: SNSI

GSA	Contractor	Risk Group	Medical PMPM	UW Margin	Premium Tax	Total PMPM
North	UnitedHealthcare Community Plan	Duals	$0.00	$0.00	$0.00	$0.00
Central	Banner - University Family Care	Duals	$0.00	$0.00	$0.00	$0.00
Central	Mercy Care	Duals	$0.00	$0.00	$0.00	$0.00
Central	UnitedHealthcare Community Plan	Duals	$0.00	$0.00	$0.00	$0.00
South	Banner - University Family Care	Duals	$0.00	$0.00	$0.00	$0.00
South	Mercy Care (Pima County Only)	Duals	$0.00	$0.00	$0.00	$0.00
North	UnitedHealthcare Community Plan	Non-Duals	$123.78	$0.00	$2.53	$126.30
Central	Banner - University Family Care	Non-Duals	$76.08	$0.00	$1.55	$77.63
Central	Mercy Care	Non-Duals	$133.86	$0.00	$2.73	$136.60
Central	UnitedHealthcare Community Plan	Non-Duals	$120.55	$0.00	$2.46	$123.01
South	Banner - University Family Care	Non-Duals	$7.41	$0.00	$0.15	$7.56
South	Mercy Care (Pima County Only)	Non-Duals	$0.03	$0.00	$0.00	$0.03

Appendix 8c: State Directed Payments - Estimated PMPMs

SDP: NF-SP

GSA	Contractor	Risk Group	Medical PMPM	UW Margin	Premium Tax	Total PMPM
North	UnitedHealthcare Community Plan	Duals	$352.36	$0.00	$7.19	$359.56
Central	Banner - University Family Care	Duals	$317.26	$0.00	$6.47	$323.74
Central	Mercy Care	Duals	$276.78	$0.00	$5.65	$282.42
Central	UnitedHealthcare Community Plan	Duals	$184.14	$0.00	$3.76	$187.90
South	Banner - University Family Care	Duals	$331.77	$0.00	$6.77	$338.55
South	Mercy Care (Pima County Only)	Duals	$360.36	$0.00	$7.35	$367.72
North	UnitedHealthcare Community Plan	Non-Duals	$350.23	$0.00	$7.15	$357.38
Central	Banner - University Family Care	Non-Duals	$409.88	$0.00	$8.36	$418.24
Central	Mercy Care	Non-Duals	$374.27	$0.00	$7.64	$381.91
Central	UnitedHealthcare Community Plan	Non-Duals	$342.87	$0.00	$7.00	$349.87
South	Banner - University Family Care	Non-Duals	$389.66	$0.00	$7.95	$397.62
South	Mercy Care (Pima County Only)	Non-Duals	$390.41	$0.00	$7.97	$398.38