ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Contract Year Ending 2026
Capitation Rate Certification
Comprehensive Health Plan Program

October 1, 2025 through September 30, 2026

Prepared for:

The Centers for Medicare & Medicaid Services

Prepared by:

AHCCCS Division of Business and Finance

August 27, 2025

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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 rate for Contract Year Ending 2026 (CYE 26) for the Arizona Comprehensive Health Plan (CHP) Program. Programs under AHCCCS and their respective contracts have been aligned with the federal fiscal year since October 1, 2018. All contract years referenced below cover the timeframe from October 1 of one year through September 30 of the following year (e.g., CYE 26 covers the timeframe between October 1, 2025, through September 30, 2026).

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 rate contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rate represents projections of future events. Actual results may vary from the projections.

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2025-2026 Medicaid Managed Care Rate Development Guide (2026 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2026 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 2026 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

The capitation rate included with this rate certification is 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, during the development of the actuarially sound capitation rate, the actuaries referenced the following:

- 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 2025-2026 Medicaid Managed Care Rate Development Guide (2026 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 4 of the 2026 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 2026 Guide.

I.1.A. Rate Development Standards

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

This section of the 2026 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 26 capitation rate for the CHP Program is effective for the 12-month time period from October 1, 2025, through September 30, 2026.

I.1.A.iii. Required Elements

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

The actuarial certification letter for the CYE 26 capitation rate for the CHP Program, signed by Elizabeth Seaman, ASA, MAAA and Luna Zong, ASA, MAAA, is in Appendix 1. Ms. Seaman and Ms. Zong 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.

Ms. Seaman and Ms. Zong certify that the CYE 26 capitation rate for the CHP Program contained in this rate certification is actuarially sound and meets 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 rate is located in Appendix 2. Additionally, the CHP Program contract includes the final and certified capitation rate in accordance with 42 CFR § 438.3(c)(1)(i). The CHP 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 to be consistent with the applicable provisions of 42 CFR Part 438 and the 2026 Guide and will use the term risk group when identifying a population not at the certified capitation rate level, such as when discussing the development of impacts where modeling was done for multiple programs.

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

This section of the rate certification provides a summary of information about the CHP Program.

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

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

The CHP Program is the health plan within the Arizona Department of Child Safety (DCS) that is responsible for managing the health care needs for children in foster care. Effective April 1, 2021, the CHP Program subcontracted with an external health plan, Mercy Care, to deliver integrated services covered under this contract.

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

The CHP Program covers integrated physical and mental health services for all CHP members, with the exception of the first 24 hours of crisis intervention services which are covered under the AHCCCS Complete Care – Regional Behavioral Health Agreement (ACC-RBHA) contracts for all Arizona Medicaid members. Additional information regarding covered services can be found in the CHP contract.

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

The health plan under DCS was formed in July 1970 by state law under Arizona Revised Statute (A.R.S.) § 8-512. The integrated CHP Program operates on a statewide basis.

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

The rate certification for the CYE 26 capitation rate for the CHP Program is effective for the 12-month time period from October 1, 2025, through September 30, 2026.

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

The populations covered under the CHP Program are children under the age of 18 who are:

- Placed in a foster home;
- In the custody of DCS and placed with a relative, in a certified adoptive home prior to the final order of adoption, or in an independent living program as provided in A.R.S. § 8-512; or
- In the custody of the Arizona Department of Juvenile Corrections or the Administrative Office of the Courts/Juvenile Probation Office and placed in foster care.

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

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

AHCCCS operates as a mandatory managed care program and choice of enrollment or auto-assignment is used pursuant to the terms of the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions. AHCCCS will enroll the child with the CHP Program and notify the CHP Program of the child's AHCCCS enrollment. The CHP Program is responsible for timely notification to AHCCCS if a member no longer meets the criteria for the CHP Program coverage as set for in A.R.S. § 8-512. Additional information regarding eligibility and enrollment criteria can be found in the Enrollment and Disenrollment section of the CHP Program contract.

Policy changes implemented by DCS since 2021 have reduced the number of children entering the foster care system, with the ongoing effect that the children entering the system have greater health needs in several areas, both physical and mental, than the historical average needs of new CHP members. Additional information on the policy changes and how the impacts are handled in the capitation rate development are included below in Section I.2.B.iii.(d).

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

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6. The special contract provisions related to payment included in the CYE 26 capitation rate are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1))
- Reinsurance Arrangement (42 CFR § 438.6(b)(1))
- State directed payments (SDPs) (42 CFR § 438.6(c))
    - Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) (42 CFR § 438.6(c)(1)(iii)(A))
    - Vaccines for Children (VFC) (42 CFR § 438.6(c)(1)(iii)(A))
    - Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(D))
    - Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(D))
    - Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(D))
    - Safety Net Services Initiative (SNSI) (42 CFR § 438.6(c)(1)(iii)(D))

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

I.1.A.iv. Rate Development Standards and FFP

The CYE 26 capitation rate for the CHP Program is based on valid rate development standards and is not based on the rate of FFP for the populations covered under the CHP Program.

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

The capitation rate was developed as one statewide rate cell.

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

The effective dates of changes to the CHP Program are consistent with the assumptions used to develop the CYE 26 capitation rate for the CHP Program.

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

The certified capitation rate was developed so the CHP Program would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 26.

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 rate, or to any portion of the capitation rate, 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 rate 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 rate 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 26 capitation rate certified in this report represents the final contracted rate.

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 26 capitation rate for the CHP Program.

I.1.A.xii. Evaluation of Unwinding of the COVID-19 PHE

This section of the 2026 Guide includes CMS recommendations for risk mitigation strategies for rating periods following the end of the public health emergency (PHE) until enrollment is expected to stabilize. All risk mitigation strategies are addressed in the contract and below in Section I.4.C. and will be submitted to CMS prior to the start of the rating period in accordance with the specific documentation requirements under 42 CFR § 438.6(b)(1).

This section also requests description of evaluations conducted, and the rationale for any applicable assumptions included or not included in rate development related to the COVID-19 PHE and related unwinding within the rate certification.

Information on all assumptions included in the rate development, based on the available and applicable state specific, as well as nationally and regionally applicable, data (outlined below in Section I.1.B.xi.(a)), to address the direct and indirect impacts of unwinding of the PHE and the maintenance of effort (MOE) requirements are described in each of the sections below:

- I.1.B.xi.(a) Available Applicable Data
- I.1.B.xi.(b) Accounting for Direct and Indirect Impacts
- I.1.B.xi.(d) Risk Mitigation Strategies

Additional evaluation conducted related to the COVID-19 PHE and related unwinding which did not result in adjustments to the rate development for CYE 26 varies by program. The CHP Program was not impacted by the MOE requirements of the PHE based on the specific populations eligible for enrollment in the CHP Program, described above in Section I.1.A.iii.(c)(iii). Enrollment in the CHP Program is predicated upon being a child under the age of 18 and part of the foster care system, and if a child is no longer part of the foster care system, their eligibility for Medicaid would transition to another AHCCCS program; whatever program the member transitioned to after leaving foster care would be the program impacted by the MOE and the subsequent unwinding of the PHE.

I.1.A.xiii. Rate Certification Procedures

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

This section of the 2026 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

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

Not applicable. This rate certification does not cover retroactive adjustments for previous capitation rates. This is a new rate certification that documents that the CHP Program capitation rate is changing effective October 1, 2025.

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

Not applicable. This rate certification will change the CHP Program capitation rate effective October 1, 2025.

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

Not applicable. This is a new rate certification that documents that the CHP Program capitation rate is changing effective October 1, 2025. In the event of any change to the capitation rate 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.xiii.(e) CMS Rate Certification Requirements for Retroactive SDP Adjustments

This section of the 2026 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.xiii.(f) CMS Rate Certification Circumstances for Limited Payment Changes

This section of the 2026 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.xiii.(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.xiii.(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 a statewide capitation rate for the CYE 26 CHP Program.

I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 26 capitation rate for the CHP Program.

I.1.B.iii. 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 AHCCCS Division of Business and Finance (DBF) Actuarial Team calculates a modified MLR where the only inclusion in the numerator is the projected gross medical expense component of the capitation rates (discounts related

to pharmacy rebates are included in this calculation), ensuring the result of the calculation will be less than or equal to the actual MLR calculation because the modified MLR calculation does not include any considerations for the allowed additional expenses under 42 CFR § 438.8(e)(3)-(4) in the numerator. For CYE 26 capitation rates, the modified MLR for DCS CHP was greater than 85 percent. Per 42 CFR § 438.5(b)(5) the AHCCCS DBF Actuarial Team reviewed past MLR results focusing in on the MLR results that correspond to the base period and for any Contractors performing below 85 percent the actuaries would make adjustments to assumptions in capitation rate setting where appropriate, however this was not necessary because all Contractors for all programs were above 85 percent MLR for the base period.

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

This section of the 2026 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell. All such assumptions and adjustments are described in the rate certification.

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

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

I.1.B.vi. 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 2026 Guide. Sections of the 2026 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.vii. Assurance Rate Assumptions Do Not Differ by FFP

All proposed differences in the assumptions, methodologies, or factors used to develop the certified CYE 26 capitation rate for the covered populations under the CHP 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.viii. Differences in Federal Medical Assistance Percentage

Variations in the assumptions used to develop the projected benefit costs for the covered populations were based on valid rate development standards and not based on the rate of Federal Medical Assistance Percentage (FMAP). In the most recent contract year, 99.89% of the covered populations under the CHP Program received the regular FMAP and the remainder was claimed at other FMAPs.

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

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

The 2026 Guide requests a comparison to the final certified rate in the previous rate certification. The comparison between the most recently certified CYE 25 CHP Program capitation rate effective April 1, 2025, and the CYE 26 capitation rate being certified in this actuarial rate certification is included in Appendix 3.

The 2026 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. As in past years, the AHCCCS 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. While the capitation rate change certified herein is less than 10%, the actuaries note that the CYE 26 capitation rate has increased significantly from the prior year; this is primarily driven by decreasing enrollment combined with increased needs for those children entering the system for foster care, consistent with the policy changes that DCS has put into place since 2021. Please see Section I.2.B.iii.(d) for additional details.

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

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

I.1.B.x. Future Rate Amendments

There are no known, or expected, future amendments to the CHP capitation rate.

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

I.1.B.xi.(a) Available Applicable Data

The AHCCCS DBF Actuarial Team and AHCCCS DBF financial analysts have reviewed data, regulations, and information from a variety of applicable sources to address the unwinding of the PHE and the MOE requirements in rate setting. For CYE 26 rate development, AHCCCS DBF Actuarial Team has used a base data time period beginning six months after the end date of the Medicaid continuous coverage protection. Further details about state specific and national data sources used for rate development after the unwinding are listed below.

- State Data Sources
    - AHCCCS historical and current encounter data including utilization and costs by category of service (COS), risk group, GSA, and program
    - AHCCCS telehealth utilization and cost data by risk group, GSA, and program

    - AHCCCS historical and current enrollment by risk group, GSA, and program
- National Data Sources
    - Consumer and Producer price inflation data published by the Bureau of Labor Statistics
    - National webinars discussing various impacts of the end of continuous coverage protections
    - Letters and guidance related to the PHE unwinding published by CMS:
        - State Health Official Letter 23-002
        - CMS Policy Guidance FAQ dated May 12, 2023, on unwinding the continuous enrollment requirement
        - State Medicaid Director Letter 23-004

I.1.B.xi.(b) Accounting for Direct and Indirect Impacts

The list above in Section I.1.A.xii. details the sections of the certification which describe assumptions included in the rate development to address the direct and indirect impacts of the unwinding of the COVID-19 PHE. The CYE 26 capitation rate uses a base data experience period that reflects changes in service delivery that have continued beyond the unwinding of the 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 CHP Program.

I.1.B.xi.(c) COVID-19 Costs Outside of Capitation Rates (Non-Risk) – Not Applicable

Not applicable. There are no COVID-19 costs covered on a non-risk basis outside of the CYE 26 capitation rate.

I.1.B.xi.(d) 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 26 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 26.

I.2. Data

This section provides documentation for the Data section of the 2026 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 26 capitation rate for the CHP Program were:

- Adjudicated and approved encounter data submitted by DCS CHP and the prior mental health Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2020 through February 2025
  - Adjudicated and approved through the second February 2025 encounter cycle
- Supplemental data files for all services provided by DCS Comprehensive Medical and Dental Program from October 2020 through March 2021, paid through March 2023
- Reinsurance payments made to the CHP Program for services
  - Incurred from October 2020 through September 2024 paid through April 2025
- Enrollment data for the CHP Program and the prior mental health Programs from the AHCCCS PMMIS mainframe
  - October 2020 through June 2025
- Annual and quarterly financial statements submitted by the CHP and prior mental health Contractors and reviewed by the AHCCCS DBF Finance & Reinsurance Team
  - October 2020 through December 2024

- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DBF Rates & Reimbursement Team
- Data from AHCCCS 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
- Detailed administrative expense data and projections from DCS CHP and the CHP integrated subcontractor, Mercy Care
- Projected CYE 26 enrollment data provided by AHCCCS DBF Budget Team
- Monthly operational outcomes report compiled by DCS, accessible from their website
- Detailed sub-capitation/block purchasing data and projections from the CHP integrated subcontractor

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 ages 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, including the CHP integrated subcontractor, sometimes use sub-capitation/block purchasing arrangements for some services. The sub-capitation/block purchase arrangements between the Contractors and their providers require that the providers submit claims, 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 repriced amounts were compared to the sub-capitation/block purchase arrangement expenses reported in the integrated subcontractor's quarterly financial statements and the repricing methodologies were adjusted as needed to ensure the repriced sub-capitated/block expense amounts used in rate development aligned with the integrated subcontractor's actual expenses. 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 DCS CHP and its integrated subcontractor 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.

DCS CHP, and all other AHCCCS Contractors, know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides 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 COS used in the rate development process.

The AHCCCS DBF Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe and ensured that only encounter data with valid AHCCCS member IDs was used in developing the CYE 26 capitation rate for the CHP 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 24 encounter data to the aggregated CHP quarterly financial statement data from DCS CHP and the integrated subcontractor for the same timeframe. The CYE 24 encounter data was also compared to the data request which the Contractors fill out each year, providing additional information regarding claims runout, revisions to financial statements for prior period adjustments, and administrative cost details. After adjustments to the encounter data for completion, the financial statements, the AHCCCS encounter data, and the annual data request amounts 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 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 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 SNSI SDP,
- data provided by DCS CHP and its integrated subcontractor, Mercy Care, on projected administrative costs,
- data provided by DCS CHP and the integrated subcontractor in the yearly supplemental data request regarding claims runout, revisions to financial statements for prior period adjustments, and administrative cost details, and
- data provided by the AHCCCS DBF Budget Team with regard to projected enrollment.

The actuaries have found the encounter data in total to be appropriate for the purposes of developing the CYE 26 capitation rate for the CHP Program.

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

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

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

The AHCCCS DBF Actuarial Team determined that the CYE 24 encounter data in total was appropriate to use as the base data for developing the CYE 26 capitation rate for the CHP Program.

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

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 26 capitation rate for the CHP 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 26 capitation rate for the CHP 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 26 capitation rate for the CHP Program.

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

This section describes adjustments made to the CYE 24 encounter data that was used as the base data for developing the CYE 26 capitation rate for the CHP Program.

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

Not applicable. No credibility adjustments were made to the CYE 24 encounter data.

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

Adjustments were made to the data to reflect the level of completion.

AHCCCS calculated completion factors using the development method with monthly encounter data from October 2020 through February 2025, by major COS. The major COS are based upon the AHCCCS form type, which indicates the type of form used to submit a claim. AHCCCS has six form types: Professional and Other Services (form type A), Prescription Drug (form type C), Dental Services (form type D), Inpatient Hospital (form type I), Nursing Facility (form type L), and Outpatient Hospital (form type O). The Dental Services form type (2.22% of CYE 24 payments) was combined with the Professional and Other Services form type (57.64% of CYE 24 payments). The Outpatient Hospital (3.89% of CYE 24 payments) and the Nursing Facility form types (0.00% of CYE 24 payments) were combined with the Inpatient Hospital form type (30.91% of CYE 24 payments). The monthly completion factors were applied to the encounter data on a monthly basis. Aggregated CYE 24 completion factors by detailed COS are shown in Appendix 4.

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

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

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

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2023 through September 30, 2024) are described below. Adjustments to the base data to address impacts of changing characteristics of the covered population resulting from DCS policy changes, as well as the removal of one-time, high-cost pharmaceutical expenses, are also described in this section. All other program and fee schedule changes which occurred or are effective on or after October 1, 2024, are described in Section I.3.B.ii.(a).

Except for non-material adjustments, the impact of each adjustment to the base data is shown separately as part of Table 1. If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the capitation rate, that adjustment was deemed non-material and has been grouped into the Other Base Data Adjustments line in Table 1. Totals may not add up due to rounding. The impacts by COS are shown in Appendix 4.

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

Removal of Differential Adjusted Payments from Base Data

The CYE 24 capitation rate for the CHP Program funded DAP made from October 1, 2023, through September 30, 2024, 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, 2024, AHCCCS has removed the impact of CYE 24 DAP from the base period. To remove the impact, the AHCCCS DBF Actuarial Team requested provider IDs for the qualifying providers for the CYE 24 DAP by specific measure from the AHCCCS DBF Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions for CYE 24 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 1. Totals may not add up due to rounding.

See Section I.4.D. for information on adjustments included in the CYE 26 capitation rate for DAP that are effective from October 1, 2025, through September 30, 2026.

Removal of Ancillary Crisis Services from Base Data

While the CHP Program covers most mental health services for its members, the CHP Program is not responsible for the first 24 hours of crisis intervention services. The first 24 hours of crisis intervention

services for all Arizona Medicaid members are included as part of the ACC-RBHA contract. In addition to the main crisis services (crisis phone lines, mobile crisis teams, and crisis stabilization services), the ACC-RBHA Contractors also cover some ancillary crisis services, such as non-emergency transportation to a crisis stabilization unit or laboratory services provided in the first 24 hours of a crisis episode. These services are not exclusively used by AHCCCS members experiencing a crisis episode, and so, while the base data obtained by the actuaries for rate development removed the main crisis services, an additional process was needed to identify those services which were ancillary crisis services based on the property of having been provided to a member during the first 24 hours of crisis services and paid for by the Contractor responsible for the first 24 hours of crisis services. These expenses are included in the development of the Crisis 24 Hour Group capitation rates within the ACC-RBHA Program. The impacts of removing the costs from the base data for these identified ancillary crisis services provided to CHP population are displayed in Table 1. Totals may not add up due to rounding.

Base Data Normalization

DCS made policy changes in July and October 2021 in response to the settlement of a lawsuit, BK vs Faust, and to implement changes required by the Family First Prevention Services Act (FFPSA), respectively. The lawsuit settlement included standardizing policy tools by which placement decisions are made to avoid discrepancies across different regions, prioritizing reductions in congregate care placements, and ensuring performance measures are in place and being met, among other requirements. The FFPSA includes reforms intended to reduce the out-of-home foster care population through changes to placement options, prevention services and programs, and eligibility requirements. While the population covered under the CHP contract is still children involved with the foster care system, these DCS policy changes have impacted the average health status and related characteristics of the covered population. Additional information on these policies can be reviewed in the SFY2024 DCS' Semi-Annual Benchmark Progress Report and the SFY2023 Semi-Annual Child Welfare Report[1]. Per the Semi-Annual Benchmark Progress Reports, the reduction in the out-of-home foster care population can be attributed to, but certainly not limited to, standardized process tools (case progress review checklists), safety discussion guides, and more training on effectively engaging with the related family members to keep the child safely in the home. The combination of these policy changes has resulted in fewer children entering and more children leaving the foster care system, proportional to the total out-of-home population, than in prior years. Consequently, there have been significant reductions in the number of children remaining in out-of-home placements; however, this has not proportionately reduced the program expenses, due to greater mental and physical health needs of those children entering and/or remaining in the foster care population than seen historically. These children and youths' complex conditions require higher levels of care, services, and interventions to reach the goals of permanency than the historical population characteristics of children in foster care.

The actuaries judged the majority of the CYE 24 base data to be appropriate to use for rate development without further adjustments for these population changes. However, the first quarter of CYE 24

[1] For additional information on the DCS policy changes, please refer to the SFY2024 DCS Report titled "DCS Semi-Annual Benchmark Progress Report Dec 2023" and the SFY2023 DCS Report titled "Semi-Annual Child Welfare Report Mar 2024", both available at: https://dcs.az.gov/reports

(October 1, 2023, through December 31, 2023) had the highest exit to entry ratio of any other quarter since the policies were implemented with nearly 1.5 children exiting CHP for each child entering CHP, which disrupted the experience enough that the actuaries judged that adjustments to preserve expected seasonality patterns for utilization and unit cost for that time of the year were both necessary, and appropriate.

Removal of High-Cost Biologic Expenses and Associated Reinsurance Payments from Base Data

During the base data period, one CHP Program member received a high-cost gene therapy drug that was covered under the AHCCCS Reinsurance Program. As the specific drug is one-time in nature, the associated expenses reimbursed by the AHCCCS Reinsurance Program were excluded from both the base data and the data used to develop the reinsurance offset included in the CYE 26 capitation rate for the CHP Program in order to avoid skewing the data. The remaining portion of expenses, for which the CHP integrated subcontractor retained financial responsibility, was included in the base data.

Table 1: Impacts of Base Data Adjustments

Base Data Adjustment	Dollar Impact	PMPM Impact
Removal of DAP	($1,770,569)	($21.05)
Removal of Ancillary Crisis	($415,128)	($4.94)
Base Data Normalization	$1,519,714	$18.07
Removal of High-Cost Biologic	($1,661,529)	($19.76)
Other Base Data Adjustments	$66,695	$0.79
Total Base Data Adjustments	**($2,260,818)**	**($26.88)**

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 capitation rate, that adjustment was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the PMPMs for each non-material adjustment into an aggregate PMPM for display. The combined overall impact is illustrated above in Table 1. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- ***Community Health Workers/Community Health Representatives ****
  Effective April 1, 2023, AHCCCS received approval to implement a State plan amendment for a new Community Health Worker (CHW)/Community Health Representative (CHR) benefit which allows Medicaid reimbursement of CHW/CHR services billed under a qualified provider, within the employee CHW/CHR's scope of practice. In March 2024, AHCCCS established a new provider type for CHW/CHR community-based organizations which is anticipated to increase billing for these services as most CHW/CHRs are employees of these organizations which had not historically been able to register as AHCCCS providers. A CHW/CHR is a non-physician, frontline public health worker who is a trusted member of the community with a close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison between

health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

- ***Fraud, Waste, and Abuse Adjustment***
  Following investigations of potential fraud, waste, and abuse since May 2023 - and subsequent suspensions or terminations of providers - the AHCCCS DBF Actuarial Team reviewed contractor encounters from affected providers as of May 2025. Irregular unit cost and quantity patterns were identified and the encounters were adjusted to align with reasonable utilization and cost standards.
- ***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.
- ***Corneal Cross Linking ****
  Effective January 1, 2024, AHCCCS began coverage of two procedure codes (0402T and J2787) for corneal cross-linking treatment used to prevent the progression of corneal ectasia.
- ***Donor Milk ****
  Effective January 1, 2024, AHCCCS began coverage of procedure code T2101, human breast milk processing, storage, and distribution only, for cases where it is medically necessary where the infant is at high risk and where the mother's own milk is absent or insufficient in quantity.
- ***Insulin Price Changes***
  The Medicaid Drug Rebate Program (MDRP) requires state Medicaid coverage of most FDA approved drugs in exchange for national rebate agreements with drug manufacturers. Effective January 1, 2024, a provision in the American Rescue Plan Act (ARPA), enacted in March 2021, removed a cap on Medicaid drug rebates that had been in place since 2010. In response, rather than pay higher rebate amounts, many drug manufacturers have instead reduced the prices of their drugs. A very specific instance of this has been a drastic cost reduction for insulin products at the point of sale since the start of 2024. The encounters for months prior to January 2024 have been adjusted in line with these cost reductions for insulin products.

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 26 capitation rates. Other base data adjustments which excluded services from the data (i.e., ancillary crisis removal, one-time high cost biologic drug expense) are described above in Section I.2.B.iii.(d).

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2026 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 rate is 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) – Not Applicable

Not applicable. There are no in lieu of services or settings (ILOS) as defined at 42 CFR § 438.2 included in the projected benefit costs.

I.3.A.iv. ILOS Cost Percentage – Not Applicable

Not applicable. There are no ILOS included in the projected benefit costs.

I.3.A.v. Institution for Mental Disease – Not Applicable

Not applicable. Institution for Mental Disease (IMD) payments in accordance with 42 CFR § 438.6(e) are for enrollees aged 21 to 64. The CHP Program only covers children under the age of 18. Therefore, no adjustment was made to encounter data or to the capitation rate.

I.3.B. Appropriate Documentation

I.3.B.i Projected Benefit Costs

The final projected benefit costs for the CHP Program are shown in Appendix 6.

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

This section provides information on the projected benefit costs included in the CYE 26 capitation rate for the CHP 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 historical changes in benefits, program requirements, and provider reimbursement levels as noted in Section I.2.B.iii. The adjusted base data per-member-per-month (PMPM) expenditures for each COS were trended forward 24 months, from the midpoint of the CYE 24 time period to the midpoint of the CYE 26 rating period by applying assumed

annual utilization and unit cost trends for each COS, using the methodology described below in Section I.3.B.iii.(a)(ii). The projected PMPMs were then adjusted for prospective program and reimbursement changes, described below. Appendix 4 contains the base data and base data adjustments, and Appendix 5 contains the projected benefit cost trends. Appendix 6 contains the development of the gross medical expense from the adjusted base data, including all prospective programmatic and fee schedule changes, as well as the impact of the DAP. Appendix 7 contains the development of the certified capitation rate from the projected gross medical expense, including the reinsurance offset, administrative expense, case management expense, underwriting (UW) gain, and premium tax.

Except for non-material changes, the impact of each program change is shown separately as part of Table 2. If a program change had an impact of 0.2% or less on the gross medical component of the capitation rate, that program change was deemed non-material and has been grouped into the Combined Miscellaneous Program Changes line in Table 2. Totals may not add up due to rounding. The impacts by COS are shown in Appendix 6.

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 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.

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 26 FQHC/RHC PPS rates. Effective October 1, 2025, the FQHC/RHC PPS rates are being rebased in accordance with Arizona's State Plan. This rebase increased the average statewide PPS rate significantly, with the total impact being roughly $1 million over the projected costs (without utilization growth) from the PPS rate updates effective

October 1, 2024 for the CHP Program. The rate increases are anticipated to increase utilization at FQHC/RHCs; this utilization increase is included with the trend projections for this category of service.

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 26 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DBF Rates & Reimbursement Team used the CYE 24 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 24 base data. The AHCCCS DBF Actuarial Team then reviewed the results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting COS.

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

The overall impact of the AHCCCS Fee-for-Service fee schedule updates is illustrated in Table 2. Totals may not add up due to rounding.

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 26. 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 26 rate development, the aggregate impact of adopted changes was allocated across risk groups and GSAs using CYE 24 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 2. Totals may not add up due to rounding.

Table 2: Impacts of Prospective Program and Reimbursement Changes

Prospective Program/Reimbursement Change	Dollar Impact	PMPM Impact
Aggregate AHCCCS FFS Fee Schedule Updates	$1,742,008	$20.71
Pharmacy and Therapeutics	($784,094)	($9.32)
Combined Miscellaneous Program Changes	($119,846)	($1.43)
Total Prospective Program and Reimbursement Changes	**$838,068**	**$9.97**

Combined Miscellaneous Program Changes

The rate development model 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 capitation rate, 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 PMPMs for each non-material adjustment into an aggregate PMPM for display. The combined overall impact is illustrated above in Table 2. Totals may not add up due to rounding. Brief descriptions of the individual program changes are provided below.

- ***Diabetic Drug Class Utilization Changes ****
  The AHCCCS DBF Actuarial Team reviewed all historical adjudicated and approved encounters for glucagon-like peptide-1 (GLP-1) receptor agonists, sodium-glucose co-transporter-2 inhibitors (SGLT2), and insulins, and determined that the changing utilization patterns of these drug classes was not fully accounted for by the projected trend assumptions and have included a separate, specific adjustment to these drug classes as part of the capitation rate development.
- ***Humira Biosimilars***
  In recent years several biosimilar and interchangeable products have become available as substitutes for Humira and are priced significantly lower than the Humira brand products. Effective August 1, 2024, AHCCCS shifted preferred status from Humira to the interchangeable biosimilar options. The impact of this shift was modeled by applying a discount factor to the drug costs consistent with the average discount between the price of the interchangeable products and Humira.
- ***Annual Syphilis Testing ****
  In alignment with recommendations from the Centers for Disease Control and Prevention and the Arizona Department of Health Services, effective October 1, 2024, AHCCCS began requiring providers to offer annual Syphilis testing for members aged 15 years and older.
- ***ASAM Continuum – U9 Modifier ****
  Effective October 1, 2024, AHCCCS implemented a provider initiative that requires the American Society of Addiction Medicine (ASAM) CONTINUUM™ assessment tool to be used in the public mental health system. In order to provide additional reimbursement to help offset the annual

subscription fees for access to the assessment tool, providers may include the U9 modifier when billing for HCPCS codes H0018, limited to twice per member stay, and H0035, limited to twice per member per year.

- ***Doula Services ****
  Effective October 1, 2024, AHCCCS expanded its preventive services to include services provided by a state certified Doula, as defined in A.R.S. §36-766, which may include care coordination, social support, coaching, and emotional support.
- ***Vaccine Related Items ****
  On October 31, 2024, AHCCCS sent a memo to all managed care plans clarifying that tetanus vaccines for EPSDT eligible members are covered outside of the Vaccines for Children program when the member is being treated in an emergency setting for trauma. On December 15, 2024, AHCCCS adjusted the vaccine administration fee for all vaccines being administered at a pharmacy to $14. AHCCCS analysts are also monitoring shifts in vaccination utilization in response to recent outbreaks, including the 2024 Mpox outbreak and the 2025 Measles outbreak.
- ***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.
- ***Fingerstick Devices for Clozapine Patients ****
  Effective October 1, 2025, AHCCCS will begin 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 will begin 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.
- ***Rx Rebates Adjustment***
  An adjustment was made to reflect the impact of Rx Rebates reported within the integrated subcontractor, Mercy Care, financial statements for children covered under CHP, as pharmacy encounter data does not include these adjustments. The data that the AHCCCS DBF Actuarial Team reviewed was the CYE 21, CYE 22, CYE 23, CYE 24, and CYE 25 Q1 financial statement reports for Mercy Care as the integrated subcontractor for the CHP Program. From this review, the AHCCCS DBF Actuarial Team determined that it would be reasonable to apply an adjustment to the projected CYE 26 Pharmacy COS.

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

All 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

AHCCCS Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base encounter data received and used as the primary data source to set the CYE 26 capitation rate therefore includes those adjustments.

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

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

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

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

The data used for development of the projected benefit cost trends was the encounter data incurred from January 2023 through January 2025, adjudicated and approved through the second February 2025 encounter cycle. The AHCCCS DBF Actuarial Team generally includes three years of experience when evaluating and developing projected benefit cost trends, however, data prior to January 2023 was more significantly affected by the disenrollments and overall population characteristic changes related to DCS policy changes, described in Section I.2.B.iii.(d), than the data after January 2023 and was thus excluded for purposes of CYE 26 trend development.

The trends were developed from data specific to the CHP population.

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

The encounter data was summarized by month and COS, and by utilization per 1000, unit cost, and PMPM values. The encounter data was adjusted for monthly completion factors developed in the same manner described in Section I.2.B.iii.(b). The data was also normalized to adjust for all program changes, fee schedule changes, and DAP removal, as appropriate. Additionally, base data normalization adjustments were applied to CYE 24 data, and reinsurance-eligible expenses related to a high-cost biologic drug incurred by one member in CYE 24 were removed from the base data, as described above in Section I.2.B.iii.(d). Projected benefit cost trends were developed to project the adjusted base data forward 24 months, from the midpoint of CYE 24 (April 1, 2024) to the midpoint of the rating period for CYE 26 (April 1, 2026). 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 with consideration of 3-month, 6-month, and 12-month moving averages, as well as linear regressions using the normalized data.

For the CHP Program, four of the fifteen 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: Outpatient and Emergency Facilities (Outpatient Facility, Emergency Facility) and Other Professional Services (Laboratory and Radiology Services, Other Professional Services). The remaining eleven 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

The PMPM trend assumptions were compared to similar assumptions made in the CYE 25 capitation rate development and judged reasonable to assume for projection to CYE 26, considering the change in the base data period, rating period, and the impact of DCS policy changes described in Section I.2.B.iii.(d).

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

The 2026 Guide requires explanation of outlier or negative trends. As in past years, the AHCCCS DBF Actuarial Team has defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. There are no negative trend assumptions included in the CYE 26 CHP capitation rate development. The actuaries assumed greater than 7% PMPM trend for the following COS: Mental Health Inpatient and LTC, Mental Health Practitioners, Residential Services, FQHC/RHC, and Physical Health Practitioners.

These high trends are primarily driven by DCS policy changes, described in Section I.2.B.iii.(d), that have resulted in a higher percentage of children in foster care with above average mental and physical health needs. The increases for these COS align both with the new policies from DCS described in Section I.2.B.iii.(d) as well as information provided by DCS CHP and therefore have been judged appropriate.

The 16.6% PMPM trend assumed for the Residential Services COS is additionally driven by a continuing increase in the number of providers contracted with the integrated subcontractor, Mercy Care, to receive higher reimbursement rates in certain cases. These providers regularly serve very high-needs members whose care often requires more intensive services.

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 for the capitation rate.

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

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

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

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

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

Projected benefit cost trends do not vary except by COS.

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

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

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

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

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

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS Division of Managed Care Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. As of August 27, 2025, no additional services have been identified as necessary services to comply with MHPAEA.

I.3.B.v. ILOS – Not Applicable

Not applicable. There are no ILOS included in the projected benefit costs.

I.3.B.vi. Retrospective Eligibility Periods

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

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

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 26 capitation rate for the CHP 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 on 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 and the VFC program are described in Section I.3.B.ii.

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

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

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

There were no material changes 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 2026 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements – Not Applicable

Not applicable. No incentive arrangements exist with the CHP Program.

I.4.B. Withhold Arrangements – Not Applicable

Not applicable. No withhold arrangement exists with the CHP Program.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2026 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 contract and capitation rate certification for the rating period which will be submitted to CMS before the start of the rating period and will not be modified or added after the start of the rating period.

I.4.C.ii. Appropriate Documentation

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

The CYE 26 contract for the CHP Program will include a risk corridor.

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

AHCCCS has a long-standing program policy of including risk corridors within many of the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 26 contract will continue AHCCCS' long-standing program policy and will include a risk corridor. This rate certification will use the term risk corridor to be consistent with the 2026 Guide. The CHP Contract refers to the risk corridor as a reconciliation.

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

The Subcontractor costs to reimbursement risk corridor will reconcile Subcontractor medical expenses to medical capitation paid to the Subcontractor in accordance with the DCS CHP contract with the Subcontractor. The risk corridor with the Subcontractor provides for payment or recoupment outside a risk corridor as agreed to in the subcontract. DCS CHP will submit the reconciliation for AHCCCS approval and AHCCCS will reconcile with DCS CHP by reimbursing excess losses to be paid to the Subcontractor. The total amount of any excess profits to be recouped from the Subcontractor will be returned to AHCCCS.

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.

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

The risk corridor did not have any effect on the development of the CYE 26 capitation rate for the CHP 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 corridor were set using actuarial judgement with consideration of conversations and input between the AHCCCS DBF Actuarial Team, the AHCCCS DBF Finance & Reinsurance Team, the AHCCCS OOD, and the CHP Program leadership.

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

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

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

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

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

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

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

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

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

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

AHCCCS provides a reinsurance program to AHCCCS Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what one would see 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 a Catastrophic case type, including reinsurance for biologic drugs. Additionally, rather than DCS CHP paying a premium, the capitation rate is instead adjusted by subtracting the reinsurance offset from the gross medical expense. One could view the reinsurance offset as a premium.

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 DCS CHP for covered services incurred above the deductible. The deductible is the responsibility of DCS CHP. The deductible for CYE 26 Regular reinsurance cases is $150,000, unchanged from the Regular reinsurance deductible for CYE 25. 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 DCS CHP whether the actual amount is above or below the reinsurance offset in the capitation rate. This can result in a loss or gain by DCS CHP based on actual reinsurance payments versus expected reinsurance payments.

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

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

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

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

Projected reinsurance offsets are developed in accordance with generally accepted actuarial principles and practices.

I.4.C.ii.(c)(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset

The methodology for setting the reinsurance offset has not changed from the CYE 25 capitation rates. The data used to develop the reinsurance offset amount are historical encounters incurred during CYE 24. The historical reinsurance payment data for catastrophic case types related to certain medical conditions and biologic/high-cost specialty drugs were also used as a validation check to ensure encounters for members with those reinsurance cases were captured within the development of the reinsurance offset. The CYE 24 encounters were adjusted for applicable historical programmatic and fee schedule changes

and trended to the CYE 26 rating period using the same trend factors described in Section I.3.B.iii.(a) above. Expenses reimbursed under the AHCCCS Reinsurance Program for a high-cost biologic drug received by one member in CYE 24 were removed from this data due to the one-time nature of the drug. These adjusted encounters were then evaluated against the applicable reinsurance rules, including deductible levels, for the CYE 26 rating period to determine calculated potential reinsurance case payments by member. The calculated reinsurance case payments were then summed and divided by the CYE 26 projected member months to develop the reinsurance offset. The reinsurance offset was then adjusted to account for changes to the covered biologics list after the base data period to get to the final reinsurance offset. This adjustment was calculated by taking the projected PMPM costs for CYE 26 for the new covered drugs for the CHP Program and applying a zero-dollar deductible and coinsurance limit of 85%.

Appendix 7 displays the reinsurance offset PMPM included in the capitation rate.

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

This section of the 2026 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 CHP Program. The contract requires the adoption of a minimum fee schedule for two sets of providers, FQHC/RHC and 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). These SDPs for FQHC/RHC and VFC providers do 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, APSI, PSI, and SNSI. The 2026 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Federally Qualified Health Centers and Rural Health Clinics

Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Arizona Medicaid State plan as a minimum fee schedule for FQHC/RHC providers. The Arizona Medicaid State plan describes the methodology for the calculation of PPS rates in Attachment 4.19-B starting on Page 3a.

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.

Access to Professional Services Initiative

The APSI SDP provides a uniform percentage increase of 91.44% to otherwise contracted rates for eligible practitioners, critical to professional training and education efforts, who deliver services to AHCCCS members. The uniform percentage increase is applicable only to services covered under the AHCCCS APSI policy. The rate increase is intended to supplement, not supplant, payments to eligible providers.

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 eligible hospitals or pediatric units.

Safety Net Services Initiative

The SNSI SDP provides a uniform percentage increase for inpatient and outpatient services provided by the eligible public safety net hospital. The SNSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. This increase is intended to supplement, not supplant, payments to the eligible public safety net hospital.

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

The FQHC/RHC and VFC minimum fee schedules and the DAP initiative are the only SDPs incorporated in the capitation rate. The 2026 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

The single rate cell for the CHP Program is affected by the FQHC/RHC and VFC minimum fee schedule SDPs and the DAP initiative.

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

The FQHC/RHC and VFC minimum fee schedule impacts are included as part of the aggregate fee schedule changes shown in Appendix 6. See Appendix 8b for the total impact by rate cell for the FQHC/RHC and VFC minimum fee schedules. For DAP, see Appendix 6 for medical impact by rate cell and Appendix 8b for total impact by rate cell.

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

Federally Qualified Health Centers and Rural Health Clinics

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

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 24 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 26 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 26 (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, 2025.

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

Not applicable. None of the SDPs for the CHP Program are based on maximum fee schedules.

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

The APSI, PSI, and SNSI SDPs are not included in the CHP certified capitation rate and will be paid out via lump sum payments. The 2026 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

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

Access to Professional Services Initiative

Anticipated payments, including premium tax, for APSI are approximately $3.09 million for the CHP Program. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Services Initiative

Anticipated payments, including premium tax, for PSI are approximately $1.59 million for the CHP Program. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 26 utilization will be used to redistribute the payments.

Safety Net Services Initiative

Anticipated payments, including premium tax, for SNSI are approximately $3.48 million for the CHP Program. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 26 utilization will be used to redistribute the payments.

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

Access to Professional Services Initiative

The actuaries certify the aggregate 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.

Pediatric Services Initiative

The actuaries certify the 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.

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

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

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

Access to Professional Services Initiative

AHCCCS has submitted the APSI 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 payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

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 payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Safety Net Services Initiative

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

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

Access to Professional Services Initiative

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

Pediatric Services Initiative

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

Safety Net Services Initiative

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

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

There are not any additional directed payments 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.(c) Confirmation Regarding Required Reimbursement Rates

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

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

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

I.5 Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2026 Guide provides information on the non-benefit component of the capitation rate.

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, and Methodology

AHCCCS requested administrative expense information from DCS CHP and the integrated subcontractor for actual and projected expenses in CYE 24, CYE 25, and CYE 26. The requested information detailed projected employee compensation (including FTE counts for DCS CHP), care management costs, data processing costs, interest charges, occupancy (rent/utilities), and other administrative expenses for the current contract year and the upcoming contract year. The CYE 26 projections for DCS CHP and the integrated subcontractor include expenses associated with care management. Care management activities performed by DCS CHP and the integrated subcontractor help to ensure that members receive appropriate physical health services, including well-child examinations, screenings, immunizations, and follow-up care. Care management also ensures that members have access to high quality, comprehensive mental health services delivered in a timely manner and in the most appropriate setting.

The projected administrative and care management expenses were reviewed by AHCCCS for reasonableness by comparing the projections against previous administrative expense projections and reported administrative expenses from financial statements submitted by DCS CHP and the integrated subcontractor, and to the wage inflation of the Consumer Price Index. Additional details were requested from DCS CHP to understand some of the administrative cost increases requested. After reviewing the requested information, and additional communications with DCS CHP, the overall projected administrative and care management expenses for CYE 26 for DCS CHP and the integrated subcontractor were deemed reasonable and appropriate for inclusion in the overall administrative expense projections.

The projected administrative expense PMPM was evaluated along with the projected gross medical expense, reinsurance offset, and care management expense PMPM amount to ensure compliance with the minimum 85 percent MLR requirement, as calculated under 42 CFR § 438.8.

The projected CYE 26 administrative expense components are shown in Appendix 7.

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

There were no methodology changes from the non-benefit cost development used in the CYE 25 rate, other than the adjustments described in the previous section.

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 26 capitation rate for the CHP Program is described above in Section I.5.B.i.(a). The PMPM amounts assumed can be found in Appendix 7.

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

The CYE 26 capitation rate for the CHP Program includes 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 26 capitation rate for the CHP Program includes a provision for contributions to reserves, risk margin, and cost of capital (i.e., underwriting (UW) gain) of 1.0%.

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

No other material or non-material non-benefit costs not already addressed in previous sections are reflected in the CYE 26 capitation rate for the CHP Program.

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

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

I.6. Risk Adjustment – Not Applicable

Not applicable. The CYE 26 capitation rate for the CHP Program does not utilize risk adjustments.

I.7. Acuity Adjustments – Not Applicable

Not applicable. The CYE 26 capitation rate for the CHP Program does not include an acuity adjustment.

Section II Medicaid Managed Care Rates with Long-Term Services and Supports – Not Applicable

Section II of the 2026 Guide is not applicable to the CHP Program. Managed long-term services and supports, as defined at 42 CFR § 438.2, are not covered services under the CHP Program. The CHP Program does cover nursing facility services, and related home and community-based services, for 90 days of short-term convalescent care.

Section III New Adult Group Capitation Rates – Not Applicable

Section III of the 2026 Guide is not applicable to the CHP Program.

Appendix 1: Actuarial Certification

We, Elizabeth Seaman, ASA, MAAA and Luna Zong, ASA, 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 rate included with this rate certification is 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 26 capitation rate for the CHP Program have been documented according to the guidelines established by CMS in the 2026 Guide. The CYE 26 capitation rate for the CHP Program is effective for the 12-month time period from October 1, 2025, through September 30, 2026.

The actuarially sound capitation rate is based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rate, we have relied upon data and information provided by teams at AHCCCS, DCS CHP, CHP's integrated subcontractor, and the previous mental health Contractors. We have relied upon AHCCCS and the Contractors for the accuracy of the data and we have accepted the data without audit, after checking the data for reasonableness and consistency.

SIGNATURE ON FILE	August 27, 2025
Elizabeth Seaman Associate, Society of Actuaries Member, American Academy of Actuaries	Date

SIGNATURE ON FILE	August 27, 2025
Luna Zong Associate, Society of Actuaries Member, American Academy of Actuaries	Date

Appendix 2: Certified Capitation Rate

CHP Capitation Rate	
Effective October 1, 2025, through September 30, 2026	$1,884.14

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rate

Rate Cell	CYE 26 Projected MMs	CYE 25 Capitation Rate	CYE 25 Projected Expenses	CYE 26 Capitation Rate	CYE 26 Projected Expenses	Percentage Impact
CHP	84,099	$1,716.13	$144,325,316	$1,884.14	$158,454,508	9.79%

Appendix 4: Base Data and Base Data Adjustments

Appendix 4: Base Data and Base Data Adjustments

	I.2.B.ii.(a)	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	Subtotal
Category of Service	Base PMPM	Completion	Adjusted PMPM	Removal of DAP	Removal of Ancillary Crisis	Base Data Normalization	Removal of High-Cost Biologic	Other Base Data Adjustments	Adjusted Base PMPM
Physical Health Inpatient and LTC	$44.18	0.9418	$46.91	(3.12%)	0.00%	(5.77%)	0.00%	0.00%	$42.83
Mental Health Inpatient and LTC	$352.98	0.9374	$376.57	(1.81%)	0.00%	0.65%	0.00%	0.00%	$372.15
Outpatient Facility	$22.45	0.9383	$23.93	(3.10%)	0.00%	(4.86%)	0.00%	0.00%	$22.06
Emergency Facility	$27.53	0.9379	$29.35	(3.20%)	0.00%	(4.86%)	0.00%	0.00%	$27.03
Pharmacy	$91.66	0.9870	$92.86	0.00%	0.00%	0.38%	(21.27%)	(0.15%)	$73.28
Transportation	$38.67	0.9756	$39.64	(0.46%)	(0.01%)	(0.87%)	0.00%	0.00%	$39.11
Dental	$23.27	1.0000	$23.27	(1.32%)	0.00%	1.56%	0.00%	0.00%	$23.32
FQHC/RHC	$51.56	0.9776	$52.75	0.00%	0.00%	2.39%	0.00%	0.00%	$54.01
Laboratory and Radiology Services	$4.13	0.9792	$4.22	(0.02%)	0.00%	1.13%	0.00%	0.00%	$4.27
Other Professional Services	$111.36	0.9764	$114.06	(3.06%)	0.00%	1.13%	0.00%	0.82%	$112.73
Physical Health Practitioners	$73.16	0.9761	$74.95	(0.03%)	0.00%	0.69%	0.00%	0.00%	$75.45
Mental Health Practitioners	$110.75	0.9752	$113.57	(0.82%)	0.00%	2.92%	0.00%	(0.01%)	$115.92
Case Management	$152.25	0.9756	$156.07	(2.47%)	(0.72%)	1.70%	0.00%	0.00%	$153.68
Rehabilitation Services	$156.10	0.9754	$160.03	(1.41%)	0.00%	3.48%	0.00%	0.00%	$163.25
Residential Services	$63.32	0.9723	$65.12	0.00%	(5.32%)	9.20%	0.00%	0.00%	$67.33
Gross Medical	**$1,323.38**	**0.9637**	**$1,373.29**	**(1.54%)**	**(0.36%)**	**1.34%**	**(1.44%)**	**0.06%**	**$1,346.41**

Appendix 5: Projected Benefit Cost Trends

Rate Cell	Trend COS	Utilization per 1000	Unit Cost	PMPM
CHP	Physical Health Inpatient and LTC	0.00%	3.00%	3.00%
CHP	Mental Health Inpatient and LTC	8.00%	0.75%	8.81%
CHP	Outpatient Facility	4.25%	1.00%	5.29%
CHP	Pharmacy	3.75%	1.50%	5.31%
CHP	Transportation	3.00%	3.00%	6.09%
CHP	Dental	0.00%	0.00%	0.00%
CHP	FQHC/RHC	5.50%	3.00%	8.66%
CHP	Other Professional Services	2.50%	0.00%	2.50%
CHP	Physical Health Practitioners	4.50%	3.00%	7.63%
CHP	Mental Health Practitioners	8.00%	0.00%	8.00%
CHP	Case Management	2.00%	1.15%	3.17%
CHP	Rehabilitation Services	6.00%	0.00%	6.00%
CHP	Residential Services	8.00%	8.00%	16.64%

Appendix 6: Development of Gross Medical Component

Appendix 6: Development of Gross Medical Component

	Appendix 4	I.3.B.iii.	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	Subtotal
Category of Service	Adjusted Base PMPM	Trend	Aggregate Fee Schedule Changes	Pharmacy and Theraputics	Combined Misc. Changes	Gross Medical PMPM
Physical Health Inpatient and LTC	$42.83	3.00%	0.07%	0.00%	0.00%	$45.47
Mental Health Inpatient and LTC	$372.15	8.81%	0.00%	0.00%	0.00%	$440.63
Outpatient Facility	$22.06	5.29%	0.02%	0.00%	0.00%	$24.46
Emergency Facility	$27.03	5.29%	0.02%	0.00%	0.00%	$29.98
Pharmacy	$73.28	5.31%	0.00%	(11.47%)	(2.22%)	$70.34
Transportation	$39.11	6.09%	2.89%	0.00%	0.00%	$45.29
Dental	$23.32	0.00%	0.00%	0.00%	0.00%	$23.32
FQHC/RHC	$54.01	8.66%	21.59%	0.00%	0.00%	$77.54
Laboratory and Radiology Services	$4.27	2.50%	(0.76%)	0.00%	0.54%	$4.47
Other Professional Services	$112.73	2.50%	3.57%	0.00%	0.08%	$122.76
Physical Health Practitioners	$75.45	7.63%	1.77%	0.00%	0.00%	$88.96
Mental Health Practitioners	$115.92	8.00%	(0.09%)	0.00%	0.00%	$135.08
Case Management	$153.68	3.17%	0.00%	0.00%	0.00%	$163.59
Rehabilitation Services	$163.25	6.00%	0.00%	0.00%	0.00%	$183.43
Residential Services	$67.33	16.64%	0.00%	0.00%	0.06%	$91.65
Gross Medical	**$1,346.41**	**6.84%**	**1.36%**	**(0.61%)**	**(0.09%)**	**$1,546.96**

DAP PMPM	**$23.25**
Gross Medical Plus DAP PMPM	**$1,570.21**

Appendix 7: Capitation Rate Development

Appendix 7: Capitation Rate Development

	Appendix 6	I.4.C.ii.(c)	Subtotal	I.5.B.i.(a)	I.5.B.i.(a)	I.5.B.ii.(c)	I.5.B.ii.(c)	I.5.B.ii.(b)	Total
Rate Cell	Gross Medical Plus DAP PMPM	RI Offset PMPM	Net Medical PMPM	Admin PMPM	Care Management PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax PMPM	Capitation Rate PMPM
CHP	$1,570.21	($21.15)	$1,549.06	$151.56	$127.38	1.00%	$18.46	$37.68	$1,884.14

Appendix 8a: State Directed Payments – CMS Prescribed Tables

Appendix 8a: State Directed Payments - CMS Prescribed Tables

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

Control name of the State directed payment	Type of payment - Section I.4.D.ii.(a)(i)(A)	Brief description - Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.D.ii.(a)(iii)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	Minimum Fee Schedule	Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Arizona Medicaid State plan as a minimum fee schedule for FQHC/RHC providers.	Rate Adjustment
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
Differential Adjusted Payments (DAP) Control name: TBD	Uniform Percentage Increase	Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.	Rate Adjustment
AZ_Fee_AMC.PC.SP.D_renewal_20251001-20260930 (APSI)	Uniform Percentage Increase	91.44% increase to otherwise contracted rates for professional services provided by eligible practitioners, applicable only to services covered under the AHCCCS APSI policy.	Separate Payment Term
AZ_Fee_IPH.OPH1_Renewal_20251001-20260930 (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
AZ_Fee_IPH.OPH3_Renewal_20251001-20260930 (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

Appendix 8a: State Directed Payments - CMS Prescribed Tables

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

Control name of the State directed payment	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Impact - Section I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	The single rate cell for the CHP Program is affected.	See Appendix 8b for total impact by rate cell.	The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates. The AHCCCS DBF Rates & Reimbursement Team developed the impacts of bringing the base FQHC/RHC encounter data up to the projected CYE 26 FQHC/RHC PPS rates, by applying the change in PPS rates as a unit cost change to the CYE 24 base data. The AHCCCS DBF Actuarial Team then reviewed the FQHC/RHC results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting category of service as part of the overall fee schedule update.	Not applicable.	Not applicable.
Vaccines for Children (VFC)	The single rate cell for the CHP Program is affected.	See Appendix 8b for total impact by rate cell.	The impact of the minimum fee schedule requirement for VFC providers is addressed as part of the fee schedule updates. The AHCCCS DBF financial analyst developed the impacts of bringing vaccines administered for the VFC program to the minimum fee schedule using CYE 24 encounter data. The AHCCCS DBF Actuarial Team then reviewed these results and applied to the rate cell level as part of the overall fee schedule update.	Not applicable.	Not applicable.
Differential Adjusted Payments (DAP) Control name: TBD	The single rate cell for the CHP Program is affected.	See Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell.	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 24 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 26 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 26 (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, 2025.	Not applicable.

Appendix 8a: State Directed Payments - CMS Prescribed Tables

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_AMC.PC.SP.D_renewal_20251001-20260930 (APSI)	$3,093,063	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Access to Professional Services Initiative (APSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved SDP preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH1_Renewal_20251001-20260930 (PSI)	$1,589,431	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Pediatric Service Initiative (PSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The PSI payment arrangement 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.OPH3_Renewal_20251001-20260930 (SNSI)	$3,481,630	The actuaries certify the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Hospital Enhanced Access Leading to Safety Net Services Initiative (SNSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The SNSI payment arrangement 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.

Appendix 8b: State Directed Payments – Estimated PMPMs

CYE 26 Estimated PMPM				
State Directed Payment	Medical	UW Gain	Premium Tax	Total
FQHC/RHC	$17.79	$0.18	$0.37	$18.33
VFC	$0.36	$0.00	$0.01	$0.37
DAP	$23.25	$0.23	$0.48	$23.96
APSI	$36.04	$0.00	$0.74	$36.78
PSI	$18.52	$0.00	$0.38	$18.90
SNSI	$40.57	$0.00	$0.83	$41.40