ARIZONA HEALTH CARE
COST CONTAINMENT SYSTEM

FINANCIAL STATEMENTS,
REQUIRED SUPPLEMENTARY INFORMATION,
AND UNIFORM GUIDANCE SUPPLEMENTARY REPORTS

Year Ended June 30, 2025

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INDEPENDENT AUDITORS' REPORT

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INDEPENDENT AUDITORS' REPORT

To the Director of the

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS, an agency of the State of Arizona)

Report on the Audit of the Financial Statements

Qualified and Unmodified Opinions

We have audited the accompanying financial statements of the governmental activities, the general fund, and the aggregate remaining fund information of AHCCCS as of and for the year ended June 30, 2025, and the related notes to the financial statements, which collectively comprise AHCCCS' basic financial statements as listed in the table of contents.

Qualified Opinion on Governmental Activities and General Fund

In our opinion, except for the effects of the matter described in the Basis for Qualified Opinions on the Governmental Activities and General Fund section of our report, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities, the general fund, and the aggregate remaining fund information of AHCCCS, as of June 30, 2025, and the respective changes in financial position thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Unmodified Opinion on Aggregate Remaining Fund Information

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the aggregate remaining fund information of AHCCCS as of June 30, 2025, and the respective changes in financial position thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Qualified and Unmodified Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America ("GAAS") and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of AHCCCS and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified audit opinions.

Matter Giving Rise to Qualified Opinions on Governmental Activities and General Fund

In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the State. Since then, AHCCCS has suspended more than 300 providers while it and law enforcement agencies complete an investigation. A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney General's Office for prosecution of substantiated claims which is a highly

complex and manual process and can take many years to finalize. See Note 8 to the financial statements for further information. As a result of these matters, we were unable to obtain sufficient appropriate audit evidence for AHCCCS' receivables and other, federal revenue and due to the federal government line items as of and for the year ended June 30, 2025. AHCCCS did not make any financial statement adjustments for potential recoveries because it lacked evidence to complete the determinations necessary to support the amounts of monies it would be required to return to the U.S. government. Consequently, we were unable to determine whether any adjustments of these amounts or additional disclosures were necessary.

Emphasis of Matters

As discussed in Note 1, the financial statements of AHCCCS are intended to present the financial position and the changes in financial position of only that portion of the governmental activities, the general fund and the aggregate remaining fund information of the State of Arizona that is attributable to the transactions of AHCCCS. They do not purport to, and do not, present fairly, the financial position of the State of Arizona at June 30, 2025, or the changes in the financial position for the year then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Notes 1 and 3 to the financial statements, AHCCCS adopted Governmental Accounting Standards Board (GASB) Statement No. 101, *Compensated Absences*, during the year ended June 30, 2025. GASB Statement No. 101 was applied retrospectively, resulting in the restatement of beginning compensated absences liabilities as of July 1, 2024. Our opinion is not modified with respect to this matter.

As discussed in Notes 1 and 12 to the financial statements, AHCCCS adopted GASB Statement No. 102, *Certain Risk Disclosures*, during the year ended June 30, 2025. GASB Statement No. 102 requires governments to disclose certain concentrations and constraints that make the reporting entity vulnerable to the risk of a substantial impact when specified events have occurred or are more likely than not to occur. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about AHCCCS' ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of AHCCCS' internal control. Accordingly, we express no such opinion.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about AHCCCS' ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the audit's planned scope and timing, significant audit findings, and certain internal control related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 5 through 26, budgetary comparison schedule – general fund on page 77, schedule of the agency's proportionate share of the net pension liability – cost sharing plan on page 78, schedule of the agency's pension contributions on page 79 and schedule of changes in the agency's total OPEB liability and related ratios on page 80 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context.

We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the required supplementary information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise AHCCCS' basic financial statements. The Schedule of Expenditures of Federal Awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the Schedule of Expenditures of Federal Awards is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

AHCCCS' Schedule of Expenditures of Federal Awards is intended to present expenditures of the federal programs of the State of Arizona that are administered by AHCCCS. AHCCCS' Schedule of Expenditures of Federal Awards does not purport to, and does not, present fairly, all the expenditures of federal awards of the State of Arizona.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated September 14, 2026 on our consideration of AHCCCS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of AHCCCS' internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering AHCCCS' internal control over financial reporting and compliance.

CBIZ CPAs P.C.

September 14, 2026

MANAGEMENT'S DISCUSSION AND ANALYSIS

Management's Discussion and Analysis
For the Fiscal Year Ended June 30, 2025

Management of the Arizona Health Care Cost Containment System ("AHCCCS" or the "Agency") provides this Management's Discussion and Analysis for the benefit of the readers of the AHCCCS financial statements. This narrative overview and analysis of the financial activities of AHCCCS is for the fiscal year ended June 30, 2025. The intent of this discussion and analysis is to look at AHCCCS' performance as a whole. We encourage readers to consider this information in conjunction with the basic financial statements and related footnotes that follow this section.

Financial Highlights

Government-Wide

The assets and deferred outflows of resources of AHCCCS exceeded its liabilities and deferred inflows of resources at fiscal year end June 30, 2025, by $581.2 million. AHCCCS' net position at June 30, 2025 is comprised of a restricted net position of $53.4 million, an unrestricted net position of $524.2 million and net investment in capital assets of $3.6 million.

AHCCCS' net position increased by $86.7 million during fiscal year 2025. The increase is primarily due to a decrease in enrollment of 10.6 percent from June 30, 2024 to June 30, 2025. During the Fiscal Year, although enrollment has decreased by 10.6 percent, the average per member cost has increased. As caseload has declined, the remaining population has higher health care needs on average. Additionally, another factor increasing net position is due to surplus appropriation, whereby unspent allocations were retained from decreased enrollment, bolstering reserves. Together, these factors enabled AHCCCS to enhance its fiscal position and strengthen financial stability when cost reductions and retained funds outpace revenue declines.

Fund Level

As of the close of fiscal year 2025, AHCCCS' total governmental funds reported an ending fund balance of $675.0 million, an increase of $98.7 million from fiscal year 2024. Total AHCCCS program expenses increased to $23,232.2 million from $21,689.9 million in fiscal year 2024, resulting in an overall increase. The $98.7 million ending fund balance increase is due to decreases in enrollment of 10.6 percent. The fund balance is also affected by normal operations due to the variances that can occur in how covered members utilize health care service expenditures, as well as the impact of year-end accrual transactions for such items as the multiple open contract year-end risk sharing reconciliations AHCCCS has with the contracted managed care organizations along with earned differential adjustment payments to certain qualifying providers.

AHCCCS is a $23,232.2 million cash or near cash basis program providing comprehensive physical and behavioral health, substance abuse and related services for eligible Arizona citizens. The $1,542.3 million increase is due to the increase in the average per member cost despite the decrease in enrollment of 10.6 percent from June 30, 2024 to June 30, 2025.

More detailed information regarding the government-wide financial statements and fund level financial statements can be found below.

Overview of the Financial Statements

AHCCCS' basic financial statements are comprised of three components: 1) government-wide financial statements, 2) fund financial statements and 3) notes to the financial statements.

Government-Wide Financial Statements (Reporting AHCCCS as a Whole)

The Government-Wide Financial Statements are designed to provide readers with a broad overview of AHCCCS' finances that are comparable to a private-sector business. The Statement of Net Position and the Statement of Activities are two financial statements that report information about AHCCCS as a whole and its activities. The presentation in these statements is intended to help answer the question: is AHCCCS, as a whole, better off or worse off financially as a result of this year's activities? These financial statements are prepared using the flow of economic resources measurement focus and the full accrual basis of accounting. They take into account all revenues and expenses connected with the fiscal year even if the cash involved has not been received or paid out.

The Statement of Net Position (page 27) presents information on all of AHCCCS' assets and deferred outflows of resources and liabilities and deferred inflow of resources, with the difference between the two reported as "net position". Over time, increases or decreases in net position, along with other financial information, serve as indicators of AHCCCS' financial position and whether it is improving or deteriorating.

The Statement of Activities (page 28) presents information showing how AHCCCS' net position changed during the most recent fiscal year. All changes in net position are reported as soon as the underlying events giving rise to the change occur, regardless of the timing of related cash flows. Therefore, revenues and expenses are reported in this statement for some items that will result in cash flows in future fiscal periods (e.g. incurred but not paid or reported fee-for-service and reinsurance claims, managed care organization risk sharing medical loss reconciliation, revenue from future Tobacco Master Settlement Agreement payments, prescription drug rebate receipts, earned but unused vacation leave, and unfunded pension benefit). Governmental Activities include state appropriations along with federal, county, and other local government intergovernmental revenues and member premium collections that primarily support the activities in this category.

The governmental activities of AHCCCS consist of programs authorized by the Social Security Act Titles XIX ("Medicaid") and XXI (Children's Health Insurance Program ("CHIP")) and behavioral health services funded from Federal Block Grants and state appropriations targeted to specific needs of individuals with serious mental illness ("SMI"). All these services are concentrated on the health and related needs of the citizens of Arizona primarily through direct health care service payments, supplemental payments to qualifying hospital facilities and prevention services provided throughout the State. The majority of the activities are reported in these categories.

The government-wide financial statements can be found on pages 27 and 28.

Fund Financial Statements (Reporting AHCCCS' Major Funds)

A fund is a legislatively authorized fiscal and accounting entity with a self-balancing set of accounts that AHCCCS uses to keep track of specific sources of funding and spending for specific activities or objectives. AHCCCS, like other State agencies, uses fund accounting to ensure and demonstrate compliance with legislative appropriation funding requirements.

Governmental funds - Governmental funds are used to account for essentially the same functions reported as governmental activities in the government-wide financial statements. However, unlike the government-wide financial statements, the governmental funds financial statements focus on near- term inflows and outflows of spendable resources, as well as on balances of spendable resources available at the end of the fiscal year. Such information may be useful in evaluating a government's near-term financial position and requirements. This approach is known as using the flow of current financial resources measurement focus and the modified accrual basis of accounting. These financial statements provide a short-term view of AHCCCS' finances that assists management in determining whether there will be adequate financial resources available to meet current needs. When an asset is recorded in governmental fund financial statements, but the revenue is not available, AHCCCS reports a deferred inflow of resources until such time as the revenue becomes available. Because the focus of governmental funds is narrower than that of the government-wide financial statements, it is useful to compare the information presented for governmental funds with similar information presented for governmental activities in the government-wide financial statements. By doing so, readers may better understand the long-term impact of the State's near-term financial decisions. Both the governmental fund balance sheet and the governmental fund statement of revenues, expenditures and changes in fund balances provide a reconciliation to facilitate this comparison between governmental funds and governmental activities. The basic governmental fund financial statements and related reconciliation can be found on pages 29 through 31 of this report.

AHCCCS reports two fund categories: General Fund and Other Governmental Funds. Information on these funds is presented separately in the governmental fund balance sheet and in the governmental fund statement of revenues, expenditures, and changes in fund balances.

Annually, the Legislature adopts an appropriated budget for AHCCCS that funds fully integrated acute care and long-term care services categorized as Traditional Medicaid services, Proposition 204 (includes childless adults up to 105% of the federal poverty level “FPL”) services, Patient Protection and Affordable Care Act ("ACA") Adult Expansion (childless adults between 106% and 136% of the FPL), KidsCare, Arizona Long Term Care Services (ALTCS), and the Department of Child Safety Comprehensive Health Plan. Additionally, supplemental payments are made to the Disproportionate Share Hospital ("DSH"), Rural Hospital; Graduate Medical Education ("GME"), nursing facility programs, non-Title XIX SMI, substance abuse and supported housing services, targeted investments program for incentive payments to certain providers who develop clinical processes that integrate physical and behavioral health care delivery and for AHCCCS administration costs. The annual appropriation is made separately for both the State share of the required matching funds and federal financial participation funds from Title XIX Medicaid and Title XXI CHIP. In addition to the appropriations and expenditure authority approved by the Legislature, AHCCCS also expends continuously appropriated funds for medical service payments from third party liability recovery program activities, electronic health records infrastructure development, certain payments to hospitals for unfunded emergency department readiness costs and level 1 trauma center costs, and behavioral health block and discretionary grants. A budgetary comparison statement has been provided for the General Fund only to demonstrate compliance with the legislative budget on page 77.

Notes to the Financial Statements

The notes to the financial statements provide additional information that is essential to a full understanding of the data provided in the government-wide and fund financial statements. The notes to the financial statements can be found on pages 32 to 76.

Government-Wide Financial Analysis

As noted earlier, the net position may serve over time as a useful indicator of a government agency's financial position.

AHCCCS Net Position
(in thousands of dollars)

	Governmental Activities	
	2025	2024 (as restated)
Current assets	$ 4,618,179	$ 4,268,331
Noncurrent assets	5,520	20,889
Total assets	4,623,699	4,289,220
Deferred outflows of resources	19,233	19,126
Current liabilities	3,940,509	3,693,208
Long-term liabilities	97,414	95,151
Total liabilities	4,037,923	3,788,359
Deferred inflows of resources	23,825	25,541
Net position		
Net investment in capital assets	3,589	18,115
Restricted	53,383	90,523
Unrestricted	524,212	385,808
Total net position	$ 581,184	$ 494,446

For AHCCCS, assets and deferred outflows of resources exceeded liabilities and deferred inflows of resources by $581.2 million at June 30, 2025, as compared to assets and deferred outflows of resources in excess of liabilities and deferred inflows of resources in the amount of $494.4 million at June 30, 2024.

The total government-wide net position increased by $86.7 million. Despite a decrease in enrollment of 10.6 percent from June 30, 2024 to June 30, 2025, the increase is due to an increase in the average per member cost. As caseload has declined, the remaining population has higher health care needs on average. In addition, there were increases in the funding received for certain health programs where the final determination of costs is dependent on future reconciliations that are not estimable at the present and are dependent on provider performance to meet certain criteria and/or thresholds. Additionally, excess hospital assessment collections will be available to fund future eligible costs but are dependent on legislative appropriations.

AHCCCS Changes in Net Position
(in thousands of dollars)

	Governmental Activities	
	2025	2024 (as restated)
Revenues		
Program revenues		
Charges for services	$ 238	$ 15
Other operating grants and contributions	2,493,586	2,312,636
Federal operating grants	16,986,118	16,241,230
General revenues		
State appropriations	3,839,140	3,205,169
Tobacco Tax	93,323	104,758
Other	-	(190)
Total Revenue	23,412,405	21,863,618
Expenses		
Health care	23,232,161	21,689,874
Excess before transfers	180,244	173,744
Transfers, net	(93,506)	(158,455)
Change in net position	86,738	15,289
Net position - beginning of year	494,446	479,157
Net position - end of year	$ 581,184	$ 494,446

COVID-19

On March 11, 2020, the World Health Organization declared the outbreak of a respiratory disease caused by a new coronavirus as a "pandemic". First identified in late 2019 and now known as COVID-19, the outbreak has impacted millions of individuals worldwide. In response, many countries implemented measures to combat the outbreak which have impacted global business operations.

In response to the growing COVID-19 pandemic, on March 18, 2020, President Trump signed into law H.R. 6021, the Families First Coronavirus Response Act ("FFCRA") (Pub. L. 116-127). Section 6008 of the FFCRA provided a temporary 6.2 percent increase to the Federal Medical Assistance Percentage (“FMAP”) extending through the last day of the calendar quarter in which the Public Health Emergency (“PHE”) terminates. One of the conditions of receipt of the enhanced federal match was a maintenance of effort ("MOE") requirement, prohibiting the agency from terminating the enrollment of any individual that was enrolled in the program as of the date of the beginning of the PHE period, as well as individuals enrolled during the PHE period. This condition had a significant impact on AHCCCS' enrollment. It required that the State continue coverage for members who may have had a change in income that would otherwise result in discontinuance. On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted, which further clarified that states could begin redeterminations in February 2023 with the disenrollments beginning April 2023 and prescribed that the 6.2 percentage point increase to the FMAP will be phased out over the course of Calendar Year 2023. The enhanced FMAP was 6.2 percentage points through the quarter ended March 31, 2023, 5.0 percentage points in the quarter ended June 30, 2023, 2.5 percentage points in the quarter ended September 30, 2023, and 1.5 percentage points in the quarter ended December 31,

2023. Although the FMAP increase is no longer directly tied to the end of the PHE, the Department of Health and Human Services expired the PHE as of May 11, 2023. Effective April 2023, AHCCCS began processing eligibility redeterminations. In April 2023, AHCCCS enrollment was 2,492,034. By June 30, 2024, AHCCCS enrollment was 2,204,281, a decrease of 287,753. By June 30, 2025, AHCCCS enrollment was 1,971,674, an additional decrease of 232,607 compared to the April 2023 enrollment number. In fiscal year 2025 enrollment decline was primarily driven by the on-going post-pandemic 'unwinding' process, where regular eligibility renewals resumed. Members who no longer qualified or failed to complete renewal paperwork were disenrolled. Increased frequency of income monitoring by DES is likely contributing to eligibility changes across multiple programs, including Medicaid. Because income changes identified through these reviews must be evaluated for both Supplemental Nutrition Assistance Program ("SNAP") and Medicaid eligibility, enhanced monitoring implemented in response to SNAP payment accuracy concerns may also be contributing to Medicaid disenrollments. Some enrollment changes likely reflect normal shifts in household circumstances, including income increases and transitions to other forms of coverage, such as employer-sponsored insurance. Enhanced data sharing practices helped the agency to better determine eligibility.

Following the national and state emergency declarations in March 2020, AHCCCS received authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. Some of these flexibilities are: expanded coverage of telehealth and telephonic codes reimbursed at the same level of reimbursement offered for in-person services; initiatives to support use of influenza vaccinations during the COVID outbreak; increase in annual hours of respite care; reimbursement of Home and Community Based Services provided by parents; elimination of the 40 hour limit on family caregiver services provided by a member's spouse; expand the provision of home delivered meals to members enrolled in Department of Economic Security/Developmental Disabilities ("DES/DD"); and allowance for students to receive medically necessary services from managed care organizations ("MCOs") rather than the Medicaid School Based Claiming program as children attend school virtually from home. The CMS approvals were granted in late March to early April 2020.

In addition to the program flexibilities, COVID-19 impacted some of the agency's collection activities. CMS approved AHCCCS' request for emergency authorities to support Arizona's response to COVID-19. For the duration of the PHE, AHCCCS waived payment of the provider enrollment application fee as well as suspended the application of premiums for children enrolled in Arizona's CHIP program (KidsCare) and adults in the Freedom-to Work program. AHCCCS resumed billing providers the enrollment application fee in April 2022. In addition, AHCCCS resumed billing premiums for adults in the Freedom-to-Work program in September 2024.

The Substance Abuse and Mental Health Services Administration ("SAMHSA") awarded AHCCCS grants to address the behavioral health impacts due to the pandemic. These grants include the following:

- COVID-19 Block Grants for Prevention and Treatment of Substance Abuse
- COVID-19 Block Grants for Community Mental Health Services

Adjustments for Disaster-Recovery States to the Fiscal Year 2024 and Fiscal Year 2025 Federal Medical Assistance Percentage (FMAP) Rates

On November 29, 2024, the Health and Human Services Department announced adjusted Federal Medical Assistance Percentage (FMAP) rates for the Federal Fiscal Year 2024 and Federal Fiscal Year 2025 for disaster-recovery FMAP adjustment States made available under the Social Security Act (the "Act"), as enacted in section 2006 of the Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act"). The Social Security Act adjusts the regular FMAP rate for qualifying states that have experienced a major, statewide disaster. The percentages listed are for Federal Fiscal Year 2024, retroactively effective from October 1, 2023, through September 30, 2024, and for Federal Fiscal Year 2025, effective October 1, 2024, through September 30, 2025. The disaster-recovery adjusted FMAP rates for federal fiscal year 2024 and 2025 are 67.93% (up from 66.29%) and 65.65% (up from 64.89%), respectively. AHCCCS has incorporated the adjusted FMAP rates for the respective Federal Fiscal Years.

American Rescue Plan Act (ARPA)

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 ("ARPA") (Pub.L.117-2) into law. Some of the provisions of the ARPA impacting fiscal 2025 and 2024 include:

- In fiscal year 2024, AHCCCS paid $408.3 million in ARPA Administrative Initiative and Programmatic Expenditures utilizing $136.1 million of the previously mentioned additional 10 percent and drew in another $272.3 million Federal dollars.
- In fiscal year 2025, AHCCCS paid $208.9 million in ARPA Administrative Initiative and Programmatic Expenditures utilizing $56.5 million of the previously mentioned additional 10 percent and drew in another $152.4 million Federal dollars.

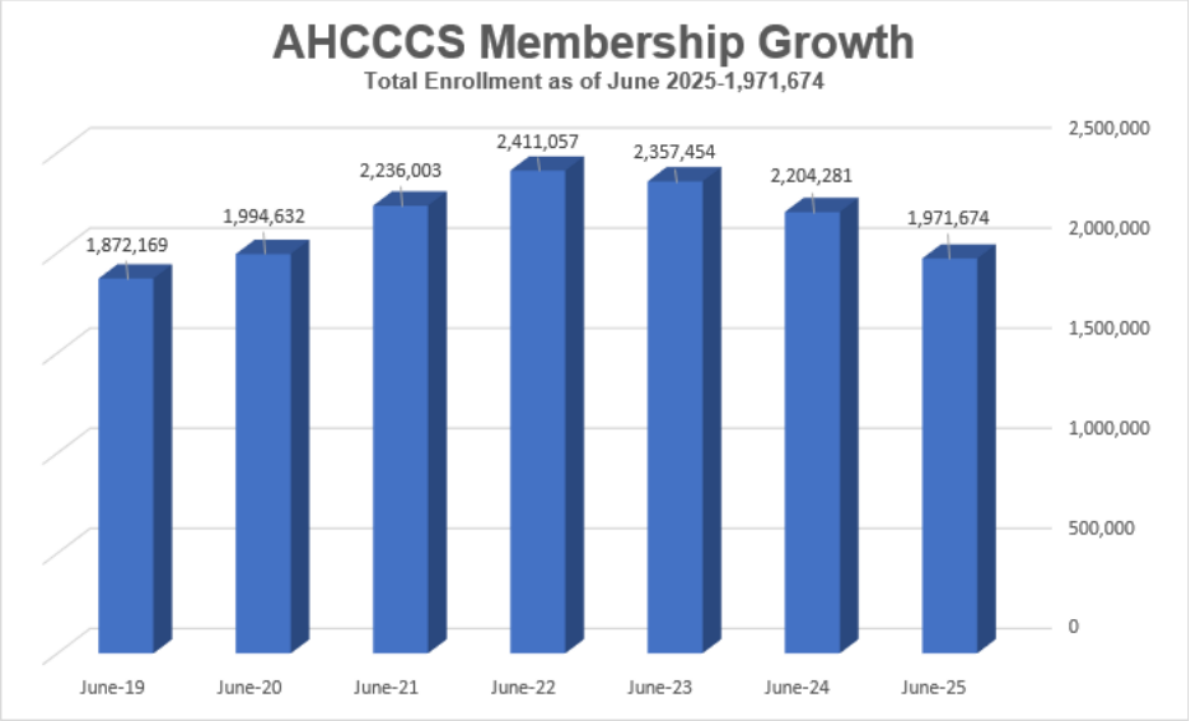
Governmental Activities

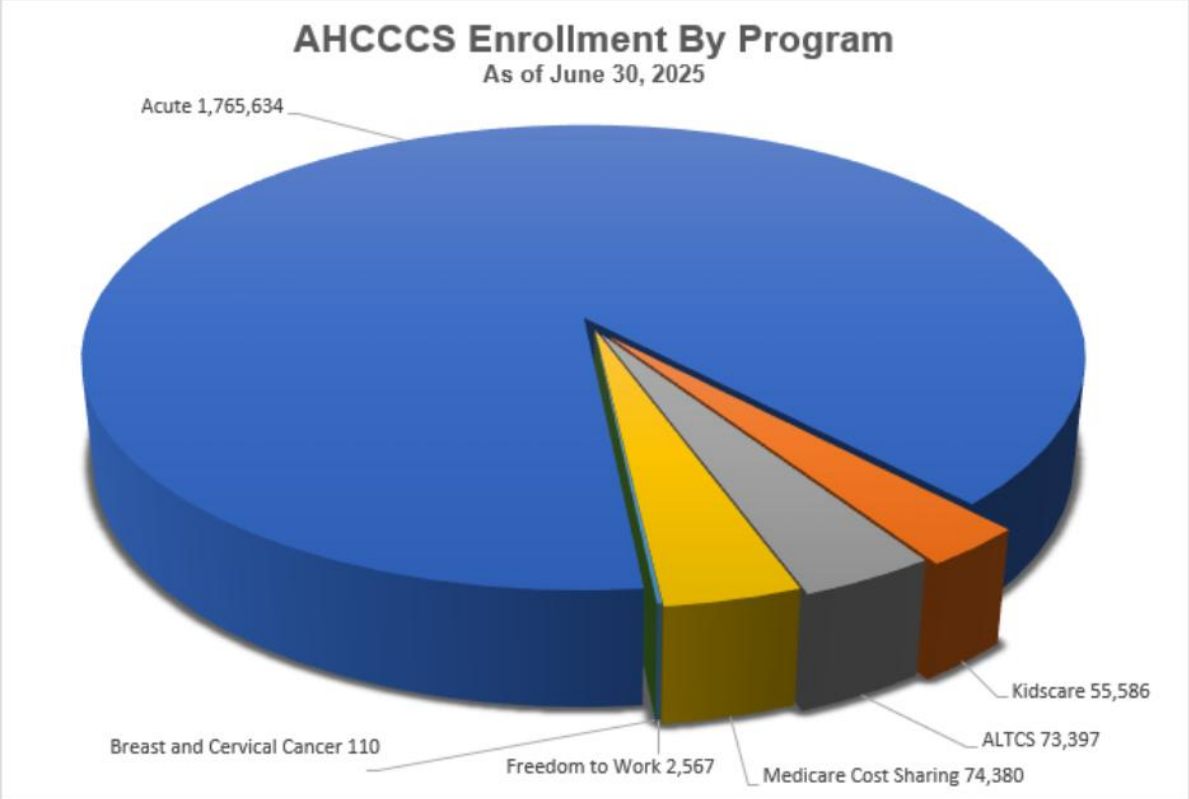
The primary driver of agency expenditures is enrollment in AHCCCS programs. In fiscal year 2025, total enrollment for all of AHCCCS' programs at June 1, 2025, was 1,971,674, a decrease of 232,607 members (10.6 percent decrease) from June 1, 2024. The fiscal year 2025 decrease comes after a 153,173 decrease from fiscal year 2024. In fiscal year 2025 enrollment decline was primarily driven by the on-going post-pandemic ‘unwinding’ process, where regular eligibility renewals resumed. Members who no longer qualified or failed to complete renewal paperwork were disenrolled. Increased frequency of income monitoring by DES is likely contributing to eligibility changes across multiple programs, including Medicaid. Because income changes identified through these reviews must be evaluated for both SNAP and Medicaid eligibility, enhanced monitoring implemented in response to SNAP payment accuracy concerns may also be contributing to Medicaid disenrollments. Some enrollment changes likely reflect normal shifts in household circumstances, including income increases and transitions to other forms of coverage, such as employer-sponsored insurance. Enhanced data sharing practices helped the agency to better determine eligibility.

AHCCCS' Medicaid program in Arizona covers approximately one-third of the Arizona population, two-thirds of nursing facility days, and approximately fifty percent of all births in the state.

AHCCCS' actual enrollment decreased in fiscal years 2023, 2024 and 2025 in contrast to the steady increases in fiscal years 2019 through 2022, after the decline experienced in fiscal year 2018. Overall, the enrollment of full-service members decreased by 228,550 members from 1,995,150 to 1,766,600 for the current fiscal year.

The following charts depict AHCCCS membership growth and enrollment by program for the reporting periods:





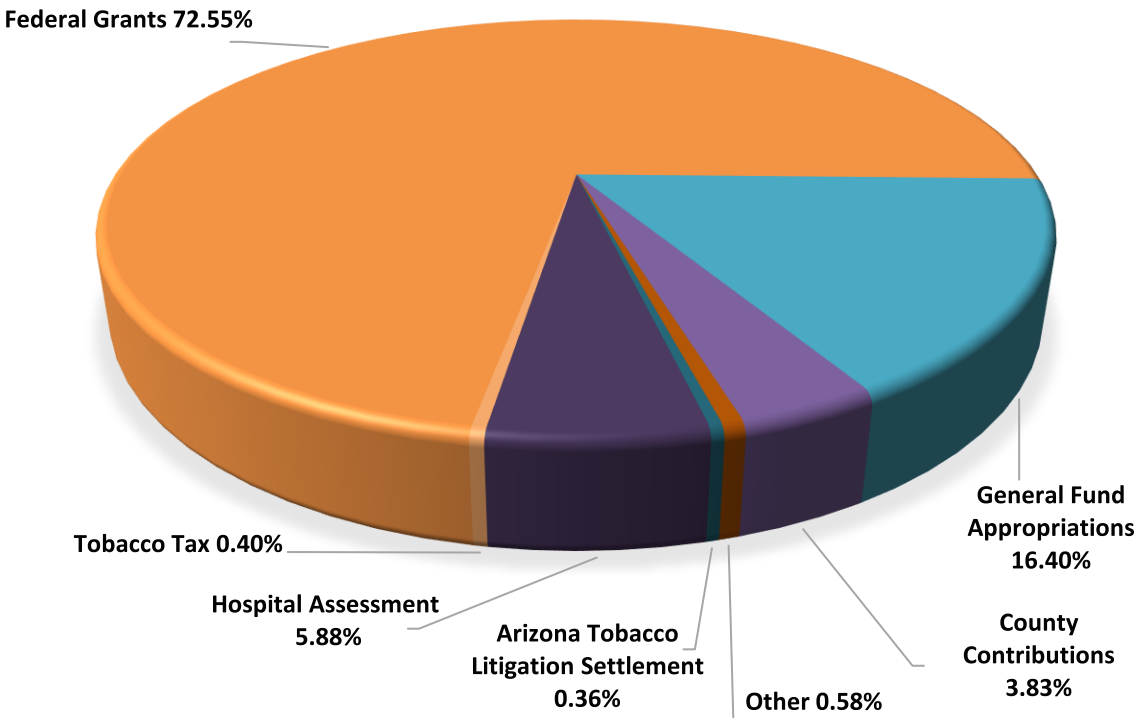
The cost of health care programs, including Medicaid, CHIP, and non-Medicaid behavioral health, totaled $23,232.2 million in fiscal year 2025, a $1,542.3 million or 7.11 percent increase from the $21,689.9 million reported in fiscal year 2024. The increase in current fiscal year program expenditures is attributable to an increase in average per member cost despite the decrease in enrollment by 10.6 percent. As shown in the statement of activities, the proportionate amount of expenditures funded from federal grants through CMS and SAMHSA increased slightly and was $16,986.1 million (73.1 percent of total) in fiscal year 2025 as compared to $16,241.2 million (74.9 percent of total) in fiscal year 2024.

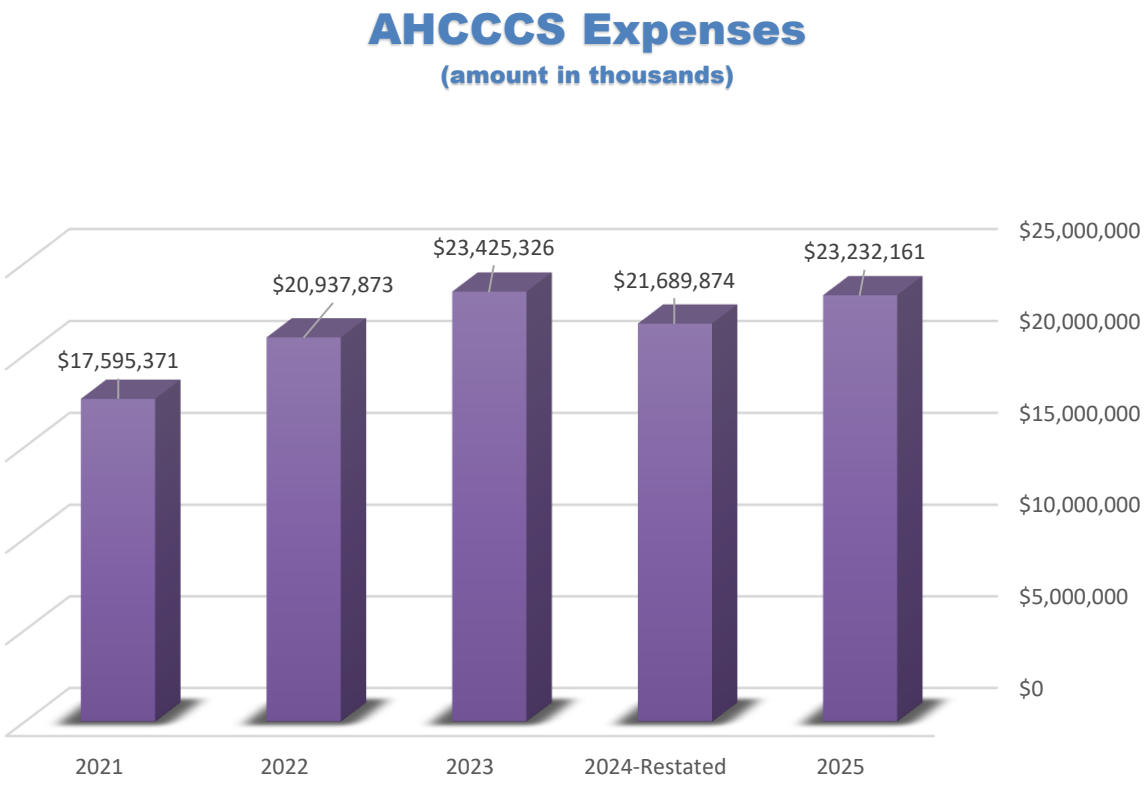
Current program funding remains significantly financed from federal financial participation primarily determined through the FMAP rate used to provide the amount of federal matching funds for qualifying State medical assistance expenditures. The FMAP is based on the relationship between Arizona's per capita personal income and the national average per capita personal income over three calendar years. The FMAP is recalculated each federal fiscal year and was at 67.93 percent through the first quarter of fiscal year 2025. The FMAP rate was reduced to 65.65 percent for the second through fourth quarters of state fiscal year 2025. Effective January 1, 2020, the Federal government enacted the Families First Coronavirus Response Act which provided an increase in the FMAP rate of 6.2 percent. In addition to the FMAP, the ACA introduced multiple new rates for the various new eligibility categories covered under the expansion. In Arizona, additional rates are applied to ACA expansion (adults and children) and Proposition 204 restoration (adult) covered populations. These new rates were all in excess of the "regular" 70.01 percent FMAP with the rates for both the expansion state (childless adults – 0 % to 105% FPL) and the newly eligible adults (adults - 106% to 135% FPL) remaining the same for both federal fiscal year 2021 and federal fiscal year 2022. On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted and prescribed that the 6.2 percentage point increase to the FMAP would be phased out over the course of calendar year 2023. The enhanced FMAP was 6.2 percentage points through the quarter ended March 31, 2023, 5.0 percentage points in the quarter ended June 30, 2023, 2.5 percentage points in the quarter ended September 30, 2023, and 1.5 percentage points in the quarter ended December 31, 2023. These older FMAP rates are still relevant as AHCCCS continues to complete contracted health plan reconciliations for older contract years.

State, county and miscellaneous funding sources combined to provide $6,426.3 million in State funding sources and appropriations in fiscal year 2025, an $803.9 million increase over the $5,622.4 million reported in fiscal year 2024. This increase is related to state appropriation increases, county contributions, capitation rate increases, increases in hospital assessments and opioid substance use disorders. The following are the components of the State match funding sources utilized in fiscal year 2025. State General Fund revenues raised primarily in the form of income and sales taxes directed to AHCCCS amounted to $2,722.8 million, and an additional $1,116.3 million was passed through from other State agencies in order to provide the State's share for Medicaid eligible medical assistance expenditures. Arizona counties contributed $896.6 million as determined by statutory funding formulas, session law and other intergovernmental agreements. Tax collections on tobacco products provided $93.3 million in State match funding. An additional $83.7 million in State revenue funding was provided by Arizona's share of tobacco litigation settlement funds. The master settlement agreement ("MSA") revenues are recorded in accordance with the Governmental Accounting Standards Board ("GASB") Technical Bulletin No. 2004-1, Tobacco Settlement Recognition and Financial Reporting Entity Issues, which clarifies how payments made to AHCCCS pursuant to the MSA with major tobacco companies, are recorded. The MSA payment decreased in fiscal year 2025. AHCCCS has accrued $51.0 million for the period January 1, 2025 through June 30, 2025, based on Arizona's Joint Legislative Budget Committee 2025 estimated payment. The amounts of the payments are dependent upon several adjustments, the magnitude of which will not be fully known until an independent auditor provides its calculations in February or March of each year. Other factors that could also affect the MSA payment amount AHCCCS ultimately receives include default or bankruptcy by one or more tobacco companies and other unforeseen withheld payment amounts. Finally, Tribal gaming receipts determined by statutory formula distributed to AHCCCS provided $41.3 million in additional funding.

The following charts depict revenues by source of the governmental activities for the fiscal year and expenses for the reporting period:

AHCCCS REVENUE BY REVENUE SOURCE - GOVERNMENTAL ACTIVITES FISCAL YEAR 2025





Financial Analysis of AHCCCS' Governmental Funds

Governmental Funds

AHCCCS' governmental funds reported combined ending fund balances totaling $675.0 million, a $98.7 million net increase from the prior year's $576.3 million ending fund balances. The increase was partially due to an increase in the Hospital Assessment Fund balance due to a decrease in the Proposition 204 and Adult Expansion enrollment. This resulted from the Hospital Assessment being set prior to the fiscal year, based on budgeted assumptions, including projected enrollment growth, which are codified in rule and difficult to adjust mid-year. When actual enrollment declined instead of growing as anticipated, the pre-determined assessment amount exceeded the funds needed for disbursement, causing the fund balance to rise, with adjustments typically deferred to the following year's assessment due to the complexity of mid-year changes.

The General Fund is the chief operating fund of the AHCCCS Traditional Medicaid, KidsCare, Department of Child Safety Comprehensive Health Plan, ALTCS for both physical and behavioral health services, DSH, Rural Hospital, and services for non-Medicaid eligible members with SMI programs. The Other Governmental Fund, which includes the Hospital Assessment Fund, is the chief operating fund of the Proposition 204 services and ACA Adult Expansion programs. These programs primarily utilize a State general fund appropriation and/or revenue sources from the hospital assessments, annual tobacco litigation settlement proceeds, taxes on tobacco products, contributions

from Arizona counties, certified public expenditure methodologies, prescription drug rebate collections, voluntary contributions of the required state match from political subdivisions and certain provider type assessed taxes to provide the required state matching funds for federal Medicaid revenue. AHCCCS also has authority to make supplemental distributions to hospitals for the GME and DSH programs funded by voluntary contributions of the required state match from political subdivisions.

The Other Governmental Funds consist of twenty individual funds comprising the $311.2 million of the total $675.0 million fund balance available for qualifying activities. The Other Governmental Funds' fiscal year 2025 fund balances consist of restricted fund balances of $1.3 million, committed fund balances of $308.6 million, and assigned fund balances in the amount of $1.3 million. Revenue from taxes on cigarettes and other related tobacco products generated $65.0 million for the current year compared to $72.9 million in fiscal year 2024. Since the passage of Proposition 203 in November 2006, tobacco tax collections remain significantly lower than the $148.1 million collection high point in fiscal year 2006. Revenues from the Proposition 204 hospital assessment generated $672.0 million in fiscal year 2025 in available state matching monies for program services that increased from the $628.2 million in fiscal year 2024.

Budgetary Highlights

Differences totaling a decrease of $154.1 million occurred between the original and the final amended administrative and programmatic expenditure budgets. In addition to the appropriation for fiscal year 2025, $1.8 million was appropriated from the State general fund for eligibility income verification costs. On the same bill, $94.1 million was reduced from appropriations made from the state general fund to AHCCCS for adjustments in formula requirements. Additionally, the appropriated amounts for the voluntary payments from political subdivisions related to DSH and GME supplemental hospital payments are eligible to be increased for any political subdivision funds including the federal matching monies in excess of the original appropriation. For fiscal year 2025, the voluntary line items for GME Federal expenditure authority were not increased. For fiscal year 2025, there was no increase for the voluntary line items for DSH. For fiscal year 2025, the voluntary line items for Nursing Facilities Federal expenditure authority were not increased. Other differences relate to special line-item adjustments that utilized surpluses from one line item to offset shortfalls in another line item. These appropriation transfers are approved by the General Accounting Office and the Governor's Office of Strategic Planning and Budgeting and are in accordance with legislative authority.

Laws 2025, Chapter 233, Sections 101 and 102 (SB1735) provided the special line items which are briefly summarized as follows:

- $1.8 million increase to the DES Eligibility Administration line.
- $94.1 million decrease to AHCCCS Medicaid Services lines.

For the year ended June 30, 2025, actual cash basis appropriated program expenditures for the General Fund were $874.9 million less than budgetary estimates.

Capital Asset Administration

AHCCCS' capital assets for its governmental activities as of June 30, 2025, are $5.5 million, net of accumulated depreciation and amortization. Capital assets include furniture, vehicles, equipment, and internally generated software (intangible assets) for projects started after June 30, 2009. Land, buildings and improvements are under the management of the State and are separately accounted for on the State's annual comprehensive financial report. Total net capital assets decreased by $15.4 million or 73.6 percent over the prior fiscal year balance. The largest component of AHCCCS' investment in capital assets continues to relate to internally developed software. The remaining capital asset changes are for disposals in excess of additions including depreciation of vehicles, furniture and equipment. The decrease in capital assets is mainly driven from the decrease in software. During the normal course of business, the agency did not have the need to add capital assets for fiscal year 2025. The combination of no new purchases during the fiscal year and depreciation/amortization of existing assets resulted in an overall decrease of the agency's capital assets.

	Governmental Activities	
	2025	2024
Vehicles, furniture & equipment	$ 60	$ 132
Software	3,617	18,085
Right-to-use asset – Building	544	952
Right-to-use asset – Subscriptions	1,299	1,720
Total investment in capital assets	$ 5,520	$ 20,889

Additional information on AHCCCS' capital assets can be found in Note 2 to the accompanying financial statements.

Contingent Liabilities

In January 2001, AHCCCS obtained a Waiver from CMS to receive federal funding for certain non-categorically linked populations including those made eligible by the November 2000 passage of Proposition 204. The Waiver requires that over the term of the original agreement (April 1, 2001 through September 30, 2011) and the new agreement (October 1, 2011 through September 30, 2021), that the population covered by the Waiver be budget neutral for CMS. It should be noted that on September 30, 2021, the waiver was extended for one additional federal fiscal year ending September 30, 2022. On September 27, 2022, CMS approved a temporary extension of the Waiver to October 28, 2022, in order to allow Arizona and CMS to continue negotiations over the extension application. On October 14, 2022, CMS extended the Waiver through September 30, 2027. Budget neutral means that CMS will not pay more for medical services with the Waiver than it would without the Waiver. The Waiver Special Terms and Conditions include a monitoring arrangement that requires AHCCCS to report the financial results of the Waiver on a quarterly basis. For the demonstration period beginning on October 1, 2016, the net variance is phased down by an applicable percent. The percentages are determined based on how long the Medicaid population has been enrolled in managed care subject to the demonstration. Under the terms, AHCCCS is limited to only retaining 25 percent of the total variance as future savings. The budget neutrality calculation is dependent on a number of variables including the number of members and the eligibility category of members. Other factors that impact the variance are the general economy and its impact on unemployment, medical inflation and policy decisions made by the Legislature that may impact program costs. Through June 30, 2025, AHCCCS remains under the cumulative reporting limit threshold for the current waiver. Accordingly, management is projecting zero liability as of June 30, 2025 to CMS related to the budget neutrality agreement and the accompanying financial statements have not been adjusted for the impact of any liability AHCCCS may have related to the Waiver budget neutrality agreement.

In fiscal 2017, the U.S. Department of Health and Human Services ("DHHS") Office of the Inspector General ("OIG") commenced a review of managed care drug rebates in Arizona for 2010 – 2013. The HHS OIG issued a report in February 2018 for their review of managed care drug rebates in Arizona from April through March 2013. The OIG's report noted instances in which physician-administered drugs were not properly submitted to the drug manufacturers for rebate. The HHS OIG recommended AHCCCS bill and collect from manufacturers, work with CMS to determine other physician-administered drugs were eligible for rebates and, if so, return the federal share.

This audit, Arizona Pharmacy Rebate Audit – AZ Audit A-09-16-02031, has been pending with CMS for several years, and no adverse findings have been issued. Their latest communication to AHCCCS, dated August 16, 2022, states they have been working with federal OIG and the CMS Division of Pharmacy and are close to a decision on the audit.

It is unclear if AHCCCS will be able to collect rebates from the drug manufacturers on such old claims. As such, AHCCCS views any recoveries as a gain contingency and will not record any amounts until received. Further, as the repayments to CMS are predicated on the receipt of the drug rebates, AHCCCS has not recorded any liability to CMS as of June 30, 2025.

On November 13, 2025, HHS OIG notified AHCCCS of their intention to conduct an audit of rebates for physician-administered and pharmacy drugs claimed by AHCCCS. The objective of the audit is to determine whether AHCCCS complied with Federal Medicaid requirements for billing manufacturers for rebates for physician-administered and pharmacy drugs. The audit period will include physician-administered and pharmacy drug claims paid during the period January 1, 2023, through September 30, 2025. As of the date of these financial statements, the audit is ongoing, and no findings have been issued. AHCCCS is in the process of gathering and providing documentation and responding to information requests related to this audit. Management is actively cooperating with HHS OIG to facilitate a thorough review, and we will evaluate any developments for appropriate recognition or further disclosure in subsequent periods.

Provider billing matter - AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in outpatient behavioral health services. AHCCCS connected the irregular billing with alleged criminal activity targeting tribal communities and other Arizonans.

Under 42 C.F.R. 455.23, when the State Medicaid Agency has conducted a preliminary investigation and a reliable indicia of fraud has been identified, the agency must suspend payments to a provider if a law enforcement agency accepts the State's referral unless good cause is established pursuant to federal regulations. In AHCCCS's case, a Memorandum of Understanding governs the referral relationship between AHCCCS Office of the Inspector General and the Arizona Attorney General's Office, Health Care Fraud & Abuse Section. At the point a referral is made and payment is suspended, only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation AHCCCS will terminate a provider's enrollment and require repayment of the identified overpayment as a result of a fraud determination.

In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the State. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program. As the extent of the fraud was revealed, AHCCCS recognized the need for holistic and systemwide changes. AHCCCS partnered with the Attorney General and Governor's Office to develop a comprehensive plan to address the fraudulent providers. Stop gap strategies implemented include, but are not limited to the following:

- Increased scrutiny of claims based on claims volume.
- Issued a moratorium on new provider registrations for impacted provider types
- Prevented Reimbursement of Claims for Impossibly Rendered Services

- Claims for Substance Abuse Services for Children under the age of 12 to Require Clinical Review Prior to Payment
- Set thresholds for services to initiate a prepayment review.
- Required claims to be billed for specific dates of service rather than ranges.
- Flagged claims for services of the same style/overlapping codes.
- Created a prepayment review process for providers utilizing suspicious billing practices.
- Eliminated retroactive billing.
- Credible Allegation of Fraud ("CAF") suspensions include both provider entities and owners/ behavioral health ("BH") practitioners.
- Implemented ID.Me identity verification for AHCCCS Online.
- Required providers to disclose any third-party billing relationships.
- Behavioral Health Providers are now considered high-risk provider types for provider enrollment.
- Per Diem codes have been set to only be able to be billed once per day.
- Practitioners, including Behavioral Health Technicians, can no longer be patients at the same provider.
- Worked with the Arizona Corporation Commission to flag suspicious registrations.
- Ensured AHCCCS coding adhered to National Correct Coding Initiative ("NCCI") standards and confirmed no edits had been turned off.
- Streamlined AHCCCS reporting of potential inappropriate conduct of licensed professionals to the appropriate professional oversight boards.
- Implemented eligibility integrity requirements for AIHP enrollment.
- Linked BHPs to BH companies they work for.
- Linked BH Providers to BH facilities they work at.
- Requiring medical records to define specialized services.
- Conducting onsite reviews for high risk quality of care referrals within 90 days.

Additional agency efforts since May 2023 include:

- Creation and publication of the Covered Behavioral Health Services Guide to connect all relevant AHCCCS policies and explain how they interact in the Behavioral Health System of Care
- Robust changes to our AHCCCS Provider Enrollment System to address Fraud, Waste and Abuse ("FWA") issues
- Update to the Behavioral Health Residential Facilities policy to provide greater detail and clarity for providers and members about what should and should not be included in services rendered by this provider type
- Creation of the prepayment review process for FFS claims and inclusion of data measurement to allow for agile modification going forward to respond to over utilization or abuse of codes
- Creation of the Community Partner Assistor Organization Reviews to prevent abuse of access to the HEA+ system
- Designated pathways of partnering on large scale quality of care investigations between the Division of Fee for Service and MCOs to prevent unnecessary member impact
- Social media campaign to encourage the public to report FWA/abuse & neglect
- Requirement of all providers to transition to Electronic Funds Transfer
- Removed the phone attestation option for AIHP enrollment, and are in the process of implementing the AIHP verification process with tribal partners and IHS based on utilization
- MOUs with AZ Board of BH Examiners and Board of Nursing to promote interagency information sharing and referrals, as well as the close referral relationship with ADHS
- Regular Public BH System Cross-Agency Collaboration meetings including all agencies, boards, commissions and the GO in the public health space
- Updates to the provider enrollment policy in AHCCCS Medicaid Policy Manual ("AMPM") 610, explicitly requiring many more disclosures of providers, and making it clear without full and transparent registration information, providers will be terminated or denied enrollment with AHCCCS

- Implementation of Alivia--a new AI powered data analytics platform for pre-pay and post-pay claims analysis
- Implemented policies which required Behavioral Health Professionals, required to oversee the clinical services provided at BHRFs and Outpatient Behavioral Health Clinics, to be reported upon registration and be listed on claims submissions

Stop gap strategies in process include, but may not be limited to, the following:

- Conducting onsite quality of care reviews for patients in treatment longer than 90 days.
- Implementing a new pre/post pay claims system.

AHCCCS continues to investigate and identify areas of concern and implement necessary system improvements to enhance Agency operations and program integrity.

A determination of any potential liability cannot be made at this time as AHCCCS is still in the process of investigating provider billing issues. As of August 2026, 333 providers suspended on or since May 16, 2023. 46 have received decisions following a hearing in front of an Administrative Law Judge at the Office of Administrative Hearings in which these provider suspensions have been upheld. 235 suspended providers have appealed out of 333 providers who have been suspended. Independently, AHCCCS may resolve a provider civil liability and demand repayment of funds improperly paid out. AHCCCS may also remove a provider suspension when further investigation has identified there is no longer a reliable indicia of fraud, but the provider still owes AHCCCS an overpayment for improperly paid claims. AHCCCS has rescinded 181 provider suspensions with additional actions including terminations, exclusions, overpayments, and civil monetary penalties.

AHCCCS OIG's identification and recovery of overpayment pursuant to investigations of currently suspended providers involves review of each provider's billing data, assessment of the legitimacy of any of those services, and calculation of the loss to AHCCCS (overpayment) caused by those illegitimate services. The likelihood of recovering the total amount paid to suspended providers is exceedingly low, because the actual loss to AHCCCS suffered in each case is not equivalent to the total amount AHCCCS paid to that provider. Some suspended providers were paid by AHCCCS for both legitimate services rendered to AHCCCS members and illegitimate services which were not rendered. Therefore, OIG's investigations include a manual process to distinguish these payments.

AHCCCS' ability to collect funds identified as overpayments is further dependent on outside factors, including the progress of criminal prosecution, provider solvency, and criminal attempts to disguise and move funds beyond the reach of authorities.

Recovery of funds may happen through criminal proceedings with restitution orders or by civil recoveries undertaken by AHCCCS. Distinguishing between these routes of recovery involves collaboration with law enforcement to identify cases that are appropriate for civil recovery led by AHCCCS rather than criminal prosecution. Due to the scale of recent fraud, OIG has developed a new process to identify overpayments and assess civil penalties that it will apply in cases designated for civil recovery and operationalized this process. This process includes mandatory notification to providers of their right to appeal determinations which can result in delay. For insolvent or undiscoverable providers, actual recovery will be delayed while AHCCCS seeks collection. For previous overpayment cases, AHCCCS has been open to repayment plans with providers for up to 24 months to allow providers to remain solvent while repaying AHCCCS. For those providers who have actively concealed their assets, recovery will be difficult.

All of the above factors make it challenging to accurately forecast future recoupment totals. Pursuant to 42 C.F.R. 433, Subpart F, AHCCCS is required to refund the Federal share of all overpayments made to providers unless the providers are bankrupt or out of business. The Federal share generally equates to approximately 75% of the total amount overpaid to a provider. The repayment must occur within one year of the discovery of an overpayment as calculated beginning with the date AHCCCS provides written notice to a provider of an overpayment determination. Note, the repayment obligation

is applicable without regard to whether AHCCCS is successful in recovery of an overpayment from the provider, however, there is an exception if a provider is out of business or bankrupt. Given the extent of the fraud, AHCCCS anticipates that overpayment written determinations which trigger the legal obligation to refund federal funds will occur on an individual case-by-case basis as investigations are concluded over the next months and years.

The Federal government will likely conduct a review to ensure that AHCCCS has correctly identified and determined overpayments as well as appropriately refunded federal funds. If a negative finding is made, future federal funding may be disallowed in the amount of the federal funds not remitted. AHCCCS has retained outside counsel experienced in negotiating resolutions with the federal government on these issues to assist in the mitigation of this risk.

Beginning in fiscal year 2024, several complaints were filed against AHCCCS, DHS, and the State of Arizona seeking damages from the death or injuries sustained by current members allegedly arising from the failure of these individuals to receive appropriate addiction treatment and/or damages for the wrongful death of an AHCCCS member due to the behavioral health/sober living home fraud scheme. From August 2023 through the date these financial statements were available to be issued, the State of Arizona, and AHCCCS, have been named in seven lawsuits and have received 42 Notices of Claims. Of these seven lawsuits, either the lawsuit has been dismissed entirely or AHCCCS has been dismissed as a defendant for all but one. Of the 42 Notices of Claims, for all but two, no lawsuit was filed and the 1-year statute of limitations has expired. For the remaining lawsuit, Plaintiffs have claimed approximately $10.0 million in damages. For the remaining two Notices of Claims, Plaintiffs have claimed approximately $11.3 million in damages. However, given that no lawsuits have been filed in connection with the Notices of Claim, and for those matters in litigation, no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such figures and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

In August 2024, the State of Arizona received a Class Action Notice of Claim identifying subclasses for certain AHCCCS members and alleging injuries or wrongful death of the claimants. The lawsuit was subsequently filed in December 2024. AHCCCS intends to vigorously defend these matters. Management, upon consultation with internal and external counsel, notes that these matters are in the early stages, and a Motion to Dismiss has been filed. Plaintiffs have in the aggregate claimed approximately $395.0 million to $430.0 million in damages, however, given that the lawsuit is in the early stages, and no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS intends to vigorously defend these matters.

Additionally, in fiscal year 2024, AHCCCS was served with several lawsuits and several Notices of Claim from AHCCCS behavioral health providers alleging AHCCCS improperly suspended and/or terminated provider participation agreements, “blacklisted” the providers, and “slow paid” claims. Management, upon consultation with internal and external counsel, notes that many of these claims are in the early stages. Through the date these financial statements were available to be issued, the State of Arizona, and AHCCCS, have been named in 11 lawsuits and have received eight Notices of Claims. Of these 11 lawsuits, for eight, the provider dismissed their claims, and no other lawsuit has been filed within the 1-year statute of limitations. For the eight Notices of Claims, no lawsuits were filed and the statute of limitations has expired. For the three remaining lawsuits, Plaintiffs have claimed approximately $508.5 million in damages. AHCCCS notes that no evidence has been disclosed to support such figures and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

In August 2024, the Arizona Attorney General's Office received a letter from attorneys purporting to represent a group of providers/facilities, and facility owners with potential claims against AHCCCS/the State arising from the suspension and/or termination of medical provider licenses or payments to providers. A number of these claimants have submitted Notices of Claim which are discussed above. Others appear to have not yet asserted claims. Management, upon consultation with internal and external counsel, notes that these matters are in the very early stages. Plaintiffs initially in the aggregate claimed approximately $1,162.3 million in damages. Subsequently, in January 2025, the group of providers filed suit against several parties including the State, AHCCCS and the AHCCCS Director alleging negligence, gross negligence, racial discrimination, lack of due process, and breach of contract, among others. Management, upon consultation with internal and external counsel, notes that these matters are in the early stages. Plaintiffs in the aggregate claimed approximately $1,000.0 million in damages in the initial lawsuit. However, in light of the dismissal of multiple plaintiffs with the first amended complaint, and their most recent litigation settlement demand, the estimated damages are now estimated by legal counsel to total approximately $14.2 million. Given these matters are in the early stages, and no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

AHCCCS Member Verification – In June 2025, an Arizona state senator alleged that AHCCCS failed to screen applicants for income and asset eligibility, resulting in approximately 20,000 millionaires being eligible for Medicaid. AHCCCS has denied these allegations and maintains that it is in compliance with all the eligibility requirements as outlined in the State Plan. Pursuant to the Arizona State Plan with CMS, AHCCCS only has resource limits for the Long-Term Care Program (ALTCS) and the Supplemental Security Income (SSI) Cash Program. For SSI Cash, resources are verified by the Social Security Administration (SSA). In addition, Arizona is a 1634 State. 1634 States automatically enroll individuals who are approved for SSI benefits. The SSA determines Medicaid eligibility for SSI recipients, and no separate application for Medicaid is required. Federal Medicaid law requires asset tests for some Aged, Blind, and Disabled eligibility categories, but not all (42 CFR §435.601). In Arizona there are individuals who are Aged, Blind, or Disabled (ABD) enrolled across a variety of AHCCCS programs, including programs that have both income and resource limits (ALTCS and SSI Cash) and programs that only have income limits, such as the Medicare Savings Programs, AHCCCS Freedom to Work Program, and AHCCCS Complete Care (ACC) plans.

For ALTCS asset verification, AHCCCS uses the New England States Consortium Systems Organization (NESCSO). NESCSO contracts with Public Consulting Group (PCG), and LexisNexis is a subcontractor of PCG for asset verification. This process is built into AHCCCS' eligibility system and is run on every ALTCS application when it is initially submitted and at each renewal. For SSI Cash, resources are verified by the Social Security Administration (42 CFR §435.120).

Economic Factors and Next Year's Budgets and Rates

AHCCCS enrollment overall, for the period June 2024 to June 2025, experienced an enrollment decrease from 2,204,281 to 1,971,674, a loss of 232,607 members for a 10.6 percent decrease. The decrease is primarily attributable to a decrease in the 1931 Families/Children and SOBRA Children/Pregnant Women of 98,860, Proposition 204 restoration adults decrease of 110,280, Adult Expansion decrease of 15,563, KidsCare decrease of 8,840, and Emergency Services decrease of 3,269 totaling a decrease of 236,812. Some of the decrease is offset by an increase mainly in Supplemental Security Income of 2,311.

AHCCCS enrollment overall, for the period June 2025 to June 2026, is currently forecasted to go from 1,971,674 to 1,835,754, which would represent a loss of 135,920 members for a 6.89 percent decrease.

The total fiscal year 2026 appropriation for AHCCCS is $22,658.7 million compared to the final $21,059.3 million appropriation for fiscal year 2025. AHCCCS' budget request for fiscal year 2027 and budget revision, was submitted to the Governor in September 2025 and November 2025, respectively. Factors such as Federal law changes, CMS decisions, global health emergencies, legal decisions, economic conditions impacting case load changes compared to projections and the eligibility system shifts in population categories may require the need of a supplemental appropriation for fiscal year 2026.

In June 2026, the budget fiscal year 2027 was signed into law. This budget includes $23 billion in appropriations and expenditure authority for AHCCCS plus $5 billion in appropriations and expenditure authority for the DDD Medicaid program within DES. The budget includes limited and one-time funding for the implementation of and administrative activities stemming from H.R.1. H.R.1 requires the State to conduct eligibility redeterminations for Medicaid expansion adults at least every six months beginning January 1, 2027. H.R.1 also imposes community engagement requirements on the same population and requires the State to monitor compliance with these requirements.

For the contract year ending 2026, AHCCCS' overall weighted capitation rate increased by 13.52 percent across all lines of business except the Department of Economic Security/Developmental Disabilities program, as compared to an overall weighted AHCCCS capitation rate increase of 6.82 percent for contract year 2025. The contract year 2026 Arizona Long Term Care System ("ALTCS" Elderly and Physically Disabled ("EPD")) capitation rates increased by 4.75 percent as compared to the 1.97 percent increase for contract year 2025. The contract year 2026, AHCCCS Complete Care and related programs ("ACC/RBHA/CHP"), aggregate capitation rates increased by 15.11 percent as compared to the 7.68 percent increase for contract year 2025. The 2026 increases are primarily based on increased average acuity of the population as healthier people continue to leave the program and people with higher health needs remain, baseline utilization and unit trends, changes in pharmacy expenses and adjustments to reflect the costs to administer and manage the programs. It is important to note that federal law requires rates to be actuarially sound and the AHCCCS actuaries develop rates based on expected cost and utilization trends. In addition, AHCCCS must conduct an access to care analysis of its rates to assure that sufficient numbers of providers are willing to serve AHCCCS members. Therefore, depending on the results of this analysis and of AHCCCS' actuarial determination of the expected costs of the managed care organizations, the actual capitation rates could differ from projections.

There are current discussions at the state levels to modify Medicaid funding methodologies which could significantly decrease Medicaid funding. The potential exists that certain funding changes passed into law could trigger either the session law or statutory requirement that AHCCCS stop collection of the Hospital Assessment if the ACA is repealed or if the FMAP for the expansion and restoration populations, as authorized by the ACA, falls below 80.0 percent. Such an outcome would likely disrupt the revenue stream supporting the Hospital Assessment Fund, leading to insufficient funding to maintain current program levels. Consequently, AHCCCS would most likely need to adjust eligibility standards, scale back services, or reduce provider reimbursement to align with the reduced available funds, potentially impacting access to care for enrolled populations.

During fiscal year 2025, the federal enactment of H.R. 1 (the “One Big Beautiful Bill Act”) introduced sweeping changes to Medicaid financing, eligibility, and administrative requirements that will materially influence AHCCCS’ financial position and operational outlook over the next several fiscal years. Although many of the most significant fiscal impacts will phase in beginning fiscal year 2026–2027, AHCCCS has started addressing the structural, administrative, and budgetary implications during fiscal year 2026. Community engagement and six-month eligibility are expected to be the most impactful.

H.R. 1 implements major nationwide reductions in federal Medicaid spending—which will reshape cost sharing responsibilities between the federal government and states. These reductions are expected to shift substantial financial burdens to states such as Arizona, particularly as federal matching funds tighten and administrative obligations grow. AHCCCS has incorporated the impact in the budget fiscal year 2027 Budget Request.

AHCCCS Leadership Changes – On April 30, 2025, Carmen Heredia resigned as the director of AHCCCS and Kristen Challacombe was appointed as interim director. Subsequent to June 30, 2025, the following additional significant leadership changes occurred at AHCCCS:

- On September 26, 2025, Governor Katie Hobbs appointed Virginia “Ginny” Rountree as Director, effective October 6, 2025, succeeding the interim director, Kristen Challacombe.
- On February 2, 2026, Director Rountree announced her resignation effective February 13, 2026, due to personal health reasons.
- On February 13, 2026, Governor Hobbs appointed Roberta Harrison as interim director, succeeding Virginia Rountree.

These changes in leadership do not affect the financial position or results of operations as of June 30, 2025. Management does not anticipate any material impact on ongoing operations from these transitions but will continue to monitor developments.

Arizona Alliance for Community Health Centers Litigation – In the litigation filed in 2019 Arizona Alliance for Community Health Centers et al. v. AHCCCS, the federal district court issued a decision adverse to AHCCCS in March 2026 concerning the reimbursement of "physician services" (services those provided by dentists, podiatrists, optometrists, and chiropractors) at federally qualified health centers (FQHCs) under the Medicaid Act. The Court enjoined AHCCCS from enforcing or applying limitations to these services. AHCCCS has appealed the ruling and has requested the Court to stay its judgment pending the appeal. AHCCCS has also filed a State Plan Amendment with CMS, clarifying its longstanding policy and practice of reimbursing physician services in FQHCs which, if approved, will become effective January 2026, predating the March ruling. The outcome of the appeal and potential financial impact cannot be determined at this time. Any required adjustments to reimbursement policies or rates resulting from a final resolution may affect future capitation rates or operational costs.

National Health Care Fraud Takedown – In June 2026, as part of the National Health Care Fraud Takedown, the Arizona Attorney General’s Office announced 42 indictments across ten cases involving alleged fraudulent Medicaid billing, among other charges. This includes two cases that specifically reference schemes to defraud AHCCCS.

Additionally, the U.S. Attorney’s Office for the District of Arizona announced federal charges against individuals in connection with schemes allegedly involving over $1.2 billion in false or fraudulent claims to federal health care programs, including specific allegations related to an Arizona substance abuse treatment clinic that billed AHCCCS approximately $44.9 million (with AHCCCS paying approximately $36.7 million).

These are allegations, and all defendants are presumed innocent until proven guilty. Management is monitoring these matters and any related investigations, potential recoveries, or impacts on the program. At this time, the financial impact, if any, on the June 30, 2025, financial statements cannot be reasonably estimated. AHCCCS intends to continue cooperating with law enforcement and pursuing appropriate program integrity actions.

Medicaid Work Requirements Lawsuit – In June 2026, Arizona, through Attorney General Kris Mayes, joined a coalition of 25 states and the District of Columbia in a federal lawsuit challenging the Centers for Medicare and Medicaid Services' (CMS) interim final rule implementing new Medicaid community engagement (work) requirements under H.R.1. The lawsuit, filed in the U.S. District Court for the District of Massachusetts, contends that certain provisions of the rule are unlawful. The outcome of litigation and any potential impact on AHCCCS operations, eligibility determinations, or program costs cannot be determined at this time.

Arizona Auditor General Report - Subsequent to fiscal year-end, the Arizona Auditor General issued a report regarding the implementation of statutory requirements applicable to the Parents as Paid Caregivers service delivery model administered through the Arizona Long Term Care System. The report concluded that certain cost-control measures required by state law, including implementation of a standardized assessment tool and other program limitations, were not fully implemented and estimated that the resulting delay may have contributed to increased program costs and reduced potential cost savings.

AHCCCS management has informed the Auditor General that it disagrees with several findings and conclusions contained in the report. Specifically, management noted that operational and policy considerations, substantial litigation risks, and ongoing efforts to evaluate and revise program requirements affected the implementation and timelines of various aspects of the Parents as Paid Caregivers service delivery model. AHCCCS management further believes that the estimates of potential cost reductions are subject to significant assumptions and uncertainties. AHCCCS management is evaluating the report's findings and recommendations and any related operational, regulatory, or financial implications. As of the date the financial statements were available to be issued, no repayment demands, federal disallowances, or other liabilities had been asserted against AHCCCS and/or DES related to these matters, and the ultimate outcome, if any, cannot be reasonably estimated. Accordingly, no amounts have been recorded in the accompanying financial statements.

Federal Funding Compliance Matter and Concentration –Subsequent to fiscal year-end, the State of Arizona received a letter dated July 14, 2026, from the U.S. Department of Health and Human Services (HHS) notifying the State of Arizona that it was not in compliance with federal Single Audit submission requirements for fiscal year 2025 and requested a corrective action plan. The letter indicates that, if the matter is not resolved, HHS may impose additional oversight or enforcement actions, including the temporary withholding of federal payments, disallowance of costs, or suspension or termination of federal awards. Additionally, on August 19, 2026, the State received correspondence from the Centers for Medicare and Medicaid Services (CMS) advising that Arizona's fiscal 2025 Single Audit reporting package is delinquent under 2 CFR part 200. The notice stated that continued noncompliance may result in Federal remedies, including potential withholding of payments or other actions. State management has responded to CMS regarding the status of the audit. AHCCCS receives a significant portion of its funding through federal programs administered by HHS, including funding from the Centers for Medicare & Medicaid Services (CMS). Accordingly, AHCCCS is subject to concentration risk associated with continued availability of federal funding and compliance with applicable federal requirements, as described in Note 12. Any significant reduction, delay, suspension, or termination of such federal funding could have a material adverse effect on AHCCCS' ability to fund healthcare services and could negatively impact the financial position and operations of both AHCCCS and the State of Arizona. AHCCCS management is working with the State and federal agencies to address the matter and is not currently able to determine the likelihood or extent of any future actions or impact on operations.

Request for Information

This financial report is designed to provide a general overview of AHCCCS' finances for the State's citizens and taxpayers, and its members, providers, and creditors. Questions concerning any of the information provided in this report or requests for additional financial information should be addressed to the Arizona Health Care Cost Containment System, Division of Business and Finance, Attention: Finance Administrator, MD 15000, 150 N. 18th Avenue, Phoenix, Arizona, 85007.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

STATEMENT OF NET POSITION

June 30, 2025
(amounts expressed in thousands)

	Governmental Activities
ASSETS	
CURRENT ASSETS	
Cash	$ 663,341
Designated cash	195,911
Restricted cash	310,101
Due from state and local governments	343,596
Due from federal government	1,675,482
Tobacco settlement receivable	51,000
Receivables and other	1,378,748
TOTAL CURRENT ASSETS	4,618,179
NONCURRENT ASSETS	
Capital assets:	
Furniture, vehicles, equipment and software, net of accumulated depreciation	3,677
Right-to-use asset - building, net of accumulated amortization	544
Right-to-use asset - subscriptions, net of accumulated amortization	1,299
TOTAL NONCURRENT ASSETS	5,520
TOTAL ASSETS	4,623,699
DEFERRED OUTFLOWS OF RESOURCES	
Pension and OPEB	19,233
LIABILITIES	
CURRENT LIABILITIES	
Accounts payable	171,328
Other accrued liabilities	11,676
Unearned revenue	45,935
Due to state and county governments	488,410
Due to federal government	999,814
Accrued programmatic claims	2,214,363
Compensated absences, current portion	7,760
Lease liability, current portion	440
Subscription liability, current portion	428
OPEB liability, current portion	355
TOTAL CURRENT LIABILITIES	3,940,509
NONCURRENT LIABILITIES	
Compensated absences, net of current portion	3,942
Lease liability, net of current portion	149
Subscription liability, net of current portion	914
Net Pension liability	84,557
OPEB liability, net of current portion	7,852
TOTAL NONCURRENT LIABILITIES	97,414
TOTAL LIABILITIES	4,037,923
DEFERRED INFLOWS OF RESOURCES	
Pension and OPEB	23,825
COMMITMENTS AND CONTINGENCIES	
NET POSITION	
NET INVESTMENT IN CAPITAL ASSETS	3,589
RESTRICTED	53,383
UNRESTRICTED	524,212
TOTAL NET POSITION	$ 581,184

See Notes to Financial Statements

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

STATEMENT OF ACTIVITIES

Year Ended June 30, 2025
(amounts expressed in thousands)

	Program Expenses	Program Revenues: Charges for Services	Program Revenues: Federal Operating Grants	Program Revenues: Other Operating Grants and Contributions	Net (Expense) Revenue and Changes in Net Position: Governmental Activities
PROGRAMS					
Government activities:					
Health care programs	$ 23,232,161	$ 238	$ 16,986,118	$ 2,493,586	$ (3,752,219)
TOTAL PROGRAMS	$ 23,232,161	$ 238	$ 16,986,118	$ 2,493,586	$ (3,752,219)
General revenues:					
State appropriations					3,839,140
Tobacco tax					93,323
Total general revenues					3,932,463
Transfers:					
Transfers, net (out)/in					(93,506)
Total general revenues and transfers					3,838,957
CHANGE IN NET POSITION					86,738
NET POSITION, BEGINNING OF YEAR, AS RESTATED					494,446
NET POSITION, END OF YEAR					$ 581,184

See Notes to Financial Statements

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BALANCE SHEET - GOVERNMENTAL FUNDS

June 30, 2025
(amounts expressed in thousands)

	General Fund	Other Governmental Funds	Total Governmental Funds
ASSETS			
Cash	431,296	232,045	$ 663,341
Designated cash	195,911	-	195,911
Restricted cash	298,086	12,015	310,101
Due from state and local governments	320,006	23,590	343,596
Due from federal government	1,653,459	22,023	1,675,482
Due from other funds	17,466	-	17,466
Tobacco settlement receivable	51,000	-	51,000
Receivables and other	1,110,933	122,826	1,233,759
TOTAL ASSETS	$ 4,078,157	$ 412,499	$ 4,490,656
LIABILITIES			
Accounts payable	162,086	9,242	$ 171,328
Other accrued liabilities	11,201	475	11,676
Unearned revenue	38,678	7,257	45,935
Due to state and county governments	453,805	216	454,021
Due to federal government	886,583	2,632	889,215
Due to general fund	-	17,466	17,466
Accrued programmatic claims	1,755,329	64,011	1,819,340
TOTAL LIABILITIES	3,307,682	101,299	3,408,981
DEFERRED INFLOWS OF RESOURCES			
Unavailable revenue	406,725	-	406,725
COMMITMENTS AND CONTINGENCIES			
FUND BALANCES			
Restricted	52,066	1,317	53,383
Committed	310,594	308,606	619,200
Assigned	1,091	1,277	2,368
Unassigned	-	-	-
TOTAL FUND BALANCES	363,750	311,200	674,950
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND FUND BALANCES	$ 4,078,157	$ 412,499	

Amounts reported for governmental activities in the statement of net position are different because:

Capital assets used in governmental activities are not financial resources and, therefore, are not reported in the funds.	5,520
Lease liability related to the right-to-use asset - building amount not reported in the funds.	(589)
Subscription-based technology agreements liabilities are not reported in the funds	(1,342)
Some liabilities, including net pension and other postemployment benefits liabilities, are not due and payable in the current period and, therefore, are not reported in the funds.	(92,764)
Deferred outflows and inflows of resources related to pensions and OPEBs are applicable to future reporting periods and, therefore, are not reported in the funds.	(4,592)
A portion of liabilities for accrued paid time off is not due and payable from current financial resources and, therefore is not reported in the funds.	(11,702)
Receivables, offsetting the above accrued paid time off liability, will not be collected in the current period, therefore are not reported in the funds.	11,702
A portion of amounts due to state, county and federal governments will not be paid in the current period, therefore is not reported in the funds.	(144,988)
Unavailable revenue is reported in the funds but not in the entity-wide statements.	406,725
A portion of accrued programmatic claims is not due and payable from current financial resources and, therefore is not reported in the funds.	(395,023)
A portion of receivables and other will not be collected in the current period, therefore is not reported in the funds.	133,287
	$ 581,184

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS

Year Ended June 30, 2025

(amounts expressed in thousands)

	General Fund	Other Governmental Funds	Total Governmental Funds
REVENUES			
State government:			
Appropriations	$ 2,652,689	$ 11	$ 2,652,700
State pass through funds	1,116,329	-	1,116,329
Federal government:			
Acute care	11,948,942	136,658	12,085,600
Long-term care	1,528,331	65,449	1,593,780
ISA/IGA pass through funds	2,985,099	1,877	2,986,976
Federal COVID-19	-	6,038	6,038
County and other local government:			
Acute care	125,494	-	125,494
Long-term care	385,342	-	385,342
IGA pass through funds	385,805	-	385,805
Tobacco litigation settlement revenue	83,737	-	83,737
Tobacco tax revenue	28,313	65,010	93,323
Gaming revenue	-	41,318	41,318
Nursing facility tax assessment	-	34,677	34,677
Hospital assessment	705,121	672,044	1,377,165
HAPA intergovernmental agreement revenue	894	35,314	36,208
Premium revenue	238	-	238
Other	15,239	8,601	23,840
TOTAL REVENUES	21,961,573	1,066,997	23,028,570
PROGRAMMATIC EXPENDITURES			
Medical Services:			
Traditional services	7,022,881	27,066	7,049,947
Proposition 204 services	6,291,276	510,566	6,801,842
Newly eligible adults	688,106	41,461	729,567
Comprehensive Health Plan (CHP)	153,832	-	153,832
KidsCare services	195,705	99	195,804
Long-term care services	5,970,748	116,283	6,087,031
School-based services	35,900	-	35,900
COVID-19 services	13,650	20	13,670
Behavioral health services	11,772	3,153	14,925
Hospital Payments:			
Disproportionate share	142,458	-	142,458
Rural and critical access hospital	28,417	-	28,417
Graduate medical education	518,123	-	518,123
Trauma center services	-	41,318	41,318
Other:			
Medicare Part D clawback	191,808	-	191,808
Housing and Health Opportunities (H2O)	8,776	-	8,776
Behavioral support services	183,234	124,522	307,756
Targeted investments	66,201	-	66,201
TOTAL PROGRAMMATIC EXPENDITURES	21,522,887	864,488	22,387,375
ADMINISTRATIVE EXPENDITURES	366,559	53,657	420,216
ADMINISTRATIVE EXPENDITURES PASSED THROUGH	28,794	-	28,794
TOTAL EXPENDITURES	21,918,240	918,145	22,836,385
EXCESS OF REVENUES OVER EXPENDITURES	43,333	148,852	192,185
OTHER FINANCING SOURCES (USES)			
Transfers from / (to) other State agencies:			
State General Fund	(14,204)	-	(14,204)
Arizona Department of Economic Security	(60,794)	-	(60,794)
Arizona Department of Education	62	-	62
Arizona Department of Health Services	42	(7,106)	(7,064)
Arizona Department of Housing	-	(4,000)	(4,000)
Arizona Department of Liquor Licenses and Control	-	(561)	(561)
Arizona Department of Revenue	(836)	-	(836)
Arizona Attorney General	(1,016)	-	(1,016)
Governor's Office	44,353	(5,323)	39,030
Arizona Department of Administration	(18,952)	-	(18,952)
Arizona Department of Child Safety	-	(1,455)	(1,455)
Arizona Department of Juvenile Correction	-	(633)	(633)
Arizona Department of Early Childhood Development	-	-	-
Arizona Board of Nursing	(23,057)	-	(23,057)
Arizona Department of Public Safety	-	(26)	(26)
Transfers between funds:			
Working Capital Exp	170	-	170
Working Capital Rev	-	(170)	(170)
TOTAL OTHER FINANCING SOURCES (USES)	(74,232)	(19,274)	(93,506)
NET CHANGE IN FUND BALANCES	(30,899)	129,578	98,679
FUND BALANCES, BEGINNING OF YEAR, RESTATED	394,649	181,622	576,271
FUND BALANCES, END OF YEAR	$ 363,750	$ 311,200	$ 674,950

See Notes to Financial Statements

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

RECONCILIATION OF THE GOVERNMENTAL FUNDS STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS TO THE GOVERNMENT-WIDE STATEMENT OF ACTIVITIES

Year Ended June 30, 2025
(amounts expressed in thousands)

Amounts reported for governmental activities in the Statement of Activities (page 28) are different because:

Change in fund balances - total governmental funds (page 30)	$	98,679
AHCCCS pension contributions are reported as expenditures in the governmental funds when made. However, they are reported as deferred outflows of resources in the Statement of Net Position because the reported net position liability is measured a year before AHCCCS' report date. Pension expense, which is the change in the net pension liability adjusted for changes in deferred outflows and inflows of resources related to pensions, is reported in the Statement of Activities.		939
Certain expenses reported in the Statement of Activities do not require the use of current financial resources and, therefore, are not reported as expenditures in the governmental funds.		1,647
With the adoption of GASB Statement No. 87, amortization of the right-to-use asset - building in the Statement of Activities exceeds the lease expense reported in the governmental funds.		14
Subscription-based technology agreements expense		(1)
Governmental funds report capital outlays as expenditures. However, in the Statement of Activities, the cost of those assets is allocated over their estimated useful lives and reported as depreciation expense. This is the amount by which depreciation exceeded capital outlays in the current period.		(14,540)
Change in net position of governmental activities (page 28)	$	86,738

(1) Description of reporting entity and summary of significant accounting policies

The accounting policies of the **Arizona Health Care Cost Containment System** ("AHCCCS" or the "Agency") conform to the accounting principles generally accepted in the United States of America applicable to governmental units. The financial statements of AHCCCS, as an agency of the State of Arizona ("State"), are not intended to represent the related financial statement information of the primary government.

A. Reporting entity

The Arizona Legislature ("Legislature") established AHCCCS in November 1981 to administer health care for the State's indigent population. AHCCCS is a state agency managed by an independent cabinet level administration created by the Legislature and is funded by a combination of federal, State, county and local funds. The federal portion is funded through the Centers for Medicare and Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("DHHS") under a Section 1115 Waiver ("Waiver") approved by CMS, which exempts the AHCCCS program from certain requirements of conventional Medicaid programs.

Under Section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that such demonstrations are likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration.

On October 14, 2022, CMS approved a request for a five-year extension of the state's section 1115 demonstration project titled "Arizona Health Care Cost Containment System (AHCCCS)" (Project Number 11-W-00275/9), in accordance with Section 1115 (a) of the Social Security Act. The approval includes the extension of 1) AHCCCS Complete Care ("ACC"), the statewide managed care system, which provides physical and behavioral health services to the majority of Arizona's Medicaid population; 2) the Arizona Long Term Care System ("ALTCS"), which provides physical, behavioral, long-term care services and supports, including home-and-community based services, to targeted populations; 3) the Comprehensive Health Plan ("CHP") for children in foster care; and 4) the AHCCCS Complete Care – Regional Behavioral Health Agreement ("ACCRBHA"), which provides integrated care for individuals with a serious mental illness ("SMI"). The extension approval will also continue the existing waiver of retroactive eligibility. The Waiver extension is for the period from October 14, 2022, through September 30, 2027.

AHCCCS provides acute and long-term health care coverage to eligible residents of Arizona. Eligible residents include those who qualify under Section 1931(b) of the Social Security Act, individuals who are aged, blind or disabled, children who meet certain age requirements from families receiving supplemental nutrition assistance, children and pregnant women whose household income meets eligibility requirements, certain single adults, childless couples, uninsured women needing active treatment for breast and/or cervical cancer and individuals with disabilities who want to work and who meet certain Supplemental Security Income ("SSI") eligibility criteria. Beginning on January 1, 2014, AHCCCS implemented the Patient Protection and Affordable Care Act ("ACA") of 2010. The ACA implementation included (a) the restoration of the childless adults (expansion state adults) who were previously eligible for AHCCCS under the voter mandated Proposition 204, (b) expanded coverage for adults from 100% to 133% of the federal poverty limit ("FPL") and (c) the mandatory child expansion for children ages 6-19 from 100% to 133% of the FPL. These three distinct populations all have enhanced federal financial participation matching rates effective January 1, 2014.

(1) Description of reporting entity and summary of significant accounting policies (continued)

The extension Waiver includes the following new Medicaid eligibility categories: (a) Indian Health Services, providing broader range of Medicaid services to the American Indian population, (b) Housing Initiative for the Housing and Health Opportunities ("H2O") services for health-related social needs ("HRSN"), including housing supports to targeted population, and (c) Targeted Investment ("TI") 2.0 which provides incentive payments to participating providers to improve health quality for targeted populations through addressing social determinants of health ("SDOH"). Through Housing and H2O, CMS is authorizing increased coverage of certain services that address health-related social needs, as evidence indicates that these HRSN services are a critical driver of an individual's access to health services that help to keep them well.

On February 16, 2024, CMS approved an amendment with 2 policies, “Parents as Paid Caregivers” (“PPCG”) and “KidsCare Expansion,” to the demonstration titled, “Arizona Health Care Cost Containment System (AHCCCS)” (Project Number 11-W-00275/9 and 21-W-00074/9), in accordance with section 1115(a) of the Social Security Act.

Approval of the Parents as Paid Caregivers amendment will allow the state to continue to reimburse legally responsible parents of minor children for providing direct care to their minor children, helping to mitigate the direct care worker shortage and improve access to timely, effective care in the home and community. The amendment also establishes a Family Support service as part of the home and community-based services (HCBS) benefit package. The Family Support service aims to support primary caregivers, including parents, and improve access to timely, effective care in the home and community. Additionally, the KidsCare Expansion amendment will allow the state to increase the Children’s Health Insurance Program eligibility thresholds from 200 percent of the federal poverty level (“FPL”) up to and including 225 percent of the FPL, with the flexibility for KidsCare coverage to go up to and include 300 percent of the FPL, subject to approval by the state legislature. The approval is effective as of the aforementioned date and will remain in effect through the demonstration approval period, which is set to expire September 30, 2027.

In addition, in December 2024, Arizona section 1115 demonstration waiver amendment for re-entry services was approved and provides expenditure authority for limited coverage for certain services furnished to certain incarcerated individuals for up to 90 days immediately prior to the individual’s expected date of release. This approval also provides expenditure authority to the state to provide non-medical transportation (“NMT”) to and from health-related social needs (“HRSN”) services and home and community-based services (“HCBS”) for Arizona Long Term Care System (“ALTCS”) eligible beneficiaries. Services in the limited expenditure authority include substance use disorder treatment, mental health care, and care coordination for individuals transitioning from jail or prison.

CMS’s approval of this section 1115(a) demonstration, as amended, is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions, and any supplemental attachments defining the nature, character, and extent of the federal involvement in this project. The state may deviate from Medicaid or CHP state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

In Arizona, health-related social needs services will be provided for individuals experiencing life transitions, including individuals who are experiencing homelessness and meet specific clinical and social risk criteria, such as beneficiaries with a health need as documented in their medical record, including but not limited to a Serious Mental Illness (“SMI”), high-cost high-needs chronic health conditions or co-morbidities, or enrolled in the Arizona Long Term Care System (“ALTCS”).

(1) Description of reporting entity and summary of significant accounting policies (continued)

AHCCCS receives quarterly federal grants for the Title XIX Medicaid program and annual grant awards for the Title XXI Children's Health Insurance Program ("CHIP") from CMS (as matching funds) to cover a portion of the health care costs of the eligible residents of the State. State appropriations and county funding levels are based on annual budgets as dictated by the Legislature and as specified by Arizona Statutory funding formula and Session Law. For fiscal year 2025, funding also includes behavioral health services funded from the Federal Block Grants received from the DHHS Substance Abuse and Mental Health Services Administration ("SAMHSA") and state appropriations targeted to specific needs of individuals with serious mental illness ("SMI"). In addition, AHCCCS receives several other grants from SAMHSA for behavioral health services which include the provision of services to Title XIX and Title XXI members as well as non-Title XIX individuals with SMI and include specific funding for crisis, substance abuse, housing, supported housing services as well as emergency use grants to address mental, substance use disorders and suicide prevention during COVID-19.

Federal funding for CHIP was reauthorized at the Federal level in late 2017 with an additional extension in early 2018 and AHCCCS expects that sufficient CHIP allotment funding will be available to continue both M-CHIP and KidsCare programs through Federal fiscal year 2027. Laws 2019, Chapter 270, Section 10 amended A.R.S. § 36-2985 to remove the language requiring AHCCCS to stop processing all new applications for KidsCare if the effective FMAP is less than one hundred percent. AHCCCS required a supplemental appropriation for fiscal year 2024 that included an additional $7.5 million in expenditure authority for the CHIP program due to the increased enrollment related to the KidsCare Expansion policy. Specifically, the KidsCare Expansion policy allows Arizona to increase the CHIP eligibility thresholds from 200 percent of the federal poverty level (FPL) up to and including 225 percent of the FPL. The expansion is expected to provide coverage to additional eligible children, with ongoing costs reflected in the state fiscal year 2025 budget and future periods.

Under AHCCCS, health care coverage is provided substantially through a competitive bidding process with private and county-sponsored health plans bidding for the enrollment of AHCCCS eligibles by geographical service area. In addition, AHCCCS purchases health care services directly from providers. During fiscal year 2019, AHCCCS moved forward with the largest integration effort in the history of the program. On October 1, 2018, AHCCCS' managed care organizations began to provide services that are designed to coordinate the provision of physical and behavioral health care services. Integrated health care delivery benefits by aligning all physical and behavioral health services under a single plan. With one provider network and one payer, health care providers are better able to coordinate care across the continuum of services and supports and members are able to more easily navigate the system, resulting in improved health outcomes.

B. Basis of presentation

The basic financial statements include both government-wide and fund financial statements. The government-wide financial statements report information on the entire Agency while the fund financial statements focus on major funds. Each presentation provides valuable information that can be analyzed and compared between years to enhance the usefulness of the information.

The government-wide financial statements (i.e., the statement of net position and the statement of activities) report information on the entire Agency. The effect of all significant interfund activity has been removed from these financial statements.

The statement of activities demonstrates the degree to which the governmental activities' direct expenses are offset by program revenues. Direct expenses are those that are clearly identifiable with a specific function. Program revenues include appropriations, contributions and grants that are restricted for the operational or capital requirements of a particular function or segment.

(1) Description of reporting entity and summary of significant accounting policies (continued)

Fund financial statements provide information about the Agency's funds. The General Fund is the Agency's primary operating fund, and it accounts for all financial resources except those required to be accounted for in another fund. AHCCCS did not have any major funds for fiscal year 2025; accordingly, all governmental funds other than the General Fund are aggregated and reported as other governmental funds.

C. Measurement focus, basis of accounting and financial statement presentation

The government-wide financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows.

The governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period. Revenues are considered to be available when they are collectible within the current period or soon enough thereafter to pay liabilities of the current period. When an asset is recorded in the governmental fund financial statements, but the revenue is not available, AHCCCS reports a deferred inflow of resources until such time as the revenue becomes available. The governmental funds' unearned revenue consists of revenue received in advance for services not yet provided. Expenditures generally are recorded when a liability is incurred, as under accrual accounting. Accrued programmatic costs include received but unpaid claims and estimates for incurred but not reported claims paid in the 31-day period following the end of the fiscal year or shortly thereafter. Actual results for accrued programmatic costs may differ from such estimates. These differences are recorded in the period in which they are identified. However, expenditures related to compensated absences are recorded only when payment is due.

In fiscal year 2025, AHCCCS reports the following significant funds:

a. The General Fund is the primary operating fund for the Title XIX Medicaid program and the Title XXI State Children's Health Insurance Program.

b. Special Revenue Funds, reported as other governmental funds, account for various health and administrative programs.

The General Fund is the only major governmental fund of AHCCCS.

D. Cash and investments

Substantially all of the cash and investments maintained by AHCCCS are held by the State of Arizona Office of the Treasurer ("Treasurer") with other State monies in an internal cash and investment pool. Investment income is allocated to AHCCCS on a pro rata basis. Amounts held by the Treasurer are recorded at fair value and totaled $1,169,353 at June 30, 2025, including designated and restricted funds of $506,012.

The State is statutorily limited (by ARS §35-312 and §35-313) to certain investment types. Additionally, State statutes require investments made to be in accordance with the "Prudent Person" rule. This rule imposes the responsibility of making investments with the judgment and care that persons of ordinary prudence would exercise in the management of their own affairs when considering both the probable safety of their capital and the probable income from that capital. The Treasurer issues a separately published Annual Financial Report that provides additional information relative to the Treasurer's total investment activities.

(1) Description of reporting entity and summary of significant accounting policies (continued)

Designated cash in the General Fund has been internally designated by AHCCCS in the amount of $195,911 for the Interagency Service Agreement ("ISA") Fund. The ISA Fund is used to properly account for, control, and report receipts and disbursements associated with ISAs which are not required to be reported in other funds.

Fund receipts consist of monies received from other entities and are utilized to match federal funding under the Medicaid and CHIP programs under the terms stated in the ISAs. Cash in the Other Governmental Funds is legally restricted in the amount of $10,701 for the Hawaii Arizona PMMIS Alliance ("HAPA") Fund, $1,278 Federal Grants Fund, $30 St. Luke's Health Initiatives Fund, and $6 Miscellaneous Grants Fund for a total of $12,015.

In accordance with the Federal Cash Management Improvement Act of 1990 guidelines, AHCCCS may only request federal funds under specified funding techniques. The application of required funding techniques is automated within the AZ360 system and controls the timing of federal funding draw downs. Any interest penalty accrued through the automated process is paid by the State from interest earned on the cash investments.

E. Capital assets

Capital assets, which consist of furniture, vehicles and equipment, and internally generated computer software, are reported in the government-wide Statement of Net Position. Tangible capital assets are defined as assets with an initial, individual cost of more than $5 and an estimated useful life in excess of one year. Such assets are recorded at historical cost and are depreciated over their estimated useful lives ranging from three to five years. Intangible capital assets consist of internally generated computer software with an initial cost greater than $1,000. Software is amortized over an estimated useful life of five to ten years. Expenditures for incomplete projects are reported as software under development. The costs of normal maintenance and repairs that do not add to the value of the asset or materially extend assets' lives are not capitalized.

AHCCCS accounts for internally generated computer software in accordance with GASB Statement No. 51, *Accounting and Financial Reporting for Intangible Assets*. In accordance with Statement No. 51, outlays associated with activities in the preliminary project stage should be expensed as incurred. Outlays related to activities in the application development stage are capitalized. Capitalization of such outlays will cease no later than the point at which the computer software is substantially complete and operational.

AHCCCS accounts for capital assets in accordance with the provisions of GASB Statement No. 42, *Accounting and Financial Reporting for Impairment of Capital Assets and for Insurance Recoveries*. GASB Statement No. 42 requires that capital assets be reviewed for impairment whenever events or changes in circumstances indicate a significant, unexpected decline in the service utility of a capital asset. If such assets are considered to be impaired and are still in use, the impairment can be recognized using the following methods: restoration cost approach, service unit approach, and a deflated depreciated replacement cost approach. If such assets are considered to be impaired and are no longer used, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. At June 30, 2025, management did not believe impairment indicators were present, and there were no idle capital assets.

Capital assets also include the right-to-use asset – building and right-to-use asset – subscriptions in accordance with GASB Statements No. 87 and GASB 96, respectively. See further information in Notes T and U below.

(1) Description of reporting entity and summary of significant accounting policies (continued)

F. Deferred outflows and inflows of resources

The statement of net position and balance sheet – governmental fund include separate sections for deferred outflows of resources and deferred inflows of resources. Deferred outflows of resources represent a consumption of net position that applies to future periods that will be recognized as an expense or expenditure in future periods. Deferred inflows of resources represent an acquisition of net position or fund balance that applies to future periods and will be recognized as revenue in future periods.

G. Pensions and other postemployment benefits (OPEB)

For purposes of measuring the net pension and other postemployment benefits (OPEB) assets and liabilities, deferred outflows of resources and deferred inflows of resources related to pensions and OPEB, and pension and OPEB expense, information about the plans' fiduciary net position and additions to/deductions from the plans' fiduciary net position have been determined on the same basis as they are reported by the plans. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms.

H. Net position / fund balance

The difference between fund assets and liabilities is “Net Position” on the government-wide statements. Net position is reported in three categories:

- Net investment in capital assets, consists of capital assets net of depreciation and the right- to-use asset – building and right-to-use asset – subscriptions, net of amortization and the related lease and subscription liabilities.
- Restricted net position is restricted due to legal restrictions from laws and regulations of other governments, or legally enforceable through enabling legislation of the State.
- Unrestricted net position consists of net position which does not meet the definition of the two preceding categories.

These categories are based primarily on the extent to which AHCCCS is bound to honor constraints on the specific purposes for which the amounts in those funds can be spent. In the governmental fund financial statements, fund balances are classified as nonspendable and spendable and are defined as follows:

Nonspendable fund balance

Nonspendable fund balance - this includes amounts that cannot be spent because they are either not spendable in form (such as inventory) or legally or contractually required to be maintained intact (such as endowments). At June 30, 2025, AHCCCS had no nonspendable fund balance.

Spendable fund balance

Restricted fund balance - this includes amounts that can be spent only for specific purposes stipulated by legal requirements imposed by other governments, external resource providers, or creditors. AHCCCS imposed restrictions do not create a restricted fund balance unless the legal document that initially authorized the revenue (associated with that portion of the fund balance) also included language that specified the limited use for which the authorized revenues were to be expended. At June 30, 2025, AHCCCS’ restricted fund balance totaled $53,383.

(1) Description of reporting entity and summary of significant accounting policies (continued)

Committed fund balance - this includes amounts that can only be used for specific purposes pursuant to constraints imposed by formal action of the Legislature. Those committed amounts cannot be used for any other purpose unless the Legislature removes or changes the specified use by taking the same type of action (for example, statute, session law, etc.) that it employed to previously commit those amounts. If the Legislative action that limits the use of the funds was separate from the action that initially created the revenues that form the basis for the fund balance, then the resultant fund balance is considered to be committed, not restricted. AHCCCS considers a resolution, a statute, or a session law action to constitute a formal action of the Legislature for the purposes of establishing committed fund balance. At June 30, 2025, AHCCCS' committed fund balance totaled $619,200.

Assigned fund balance - this includes amounts constrained by the Legislature for specific purposes. Assigned fund balances include all remaining amounts (except negative amounts) that are reported in the governmental funds, other than the general fund, that are not classified as nonspendable and are neither restricted nor committed and amounts in the general fund that are intended to be used for a specific purpose. By reporting particular amounts that are not restricted or committed in a special revenue fund, AHCCCS has assigned those amounts to the purpose of the respective funds. At June 30, 2025, AHCCCS' assigned fund balance totaled $2,368.

Unassigned fund balance - this includes the remaining spendable amounts which are not included in one of the other classifications. At June 30, 2025, AHCCCS' unassigned fund balance totaled $0.

AHCCCS has neither adopted a minimum fund balance policy nor any agency specific policy for the order of spending fund balances; rather, AHCCCS follows the policies of the State and adheres to the purpose of legislative appropriations or federal grant regulations.

When an expenditure is incurred for purposes for which restricted, committed, and unassigned fund balance is available, the State considers restricted, committed, and unassigned amounts to have been spent in that order.

I. Capitation payments

Contracted health plans ("Contractors") receive fixed capitation payments, generally in advance, based on actuarially determined rates for each AHCCCS member enrolled with the plan. The plans are required to provide all covered health care services to their members, regardless of the cost of care.

For each contract year for the contracted health plans, reconciliations are performed to recoup the excess funds from each plan above a certain profit corridor or if the costs exceed the amount of the capitation and reinsurance payments to make a payment to cover the loss below a certain corridor. Therefore, profits in excess of the percentages set forth in the AHCCCS policy shall be recouped by AHCCCS and losses in excess of the percentages set forth in the AHCCCS policy shall be paid to the Contractor. This methodology ensures that profit and loss are subject to certain risk mitigation limitations.

AHCCCS pays prospective capitation as well as prior period coverage ("PPC"). The PPC period generally is from the effective date of eligibility to the day a member is enrolled with a contracted health plan. There are several risk mitigation strategies where AHCCCS offers the Contractors a risk corridor for both PPC and prospective expenses which protects the Contractors from excessive losses, while at the same time placing an upper limit on profits.

(1) Description of reporting entity and summary of significant accounting policies (continued)

J. Reinsurance payments

AHCCCS provides a stop-loss reinsurance program for its contracted health plans for partial reimbursement, after a deductible is met, of qualifying covered medical services incurred for members. 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 will reimburse the Contractor for covered services incurred above the deductible level. The deductible is the responsibility of the Contractor. This reinsurance provides partial reimbursement of reinsurance eligible covered services and will reimburse 75% of eligible costs above the deductible of covered expenses. The deductible effective October 1, 2020, for AHCCCS Complete Care ("ACC") and Regional Behavioral Health Authorities ("RBHA") contractors is $150,000. Annual deductible levels apply to all members except for State Only Transplant members.

The reinsurance program also provides reimbursement for covered organ transplantation. Annual deductible levels do not apply to State Only Transplant members. The reinsurance for catastrophic disorders covers certain high-cost behavioral health, blood related disorders and biologic/high-cost specialty drug. For catastrophic reinsurance cases, there is no deductible level with the coinsurance of 85% of the eligible expenses.

Transplant reinsurance coverage is available to partially reimburse Contractors for the cost of care for an enrolled member who meets transplant reinsurance criteria. Individuals who qualify for transplant services, but who are later determined ineligible, due to excess income, may qualify for extended eligibility (refer to State Only Transplants Option 1 and Option 2).

Reinsurance coverage for State Only Option 1 and Option 2 members for transplants received at an AHCCCS contracted facility is paid at the lesser of 1) 100% of the AHCCCS contract amount for the transplantation services rendered, less the transplant share of cost; or 2) 100% of the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplant services rendered less the transplant share of cost, or the Contractor paid amount, less the transplant share of cost.

K. Fee-for-service payments

The AHCCCS program is responsible for the cost of providing behavioral health and medical services on a fee-for-service basis. Tribal Regional Behavioral Health Authorities ("TRBHAs") coordinate the delivery of comprehensive mental health services for American Indian/Alaskan Native ("AI/AN") members. In addition, the fee-for-service program serves AI/AN members who choose to receive their coverage through the American Indian Health Program ("AIHP"). Furthermore, the American Indian Medical Home ("AIMH") program supports Primary Case Management ("PCM"), diabetes education and care coordination for its AIHP members. The Tribal Arizona Long Term Care System ("Tribal ALTCS") program provides Medicaid services to elderly and/or physically disabled American Indians who are determined eligible for ALTCS. Finally, persons enrolled in the Emergency Services Program ("ESP"), prior quarter coverage for members enrolled in a health plan and persons enrolled in a health plan for less than 30 days may receive services on a fee-for-service basis.

(dollar amounts expressed in thousands)

(1) Description of reporting entity and summary of significant accounting policies (continued)

The ESP provides for emergency medical care to persons who are not eligible for full AHCCCS coverage due to their lack of United States citizenship or lawful alien status. Outpatient medical services for the ESP, prior quarter coverage, members enrolled in a health plan for less than 30 days and American Indian program enrolled members that receive services at a non-Indian Health Services ("IHS")/638 facility are reimbursed using the AHCCCS Outpatient Hospital Fee Schedule. Inpatient medical services for these populations are reimbursed based on the category of service provided and an inpatient per-diem reimbursement rate system or at the outlier reimbursement rate. Professional and non-hospital services for these populations are reimbursed at the AHCCCS fee for service rates.

Inpatient and outpatient medical services provided at an IHS facility are reimbursed at rates determined by the U.S. Department of Health and Human Services, Indian Health Services. Tribal-owned facilities contracted with IHS are reimbursed at rates determined by the U.S. Department of Health and Human Services, Indian Health Services or at the AHCCCS fee-for-service rates. Off-reservation services provided by non-IHS/638 providers are reimbursed based on the AHCCCS fee-for-service rates, AHCCCS inpatient per-diem reimbursement rate system or at the outlier reimbursement rate and the AHCCCS Outpatient Hospital Fee Schedule.

L. Incurred but not reported programmatic expenditures

In the accompanying financial statements, health care services expenditures include paid claims, received but unpaid programmatic claims, and an estimate made by management for incurred but not reported ("IBNR") programmatic claims. These IBNR programmatic claims include charges by physicians, hospitals and other health care providers for services rendered to eligible members during the period for which claims have not yet been submitted as well as prior period capitation payments for members enrolled retrospectively.

The estimates for IBNR programmatic claims are developed using historical data for payment patterns and other relevant factors. Such liabilities are necessarily based on assumptions and estimates, and while management believes the amount is adequate, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed by management and adjustments are reflected in the period determined. Activity included in the liability for accrued programmatic claims and medical services expenditures for the year ended June 30, 2025 is as follows:

Claims unpaid as of June 30, 2024	$ 589,402
Incurred related to:	
Current year	2,552,689
Prior years	(125,790)
Total incurred	2,426,899
Paid related to:	
Current year	(1,961,137)
Prior years	(463,619)
Total paid	(2,424,756)
Claims unpaid as of June 30, 2025	$ 591,545

(1) Description of reporting entity and summary of significant accounting policies (continued)

M. Hospital Assessment Fund

The hospital assessment fund, established pursuant to ARS §36-2901.09 on January 1, 2014, consists of monies collected from an assessment on hospitals for the purpose of funding a portion of the non-federal share of costs for the Proposition 204 eligible population. AHCCCS recorded assessment revenues in the amount of $672,045 and expenditures in the amount of $538,545 during fiscal year 2025 ending with a net fund balance of $299,261 at June 30, 2025.

N. Hospital and nursing facility payments

CMS and the Legislature authorized AHCCCS to make Disproportionate Share, Graduate Medical Education, Rural Hospital, Critical Access Hospital, Trauma Center, Housing and Health Opportunities and Nursing Facility supplemental expenditures in fiscal year 2025. Disproportionate share expenditures to Arizona hospitals that provided care to a disproportionate share (as defined) of the State's indigent population totaled $142,458. Graduate Medical Education expenditures to reimburse hospitals with GME programs for the additional costs of treating AHCCCS members utilizing graduate medical students totaled $518,123. Critical Access Hospital expenditures to provide increased reimbursement to small rural hospitals that are federally designated as critical access hospitals and Rural Hospital expenditures to increase inpatient reimbursement rates for qualifying rural hospitals totaled $28,417. Trauma center services to reimburse hospitals in Arizona for unrecovered trauma center readiness costs and unrecovered emergency services costs totaled $41,318. Housing and Health Opportunities services for health-related social needs ("HRSN"), including housing supports to American Indian population expenditures to reimburse qualifying H2O programs totaled $8,776. Nursing Facility supplemental expenditures utilize a quality assessment on health care items and services provided by nursing facilities to qualify for federal matching funds for supplemental payments for covered Medicaid expenditures, not to exceed the Medicare upper payment limit. The expenditures are included with long-term care health care services and totaled $100,125.

O. Health Care Investment Fund

Arizona House Bill 2668 Chapter 46 from March 25, 2020 establishes the Health Care Investment Fund and a second hospital assessment on hospitals' revenue for the purpose of funding the non-federal share of the Directed Payments made to the hospitals pursuant to 42 Code of Federal Regulations ("CFR") 438.6(c). These Directed Payments supplement the base reimbursement level for hospital services for AHCCCS recipients and increase base reimbursement rates for the dental and physician fee schedules to rates in effect before fiscal year 2008-2009. This initiative is known as the "Hospital Enhanced Access Leading to Health Improvements Initiative" ("HEALTHII") program.

The HEALTHII program uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class aggregate targeted pay-to-cost ratio for Medicaid managed care services. The quarterly payments started in the quarter ending December 2020. The amount of the Directed HEALTHII payments for the period July 1, 2024 to June 30, 2025 was $2,883,507 which includes $2,199,346 federal share and $684,161 non-federal share covered by the hospital assessments collected in Health Care Investment Fund.

For fiscal year 2025, the revenue recognized in the Health Care Investment Fund, which is part of the General Fund, totaled $705,121, the expenditures totaled $725,861, and transfers to the Arizona Department of Economic Security totaled $22,767. This fiscal 2025 activity, plus the beginning of year fund balance of $147,594 resulted in a fund balance of $104,087 as of June 30, 2025. These revenues and expenditures are presented in the Hospital Assessment line item on the fiscal 2025 Statement of Revenues, Expenditures, and Changes in Fund Balances – Governmental Funds.

(1) Description of reporting entity and summary of significant accounting policies (continued)

P. Taxes

AHCCCS is an agency of the State of Arizona and is not subject to income taxes.

Q. Management's use of estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities, and the reported amounts of revenues and expenditures at June 30, 2025. Actual results may differ from these estimates. Material estimates potentially susceptible to change in the near term relate to the accrued programmatic claims liability.

R. CMS 1115 Waiver

Section 1115 Waiver - On October 14, 2022, CMS approved a five-year extension of Arizona's Section 1115 demonstration (AHCCCS, Project No. 11 W 00275/9) through September 30, 2027, continuing the State's managed care programs, including ACC, ALTCS, CHP, and ACC RBHA, and maintaining the waiver of retroactive eligibility.

The extension authorizes updated expenditure authority, including payments to Indian Health Service and Tribal 638 facilities, expanded adult dental coverage for American Indian/Alaska Native members, implementation of Targeted Investments (TI) 2.0 provider incentives, and coverage of certain health related social need services under the Housing and Health Opportunities (H2O) initiative.

Subsequent amendments approved in 2024 authorize the continuation of Parents as Paid Caregivers, expansion of KidsCare eligibility thresholds, and limited prerelease coverage for certain incarcerated individuals, including behavioral health services, care coordination, and related non-medical transportation. All approvals are subject to CMS waiver authorities and special terms and conditions.

AHCCCS has classified the Arizona Tobacco Litigation Settlement Fund, created by ballot Proposition 204, as part of its General Fund. These funds are restricted for use as specified in the litigation settlement and/or legislation. Annual settlement payments, based on cigarette sales from the preceding calendar year are made in April. In addition, supplemental payments may be received as tobacco companies enter into the tobacco master settlement agreement. AHCCCS received annual and strategic contribution fund payments of $83,737 in fiscal year 2025 for the period from January 1, 2024 to December 31, 2024 (received in April 2025). Revenue for the period from July 1, 2024 to December 31, 2024 totaled approximately $32,737. Additionally, revenue and a related receivable of $51,000 were accrued for the period of January 1, 2025 through June 30, 2025 and are included in Tobacco Settlement Receivable and Other Operating Grants and Contributions in the accompanying Statement of Net Position and Statement of Activities.

Per Laws 2020, Chapter 46, AHCCCS implemented a new Health Care Investment Fund that was effective October 1, 2020. The funding, $705.1 million for fiscal year 2025, supports hospitals and provider reimbursement through directed payments and capitation rate increases for certain services.

(dollar amounts expressed in thousands)

(1) Description of reporting entity and summary of significant accounting policies (continued)

S. Prescription drug rebate program

The ACA included a provision to extend drug rebates to managed care programs and to increase the rebate amount drug manufacturers are required to pay under the Medicaid drug rebate program. AHCCCS received CMS approval on January 26, 2011 to participate in the drug rebate program, both managed care and fee-for-service, for drugs dispensed on or after March 23, 2010. AHCCCS received rebate reimbursements and delinquent account interest in the amount of $1,224,101 in fiscal year 2025. Of this amount, $773,140 was returned to the Federal government in fiscal 2025 and $180,556 was returned subsequent to June 30, 2025. This amount is netted against the due from the Federal government in the accompanying financial statements. The remaining $270,405 is available to offset a portion of General Fund current and future fiscal year expenditures. Additionally, AHCCCS has accrued the unpaid invoice balance of $481,815 as of June 30, 2025 which is included in receivables and other in the accompanying Statement of Net Position. Of this accrued receivable, $373,502 will be returned to the Federal government and is netted against the due from the Federal government in the accompanying financial statements and $108,313 is available to offset future fiscal year expenditures, which is netted against the due from state and local governments in the accompanying financial statements.

T. Leases

GASB Statement No. 87 (GASB 87), *Leases*, establishes a single model for lease accounting based on the principle that leases are financings of the right to use an underlying asset. Under GASB 87, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about government's leasing activities.

AHCCCS adopted GASB 87 as of July 1, 2021. AHCCCS is the lessee of a leased building (office space). The lease agreement expires on October 31, 2026. The lease is not subject to a sublease, sale-leaseback or lease-leaseback. The base rent is inclusive of any and all applicable local government rental taxes. This is a full-service lease. Upon adoption of GASB 87, *Leases*, on July 1, 2021, AHCCCS recognized a right-to-use asset - building and lease liability of $2,176 based on the estimated future cash flows over the remaining lease term of 64 months and an estimated discount rate of 0.0980%. There were no new leases entered into in fiscal year 2025 nor any remeasurements.

Lease liability activity for the year ended June 30, 2025 is as follows:

Balance, July 1, 2024	$	1,012
Increases		-
Remeasurements		-
Decreases		(423)
Balance, June 30, 2025		589
Less: Current portion		(440)
Long-term portion	$	149

(dollar amounts expressed in thousands)

(1) Description of reporting entity and summary of significant accounting policies (continued)

The following schedule details the minimum lease payments to maturity for AHCCCS' lease liability at June 30, 2025:

Years Ending June 30	Principal	Interest	Total
2026	$ 440	$ 4	$ 444
2027	149	1	150
Total	$ 589	$ 5	$ 594

U. Subscription-Based Information Technology Agreements (SBITA)

GASB Statement No. 96 (GASB 96), *Subscription-Based Information Technology Arrangements* ("SBITA"), is defined as a contract that conveys control of the right to use another party's information technology software, alone or in combination with tangible capital assets, as specified in the contract for a period of time in an exchange or exchange-like transaction. GASB 96 is effective for fiscal years beginning after June 15, 2022, and all reporting periods thereafter.

AHCCCS adopted GASB 96 as of July 1, 2022. AHCCCS has entered into SBITAs for software related to the statewide Enterprise Resource Planning and healthcare systems. The SBITAs expire through March 2032. Upon adoption of GASB 96 on July 1, 2022, AHCCCS recognized a right-to-use asset - subscriptions and subscriptions liability of $4,703 based on the estimated future cash flows over the remaining subscription terms and estimated discount rates. There were no new subscription-based technology agreements entered into in fiscal year 2025.

Subscription liability activity for the year ended June 30, 2025 is as follows:

Balance, July 1, 2024	$ 1,762
Increases	-
Remeasurements	-
Decreases	(420)
Balance, June 30, 2025	1,342
Less: Current portion	(428)
Long-term portion	$ 914

The following schedule details the minimum agreement payments to maturity for AHCCCS' SBITA liability at June 30, 2025:

Years Ending June 30	Principal	Interest	Total
2026	$ 428	$ 23	$ 451
2027	334	15	349
2028	225	10	235
2029	94	6	100
2030	96	4	100
Thereafter	165	3	168
Total	$ 1,342	$ 61	$ 1,403

(dollar amounts expressed in thousands)

(1) Description of reporting entity and summary of significant accounting policies (continued)

V. New accounting pronouncements

During the year ended June 30, 2025, AHCCCS adopted Governmental Accounting Standards Board Statement No. 101, Compensated Absences. GASB 101 establishes revised recognition and measurement requirements for compensated absences and requires the recognition of liabilities for leave that is more likely than not to be used or paid. The statement also requires the inclusion of certain salary-related payments associated with compensated absences. AHCCCS applied the provisions of GASB 101 retrospectively. The adoption resulted in a restatement of beginning compensated absences liabilities as of July 1, 2024. Additional information regarding the adoption and related restatement is presented in Note 3.

During fiscal year 2025, AHCCCS adopted Governmental Accounting Standards Board Statement No. 102, *Certain Risk Disclosures*. GASB 102 requires governments to disclose certain concentrations and constraints that make the reporting entity vulnerable to the risk of a substantial impact if specified events associated with those concentrations or constraints have occurred or are more likely than not to occur within 12 months of the financial statement issuance date. The adoption of this standard did not have an effect on beginning net position, fund balance, or changes in net position. See Note 12 for additional disclosures required by this statement.

(2) Capital assets

Capital asset balances and current fiscal year activity are as follows:

Governmental Activities:	Balance June 30, 2024	Increases	Decreases	Balance June 30, 2025
Capital assets, being depreciated:				
Vehicles, Furniture & Equipment	$ 4,959	$ -	$ -	$ 4,959
Software	153,089	-	-	153,089
Total capital assets, being depreciated	158,048	-	-	158,048
Less accumulated depreciation for:				
Vehicles, Furniture & Equipment	(4,827)	(72)	-	(4,899)
Software	(135,004)	(14,468)	-	(149,472)
Total accumulated depreciation	(139,831)	(14,540)	-	(154,371)
Total capital assets being depreciated, net	$ 18,217	$ (14,540)	$ -	$ 3,677
Total governmental activities capital assets, net	$ 18,217	$ (14,540)	$ -	$ 3,677

For the year ended June 30, 2025, depreciation expense on capital assets totaled approximately $14,540.

(dollar amounts expressed in thousands)

(2) Capital assets (continued)

Software includes the costs of developing and implementing the new ACA compliant eligibility system. The automated eligibility system qualified AHCCCS for 75 percent enhanced FFP for certain eligibility determination administrative functions that previously were eligible for the 50 percent FFP rate.

Right-to-use asset activity for leases and subscriptions for the year ended June 30, 2025 is as follows:

	Balance July 1, 2024	Increases	Remeasure-ments	Decreases	Balance June 30, 2025
Right-to-use assets:					
Subscriptions	$ 2,563	$ -	$ -	$ -	$ 2,563
Buildings	2,176	-	-	-	2,176
Total right-to-use assets	4,739	-	-	-	4,739
Less accumulated amortization for:					
Subscriptions	(843)	(421)	-	-	(1,264)
Buildings	(1,224)	(408)	-	-	(1,632)
Total accumulated amortization	(2,067)	(829)	-	-	(2,896)
Total right-to-use assets, net	$ 2,672	$ (829)	$ -	$ -	$ 1,843

(3) Compensated absences

Effective for state fiscal year 2025, AHCCCS adopted GASB Statement No. 101, *Compensated Absences*. This statement requires accrual of a liability for leave more likely than not to be used or paid after year-end, plus any directly tied employee-related expenses (“ERE”).

This adoption had been applied retrospectively. As a result, the compensated absences liability as of July 1, 2024 (beginning of the fiscal year), was restated from $5,733 (as previously reported, which did not accrue for sick leave) to $11,434, as noted in the table below. This restatement increased the liability by approximately $5,701. A corresponding increase in unavailable revenue offset the liability increase, resulting in no net change to beginning net position. Prior-year information has been restated accordingly.

It is the State’s policy to permit employees to accumulate earned but unused vacation, compensatory and sick pay benefits. Employees may accumulate up to 240 or 320 hours of vacation depending upon their position classification. Vacation hours in excess of the maximum amount that are unused at the calendar year end are forfeited. State employees are eligible to receive payment for an accumulated sick leave balance of 500 hours or more with a maximum of 1,500 hours, upon retirement date, times the eligibility percentage. The eligibility percentage varies based upon the number of accumulated sick hours from 25% for 500 hours to a maximum of 50% for 1,500 hours. The maximum benefit value is $30,000. Per Arizona Revised Statute 38-615E, the benefit shall be paid either in a lump sum or in installments over three years. The Retiree Accumulated Sick Leave Fund is accounted for on the State’s financial statements as an Internal Service Fund.

(dollar amounts expressed in thousands)

(3) Compensated absences (continued)

The amount recorded in the government-wide financial statements consists of employees earned (accrued) annual vacation, compensatory, military, holiday, recognition, parental, and sick time benefits more likely than not to be used, plus EREs directly related to the leave. The compensated absences liability includes a $7,760 current liability and a $3,942 non-current liability with a total liability of $11,702. Balances and current fiscal year activity are as follows:

Balance, June 30, 2024 (as previously reported)	$	5,733
Implementation of GASB Statement No. 101		5,701
Balance, June 30, 2024 (as restated)	$	11,434
Additions		12,193
Reductions		(11,925)
Balance, June 30, 2025	$	11,702

(4) Other governmental funds

At June 30, 2025, the other governmental fund balance included activity within the following funds:

- Tobacco Tax and Health Care Fund, Medically Needy Account (“MNA”) - The Arizona Department of Revenue allocates funding to the MNA which provides funding for services provided through the Title XIX Medicaid and other legislatively authorized health related services or programs. Revenue sources for the MNA include tobacco tax proceeds and investment income.

- Tobacco Products Tax Fund, Emergency Health Services Account (“EHSA”) - The Arizona Department of Revenue allocates the tobacco tax revenue to the EHSA which is used solely for the reimbursement of uncompensated care, primary care services and trauma center readiness costs. Monies remaining unexpended and unencumbered in the account on June 30th of each year revert to the Proposition 204 Protection Account, a general fund. Revenue sources for the EHSA include tobacco tax proceeds and investment income.

- Trauma and Emergency Services Fund - This fund is comprised of gaming revenues to be used to reimburse hospitals in Arizona for unrecovered trauma center readiness costs and unrecovered emergency services costs.

- Nursing Facility Assessment Fund - This fund consists of monies received from the nursing facility assessment, federal monies received as a result of expenditures made attributable to monies deposited in the fund, interest, legislative appropriations, grants, gifts, contributions and devices. The monies in this fund shall be used to qualify for federal matching funds for supplemental payments for nursing facility services and administrative cost to administer the fund.

- Hospital Assessment Fund - This fund consists of monies collected from an assessment on hospitals for the purposes of funding a portion of the non-federal share of the Medicaid expansion and the entire Proposition 204 population on and after January 1, 2014.

- Third Party Liability and Recovery Audit Fund - This fund is comprised of monies recovered from first and third party payers under various AHCCCS recovery programs prior to disbursement to the appropriate parties, contractors and programs. These programs primarily include casualty, special treatment trusts, estate, health insurance recoveries, and recovery audit collections.

(4) Other governmental funds (continued)

- Substance Abuse Services Fund - This fund consists of monies received from a surcharge in the amount of thirteen percent on every fine, penalty and forfeiture imposed and collected by the courts for criminal offenses and civil penalties pursuant to ARS § 12-116.02. AHCCCS may expend monies in the fund for administration of the fund and for drug screening, education or treatment for persons who have been ordered by the court to attend and who do not have sufficient financial ability to pay.

- Substance Abuse Services Fund - Alcohol - This fund consists of monies received from a surcharge in an amount of thirteen percent on every fine, penalty and forfeiture imposed and collected by the courts for criminal offenses and civil penalties pursuant to ARS § 12-116.02. AHCCCS may expend monies in the fund for administration of the fund and for alcohol screening, education or treatment for persons who have been ordered by the court to attend and who do not have sufficient financial ability to pay.

- Seriously Mentally Ill Housing Trust Fund - This fund consists of monies received from the sale of abandoned property and investment earnings. AHCCCS may expend monies for housing projects and rental assistance for seriously mentally ill persons.

- Miscellaneous Funds - These funds account for various grants and other money received for specific purposes including the Hawaii Arizona PMMIS Alliance (“HAPA”). HAPA represents AHCCCS’ project with Hawaii whereby AHCCCS provides data processing services for Hawaii’s Medicaid program. The Federal Grants Fund includes the behavioral health grants awarded to the agency by the SAMHSA.

(dollar amounts expressed in thousands)

(4) Other governmental funds (continued)

Other governmental funds earned, expended and transferred during the fiscal year ended June 30, 2025 were as follows:

	Fund Balance June 30, 2024	Revenues	Interest Earned	Expenditures	Transfers In/(Out)	Fund Balance June 30, 2025
Tobacco Tax and Health Care Fund, Medically Needy Account	$ -	$ 51,528	$ -	$ (50,828)	$ (700)	$ -
Tobacco Products Tax Fund, Emergency Health Services Account	-	13,482	-	(13,482)	-	-
Trauma and Emergency Services Fund	-	41,318	-	(41,318)	-	-
Nursing Facility Assessment Fund	-	100,125	-	(100,125)	-	-
Hospital Assessment Fund	165,761	672,045	-	(538,545)	-	299,261
Third Party Liability and Recovery Audit Fund	-	6,367	-	(6,367)	-	-
Substance Abuse Services Fund	110	1,100	-	(1,062)	-	148
Substance Abuse Services Fund - Alcohol	204	729	-	(703)	-	230
Seriously Mentally Ill Housing Trust Fund	13,476	2,035	493	(3,037)	(4,000)	8,967
Miscellaneous Funds	2,071	177,501	274	(162,678)	(14,574)	2,594
	$ 181,622	$1,066,230	$ 767	$ (918,145)	$ (19,274)	$ 311,200

(dollar amounts expressed in thousands)

(5) Retirement plan

AHCCCS contributes to the Arizona State Retirement System ("ASRS" or the "Plan") described below. The Plan is a component unit of the State of Arizona.

Statement of Net Position and Statement of Activities	Governmental Activities
Net pension assets	$ -
Net pension liabilities	84,557
Deferred outflows of resources	15,378
Deferred inflows of resources	5,718
Pension expenses	8,505

AHCCCS' accrued payroll and employee benefits includes no amounts of outstanding pension contribution amounts payable to all pension plans for the year ended June 30, 2025. In addition, AHCCCS reported $9,330 of pension contributions as expenditures in the governmental funds related to all pension plans to which it contributes.

Plan description - AHCCCS employees participate in the ASRS. The ASRS administers a cost-sharing multiple-employer defined benefit pension plan, a cost-sharing multiple-employer defined benefit health insurance premium benefit ("OPEB") plan, and a cost-sharing multiple-employer defined benefit long-term disability ("OPES") plan. The Arizona State Retirement System Board governs the ASRS according to the provisions of A.R.S. Title 38, Chapter 5, Articles 2 and 2.1. The ASRS issues a publicly available financial report that includes its financial statements and required supplementary information. The report is available on its Web site at www.azasrs.gov.

Benefits provided - The ASRS provides retirement, health insurance premium supplement, long-term disability, and survivor benefits. State statute establishes benefit terms. Retirement benefits are calculated on the basis of age, average monthly compensation, and service credit as follows:

ASRS	Retirement Initial membership date:	
	Before July 1, 2011	On or after July 1, 2011
Years of service and age required to receive benefit	Sum of years and age equals 80 10 years age 62 5 years age 50* any years age 65	30 years age 55 25 years age 60 10 years age 62 5 years age 50* any years age 65
Final average salary is based on	Highest 36 consecutive months of last 120 months	Highest 60 consecutive months of last 120 months
Benefit percent per year of service	2.1% to 2.3%	2.1% to 2.3%

*With actuarially reduced benefits.

(dollar amounts expressed in thousands)

(5) Retirement plan (continued)

Retirement benefits for members who joined the ASRS prior to September 13, 2013, are subject to automatic cost-of-living adjustments based on excess investment earning. Members with a membership date on or after September 13, 2013, are not eligible for cost-of-living adjustments. Survivor benefits are payable upon a member's death. For retired members, the survivor benefit is determined by the retirement benefit option chosen. For all other members, the beneficiary is entitled to the member's account balance that includes the member's contributions and employer's contributions, plus interest earned.

Contributions - In accordance with state statutes, annual actuarial valuations determine active member and employer contribution requirements. The combined active member and employer contribution rates are expected to finance the costs of benefits employees earn during the year, with an additional amount to finance any unfunded accrued liability. For the year ended June 30, 2025, active ASRS members were required by statute to contribute at the actuarially determined rate of 12.27 percent (12.12 percent for retirement and 0.15 percent for long-term disability) of the members' annual covered payroll, and AHCCCS was required by statute to contribute at the actuarially determined rate of 12.27 percent (12.05 percent for retirement, 0.07 percent for health insurance premium benefit, and 0.15 percent for long-term disability) of the active members' annual covered payroll. In addition, AHCCCS was required by statute to contribute at the actuarially determined rate of 10.19 percent (10.14 percent for retirement, 0.00 percent for health insurance premium benefit, and 0.05 percent for long-term disability) of annual covered payroll of retired members who worked for AHCCCS in positions that would typically be filled by an employee who contributes to the ASRS.

During fiscal year 2025, AHCCCS paid for ASRS pension contributions as follows: 95.5 percent from the General Fund and 4.5 percent from other governmental funds.

Pension liability - At June 30, 2025, AHCCCS reported a liability of $84,557 for its proportionate share of the ASRS' net pension liability. The net pension liability was measured as of June 30, 2024. The total pension liability was determined by an actuarial valuation as of June 30, 2023, and rolled forward using generally accepted actuarial procedure to June 30, 2024. AHCCCS's proportion of the net pension liability was based on AHCCCS's actual contributions to the plan relative to the total of all participating employers' contributions for the year ended June 30, 2024. AHCCCS's proportion measured as of June 30, 2024, was 0.52843 percent, which was a decrease of 0.00288 percent from its proportion measured as of June 30, 2023 of 0.53131.

Pension expense and deferred outflows/inflows of resources - For the year ended June 30, 2025, AHCCCS recognized pension expense for ASRS of $8,505. At June 30, 2025, AHCCCS reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

ASRS	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 4,720	$ -
Change in assumptions	-	-
Net difference between projected and actual earnings on pension plan investments	-	5,400
Changes in proportion and differences between AHCCCS contributions and proportionate share of contributions	1,328	318
AHCCCS contributions subsequent to the measurement date	9,330	-
Total	$ 15,378	$ 5,718

(dollar amounts expressed in thousands)

(5) Retirement plan (continued)

The $9,330 reported as deferred outflows of resources related to ASRS pensions resulting from AHCCCS contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ending June 30, 2026. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to ASRS pension will be recognized as an increase (decrease) in pension expense as follows:

Years Ending June 30		
2026	$	3,986
2027		(1,367)
2028		(991)

Actuarial assumptions – The significant actuarial assumptions used to measure the total pension liability are as follows:

ASRS	
Actuarial valuation date	June 30, 2023
Actuarial roll forward date	June 30, 2024
Actuarial cost method	Entry age normal
Asset valuation Method	Fair Value
Discount rate of return	7.0%
Projected salary increases	2.9 – 8.4%
Inflation	2.3%
Permanent benefit increase	Included
Mortality rates	2017 SRA Scale U-MP

The actuarial assumptions related to funding were selected on the basis of an experience study which was performed for the five-year period ending June 30, 2020. The ASRS Board adopted the experience study which recommended changes, and those changes were effective as of the June 30, 2021 actuarial valuation.

The actuarial assumptions pertain to assumptions utilized for financial reporting purposes. They differ from the assumptions utilized for funding purposes. The principal difference between the actuarial assumptions for financial reporting purposes and those utilized for funding purposes are the amortization methodology and the valuation of assets.

(dollar amounts expressed in thousands)

(5) Retirement plan (continued)

The long-term expected rate of return on ASRS pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target allocation and best estimates of geometric real rates of return for each major asset class are summarized in the following table:

Asset Class	Target Asset Allocation	Long-term Expected Geometric Real Rate of Return
Public Equity	44%	4.48%
Credit	23%	4.40%
Real Estate	17%	6.05%
Private Equity	10%	6.11%
Interest Rate Sensitive	6%	(0.45)%
Total	100%	

Discount rate - The discount rate used to measure the ASRS total pension liability was 7.0 percent. The projection of cash flows used to determine the discount rate assumed that contributions from participating employers will be made based on the actuarially determined rates based on the ASRS Board's funding policy, which establishes the contractually required rate under Arizona statute. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Sensitivity of AHCCCS' proportionate share of the ASRS net pension liability to changes in the discount rate - The following table presents AHCCCS' proportionate share of the net pension liability calculated using the discount rate of 7.0 percent, as well as what AHCCCS' proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1 percentage point lower (6.0 percent) or 1 percentage point higher (8.0 percent) than the current rate:

	1% Decrease	Current Discount Rate	1% Increase
	(6.0%)	(7.0%)	(8.0%)
AHCCCS' proportionate share of the net pension liability	$ 129,474	$ 84,557	$ 47,122

Pension plan fiduciary net position - Detailed information about the pension plan's fiduciary net position is available in the separately issued ASRS financial report.

OPEB provided as part of state employment include the ASRS sponsored cost-sharing plan for the Long-Term Disability Fund and the Health Benefit Supplement Fund, as well as the Arizona Department of Administration sponsored single employer defined benefit post-employment plan.

(dollar amounts expressed in thousands)

(5) Retirement plan (continued)

Cost-sharing plan - The ASRS provides health insurance premium supplemental benefits and disability benefits to retired members, disabled members, and eligible dependents through the Health Benefit Supplement Fund ("HBS") and the Long-Term Disability Fund ("LTD"), which are cost-sharing, multiple-employer defined benefit postemployment plans. Title 38, Chapter 5 of the Arizona Revised Statutes ("ARS") assigns the authority to establish and amend the benefit provisions of the HBS plan and the LTD plan to the Arizona State Legislature.

(6) Other postemployment benefits (OPEB)

The ASRS issues a publicly available financial report that includes the financial information and disclosure requirements for the HBS plan and the LTD plan. That report may be obtained by visiting www.azasrs.gov.

Contributions - For the ASRS HBS and LTD plans, contributions are recognized as revenues when due, pursuant to statutory and contractual requirements. Benefits and refunds are recognized when due and payable and expenses are recorded when the corresponding liabilities are incurred, regardless of when contributions are received or payments are made.

Funding policy - The contribution requirements of plan members and AHCCCS are established by Title 38, Chapter 5 of the ARS. These contribution requirements are established and may be amended by the Arizona State Legislature. For the year ended June 30, 2025, active ASRS members and AHCCCS were each required by statute to contribute at the actuarially determined rate of 0.15 percent of the members' annual covered payroll for LTD. AHCCCS also contributed 0.07 percent for the HBS. In addition, AHCCCS was required to contribute 0.05 percent for long-term disability based on annual covered payroll for retired members who worked for AHCCCS in positions that an employee who contributes to ASRS would typically fill. However, in 2025 AHCCCS was not required to contribute to the health benefits supplemental fund (HBS) for these employees. AHCCCS' contributions for the current and two preceding years for OPEB, all of which were equal to the required contributions, were as follows:

Fiscal Year	Health Benefit Supplemental Fund	Long-term Disability Fund
2025	$ 54	$ 116
2024	80	109
2023	76	97

Changes in AHCCCS' OPEB liability (asset) for the HBS and LTD plans during fiscal year 2025 were as follows:

	HBS	LTD	TOTAL
Beginning balances	$ (2,927)	$ 70	$ (2,857)
Increases	1,446	228	1,674
Decreases	(1,785)	(284)	(2,069)
Ending balances	$ (3,266)	$ 14	$ (3,252)

For the year ended June 30, 2025, OPEB expense totaled approximately $(413).

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

At June 30, 2025, AHCCCS reported deferred outflows of resources and deferred inflows of resources related to the HBS and LTD OPEB plans from the following sources:

ASRS	HBS + LTD Deferred Outflows of Resources	HBS + LTD Deferred Inflows of Resources
Differences between expected and actual experience	$ 146	$ 826
Change in assumptions	10	117
Change in proportions	21	56
Difference between projected and actual investment earnings	-	240
AHCCCS contributions subsequent to the measurement date	170	-
Total	$ 347	$ 1,239

Actuarial assumptions - The actuarial assumptions used to determine the OPEB liability for the HBS and LTD plans are presented in the following table:

ASRS	
Actuarial valuation date	June 30, 2023
Measurement date	June 30, 2024
Actuarial cost method	Entry age normal
Asset valuation method	Fair value
Investment rate of return	7.0%
Inflation	2.3%
Mortality rates (HBS)	2017 SRS Scale U-MP
Recovery rates (LTD)	2012 GLDT

Actuarial assumptions used in the June 30, 2023 valuation were based on the results of an actuarial experience study for the 5-year period ended June 30, 2020.

The actuarial assumptions pertain to assumptions utilized for financial reporting requirements and differ from the assumptions utilized for funding purposes. The principal differences between the actuarial assumptions for financial reporting purposes and those utilized for funding purposes are the amortization methodology and valuation of assets.

The long-term expected rate of return on HBS and LTD plan investments is the same as that for ASRS pension plan investments. The method used to derive this rate is described in Note 5.

Discount rate - The discount rate used to measure the total HBS and LTD liability was 7.0 percent. The projection of cash flows used to determine the discount rate assumed that contributions from participating employers will be made based on the actuarially determined rates based on the ASRS Board's funding policy, which establishes the contractually required rate under Arizona statute. Based on those assumptions, the fiduciary net position of the HBS and LTD Funds was projected to be available to make all projected future benefit payments of current members. Therefore, the long-term expected rate of return on investments was applied to all periods of projected benefit payments to determine the total HBS and LTD liability.

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

Sensitivity of AHCCCS' proportionate share of the net ASRS OPEB liability to changes in the discount rate - The following table presents AHCCCS' proportionate share of the net ASRS OPEB liability calculated using the discount rate of 7.0 percent, as well as what AHCCCS' proportionate share of the net ASRS OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (6.0 percent) or 1 percentage point higher (8.0 percent) than the current rate:

	1% Decrease	Current Discount Rate	1% Increase
	(6.0%)	(7.0%)	(8.0%)
AHCCCS' proportionate share of the net HBS liability	$ (2,374)	$ (3,266)	$ (4,024)
AHCCCS' proportionate share of the net LTD Liability	$ 48	$ 14	$ (20)

Schedule of Net Deferred Outflows and Inflows of Resources by Employer to be Recognized in HBS and LTD expense:

Fiscal Year	HBS	LTD
2025	$ (616)	$ (24)
2026	(148)	(3)
2027	(149)	(23)
2028	(64)	(21)
2029	(11)	(8)
Thereafter	-	(6)

Single-employer plan

The Arizona Department of Administration ("ADOA") administers a single-employer defined benefit post-employment plan (ADOA Plan) that provides medical and accidental benefits to retired State employees and their dependents. Title 38, Chapter 4 of the ARS assigns the authority to establish and amend the benefit provisions of the ADOA Plan to the Arizona State Legislature. The ADOA pays the medical costs incurred by retired employees, net of related premiums, which are paid entirely by the retiree or on behalf of the retiree. These premium rates are based on a blend of active employee and retiree experience, resulting in a contribution basis that is lower than the expected claim costs for retirees, creating an implicit subsidization of retirees by the ADOA Plan. ADOA does not issue a separate, publicly available financial report for the ADOA Plan; however, the State of Arizona Annual Comprehensive Financial Report presents state-wide prior year information, which can be obtained by visiting gao.az.gov. A portion of the ADOA Plan's implicit rate subsidy, if not fully funded, represents an obligation of AHCCCS for its proportionate share of the net OPEB obligation.

Since the plan does not have a formal trust, GASB Statement No. 75 requires state and local government employers to recognize the total OPEB liability and the OPEB expense on their financial statements, along with the related deferred outflows and inflows of resources.

In addition to the deferred outflows/inflows related to plan experience and assumption changes, GASB Statement No. 75 states the benefit payments and administrative costs incurred subsequent to the measurement date and before the end of the employer's reporting period should be reported as a deferred outflow of resources.

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

Funding policy - The ADOA's current funding policy is pay-as-you-go for OPEB benefits. There are no dedicated assets at this time to offset the actuarial accrued liability.

OPEB expense and total OPEB liability - AHCCCS' proportionate share of OPEB expense and changes in the OPEB liability of the ADOA Plan for year ended June 30, 2025, are as follows:

Statement of OPEB Expenses

Service Cost	$ 1,090
Interest on total OPEB liability	438
Expensed portion of current-period changes of assumptions	-
Recognition of beginning of the year deferred inflows as OPEB expense	(21)
Amortization of current year outflows (inflows) due to liabilities	(2,214)
OPEB expense	$ (707)

Schedule of Change of Total OPEB Liability and Related Ratios:

Service Cost	$ 1,090
Interest on total OPEB liability	438
Changes of benefit terms	-
Difference between expected and actual experience of the total OPEB liability	-
Difference between expected and actual experience from the change in Proportionate Share	-
Changes of assumptions	(171)
Expected benefit payments	(307)
Net change in total OPEB liability	1,050
Total OPEB liability at 6/30/2024	10,409
Total OPEB liability at 6/30/2025	$ 11,459

At June 30, 2025, AHCCCS reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

ADOA	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 147	$ 12,153
Change in assumptions	2,400	4,492
Change in proportion	606	223
AHCCCS contributions subsequent to the measurement date	355	-
Total	$ 3,508	$ 16,868

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

Deferred Outflows and Deferred Inflows to be Recognized in Future OPEB Expense:

Years Ending June 30,	
2026	$ (1,943)
2027	(2,449)
2028	(3,037)
2029	(2,780)
2030	(2,096)
Thereafter	(1,410)
Total	$ (13,715)

Statement of Outflows and Inflows Arising from Current Reporting Period:

	Recognition Period (or amortization years)	Total (Inflow) or Outflow	2024 Recognized in current OPEB expense	Deferred (Inflow) or Outflow in future expense
Due to Liabilities:				
Differences in expected and actual experience	8.1274	$ -	$ -	$ -
Assumption changes	8.1274	(171)	(21)	(150)
Total		$ (171)	$ (21)	$ (150)

Actuarial methods and assumptions - The actuarial assumptions used to value the liabilities include assumptions of the health care trend assumptions, the aging factors as well as the cost method used to develop the OPEB expenses. The demographic assumptions are based on the same as those used in the Arizona State Retirement System Annual Actuarial Valuation as of June 30, 2023. Since the prior measurement date, the discount rate changed from 3.86% as of June 30, 2023 to 3.97% as of June 30, 2024.

The ADOA Plan's actuarial methods and significant assumptions for a measurement date as of June 30, 2024 are as follows:

Actuarial valuation date	June 30, 2023
Measurement date	June 30, 2024
Reporting date	June 30, 2025
Actuarial cost method	Individual entry age normal
Discount rate	3.97% as of June 30, 2024
Inflation	2.30%
Salary increases	0.00% to 5.50%, not including wage inflation of 2.90%
Health care cost trend rates	Pre-65: Initial rate of 7.20% declining to an ultimate rate of 4.25% after 16 years; Post-65: Initial rate of 5.10% declining to an ultimate rate of 4.25% after 10 years

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

Mortality rates	Healthy Employee	Pub-2010 General Employee Mortality table Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2017.
	Healthy Retirees and Spouses	2017 State Retirees of Arizona mortality table. Generational mortality improvements in accordance with the Ultimate MP scales (through 2020) and projected from the year 2017.
	Disabled Retirees	Pub-2010 Disabled Retiree Mortality. Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2017.
Participation Trends		35% of employees not currently waiving medical coverage eligible to return and receive subsidized postretirement welfare coverage were assumed to elect medical coverage. Active members currently declining coverage were assumed to decline coverage at retirement. 30% of retirees are assumed to also have a spouse that elects coverage.

Discount rate – The discount rate for ADOA OPEB funded entirely on a pay-as-you-go basis is the yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA or higher (or equivalent quality on another rating scale). For the measurement date of June 30, 2024, the index value of Bond Buyer 20-Bond General Obligation Municipal Bond was used.

The discount rate equals the tax-exempt municipal bond rates based on the index of 20-year general obligation bonds with an average AA credit rating as of the measurement date. For the purposes of this valuation the municipal bond rate is 3.97%. The discount rate was 3.86% as of the prior measurement date.

Sensitivity of AHCCCS' proportionate share of the ADOA OPEB liability to changes in the discount rate and health care cost trend rates - The following table presents AHCCCS' proportionate share of the ADOA OPEB liability calculated using the discount rate of 3.97%, as well as what AHCCCS' proportionate share of the ADOA OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (2.97%) or 1 percentage point higher (4.97%) than the current rate.

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

Also shown is the OPEB liability computed with the current health care cost trend rates and with the trend rates that are 1 percentage point lower or 1 percentage point higher than the current rates:

	1% Decrease	Current Discount Rate	1% Increase
	(2.97%)	(3.97%)	(4.97%)
Sensitivity of Total OPEB Liability to the Discount Rate Assumption	$ 13,176	$ 11,459	$ 10,061

	1% Decrease	Current Healthcare Cost Trend Rate Assumption	1% Increase
Sensitivity of Total OPEB Liability to the Healthcare Cost Trend Rate Assumption	$ 9,654	$ 11,459	$ 13,766

(7) Budgetary basis of accounting

The financial statements of AHCCCS are prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). AHCCCS, like other State agencies, prepares its annual operating budget on a basis that differs from the GAAP basis. Encumbrances as of June 30th can be liquidated during a four-week administrative period known as the 13th month. The budget basis expenditures reported in the financial statements include both the fiscal year paid and the 13th month activity. The State does not have a legally adopted budget for revenues. AHCCCS' controlling statute for programmatic payments administrative adjustment procedures varies from the statutory requirement of other State agencies. AHCCCS is permitted to pay for approved system covered medical services presented after the close of the fiscal year in which they were incurred with either remaining prior year or current year available appropriations.

(dollar amounts expressed in thousands)

(7) Budgetary basis of accounting (continued)

The following is a reconciliation of the GAAP Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds to the budgetary comparison schedules for the year ended June 30, 2025:

	General Fund Actual
Budgetary Basis Fund Balance, June 30, 2025	$ 874,909
Budgetary Basis of Accounting	
Increases to fund balance:	
Due from state, county and local governments	320,006
Due from the federal government (net)	766,876
Due from other fund	17,466
Tobacco settlement receivable	51,000
Receivables and other	1,077,876
Total increases	2,233,224
Decrease to fund balance:	
Cash	$ (1,369)
Unearned revenue	(38,677)
Due to state, county and local governments	(453,805)
Accrued programmatic costs	(1,755,329)
Payables and other	(88,478)
Unavailable revenue, net	(406,725)
Total decreases	(2,744,383)
Total GAAP basis fund balance	$ 363,750

Non-appropriated expenditures of $3,789,349 in the General Fund consist primarily of federal and state matching pass-through payments to other agencies.

(8) Contingencies, risks and uncertainties

COVID-19 - On March 11, 2020, the World Health Organization declared the outbreak of a respiratory disease caused by a new coronavirus as a "pandemic". First identified in late 2019 and now known as COVID-19, the outbreak has impacted millions of individuals worldwide. In response, many countries have implemented measures to combat the outbreak which have impacted global business operations.

In response to the growing COVID-19 pandemic, on March 18, 2020, President Trump signed into law H.R. 6021, the Families First Coronavirus Response Act ("FFCRA") (Pub. L. 116-127). Section 6008 of the FFCRA provided a temporary 6.2 percent increase to the FMAP extending through the last day of the calendar quarter in which the Public Health Emergency (“PHE”) terminates. One of the conditions of receipt of the enhanced federal match was a maintenance of effort ("MOE") requirement, prohibiting AHCCCS from terminating the enrollment of any individual enrolled in the program as of the date of the beginning of the PHE period, as well as individuals enrolled during the PHE period. This condition had a significant impact on AHCCCS' enrollment. It required the state continue coverage for members who may have had a change in income that would otherwise result in discontinuance. On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted, which further clarified states could begin redeterminations in February 2023 with the disenrollments beginning April 2023 and prescribed the 6.2 percentage point increase to the FMAP was phased out over the course of Calendar Year 2023. The enhanced FMAP was 6.2 percentage points through the quarter ended March 31, 2023, 5.0 percentage points in the quarter ended June 30, 2023,

(8) Contingencies, risks and uncertainties (continued)

2.5 percentage points in the quarter ended September 30, 2023, and 1.5 percentage points in the quarter ended December 31, 2023. Although the FMAP increase is no longer directly tied to the end of the PHE, the Department of Health and Human Services expired the PHE as of May 11, 2023. Effective April 2023, AHCCCS began processing eligibility redeterminations. In April 2023 AHCCCS enrollment was 2,492,034. By June 2025, AHCCCS enrollment was 1,971,674, a decrease of 520,360.

Following the national and state emergency declarations in March 2020, AHCCCS received authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. Some of these flexibilities are: expanded coverage of telehealth and telephonic codes reimbursed at the same level of reimbursement offered for in-person services; initiatives to support use of influenza vaccinations during the COVID outbreak; increase in annual hours of respite care; reimbursement of Home and Community Based Services provided by parents; elimination of the 40 hour limit on family caregiver services provided by a member's spouse; expand the provision of home delivered meals to members enrolled in Department of Economic Security/Developmental Disabilities ("DES/DD"); and allowance for students to receive medically necessary services from managed care organizations ("MCOs") rather than the Medicaid School Based Claiming program as children attend school virtually from home. The CMS approvals were granted in late March to early April 2020.

In addition to the program flexibilities, COVID-19 impacted some of the agency's collection activities. CMS approved AHCCCS' request for emergency authorities to support Arizona's response to COVID-19. For the duration of the PHE, AHCCCS waived payment of the provider enrollment application fee as well as suspended the application of premiums for children enrolled in Arizona's CHIP program (KidsCare) and adults in the Freedom-to Work program. AHCCCS resumed billing providers the enrollment application fee in April 2022. In addition, AHCCCS resumed billing premiums for adults in the Freedom-to-Work program in September 2024.

The Substance Abuse and Mental Health Services Administration ("SAMHSA") awarded AHCCCS grants to address the behavioral health impacts due to the pandemic. These grants include the following:

- COVID-19 Block Grants for Prevention and Treatment of Substance Abuse
- COVID-19 Block Grants for Community Mental Health Services

In addition to the FFCRA, on March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (“ARPA”) (Pub.L. 117-2) into law. Section 9817 of the ARPA provides qualifying states with a temporary 10 percentage point increase to the “FMAP” for certain Medicaid expenditures for “HCBS”. On May 13, 2021, CMS published State Medicaid Director Letter (“SMDL”) #21-003, which further clarified the qualifying services, improvement activities, and reporting requirements expected of states under Section 9817 of the ARPA. The increased FMAP was available for qualifying expenditures between April 1, 2021, and March 31, 2022.

In accordance with Section 9817(b) of the ARPA, states must comply with two program requirements to receive the increased FMAP rate for “HCBS” expenditures: (1) federal funds attributable to the increased FMAP must be used to supplement existing state funds, (2) states must use the state funds equivalent to the amount of federal funds attributable to the increased FMAP rate, to implement or supplement the implementation of one or more activities to strengthen HCBS under the Medicaid program.

(8) Contingencies, risks and uncertainties (continued)

On January 19, 2022, CMS granted conditional approval to AHCCCS' spending plan. Arizona has identified four key populations at the center of the efforts outlined in its spending plan. They include: (a) Arizona's seniors, (b) individuals with disabilities, (c) individuals living with a Serious Mental Illness ("SMI"), and (d) children with behavioral health needs. Additionally, this spending plan will allow for transformational change of the delivery system, which will enhance care delivery to individuals who are accessing general mental health and substance use services.

States will be permitted to use the state funds equivalent to the amount of the federal funds attributable to the increase FMAP rate through March 31, 2025, on activities aligned with the goals of ARPA.

Budget neutrality agreement - In January 2001, AHCCCS obtained a Waiver from CMS to receive federal funding for certain non- categorically linked populations including those made eligible by the November 2000 passage of Proposition 204. The Waiver requires over the term of the original agreement (April 1, 2001 through September 30, 2011) and the new agreement (October 1, 2011 through September 30, 2021), the population covered by the Waiver be budget neutral for CMS.

It should be noted on September 30, 2021, the waiver was extended for one additional federal fiscal year ending September 30, 2022. On September 27, 2022, CMS approved a temporary extension of the Waiver to October 28, 2022 in order to allow Arizona and CMS to continue negotiations over the extension application. On October 14, 2022, CMS extended the Waiver through September 30, 2027. As part of this extension, the five-year period from October 1, 2022 through September 30, 2027 has a budget neutrality agreement specific to those five years. Effective with the January 1, 2014 implementation of the eligibility expansion under the ACA to include the new adult group, members with income between 100% and 133% of the FPL, the budget neutrality measurement is performed separately for the new adult population.

Budget neutral means CMS will not pay more for medical services with the Waiver than it would without the Waiver. The Waiver Special Terms and Conditions include a monitoring arrangement that requires AHCCCS to report the financial results of the Waiver on a quarterly basis. For the demonstration period beginning on October 1, 2016, the net variance is phased down by an applicable percent. The percentages are determined based on how long the Medicaid population has been enrolled in managed care subject to the demonstration. Under the terms, AHCCCS is limited to only retaining 25 percent of the total variance as future savings. The budget neutrality calculation is dependent on a number of variables including the number of members and the eligibility category of members. Other factors that impact the variance are the general economy and its impact on unemployment, medical inflation and policy decisions made by the Legislature may impact program costs. Through September 30, 2022, AHCCCS remained under the cumulative reporting limit threshold and does not project any liability related to the budget neutrality agreement.

With the new extension waiver flexibilities, the budget neutrality limit on Title XIX funding still needs to be monitored per the Special Terms and Conditions, "XVI. MONITORING BUDGET NEUTRALITY". The budget neutrality expenditure limit is determined either by using a per capita cost method or aggregate basis, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing Federal Financial Participation without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations,

(8) Contingencies, risks and uncertainties (continued)

CMS assures the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. The Agency projects it will stay within the budget neutrality limits during the demonstration period from October 1, 2022, through September 30, 2027. Therefore, AHCCCS does not currently anticipate the need for federal funding to be returned to CMS due to exceeding the budget neutrality limitations. However, there can be no assurance AHCCCS will not exceed the budget neutrality limitations and federal funding will be returned to CMS.

Litigation and investigations - AHCCCS has been named as a defendant in a variety of litigation, all of which are being defended by in-house and external legal counsel. It is the opinion of AHCCCS upon consultation with legal counsel, that none of the claims are likely to have a material adverse effect on AHCCCS' financial statements. In addition, AHCCCS believes the funding of any material adverse judgment, sanction or repayment obligation in excess of its appropriation would require a special appropriation by the State or would qualify for coverage by the Arizona Department of Administration, Risk Management Division which is tasked with the management and mitigation of liability, property and workers' compensation claims.

Compliance with laws and regulations - AHCCCS is subject to numerous laws, regulations and oversight by the federal government. These laws and regulations include, but are not necessarily limited to, matters such as government health care program participation requirements, reimbursement for member services and Medicaid fraud and abuse. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of significant financial sanctions.

Managed care drug rebates - In fiscal 2017, the DHHS OIG commenced a review of managed care drug rebates in Arizona for 2010 – 2013. The HHS OIG issued a report in February 2018 for their review of managed care drug rebates in Arizona from April through March 2013. The OIG's report noted instances in which physician-administered drugs were not properly submitted to the drug manufacturers for rebate. The HHS OIG recommended AHCCCS bill and collect from manufacturers, work with CMS to determine other physician-administered drugs were eligible for rebates and, if so, return the federal share.

AHCCCS plans to bill and collect the appropriate amount of rebates for single-source and top-20 multiple source physician-administered drugs during the audit period after thoroughly reviewing the disputed utilization records with the contracted rebate vendor. However, AHCCCS disagrees with the OIG finding that Arizona was required to obtain rebates for other physician-administered drugs during the audit period and is communicating with CMS to determine whether these drugs were eligible for rebates.

This audit, Arizona Pharmacy Rebate Audit – AZ Audit A-09-16-02031, has been pending with CMS for several years, and no adverse findings have been issued. Their latest communication to AHCCCS dated August 16, 2022, states they have been working with federal OIG and the CMS Division of Pharmacy and are close to a decision on the audit. No further communication has been received from CMS regarding this matter as of the date of this report.

It is unclear if AHCCCS will be able to collect rebates from the drug manufacturers on such old claims. As such, AHCCCS views any recoveries as a gain contingency and will not record any amounts until received. Further, as the repayments to CMS are predicated on the receipt of the drug rebates, AHCCCS has not recorded any liability to CMS through June 30, 2025.

Provider billing matter – AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in outpatient behavioral health services. AHCCCS connected the irregular billing with alleged criminal activity targeting tribal communities and other Arizonans.

(8) Contingencies, risks and uncertainties (continued)

Under 42 C.F.R. 455.23, when the State Medicaid Agency has conducted a preliminary investigation and a reliable indicia of fraud has been identified, the agency must suspend payments to a provider if a law enforcement agency accepts the State's referral unless good cause is established pursuant to federal regulations. In AHCCCS's case, a Memorandum of Understanding governs the referral relationship between AHCCCS Office of the Inspector General and the Arizona Attorney General's Office, Health Care Fraud & Abuse Section. At the point a referral is made and payment is suspended, only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation AHCCCS will terminate a provider's enrollment and require repayment of the identified overpayment as a result of a fraud determination.

In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program. As the extent of the fraud was revealed, AHCCCS recognized the need for holistic and systemwide changes. AHCCCS partnered with the Attorney General and Governor's Office to develop a comprehensive plan to address the loopholes fraudulent providers were exploiting. Stop gap strategies implemented include, but are not limited to the following:

- Increased scrutiny of claims based on claims volume.
- Issued a moratorium on new provider registrations for impacted provider types.
- Prevented Reimbursement of Claims for Impossibly Rendered Services.
- Claims for Substance Abuse Services for Children under the age of 12 to Require Clinical Review Prior to Payment.
- Set thresholds for services to initiate a prepayment review.
- Required claims to be billed for specific dates of service rather than ranges.
- Flagged claims for services of the same style/overlapping codes.
- Created a prepayment review process for providers utilizing suspicious billing practices.
- Eliminated retroactive billing.
- Credible Allegation of Fraud ("CAF") suspensions include both provider entities and owners/ behavioral health ("BH") practitioners.
- Implemented ID.Me identity verification for AHCCCS Online.
- Required providers to disclose any third-party billing relationships.
- Behavioral Health Providers are now considered high-risk provider types for provider enrollment.
- Per Diem codes have been set to only be able to be billed once per day.
- Practitioners, including Behavioral Health Technicians, can no longer be patients at the same provider.
- Worked with the Arizona Corporation Commission to flag suspicious registrations.
- Ensured AHCCCS coding adhered to National Correct Coding Initiative ("NCCI") standards and confirmed no edits had been turned off.
- Streamlined AHCCCS reporting of potential inappropriate conduct of licensed professionals to the appropriate professional oversight boards.
- Implemented eligibility integrity requirements for AIHP enrollment.
- Linked BHPs to BH companies they work for.
- Linked BH Providers to BH facilities they work at.
- Requiring medical records to define specialized services.
- Conducting onsite reviews for high-risk quality of care referrals within 90 days.

(8) Contingencies, risks and uncertainties (continued)

Additional agency efforts since May 2023 include:

- Creation and publication of the Covered Behavioral Health Services Guide to connect all relevant AHCCCS policies and explain how they interact in the Behavioral Health System of Care
- Robust changes to our AHCCCS Provider Enrollment System to address Fraud, Waste and Abuse ("FWA") issues
- Update to the Behavioral Health Residential Facilities policy (to be published shortly) to provide greater detail and clarity for providers and members about what should and should not be included in services rendered by this provider type
- Creation of the prepayment review process for FFS claims and inclusion of data measurement to allow for agile modification going forward to respond to over utilization or abuse of codes
- Creation of the Community Partner Assistor Organization Reviews to prevent abuse of access to the HEA+ system
- Designated pathways of partnering on large scale quality of care investigations between the Division of Fee for Service and MCOs to prevent unnecessary member impact
- Social media campaign to encourage the public to report FWA/abuse & neglect
- Requirement of all providers to transition to Electronic Funds Transfer
- Removed the phone attestation option for AIHP enrollment, and are in the process of implementing the AIHP verification process with tribal partners and IHS based on utilization
- MOUs with AZ Board of BH Examiners and Board of Nursing to promote interagency information sharing and referrals, as well as the close referral relationship with ADHS
- Regular Public BH System Cross-Agency Collaboration meetings including all agencies, boards, commissions and the GO in the public health space
- Updates to the provider enrollment policy in the AHCCCS Medicaid Policy Manual ("AMPM") 610, explicitly requiring many more disclosures of providers, and making it clear without full and transparent registration information, providers will be terminated or denied enrollment with AHCCCS
- Implementation of Alivia--a new AI powered data analytics platform for pre-pay and post-pay claims analysis
- Implemented policies which required Behavioral Health Professionals, required to oversee the clinical services provided at BHRFs and Outpatient Behavioral Health Clinics, to be reported upon registration and be listed on claims submissions

Stop gap strategies in process include, but may not be limited to, the following:

- Conducting onsite quality of care reviews for patients in treatment longer than 90 days.
- Implementing a new pre/post pay claims system.

AHCCCS continues to investigate and identify areas of concern and implement necessary system improvements to enhance Agency operations and program integrity.

A determination of any potential liability cannot be made at this time as AHCCCS is still in the process of investigating provider billing issues. As of August 2026, 333 providers were suspended on or since May 16, 2023. 46 have received decisions following a hearing in front of an Administrative Law Judge at the Office of Administrative Hearings in which these provider suspensions have been upheld. 235 suspended providers have appealed out of 333 providers who have been suspended. Independently, AHCCCS may resolve a provider civil liability and demand repayment of funds improperly paid out. AHCCCS may also remove a provider suspension when further investigation has identified there is no longer a reliable indicia of fraud, but the provider still owes AHCCCS an overpayment for improperly paid claims. AHCCCS has rescinded 181 provider suspensions with additional actions including terminations, exclusions, overpayments, and civil monetary penalties.

(8) Contingencies, risks and uncertainties (continued)

AHCCCS OIG's identification and recovery of overpayment pursuant to investigations of currently suspended providers involves review of each provider's billing data, assessment of the legitimacy of any of those services, and calculation of the loss to AHCCCS (overpayment) caused by those illegitimate services. The likelihood of recovering the total amount paid to suspended providers is exceedingly low, because the actual loss to AHCCCS suffered in each case is not equivalent to the total amount AHCCCS paid to that provider. Some suspended providers were paid by AHCCCS for both legitimate services rendered to AHCCCS members and illegitimate services which were not rendered. Therefore, OIG's investigations include a manual process to distinguish these payments.

AHCCCS' ability to collect funds identified as overpayments is further dependent on outside factors, including the progress of criminal prosecution, provider solvency, and criminal attempts to disguise and move funds beyond the reach of authorities.

Recovery of funds may happen through criminal proceedings with restitution orders or by civil recoveries undertaken by AHCCCS. Distinguishing between these routes of recovery involves collaboration with law enforcement to identify cases that are appropriate for civil recovery led by AHCCCS rather than criminal prosecution.

Due to the scale of recent fraud, OIG has developed a new process to identify overpayments and assess civil penalties that it will apply in cases designated for civil recovery and will begin to operationalize this process in the coming weeks. This process includes mandatory notification to providers of their right to appeal determinations which can result in delay. For insolvent or undiscoverable providers, actual recovery will be delayed while AHCCCS seeks collection. In overpayment cases previously, AHCCCS has been open to repayment plans with providers for up to 24 months, to allow providers to remain solvent while repaying AHCCCS. For those providers who have actively concealed their assets, recovery will be difficult.

All of the above factors make it challenging to accurately forecast future recoupment totals. Pursuant to 42 C.F.R. 433, Subpart F, AHCCCS is required to refund the Federal share of all overpayments made to providers unless the providers are bankrupt or out of business. The Federal share generally equates to approximately 75% of the total amount overpaid to a provider. The repayment must occur within one year of the discovery of an overpayment as calculated beginning with the date AHCCCS provides written notice to a provider of an overpayment determination. Note, the repayment obligation is applicable without regard to whether AHCCCS is successful in recovery of an overpayment from the provider, however, there is an exception if a provider is out of business or bankrupt. Given the extent of the fraud, AHCCCS anticipates that overpayment written determinations which trigger the legal obligation to refund federal funds will occur on an individual case-by-case basis as investigations are concluded over the next months and years.

The Federal government will likely conduct a review to ensure that AHCCCS has correctly identified and determined overpayments as well as appropriately refunded federal funds. If a negative finding is made, future federal funding may be disallowed in the amount of the federal funds not remitted. AHCCCS has retained outside counsel experienced in negotiating resolutions with the federal government on these issues to assist in the mitigation of this risk.

(8) Contingencies, risks and uncertainties (continued)

Beginning in fiscal year 2024, several complaints were filed against AHCCCS, DHS, and the State of Arizona seeking damages from the death or injuries sustained by current members allegedly arising from the failure of these individuals to receive appropriate addiction treatment and/or damages for the wrongful death of an AHCCCS member due to the behavioral health/sober living home fraud scheme. From August 2023 through the date these financial statements were available to be issued, the State of Arizona, and AHCCCS, have been named in seven lawsuits and have received 42 Notices of Claims. Of these seven lawsuits, either the lawsuit has been dismissed entirely or AHCCCS has been dismissed as a defendant for all but one. Of the 42 Notices of Claims, for all but two, no lawsuit was filed and the 1-year statute of limitations has expired. For the remaining lawsuit, Plaintiffs have claimed approximately $10,000 in damages. For the remaining two Notices of Claims, Plaintiffs have claimed approximately $11,300 in damages. However, given that no lawsuits have been filed in connection with the Notices of Claim, and for those matters in litigation, no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such figures and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

In August 2024, the State of Arizona received a Class Action Notice of Claim identifying subclasses for certain AHCCCS members and alleging injuries or wrongful death of the claimants. The lawsuit was subsequently filed in December 2024. AHCCCS intends to vigorously defend these matters. Management, upon consultation with internal and external counsel, notes that these matters are in the early stages, and a Motion to Dismiss has been filed. Plaintiffs have in the aggregate claimed approximately $395,000 to $430,000 in damages, however, given that the lawsuit is in the early stages, and no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS intends to vigorously defend these matters.

Additionally, in fiscal year 2024, AHCCCS was served with several lawsuits and several Notices of Claim from AHCCCS behavioral health providers alleging AHCCCS improperly suspended and/or terminated provider participation agreements, “blacklisted” the providers, and “slow paid” claims. Management, upon consultation with internal and external counsel, notes that many of these claims are in the early stages. Through the date these financial statements were available to be issued, the State of Arizona, and AHCCCS, have been named in 11 lawsuits and have received eight Notices of Claims. Of these 11 lawsuits, for eight, the provider dismissed their claims, and no other lawsuit has been filed within the 1-year statute of limitations. For the eight Notices of Claims, no lawsuits were filed and the statute of limitations has expired. For the three remaining lawsuits, Plaintiffs have claimed approximately $508,506 in damages. AHCCCS notes that no evidence has been disclosed to support such figures and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

In August 2024, the Arizona Attorney General’s Office received a letter from attorneys purporting to represent a group of providers/facilities, and facility owners with potential claims against AHCCCS/the State arising from the suspension and/or termination of medical provider licenses or payments to providers. A number of these claimants have submitted Notices of Claim which are discussed above. Others appear to have not yet asserted claims. Management, upon consultation with internal and external counsel, notes that these matters are in the very early stages. Plaintiffs initially in the aggregate claimed approximately $1,162,288 in damages. Subsequently, in January 2025, the group of providers filed suit against several parties including the State, AHCCCS and the AHCCCS Director alleging negligence, gross negligence, racial discrimination, lack of due process, and breach of contract, among others. Management, upon consultation with internal and external counsel, notes that these matters are in the early stages. Plaintiffs in the aggregate claimed approximately $1,000,000 in damages in the initial lawsuit. However, in light of the dismissal of multiple plaintiffs with the first amended complaint, and their most recent litigation settlement demand, the estimated damages are now estimated by legal counsel to total approximately $14,000.

(8) Contingencies, risks and uncertainties (continued)

Given these matters are in the early stages, and no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

AHCCCS Member Verification – In June 2025, an Arizona state senator alleged that AHCCCS failed to screen applicants for income and asset eligibility, resulting in approximately 20,000 millionaires being eligible for Medicaid. AHCCCS denied the allegations and maintains that it is in compliance with all the eligibility requirements as outlined in the State Plan. Pursuant to the Arizona State Plan with CMS, AHCCCS only has resource limits for the Long-Term Care Program ("ALTCS") and the Supplemental Security Income ("SSI") Cash Program. For SSI Cash, resources are verified by the Social Security Administration ("SSA"). In addition, Arizona is a 1634 State. 1634 States automatically enroll individuals who are approved for SSI benefits. The SSA determines Medicaid eligibility for SSI recipients, and no separate application for Medicaid is required.

Federal Medicaid law requires asset tests for some Aged, Blind, and Disabled eligibility categories, but not all (42 CFR §435.601). In Arizona there are individuals who are Aged, Blind, or Disabled ("ABD") enrolled across a variety of AHCCCS programs, including programs that have both income and resource limits (ALTCS and SSI Cash) and programs that only have income limits, such as the Medicare Savings Programs, AHCCCS Freedom to Work Program, and AHCCCS Complete Care ("ACC") plans.

For ALTCS asset verification, AHCCCS uses the New England States Consortium Systems Organization ("NESCSO"). NESCSO contracts with Public Consulting Group ("PCG"), and LexisNexis is a subcontractor of PCG for asset verification. This process is built into AHCCCS' eligibility system and is run on every ALTCS application when it is initially submitted and at each renewal. For SSI Cash, resources are verified by the Social Security Administration (42 CFR §435.120).

(9) Interfund receivables, payables and transfers

Interfund activity is defined as transactions between funds administered by AHCCCS. The interfund balances as of June 30, 2025 consist of transfers from the Other Funds to the General Fund in the amount of $17,466.

In the government-wide statement of activities, the interfund activity has been eliminated. The total net transfers out of $93,506 reported on the statement of activities represents transfer activities to other State agencies.

(dollar amounts expressed in thousands)

(10) Transactions with other State agencies and counties

Transactions with other State agencies and counties - AHCCCS contracts for administrative and programmatic services from other State agencies. Charges for administrative services are based on the performing agencies' actual cost. Charges for programmatic services are generally based on actuarially determined capitation rates. The following is a summary of contracted services provided:

Administrative services - The Arizona Department of Economic Security ("ADES") charges AHCCCS to determine eligibility for certain AHCCCS members. The Arizona Department of Administration charges AHCCCS for data center services, communication lines, risk management and training. The Arizona Department of Health Services ("ADHS") charges AHCCCS for licensure and screening services and administrative costs associated with the CHIP Vaccine for Children program and the Arizona State Immunization Information System. The Arizona Board of Nursing charges AHCCCS for the cost of administering the nurse aid training program for nurse assistants. The Arizona Office of Administrative Hearings charges AHCCCS for administrative hearing services. These expenditures are included in administrative expenditures or other sources (uses) in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds.

The following is a summary of transactions with these State agencies for the administrative services described above for the year ended June 30, 2025:

	Expenditures
Arizona Department of Economic Security	$ 120,711
Arizona Department of Administration	21,618
Arizona Department of Health Services	128
Arizona Board of Nursing	-
Arizona Office of Administrative Hearings	442

Programmatic services - Certain health care related programmatic services are provided by ADES. AHCCCS receives the State and federal funds for these services and transfers them to ADES pursuant to the terms of an intergovernmental agreement.

The amount of $3,873,505 passed through to ADES for the year ended June 30, 2025 is classified as long-term care services expenditures in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds.

The amount of $7,030 paid to the Department of Health Services in fiscal year 2025 is for the vaccine costs based on the CDC Federal Contract Price sheet.

Long-term care revenues include $399,872 from Arizona counties during fiscal year 2025. AHCCCS refunded to the counties $36,165 for fiscal year 2025 representing excess of revenue over expenditures.

(dollar amounts expressed in thousands)

(11) Other pass-through funds

Arizona school districts are eligible for federal matching funds for the administrative functions related to Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") outreach services at the school level. Arizona school districts also are eligible for federal matching funds on a fee-for-service basis for the provision of certain AHCCCS program services provided to eligible students. These amounts are included within federal pass-through funds in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds.

Arizona county and local governments contributed $167,813 to qualify for matching federal funds for the Graduate Medical Education, Disproportionate Share Hospital program payments and for the provision of qualifying services to hospitalized inmates. These amounts are included within county IGA pass through funds in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds.

Arizona counties contributed $4,914 as determined by statutory calculation for administrative costs incurred by ADES for eligibility determinations and other operating costs associated with Proposition 204.

For the year ended June 30, 2025, AHCCCS recorded the following pass through revenue in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds:

	Funds Passed Through
Arizona School Districts	
Administrative Services Federal Funds	$ 21,648
Program Services Federal Funds	43,518
Arizona Department of Economic Security	
County Contribution for Administrative Costs	4,914
	$ 70,080

(12) Concentrations and constraints

For the year ended June 30, 2025, AHCCCS implemented the provisions of GASB Statement No. 102, *Certain Risk Disclosures*. AHCCCS is substantially dependent on federal financial participation funding received through the Medicaid program administered by CMS. This dependence represents a significant concentration because federal funding comprises a significant portion of the resources used to finance AHCCCS operations and healthcare services provided to eligible Arizona residents. Subsequent to June 30, 2025, AHCCCS became aware of certain communications from federal agencies, as described in Note 13, that could affect future Medicaid funding, reimbursement methodologies, program requirements, or other sources of federal financial participation. Because of AHCCCS' significant reliance on federal funding, any substantial reduction, delay, suspension, termination, or restriction of such funding could adversely affect AHCCCS' ability to provide healthcare services to eligible Arizona residents and could have a substantial impact on the Agency's financial position, operations, and the State's ability to administer its Medicaid program. AHCCCS continues to monitor federal regulatory developments and evaluate the potential financial and operational impacts.

(13) Subsequent events

AHCCCS has evaluated subsequent events through September 14, 2026 which is the date the financial statements were available to be issued.

(13) Subsequent events (continued)

AHCCCS enrollment – AHCCCS enrollment overall, for the period June 2025 to June 2026, is currently forecasted to go from 1,971,674 to approximately 1,835,754, which would represent a loss of approximately 135,920 members for a 6.9 percent decrease. Enrollment has steadily declined since the PHE unwinding process, bringing membership levels closer to pre-pandemic trends and reflecting a more consistent pattern aligned with historical norms.

Working Families Tax Cut Act (aka One Big Beautiful Bill Act) – On July 4, 2025, President Trump signed into law the One Big Beautiful Bill Act (H.R. 1). This budget reconciliation legislature includes significant Medicaid reforms that will affect AHCCCS operations and funding. The federal government estimates these Medicaid reforms will reduce federal spending by more than $800 billion between fiscal years 2026 and 2034, primarily through coverage reductions, eligibility adjustments, and shifts of costs to the states. These reductions are expected to shift substantial financial burdens to states such as Arizona, particularly as federal matching funds tighten and administrative obligations grow. AHCCCS has incorporated the impact in the budget fiscal year 2027 Budget Request.

AHCCCS anticipates these federal changes to result in substantial impacts, including potential coverage losses for members over time due to work requirements, eligibility restrictions, and other provisions. The full extent of the financial and operational impact on AHCCCS and its future fiscal position is currently under assessment and not yet reasonably estimable at this time. Although many of the most significant fiscal impacts will phase in beginning fiscal year 2026–2027, AHCCCS has started addressing the structural, administrative, and budgetary implications during fiscal year 2026. Community engagement and six months' eligibility are expected to be the most impactful.

There are current discussions at the state levels to modify Medicaid funding methodologies which could significantly decrease Medicaid funding. The potential exists that certain funding changes passed into law could trigger either the session law or statutory requirement that AHCCCS stop collection of the Hospital Assessment if the ACA is repealed or if the FMAP for the expansion and restoration populations, as authorized by the ACA, falls below 80.0 percent. Such an outcome would likely disrupt the revenue stream supporting the Hospital Assessment Fund, leading to insufficient funding to maintain current program levels. Consequently, AHCCCS would most likely need to adjust eligibility standards, scale back services, or reduce provider reimbursement to align with the reduced available funds, potentially impacting access to care for enrolled populations.

Budget fiscal year 2027 - In June 2026, the budget fiscal year 2027 was signed into law. This budget includes $23 billion in appropriations and expenditure authority for AHCCCS plus $5 billion in appropriations and expenditure authority for the DDD Medicaid program within DES. The budget includes limited and one-time funding for the implementation of and administrative activities stemming from H.R.1. H.R.1 requires the State to conduct eligibility redeterminations for Medicaid expansion adults at least every six months beginning January 1, 2027. H.R.1 also imposes community engagement requirements on the same population and requires the State to monitor compliance with these requirements.

Contract year 2026 capitation rates - For the contract year ending 2026, AHCCCS' overall weighted capitation rate increased by 13.52 percent across all lines of business except the Department of Economic Security/Developmental Disabilities program, as compared to an overall weighted AHCCCS capitation rate increase of 6.82 percent for contract year 2025. The contract year 2026 Arizona Long Term Care System ("ALTCS" Elderly and Physically Disabled ("EPD")) capitation rates increased by 4.75 percent as compared to the 1.97 percent increase for contract year 2025. The contract year 2026, AHCCCS Complete Care and related programs ("ACC/RBHA/CHP"), aggregate capitation rates increased by 15.11 percent as compared to the 7.68 percent increase for contract year 2025. The 2026 increases are primarily based on increased average acuity of the population as healthier people continue to leave the program and people with higher health needs remain, baseline utilization and unit trends, changes in pharmacy expenses and adjustments to

(13) Subsequent events (continued)

reflect the costs to administer and manage the programs. It is important to note that federal law requires rates to be actuarially sound and the AHCCCS actuaries develop rates based on expected cost and utilization trends. In addition, AHCCCS must conduct an access to care analysis of its rates to assure that sufficient numbers of providers are willing to serve AHCCCS members. Therefore, depending on the results of this analysis and of AHCCCS' actuarial determination of the expected costs of the managed care organizations, the actual capitation rates could differ from projections.

AHCCCS fiscal 2026 and 2027 appropriations - The total fiscal year 2026 appropriation for AHCCCS is $22,659 million, compared to the final $21,059 million appropriation for fiscal year 2025. AHCCCS' budget request for fiscal year 2027 and budget revision, was submitted to the Governor in August 2025 and November 2025, respectively. Management anticipates that a supplemental appropriation for 2026 will be required to address the funding needs associated with the mid-year capitation rate increases, driven by higher member acuity resulting from the recent decrease in enrollment.

ALTCS-EPD Update – In 2024, AHCCCS paused member transition activities for the procurement of new contracts under the Arizona Long Term Care System-Elderly and/or Physically Disabled (ALTCS-EPD) program, originally scheduled to begin October 1, 2024. Following an Administrative Law Judge recommendation favorable to the appellants, AHCCCS issued a Director's Decision on September 8, 2024, denying the appeals. The Decision determined that AHCCCS properly exercised its discretion in the procurement process and that non-awarded plans failed to timely protest alleged deficiencies. AHCCCS initially planned to proceed with awards to Health Net Access, Inc. (dba Arizona Complete Health-Long Term Care Plan) and Arizona Physicism's IPA, Inc. (dba UnitedHealthcare Community Plan), while extending existing contracts through September 30, 2025. The non-awarded health plans filed appeals in Maricopa County Superior Court seeking judicial review.

In 2025, a settlement agreement was initially reached that would have allowed a transition to new contracts beginning October 1, 2025; however, a subsequent legal challenge resulted in a court-issued stay that halted implementation of the new contracts. In August 2025, AHCCCS notified members of a one-year extension of the current contracts with Mercy Care, Banner-University Family Care, and Arizona Physicians IPA through September 30, 2026, effective October 1, 2025.

AHCCCS has since terminated the YH24-0001 ALTCS-EPD procurement, and the related contract awards that were issued in December 2023. A new health plan proposal for the ALTCS-EPD program will be issued by AHCCCS with submissions for the new procurement expected to be due in the Fall of 2026. As a result, the pending Superior Court matter was dismissed as moot.

This extension and termination maintain continuity of care for ALTCS-EPD members while AHCCCS prepares for a fresh procurement process.

AHCCCS Data Breach – In August 2025, a data breach occurred involving misaddressed member communications. The incident occurred during a routine mailing to members regarding their health plan enrollment. AHCCCS was alerted by a member who received a letter addressed to a different individual. AHCCCS immediately halted its mailing process and launched an internal investigation.

The breach resulted in the disclosure of limited protected health information (PHI) including member names, AHCCCS identification numbers (A#), and health plan names for 3,177 members. No Social Security numbers, financial data, or clinical information were involved.

(13) Subsequent events (continued)

AHCCCS has taken the following steps to mitigate the issue, including:

- Halting the mailing process immediately upon discovery.
- Conducting a thorough review of the mailing system and procedures.
- Notifying affected members and offering guidance on how to protect their information.

AHCCCS remains committed to safeguarding member data. In accordance with federal and state privacy laws, AHCCCS has taken all necessary steps to assess the scope of the breach, notify affected individuals, and prevent future incidents.

Managed care drug rebates - On November 13, 2025, HHS OIG notified AHCCCS of their intention to conduct an audit of rebates for physician-administered and pharmacy drugs claimed by AHCCCS. The objective of the audit is to determine whether AHCCCS complied with Federal Medicaid requirements for billing manufacturers for rebates for physician-administered and pharmacy drugs. The audit period will include physician-administered and pharmacy drug claims paid during the period January 1, 2023, through September 30, 2025.

AHCCCS is in the process of gathering and providing documentation and responding to information requests related to this audit. Management is actively cooperating with HHS OIG to facilitate a thorough review, and we will evaluate any developments for appropriate recognition or further disclosure in subsequent periods.

As of the date of these financial statements, the audit is ongoing, and no findings have been issued. Management does not currently anticipate any material adjustments or other significant impacts from this audit. However, as with any ongoing audit, potential findings—should they arise—could result in rebate-related recoveries, federal funding adjustments, or other consequences, though the amount of any such impact, if any, cannot be reasonably estimated at this time.

Rural Health Transformation Program Funding – On December 29, 2025, the Centers for Medicare & Medicaid Services (“CMS”) announced awards under the Rural Health Transformation Program, a $50 billion federal initiative over five years (fiscal years 2026 through 2030) established pursuant to the Working Families Tax Cuts legislation. The program aims to strengthen and modernize health care in rural communities nationwide by expanding access to care, enhancing the rural health workforce, modernizing facilities and technology, and supporting innovative care models.

Arizona has been awarded $166,988,956 for the first year (2026), as part of the statewide allocations averaging approximately $200 million. Management is in the process of assessing the operational and financial impacts of this award and will continue to monitor developments and provide updates in future periods as implementation progresses. No material contingencies or adjustments related to this award have been identified at this time.

AHCCCS Leadership Changes – On April 30, 2025, Carmen Heredia resigned as the director of AHCCCS and Kristen Challacombe was appointed as interim director. Subsequent to June 30, 2025, the following additional significant leadership changes occurred at AHCCCS:

- On September 26, 2025, Governor Katie Hobbs appointed Virginia “Ginny” Rountree as Director, effective October 6, 2025, succeeding the interim director, Kristen Challacombe.
- On February 2, 2026, Director Rountree announced her resignation effective February 13, 2026, due to personal health reasons.
- On February 13, 2026, Governor Hobbs appointed Roberta Harrison as interim director, succeeding Virginia Rountree.

(13) Subsequent events (continued)

These changes in leadership do not affect the financial position or results of operations as of June 30, 2025. Management does not anticipate any material impact on ongoing operations from these transitions but will continue to monitor developments.

Arizona Alliance for Community Health Centers Litigation – In the litigation filed in 2019 *Arizona Alliance for Community Health Centers et al. v. AHCCCS*, the federal district court issued a decision adverse to AHCCCS in March 2026 concerning the reimbursement of "physician services" (services those provided by dentists, podiatrists, optometrists, and chiropractors) at federally qualified health centers (FQHCs) under the Medicaid Act. The Court enjoined AHCCCS from enforcing or applying limitations to these services. AHCCCS has appealed the ruling and has requested the Court to stay its judgment pending the appeal. AHCCCS has also filed a State Plan Amendment with CMS, clarifying its longstanding policy and practice of reimbursing physician services in FQHCs which, if approved, will become effective January 2026, predating the March ruling. The outcome of the appeal and potential financial impact cannot be determined at this time. Any required adjustments to reimbursement policies or rates resulting from a final resolution may affect future capitation rates or operational costs.

National Health Care Fraud Takedown – In June 2026, as part of the National Health Care Fraud Takedown, the Arizona Attorney General's Office announced 42 indictments across ten cases involving alleged fraudulent Medicaid billing, among other charges. This includes two cases that specifically reference schemes to defraud AHCCCS.

Additionally, the U.S. Attorney's Office for the District of Arizona announced federal charges against individuals in connection with schemes allegedly involving over $1.2 billion in false or fraudulent claims to federal health care programs, including specific allegations related to an Arizona substance abuse treatment clinic that billed AHCCCS approximately $44.9 million (with AHCCCS paying approximately $36.7 million).

These are allegations, and all defendants are presumed innocent until proven guilty. Management is monitoring these matters and any related investigations, potential recoveries, or impacts on the program. At this time, the financial impact, if any, on the June 30, 2025, financial statements cannot be reasonably estimated. AHCCCS intends to continue cooperating with law enforcement and pursuing appropriate program integrity actions.

Medicaid Work Requirements Lawsuit – In June 2026, Arizona, through Attorney General Kris Mayes, joined a coalition of 25 states and the District of Columbia in a federal lawsuit challenging the Centers for Medicare and Medicaid Services' (CMS) interim final rule implementing new Medicaid community engagement (work) requirements under H.R.1. The lawsuit, filed in the U.S. District Court for the District of Massachusetts, contends that certain provisions of the rule are unlawful. The outcome of litigation and any potential impact on AHCCCS operations, eligibility determinations, or program costs cannot be determined at this time.

Arizona Auditor General Report - Subsequent to fiscal year-end, the Arizona Auditor General issued a report regarding the implementation of statutory requirements applicable to the Parents as Paid Caregivers service delivery model administered through the Arizona Long Term Care System. The report concluded that certain cost-control measures required by state law, including implementation of a standardized assessment tool and other program limitations, were not fully implemented and estimated that the resulting delay may have contributed to increased program costs and reduced potential cost savings.

(13) Subsequent events (continued)

AHCCCS management has informed the Auditor General that it disagrees with several findings and conclusions contained in the report. Specifically, management noted that operational and policy considerations, substantial litigation risks, and ongoing efforts to evaluate and revise program requirements affected the implementation and timelines of various aspects of the Parents as Paid Caregivers service delivery model. AHCCCS management further believes that the estimates of potential cost reductions are subject to significant assumptions and uncertainties. AHCCCS management is evaluating the report's findings and recommendations and any related operational, regulatory, or financial implications. As of the date the financial statements were available to be issued, no repayment demands, federal disallowances, or other liabilities had been asserted against AHCCCS and/or DES related to these matters, and the ultimate outcome, if any, cannot be reasonably estimated. Accordingly, no amounts have been recorded in the accompanying financial statements.

Federal Funding Compliance Matter and Concentration – Subsequent to fiscal year-end, the State of Arizona received a letter dated July 14, 2026, from the U.S. Department of Health and Human Services (HHS) notifying the State of Arizona that it was not in compliance with federal Single Audit submission requirements for fiscal year 2025 and requested a corrective action plan. The letter indicates that, if the matter is not resolved, HHS may impose additional oversight or enforcement actions, including the temporary withholding of federal payments, disallowance of costs, or suspension or termination of federal awards. Additionally, on August 19, 2026, the State received correspondence from the Centers for Medicare and Medicaid Services (CMS) advising that Arizona's fiscal 2025 Single Audit reporting package is delinquent under 2 CFR part 200. The notice stated that continued noncompliance may result in Federal remedies, including potential withholding of payments or other actions. State management has responded to CMS regarding the status of the audit. AHCCCS receives a significant portion of its funding through federal programs administered by HHS, including funding from the Centers for Medicare & Medicaid Services (CMS). Accordingly, AHCCCS is subject to concentration risk associated with continued availability of federal funding and compliance with applicable federal requirements, as described in Note 12. Any significant reduction, delay, suspension, or termination of such federal funding could have a material adverse effect on AHCCCS' ability to fund healthcare services and could negatively impact the financial position and operations of both AHCCCS and the State of Arizona. AHCCCS management is working with the State and federal agencies to address the matter and is not currently able to determine the likelihood or extent of any future actions or impact on operations.

REQUIRED SUPPLEMENTARY INFORMATION

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BUDGETARY COMPARISON SCHEDULE - GENERAL FUND

Year Ended June 30, 2025
(Unaudited)
(amounts expressed in thousands)

	Original Appropriation (Budget)	Final Appropriation (Budget)	Actual	Variance with Final Budget
REVENUES				
State appropriations	$ -	$ -	$ 2,577,723	$ -
State ISA pass through funds	-	-	1,135,364	-
Federal government	-	-	13,392,835	-
Federal ISA/IGA pass through funds	-	-	2,955,851	-
County and other local government	-	-	526,143	-
County IGA pass through funds	-	-	336,537	-
Tobacco tax revenue	-	-	28,170	-
Tobacco litigation settlement	-	-	83,737	-
Other	-	-	721,669	-
Total revenues	-	-	21,758,029	-
OTHER FINANCING SOURCES				
Operating transfers in	-	-	-	-
TOTAL REVENUES AND OTHER FINANCING SOURCES	-	-	21,758,029	-
PROGRAMMATIC EXPENDITURES				
Traditional services	7,881,643	7,806,143	7,729,290	76,853
Proposition 204 services	6,859,520	6,848,520	6,191,924	656,596
Newly eligible adults	675,982	675,982	620,615	55,367
Comprehensive Health Plan (CHP)	216,754	212,978	195,091	17,887
KidsCare services	170,533	166,757	153,596	13,161
Targeted investment	56,000	56,000	680	55,320
Disproportionate share	5,087	5,087	268	4,819
Rural and critical access hospitals	28,417	28,417	28,219	198
Voluntary Political Subdivision Programs	534,577	534,577	437,752	96,825
Long-term care services	2,410,323	2,348,406	2,185,326	163,080
Behavioral health services	94,278	94,278	83,779	10,499
Behavioral support services	79,466	79,466	28,136	51,330
TOTAL PROGRAMMATIC EXPENDITURES	19,012,580	18,856,611	17,654,676	1,201,935
ADMINISTRATIVE EXPENDITURES	329,879	331,711	298,846	32,865
TOTAL APPROPRIATED EXPENDITURES	19,342,459	19,188,322	17,953,522	1,234,800
PRIOR YEAR APPROPRIATED EXPENDITURES	-	-	-	-
NON-APPROPRIATED EXPENDITURES	-	-	3,789,349	-
REVENUES AND OTHER FINANCING SOURCES OVER EXPENDITURES	-	-	15,158	-
FUND BALANCES, BEGINNING OF YEAR	-	-	859,751	-
FUND BALANCES, END OF YEAR	$ -	$ -	$ 874,909	$ -

See Notes to Financial Statements
See Independent Auditors' Report

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF THE AGENCY'S PROPORTIONATE SHARE OF THE NET PENSION LIABILITY - COST SHARING PLAN

(Unaudited)

(amounts expressed in thousands)

	Reporting Fiscal Year (Measurement Date)											
	2025 (2024)	2024 (2023)	2023 (2022)	2022 (2021)	2021 (2020)	2020 (2019)	2019 (2018)	2018 (2017)	2017 (2016)	2016 (2015)	2015 (2014)	2014 through 2006
Agency's proportion of the net pension liability	0.528430%	0.531310%	0.501860%	0.512800%	0.504300%	0.522860%	0.537230%	0.529910%	0.470770%	0.455146%	0.470599%	Information
Agency's proportionate share of the net pension liability	$ 84,557	$ 85,974	$ 81,915	$ 67,380	$ 87,378	$ 76,082	$ 74,925	$ 82,550	$ 75,987	$ 70,896	$ 69,633	not available
Agency's covered payroll	$ 72,934	$ 69,354	$ 59,542	$ 59,622	$ 54,760	$ 54,785	$ 53,128	$ 49,620	$ 42,430	$ 42,770	$ 43,181	
Agency's proportionate share of the net pension liability as a percentage of its covered payroll	115.94%	123.96%	137.58%	113.01%	159.57%	138.87%	141.03%	166.36%	179.09%	165.76%	161.26%	
Plan fiduciary net position as a percentage of the total pension liability	76.93%	75.47%	74.26%	78.58%	69.33%	73.24%	73.40%	69.92%	67.06%	68.35%	69.49%	

See Notes to Financial Statements
See Independent Auditors' Report

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF THE AGENCY'S PENSION CONTRIBUTIONS

(Unaudited)

(amounts expressed in thousands)

	Fiscal Year									
	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Statutorily required contribution	$ 8,888	$ 8,774	$ 8,267	$ 7,151	$ 6,946	$ 6,270	$ 6,125	$ 5,792	$ 5,349	$ 4,604
Agency's contributions in relation to the statutorily required contribution	8,888	8,774	8,267	7,151	6,946	6,270	6,125	5,792	5,349	4,604
Agency's contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Agency's covered payroll	$ 73,759	$ 72,934	$ 69,354	$ 59,542	$ 59,622	$ 54,760	$ 54,785	$ 53,128	$ 49,620	$ 42,430
Agency's contributions as a percentage of its covered payroll	12.05%	12.03%	11.92%	12.01%	11.65%	11.45%	11.18%	10.90%	10.78%	10.85%

See Notes to Financial Statements
See Independent Auditors' Report

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
SCHEDULE OF CHANGES IN THE AGENCY'S TOTAL OPEB LIABILITY AND RELATED RATIOS

(Unaudited)
(amounts expressed in thousands)

	Reporting Fiscal Year (1) (Measurement Date)							
	2025 (2024)	2024 (2023)	2023 (2022)	2022 (2021)	2021 (2020)	2020 (2019)	2019 (2018)	2018 (2017)
Total OPEB Liability								
Service cost	$ 1,090	$ 1,540	$ 2,313	$ 2,376	$ 2,063	$ 1,526	$ 1,043	$ 1,397
Interest on the total OPEB liability	438	743	482	774	801	636	555	532
Changes of benefit term	-	-	-	-	-	-	-	(1,452)
Difference between expected and actual experience	-	(10,298)	-	(9,360)	-	768	-	(436)
Difference between expected and actual experience - Change in Proportion	-	(298)	-	809	-	1,174	-	-
Changes of assumptions or other inputs	(171)	373	(6,470)	(520)	3,403	5,038	(687)	(3,783)
Benefit payments	(307)	(519)	(467)	(601)	(532)	(481)	(448)	(478)
Net changes	$ 1,050	$ (8,459)	$ (4,142)	$ (6,522)	$ 5,735	$ 8,661	$ 463	$ (4,220)
Total OPEB liability - beginning	10,409	18,868	23,010	29,532	23,797	15,136	14,673	18,893
Total OPEB liability - ending (2)	$ 11,459	$ 10,409	$ 18,868	$ 23,010	$ 29,532	$ 23,797	$ 15,136	$ 14,673
Covered-employee payroll	$ 72,611	$ 70,565	$ 60,259	$ 58,560	$ 56,671	$ 55,181	$ 50,072	$ 48,756
Total OPEB liability as a percentage of covered-employee payroll	15.78%	14.75%	31.31%	39.29%	52.11%	43.13%	30.23%	30.09%

(1) AHCCCS implemented GASB 75 in fiscal year 2018. Therefore, 10 years of data is not yet available, but will accumulate over time.
(2) There are no dedicated assets at this time to offset the total OPEB liability.

UNIFORM GUIDANCE SUPPLEMENTARY REPORTS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended June 30, 2025
(amounts expressed in thousands)

Federal Grantor/Pass Through Agency/Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Grantor Identifying Number	Contract Number	Passed through to Subrecipients	Federal Expenditures
U.S. Department of Health and Human Services					
Centers for Medicare and Medicaid Services					
Medical Assistance Program (Medicaid; Title XIX)	93.778	N/A	11-W-00275/09	$ -	$ 16,442,951
COVID-19 Medical Assistance Program (Medicaid; Title XIX)	93.778	N/A	11-W-00275/09	-	172,417
Total Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster				-	16,615,368
Centers for Medicare and Medicaid Services					
Children's Health Insurance Program (Title XXI)	93.767	N/A	21-W-00074/09	-	327,501
COVID-19 Children's Health Insurance Program (Title XXI)	93.767	N/A	21-W-00074/09	-	14
Total Children's Health Insurance Program (Title XXI)				-	327,515
Substance Abuse and Mental Health Services Administration					
Block Grants for Community Mental Health Services	93.958	N/A	B09SM087334	1,811	2,171
Block Grants for Community Mental Health Services	93.958	N/A	B09SM089599	13,819	14,311
Block Grants for Community Mental Health Services	93.958	N/A	B09SM090317	3,421	3,421
Block Grants for Community Mental Health Services	93.958	N/A	B09SM087276	170	170
Block Grants for Community Mental Health Services	93.958	N/A	B09SM089137	299	299
COVID-19 Block Grants for Community Mental Health Services	93.958	N/A	B09SM085862	86	86
COVID-19 Block Grants for Community Mental Health Services	93.958	N/A	B09SM083960	2,777	2,973
COVID-19 Block Grants for Community Mental Health Services	93.958	N/A	B09SM085335	9,947	12,483
Total Block Grants for Community Mental Health Services				32,330	35,914
Substance Abuse and Mental Health Services Administration					
Block Grants for Prevention and Treatment of Substance Abuse	93.959	N/A	B08TI085792	1,055	4,992
Block Grants for Prevention and Treatment of Substance Abuse	93.959	N/A	B08TI087024	28,943	34,737
Block Grants for Prevention and Treatment of Substance Abuse	93.959	N/A	B08TI088091	7,750	7,752
Block Grants for Prevention and Treatment of Substance Abuse	93.959	N/A	B08TI084568	111	111
COVID-19 Block Grants for Prevention and Treatment of Substance Abuse	93.959	N/A	B08TI083525	2,563	2,748
COVID-19 Block Grants for Prevention and Treatment of Substance Abuse	93.959	N/A	B08TI083927	11,032	14,897
Total Block Grants for Prevention and Treatment of Substance Abuse				51,454	65,237
Substance Abuse and Mental Health Services Administration					
Projects for Assistance in Transition from Homelessness (PATH)	93.150	N/A	X06SM088801	1,350	1,399
Substance Abuse and Mental Health Services Administration					
Projects of Regional and National Significance (93.243)					
Arizona Pilot Program for Treatment for Pregnant and Postpartum Women	93.243	N/A	H79TI08171	3,827	4,071
Centers for Disease Control and Prevention					
Activities to Support State, Tribal, Local and Territorial (STLT) Health Department Response to Public Health or Healthcare Crises	93.391	N/A	6NU58DP006992-03-03	-	106
COVID-19 Activities to Support State, Tribal, Local and Territorial (STLT) Health Department Response to Public Health or Healthcare Crises	93.391	N/A	6NU58DP006992-03-03	-	196
Total				-	302
Centers for Disease Control and Prevention					
COVID-19 Community Health Workers For Public Health Response and Resilient	93.495	N/A	NU58DP006992	1,124	1,871
Substance Abuse and Mental Health Services Administration					
State Opioid Response (SOR)	93.788	N/A	H79TI085739, H79TI087838	23,298	33,606
Health Careers Opportunity Program	93.822	N/A	5D18HP32129-05-00	-	13
Total U.S. Department of Health and Human Services				113,383	17,085,296
U.S. Department of Treasury					
Passed through the Office of the Arizona Governor					
COVID-19 - The Coronavirus State and Local Fiscal Recovery Funds (SLFRF)	21.027	EL9HZNBAN1B9	ISA-ARPA-AHCCCS-110122-01 & ISA-AHCCCS-ARPA-070121-01	10,500	44,846
Total U.S. Department of Treasury				10,500	44,846
TOTAL EXPENDITURES OF FEDERAL AWARDS				$ 123,883	$ 17,130,142

See Independent Auditors' Report
See Notes to Schedule of Expenditures of Federal Awards

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended June 30, 2025

(1) Basis of presentation

The accompanying Schedule of Expenditures of Federal Awards (the "Schedule") includes the federal grant activity of the ***Arizona Health Care Cost Containment System*** ("***AHCCCS")*** under programs of the federal government for the year ended June 30, 2025. The information in the Schedule is presented in accordance with the requirements of *Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Because the Schedule presents only a selected portion of the operations of ***AHCCCS,*** it is not intended to and does not present the financial position, changes in net position or cash flows of ***AHCCCS.***

Additionally, our audit of ***AHCCCS'*** major federal programs was conducted as part of the State of Arizona's Single Audit for the year ended June 30, 2025. The State of Arizona's major federal programs were determined by the Office of the Auditor General by applying the risk-based approach for determining major federal programs in accordance with the Uniform Guidance. Our Report on Compliance for Each Major Federal Program relates only to the portion of the programs that were administered by ***AHCCCS*** and does not purport to, and does not, report on compliance over other portions, if any, of the major federal programs or any other major federal programs of the State of Arizona.

(2) Summary of significant accounting policies

Expenditures reported on the Schedule are reported on the accrual basis of accounting, except for amounts passed through to subrecipients which are reported when disbursed to the subrecipient. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Negative amounts, if any, shown on the Schedule represent adjustments or credits made in the normal course of business to amounts reported as expenditures in prior years. ***AHCCCS*** has elected not to use the de minimis indirect cost rate allowed under the Uniform Guidance.

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INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Director of

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS, an agency of the state of Arizona)

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the governmental activities, the general fund, and the aggregate remaining fund information of ***Arizona Health Care Cost Containment System*** **("AHCCCS")** as of and for the year ended June 30, 2025 and the related notes to the financial statements, which collectively comprise AHCCCS' basic financial statements and have issued our qualified report thereon dated September 14, 2026.

We have qualified our opinion on the governmental activities and general fund because we were unable to obtain sufficient appropriate audit evidence for AHCCCS' receivables and other, federal revenue and due to the federal government line items as a result of the provider billing matter described in Note 8 to the financial statements as of and for the year ended June 30, 2025. Consequently, we were unable to determine whether any adjustments of these amounts or additional disclosures were necessary.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered ***AHCCCS'*** internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of ***AHCCCS'*** internal control. Accordingly, we do not express an opinion on the effectiveness of ***AHCCCS'*** internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We identified deficiencies in internal control, described in the accompanying schedule of findings and questioned costs as items 2025-001, 2025-002, and 2025-003 that we consider to be material weaknesses.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether ***AHCCCS'*** financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed an instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and which are described in the accompanying schedule of findings and questioned costs as item 2025-001.

AHCCCS' Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the findings identified in our audit and described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of ***AHCCCS'*** internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering ***AHCCCS'*** internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

CBIZ CPAs P.C.

September 14, 2026

CBIZ CPAs P.C.

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INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

To the Director of

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS, an agency of the state of Arizona)

Report on Compliance for Each Major Federal Program

Qualified and Unmodified Opinions

We have audited ***Arizona Health Care Cost Containment System's ("AHCCCS")*** compliance with the types of compliance requirements identified as subject to audit in the U.S. Office of Management and Budget ("OMB") Compliance Supplement that could have a direct and material effect on ***AHCCCS'*** major federal programs for the year ended June 30, 2025. ***AHCCCS'*** major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Qualified Opinion on ALN 93.778 – Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster

In our opinion, except for the noncompliance described in the Basis for Qualified and Unmodified Opinions section of our report, ***AHCCCS*** complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on ALN 93.778 – Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, for the year ended June 30, 2025.

Unmodified Opinion on the Other Major Federal Programs (ALN 93.767 Children's Health Insurance Program (Title XXI) and ALN 21.027 COVID-19 Coronavirus State and Local Fiscal Recovery Funds (SLFRF))

In our opinion, ***AHCCCS*** complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its other major federal programs *(ALN 93.767 Children's Health Insurance Program (Title XXI) and ALN 21.027 COVID-19 Coronavirus State and Local Fiscal Recovery Funds (SLFRF))* for the year ended June 30, 2025.

Basis for Qualified and Unmodified Opinions

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*); and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of ***AHCCCS*** and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for each major federal program. Our audit does not provide a legal determination of ***AHCCCS'*** compliance with the compliance requirements referred to above.

Matter Giving Rise to Qualified Opinion on ALN 93.778 – Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster

As described in the accompanying schedule of findings and questioned costs, ***AHCCCS*** did not comply with requirements regarding ALN 93.778 – Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster as described in finding number 2025-004 for Special Tests and Provisions – Utilization Control and Program Integrity.

Compliance with such requirements is necessary, in our opinion, for ***AHCCCS*** to comply with the requirements applicable to that program.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules, and provisions of contracts or grant agreements applicable to ***AHCCCS'*** federal programs.

Auditors' Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on ***AHCCCS'*** compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about ***AHCCCS'*** compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding ***AHCCCS'*** compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of ***AHCCCS'*** internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of ***AHCCCS'*** internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Our audit of ***AHCCCS'*** major federal programs was conducted as part of the State of Arizona's Single Audit for the year ended June 30, 2025. The State of Arizona's major federal programs were determined by the Office of the Auditor General applying the risk-based approach for determining major federal programs in accordance with the Uniform Guidance. Our Report on Compliance for Each Major Federal Program relates only to the portion of the programs that were administered by ***AHCCCS*** and does not purport to, and does not, report on compliance over other portions, if any, of the major federal programs or any other major federal programs of the State of Arizona.

Other Matters

The results of our auditing procedures disclosed instances of noncompliance which are required to be reported in accordance with the Uniform Guidance and which are described in the accompanying schedule of findings and questioned costs as items 2025-005, 2025-006 and 2025-007. Our opinion on each major federal program is not modified with respect to these matters.

AHCCCS' Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the noncompliance findings identified in our compliance audit described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

Report on Internal Control Over Compliance

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, we did identify certain deficiencies in internal control over compliance that we consider to be material weaknesses.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance. We consider the deficiencies in internal control over compliance described in the accompanying schedule of findings and questioned costs as items 2025-004, 2025-005, 2025-006 and 2025-007 to be material weaknesses.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

AHCCCS' Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the internal control over compliance findings identified in our compliance audit described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

CBIZ CPAs P.C.

September 14, 2026

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2025

Section I – Summary of Auditors' Results

Financial Statements

1.	Type of report the auditor issued on whether the financial statements audited were prepared in accordance with U.S. generally accepted accounting principles:	Qualified
2.	Is a going concern emphasis-of-matter paragraph included in the auditors' report?	No
3.	Internal control over financial reporting:	
	a. Material weakness(es) identified?	Yes
	b. Significant deficiency(ies) identified?	None reported
4.	Noncompliance material to financial statements noted?	No

Federal Awards

1.	Internal control over major federal programs:	
	a. Material weakness(es) identified?	Yes
	b. Significant deficiency(ies) identified?	None reported
2.	Type of Auditor's report issued on compliance for major federal program:	93.778 – Qualified 93.767 – Unmodified 21.027 – Unmodified
3.	Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	Yes
4.	Identification of major federal programs:	

Assistance Listing Number	Name of Federal Program or Cluster
93.778	Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster
93.767	Children's Health Insurance Program (Title XXI)
21.027	COVID-19 - Coronavirus State and Local Fiscal Recovery Funds (SLFRF)

5.	Dollar threshold used to distinguish between type A and type B programs:	State of Arizona threshold $38,899,764
6.	Auditee qualified as a low-risk auditee?	No

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2025

Section II – Financial Statement Findings

Item: 2025-001

Subject: Timeliness in Reporting

Criteria or Specific Requirement: AHCCCS' close and financial reporting processes involve a significant volume of complex accounting transactions and estimates that require personnel with the requisite skills, knowledge and expertise to ensure the accuracy and timeliness of the year-end close and financial reporting process as well as the accuracy and timeliness of other quarterly financial reporting. Additionally, State law requires State agencies submit their financial and federal award information to the Arizona Department of Administration ("ADOA") by a specified date to meet the State's financial reporting and single audit deadlines. For fiscal 2025, AHCCCS' financial reporting and federal award information was due to ADOA by November 14, 2025.

Condition: For fiscal 2025, AHCCCS' financial reporting and federal award information was due to ADOA by November 14, 2025 and was not submitted to ADOA until July 17, 2026.

Cause: The delay in issuing the final financial statements continues to be driven by the residual impact of prior year timing challenges, combined with new requirements and data dependencies. Specifically, GASB Statement No. 101 (Compensated Absences) was effective for State Fiscal Year 2025; however, the required data from the Arizona Department of Administration (ADOA) was not received until December 17, 2025—over a month after the November 14, 2025, due date. Additionally, AHCCCS self-identified certain errors in our fiscal year 2024 amounts that required a restatement, which further contributed to the timeline for the fiscal year 2025 report. Additionally, AHCCCS continued to experience employee turnover in fiscal 2025 and into fiscal 2026. Lastly, these matters were exacerbated as a result of the COVID-19 pandemic, the end of the Public Health Emergency and related disenrollment, and the myriad of federal and state regulatory changes that have impacted the Medicaid program. This continues to increase the volume and complexity of accounting activity within AHCCCS.

Effect: The State was not able to meet its financial reporting and audit requirements and deadlines. This also impacted decision-makers' ability to rely on financial information that is not provided in a timely manner. Additionally, the delay in the federal award reporting resulted in the State's delay in issuing its single audit reporting package, which was due March 31, 2026, and could result in actions being taken by federal grantors on various federal awards. This is deemed to be a material weakness in internal control over financial reporting.

Identification as a Repeat Finding: Repeat finding – prior year 2024-001

Recommendation: AHCCCS should submit financial reporting and federal award information to ADOA within the required timelines. We recommend that given the size and complexity of the program and as a result of turnover throughout the agency, AHCCCS continue to advance internal process efficiencies, and enhance coordination with data providers such as internal departments and ADOA.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2025

Item: 2025-002

Subject: Provider Billing Matter

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services in its Medical Assistance Program (noncompliance in a federal program as described in finding 2025-004, that had a direct and material effect on the determination of financial statement amounts). These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud (CAF) payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. See also compliance finding at 2025-004 below.

A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. Therefore, AHCCCS could not determine whether any financial statement adjustments or additional disclosures were necessary as a result of the federal noncompliance.

Cause: AHCCCS did not make any financial statement adjustments for potential repayment or recoveries because it lacked evidence to complete the determinations necessary to support the amount of monies it would be required to return to the U.S. government. The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner.

Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post- payment review of behavioral health claims.

Effect: We were unable to obtain sufficient appropriate audit evidence for AHCCCS' receivables and other, federal revenue, and due to the federal government line items and resulted in a qualified opinion on the basic financial statements as of and for the year ended June 30, 2025. Material unrecorded receivables, federal revenue and due to the federal government may exist. This is deemed to be a material weakness in internal control over financial reporting.

Identification as a Repeat Finding: Repeat finding – prior year 2024-003

Recommendation: We recommend that AHCCCS continue its investigations and refer Credible Allegations of Fraud ("CAF") cases to law enforcement officials. Additionally, we recommend AHCCCS continue to work with Centers for Medicare & Medicaid Services ("CMS") to determine what, if any, amounts may be required to be remitted to CMS. We also recommend that once amounts are known, AHCCCS should record the balances within the financial statements in accordance with GAAP. Lastly, we recommend AHCCCS review their internal controls to ensure the controls in place are sufficient to timely detect unnecessary utilization of care and services.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Item: 2025-003

Subject: Data Breach

Criteria or Specific Requirement: AHCCCS is required to implement administrative, operational, and procedural safeguards to adequately protect the privacy of protected health information and to prevent the breach or disclosure of unsecured sensitive data. Per 45 CFR Part 164 Subpart D, AHCCCS is required to notify affected individuals. If a breach affects more than 500 individuals, AHCCCS must also notify the media within 60 calendar days after discovery of the breach. AHCCCS must also notify the U.S. Department of Health and Human Services ("HHS") Secretary of any reportable breaches.

Condition: In August 2025, AHCCCS identified a data breach involving misaddressed member communications. The incident occurred during a routine mailing to members regarding their health plan enrollment. AHCCCS was alerted by a member who received a letter addressed to a different individual. AHCCCS immediately halted its mailing process and launched an internal investigation. Once this data breach was discovered, AHCCCS took the required steps to notify the impacted individuals, the media, and the HHS Secretary in a timely manner.

Cause: Due to a human error during a mail merge during a routine mailing to members regarding their health plan enrollment, general information communications were sent to the wrong individuals.

Effect: The breach resulted in the disclosure of limited protected health information (PHI) including member names, AHCCCS identification numbers (A#), and health plan names for 3,177 members. No Social Security numbers, financial data, or clinical

information were involved. This is deemed to be a material weakness in internal control over financial reporting.

Identification as a Repeat Finding: Not a repeat finding

Recommendation: We recommend that AHCCCS review their existing quality assurance for outbound communications policies and procedures and develop a process to ensure procedures are consistently being followed. In addition, AHCCCS should provide regular training and refresher training to employees responsible for outbound communications to reinforce policy requirements, increase awareness of common errors, and promote consistent application of established procedures. We also recommend AHCCCS monitor employees' adherence to the policies and procedures on a periodic basis to ensure they are consistently followed and inform employees of updates to the policies and procedures throughout the year.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Section III – Federal Award Findings

Item: 2025-004

Assistance Listing Number: 93.778

Program: Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, COVID-19 Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Numbers: 11-W-00275/09

Award Year: July 1, 2024 – June 30, 2025

Compliance Requirement: Special Tests and Provisions – Utilization Control and Program Integrity

Criteria: AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).

AHCCCS must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. AHCCCS must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. AHCCCS may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud ("CAF") payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. For example, providers billed for:

- Excessive hours of services in a 24-hour period for a single member,
- Multiple services for the same member at the same time,
- AHCCCS members who were not physically present ("ghost billing"),
- Services after a member's date of death, and
- Services that were not medically necessary.

Questioned Costs: Unknown

Context: Under 42 C.F.R. § 455.23 and the terms of the Provider Participation Agreement, AHCCCS may suspend payments to a provider if a Credible Allegation of Fraud ("CAF") has been identified. Providers are informed of the reason for their suspension in a Notice of CAF Suspension. CAF suspensions are based on preliminary findings of reliable indicia of fraud and may be lifted if AHCCCS determines there is no fraud occurring and/or good cause has been established under 42 C.F.R. § 455.23. Upon the conclusion of an investigation, AHCCCS may terminate a provider and/or lift their suspension at that time. At the point a referral is made, and payment is suspended, only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation, AHCCCS will terminate a provider's enrollment and require repayment of the identified overpayment. The investigation is on-going and AHCCCS is not currently able to estimate a total overpayment or amount of improper payments made to the providers. Therefore, we are unable to estimate any questioned costs related to the fraud allegations.

Effect:

In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers.

Once a credible allegation of fraud determination is made, AHCCCS is required to suspend all payments to a provider unless there is good cause not to while investigations are conducted. The credible allegation of fraud determination results from the agency's preliminary investigation, and the agency must then make a fraud referral to the Arizona Attorney General's Healthcare Fraud and Abuse Section or a federal law enforcement agency for a full investigation. During this time, providers may continue to bill AHCCCS for services provided, but any reimbursement to these providers is withheld pending the outcome of further investigation. Under state statute, providers are entitled to appeal a suspension placed by AHCCCS. AHCCCS is working closely with the Arizona Attorney General's Healthcare Fraud and Abuse Section, the Federal Bureau of Investigation ("FBI"), the U.S. Department of Health and Human Services ("HHS"), the U.S. Attorney's Office, the Internal Revenue Service ("IRS"), and local and tribal law enforcement to disrupt organized bad actors, apprehend them, and prosecute them to the full extent allowed by law. At present, the investigation is on-going and a determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. As a result, we have issued a qualified opinion on the basic financial statements as of and for the year ended June 30, 2025.

As a result of this matter, we have concluded that AHCCCS did not comply with the compliance requirements and have issued a qualified opinion on compliance. This matter is deemed to be a material weakness in internal control over compliance.

Cause:

The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post- payment review of behavioral health claims. AHCCCS' claims processing system uses the CMS required claim edit protocols to look for improperly billed claims as noted in the National Correct Coding Initiative ("NCCI") and such edit protocols are updated regularly per CMS requirements. However, AHCCCS could have implemented additional controls that may have detected these issues more timely. While not required by CMS, AHCCCS did not have sufficient edits to restrict the inappropriate use of per diem codes or restrict some behavioral health codes from being billed for the same member on the same date of service. Further, AHCCCS did not have sufficient controls in which claims were reviewed by a medical professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

Identification as a Repeat Finding:

Repeat finding – prior year 2024-004

Recommendation: We recommend that AHCCCS continue its investigations and refer Credible Allegations of Fraud ("CAF") cases to law enforcement officials. Additionally, we recommend AHCCCS continue to work with CMS to determine what, if any, amounts may be required to be remitted to CMS.

We also recommend that AHCCCS continue to review and enhance existing policies and procedures and related controls to ensure sufficient processes and controls are in place to timely detect unnecessary utilization of care and services and to prevent fraud.

We further recommend that AHCCCS continue to examine the existing Medicaid payment system and continue to implement system-wide improvements. These improvements should include the establishment of additional reporting to flag concerning claims for pre-payment review, setting of billing thresholds and establishing prepayment review for various behavioral health claim types. We also recommend that AHCCCS establish sufficient controls in which claims are reviewed by a medical professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Item: 2025-005

Assistance Listing Numbers: 93.778 and 93.767

Programs: Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, COVID-19 Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster and Children's Health Insurance Program (CHIP; Title XXI)

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Numbers: 11-W-00275/09 and 21-W-00074/09

Award Year: July 1, 2024 – June 30, 2025

Compliance Requirement: Special Tests and Provisions – Utilization Control and Program Integrity

Criteria: AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of

provider fraud must be referred to the state Medicaid Fraud Control Unit ("MFCU") or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21). Additionally, in accordance with AHCCCS policy, the AHCCCS Office of Inspector General ("OIG") is required to regularly follow up on deferred investigations and provide updates at least every quarter to the State MFCU.

Condition: AHCCCS did not follow up in a timely manner for certain deferred member investigations.

Questioned Costs: Unknown

Context: In a population of 1,954 deferred member cases with identified credible allegations of member fraud assigned during fiscal year 2025, we conducted a non-statistical sample of 60 member investigations to ascertain if AHCCCS performed a preliminary investigation of potential incidents of fraud or abuse committed by members on a timely basis. We also reviewed to ensure AHCCCS was following up on any deferred member cases in a timely manner. In our sample of 60 member investigations, we noted that for 4 of 60 member investigations in which the investigation had been deferred, AHCCCS did not follow up in a timely manner in accordance with its internal policy on those deferred investigations. For the 4 member investigations, we noted that the deferral period ranged from 8 to 52 days after quarter-end, which was well outside of AHCCCS' internal policy.

Effect: Untimely follow up on fraud or abuse incident investigations could result in AHCCCS making unnecessary payments and compromise its ability to investigate cases. This is deemed to be a material weakness in internal control over compliance.

Cause: As AHCCCS OIG continued to refine and enhance its case review and tracking processes, certain process gaps and inconsistencies were identified that contributed to the instances of noncompliance noted in the finding. A review of the four missed items identified several contributing factors related to process execution, oversight, and tracking mechanisms. First, investigator documentation incorrectly indicated that required actions had been completed, creating the appearance that one case was finalized when outstanding work remained. Second, although some cases were pulled and assigned for review, supervisory verification of completion did not occur, resulting in unresolved deficiencies going undetected. Third, certain cases were not selected as part of AHCCCS' quarterly review process, limiting the opportunity to identify and correct the missed items through internally established quality assurance controls. Finally, reliance on manual spreadsheet tracking and processing introduced the potential for human error, including inaccurate entries, omissions, and tracking inconsistencies that contributed to the missed items. Collectively, these factors reflect gaps in documentation accuracy, supervisory oversight, review selection processes, and manual tracking controls that allowed the four items to remain undetected.

Identification as a Repeat Finding: Repeat finding – prior year 2024-005

Recommendation: We recommend that AHCCCS strengthen controls over case processing and monitoring by implementing procedures to ensure the accuracy and completeness of investigator documentation, requiring documented supervisory review and

approval of completed cases, and enhancing review selection and follow-up procedures to verify that all required actions have been performed. In addition, AHCCCS should reduce reliance on manual spreadsheet tracking by implementing automated tracking and exception-reporting mechanisms, where feasible, and performing periodic reconciliations of open and closed cases. These actions would improve accountability, strengthen oversight, and help ensure that processing deficiencies are identified and corrected in a timely manner before cases are considered complete.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Item: 2025-006

Assistance Listing Numbers: 93.778 and 93.767

Programs: Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, COVID-19 Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster and Children's Health Insurance Program (CHIP; Title XXI)

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Numbers: 11-W-00275/09 and 21-W-00074/09

Award Year: July 1, 2024 – June 30, 2025

Compliance Requirement: Special Tests and Provisions – Medicaid Recovery Audit Contractors (RACs)

Criteria: Under Section 1902(a)(42)(B) of the Social Security Act (42 U.S.C. § 1396a) and 42 CFR part 455, subpart F, states are required to establish and maintain a Medicaid Recovery Audit Contractor (RAC) program to identify underpayments and overpayments and to recoup overpayments for services paid under the State plan and any waivers. The program must be established consistent with State law and generally in the same manner as the Secretary contracts with contingency-fee contractors for the Medicare Fee-for-Service RAC program under Section 1893(h) of the Act (42 U.S.C. § 1395ddd). Subpart F includes requirements related to contracting, conducting post-payment reviews, recovery of overpayments, provider notification and appeals, coordination with other auditing entities and the Medicaid Fraud Control Unit (MFCU), and reporting program results to CMS (including reporting on Form CMS-64.9O RAC in accordance with CMS instructions). Under Section 1902(a)(42)(B)(i) of the Act (42 USC 1396a) and 42 CFR section 455 Subpart F, states and territories are required to establish programs to contract with one or more Medicaid RACs to identify underpayments and overpayments, and recoup overpayments under the state plan and under any waiver of the state plan with respect to all services for which payment is made to any entity under such plan or waiver.

Condition: AHCCCS has executed a contract with a Medicaid RAC consistent with federal requirements (42 CFR section 455.508), and has also developed internal processes with the Medicaid RAC to develop the RAC program. Additionally, AHCCCS maintains meeting minutes of regular communication with the Medicaid RAC to coordinate the program's implementation and progress. However, the RAC program has yet to be fully operational to perform its overall objective to identify under/overpayments and initiate any potential recoupments paid under the State plan and any waivers.

Specifically, we noted that AHCCCS:

- Has set limits on the number and frequency of medical records to be reviewed by the RACs, however the program was placed on hold in early fiscal 2025 to reassess the program's system processes, which prevented any further review of medical records by the RAC program through June 30, 2025 as defined by 42 CFR 455.506(e).
- While AHCCCS has policies in place, they have not yet performed procedures under its RAC program to make referrals of suspected fraud and/or abuse to the appropriate entities (e.g., the MFCU) as defined by 42 CFR Section 455.506(d).
- Has not completed the required reporting of Medicaid RAC program performance results on the CMS-64.9O RAC form for the applicable quarters, as required by 42 CFR part 455.502, subpart F and CMS-64 reporting instructions. As a result, AHCCCS was not conducting the required RAC activities (e.g., post-payment reviews and associated recoveries, provider notifications and appeals processing, coordination, and reporting) during the period under audit.

Questioned Costs: N/A

Context: In connection with our testing of the RAC compliance requirements, we noted AHCCCS contracted with a Medicaid Recovery Audit Contractor (RAC) and established policies and processes to support RAC program implementation. However, the RAC program was not fully operational during fiscal year 2025 and did not perform required RAC activities, including post-payment reviews, recovery activities, fraud and abuse referrals, and required CMS reporting.

Effect: AHCCCS is not currently conducting the required RAC activities under 42 CFR section 455.506. This is deemed to be a material weakness in internal control over compliance.

Cause: AHCCCS paused implementation of its RAC program due to concerns stemming from pervasive provider complaints reported in another state's RAC rollout. Following this pause, AHCCCS began meeting regularly with its RAC to discuss review methodologies and potential process amendments to address those concerns. However, the pause and extended design phase delayed operationalization of the program and the establishment of procedures for coordination, referrals, and required reporting.

Identification as a Repeat Finding: Not a repeat finding.

Recommendation: We recommend AHCCCS finalize and implement RAC operational procedures covering post-payment reviews, recoveries, provider notifications and appeals, coordination with other audit entities and the MFCU, and CMS-64.9O (RAC)

reporting. We also recommend AHCCCS establish a monitoring plan and timeline for RAC activities and deliverables, including documentation standards for coordination and referrals. Lastly, we recommend AHCCCS resume (or initiate) RAC reviews and reconcile recoveries and contingency fees in accordance with contract terms and federal requirements.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Item: 2025-007

Assistance Listing Number: 93.778

Program: Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, COVID-19 Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Number: 11-W-00275/09

Award Year: July 1, 2024 – June 30, 2025

Compliance Requirement: Eligibility

Criteria: The Office of Management and Budget ("OMB") Compliance Supplement identifies Eligibility as a key compliance requirement, requiring that Medicaid benefits be provided only to eligible individuals and that eligibility determinations, including disenrollments, are performed accurately and timely. States are responsible for ensuring (a) timely termination of eligibility (e.g., upon death), and (b) recovery of payments made on behalf of ineligible individuals.

Condition: During testing of Medicaid eligibility and enrollment, we identified an instance in which a beneficiary remained enrolled in Medicaid for approximately 18 months after the date of death, resulting in continued capitation payments to the managed care organization (MCO). In addition to the disenrollment issue, we noted deficiencies in the recoupment process. Although AHCCCS initiated recovery efforts after disenrollment, the system was designed to recoup only within the current and one-year prior contract years.

Questioned Costs: $14,254.93

Context: In a population of 519,221 Title 19 disenrollment proceedings during fiscal 2025, we conducted a non-statistical sample of 60 Title 19 disenrollments. In our sample, we noted one instance in which a beneficiary remained enrolled in Medicaid for approximately 18 months after the date of death, resulting in continued capitation

payments to the managed care organization (MCO). Specifically, the member died in March 2023, and a death notification was transmitted from the Social Security Administration's SOLQI system to the AHCCCS HEAplus system. While HEAplus received the notification, it did not receive a date of death, and system rules require both a death indicator and date of death to be present to trigger automatic disenrollment. As a result the member was not automatically disenrolled, no manual review or follow-up procedures were performed to resolve the incomplete data, and the member remained actively enrolled until October 2024, when the date of death was finally provided, allowing AHCCCS to process the disenrollment. During this period, capitation payments continued to be made on behalf of the deceased member.

Based on our finding, AHCCCS reviewed the entire impacted population and identified 24 additional cases where untimely disenrollment occurred due to similar system limitations involving incomplete death data from SOLQI.

In addition to the disenrollment issue noted above for the one instance, we also noted that for the one exception noted above, there was also a deficiency in the recoupment process. Although AHCCCS initiated recovery efforts after disenrollment, the system was designed to recoup only within the current and one-year prior contract years. As a result, only 13 of the 18 months of capitation payments were recouped for the selected case, and amounts paid outside of the system-defined recoupment window were not recovered.

Based on our finding, AHCCCS reviewed the entire impacted population and identified 7 additional members impacted by this recoupment limitation, which were included in the 24 cases above. The total impact of the recoupment limitation issue noted above was $14,254.93 of capitation payments that were not properly recouped.

Effect: As a result of these deficiencies, Federal funds were used to pay for services on behalf of ineligible (deceased) beneficiaries; AHCCCS did not fully recoup improper payments, resulting in known unrecovered costs; and the state is at increased risk of ongoing noncompliance with federal eligibility requirements and improper payments. This is deemed to be a material weakness in internal control over compliance.

Cause: The condition was caused by deficiencies in internal controls, including (a) HEAplus system limitations that prevented automatic disenrollment when death notifications lacked a date of death, (b) absence of manual review and monitoring controls to identify and resolve incomplete death records; and (c) system constraints in the recoupment process that limited recovery to the current and prior contract years, preventing full recovery of improper payments.

Identification as a Repeat Finding: Not a repeat finding.

Recommendation: We recommend that AHCCCS strengthen internal controls over eligibility termination and improper payment recovery processes by:

- Enhancing HEAplus system functionality to flag and initiate action on death notifications with incomplete data, including requiring timely resolution before continued enrollment;

- Implementing monitoring controls and manual review procedures to identify members with unresolved death indicators and ensure timely disenrollment;
- Improving data validation and coordination with external data sources to ensure complete and accurate death information is obtained;
- Modifying recoupment system capabilities to allow for full recovery of improper payments beyond contract year limitations; and
- Establishing processes to ensure all improper payments are identified, tracked, and recovered, regardless of timing.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

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SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

Item:	2024-001
Subject:	Timeliness in Reporting and Adequacy of Staffing
Criteria or Specific Requirement:	AHCCCS' close and financial reporting processes involve a significant volume of complex accounting transactions and estimates that require sufficient personnel with the requisite skills, knowledge and expertise to ensure the accuracy and timeliness of the year-end close and financial reporting process as well as the accuracy and timeliness of other quarterly financial reporting. Additionally, State law requires State agencies submit their financial and federal award information to the Arizona Department of Administration ("ADOA") by a specified date to meet the State's financial reporting and single audit deadlines. For fiscal 2024, AHCCCS' financial reporting and federal award information was due to ADOA by November 15, 2024.
Condition:	For the year ended June 30, 2024, AHCCCS encountered delays in the close and financial reporting process. Additionally, AHCCCS experienced delays in certain required quarterly reporting and required extensions from various funding agencies, most notably the Centers for Medicare & Medicaid Services ("CMS"). For fiscal 2024, AHCCCS' financial reporting and federal award information was due to ADOA by November 15, 2024 and was not submitted to ADOA until March 14, 2025.
Cause:	The delays in AHCCCS' close and financial reporting process were caused by delays in the fiscal 2023 audit which was not finalized and issued until September 2024. As a result, the fiscal 2024 audit did not begin until November 2024. Additionally, AHCCCS' Division of Business and Finance continued to experience employee turnover into fiscal 2024. These matters were exacerbated as a result of the COVID-19 pandemic, the end of the Public Health Emergency and related disenrollment, and the myriad of federal and state responses that continue to impact the Medicaid program. This continues to increase the volume and complexity of accounting activity within AHCCCS. Although the fiscal year 2024 audit began late, the procedural improvements implemented resulted in the fiscal 2024 audit being completed in a far more timely manner.
Effect:	The State was not able to meet its financial reporting and audit requirements and deadlines. This also impacted decision-makers' ability to rely on financial information that is not provided in a timely manner. Additionally, the delay in the federal award reporting resulted in the State's delay in issuing its single audit reporting package, which is due March 31, 2025, and could result in actions being taken by federal grantors on various federal awards. This is deemed to be a material weakness in internal control over financial reporting.
Type of Finding:	Material weakness in internal control over financial reporting

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SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

Current Status: Partial corrective action taken. AHCCCS continued to implement procedural improvements which resulted in improvements in the accounting and financial reporting processes. However, since the fiscal 2025 audit was not completed within the state's prescribed timeline, this appears as a repeat finding at 2025-001.

Reasons for recurrence: The delay in issuing the final financial statements continues to be driven by the residual impact of prior year timing challenges, combined with new requirements and data dependencies. Specifically, GASB Statement No. 101 (Compensated Absences) was effective for State Fiscal Year 2025; however, the required data from the Arizona Department of Administration (ADOA) was not received until December 17, 2025—over a month after the November 14, 2025, due date. Additionally, AHCCCS self-identified certain errors in our fiscal year 2024 amounts that required a restatement, which further contributed to the timeline for the fiscal year 2025 report.

Actions taken: To improve timeliness, AHCCCS revamped their financial reporting process to align with best practices, enhancing efficiency and accuracy. This includes refining policies and procedures, implementing targeted training programs, and increasing documentation efforts to streamline preparation and review. Additionally, new staff members have gained greater proficiency in their roles, strengthening overall reporting capabilities. Further, AHCCCS and ADOA hold weekly, recurring meetings to discuss and resolve items affecting timelines.

Actions remaining: To ensure timely issuance moving forward, AHCCCS will continue to further advance staff proficiency, enhance internal timelines, strengthen coordination with auditors, and expand documentation efforts. With these continued improvements, AHCCCS is confident in achieving further progress towards a timely financial statement issuance in the upcoming reporting cycle.

Item: 2024-002

Subject: Audit Adjustments

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: In connection with our audit, we encountered several audit adjustments to present the financial statements and schedule of expenditures of federal awards of AHCCCS in accordance with GAAP. For the year ended June 30, 2024, several

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

audit adjustments were made to properly adjust accruals, reconcile balances, correct errors and properly present financial information in the financial statements and schedule of expenditures of federal awards. We noted 7 adjusting entries which resulted in a decrease of approximately $20.1 million to assets, a decrease of approximately $13.4 million to liabilities, a decrease of approximately $6.7 million to net position and a decrease of $6.7 million to net income. Additionally, we noted the adjusting entries resulted in a net decrease in the total expenditures of federal awards of approximately $24.6 million as presented on the Schedule of Expenditures of Federal Awards.

Cause: The audit adjustments were caused largely by turnover within AHCCCS' Division of Business and Finance, poor or nonexistent process documentation, an extensive learning curve of the newly assembled AHCCCS audit team responsible for the coordination and administration of the audit, and financial/accounting system challenges. Specifically, the financial/accounting system challenges stemmed from a shift in the methodology used to compile financial statements. In fiscal year 2022 and prior, AHCCCS relied on a data warehouse to compile financial statements, which followed a defined data-driven process. However, due to the absence of process documentation, the new audit team was unable to replicate or effectively utilize the data warehouse processes in the past 2 audit cycles. As a result, AHCCCS pivoted to a manual process for compiling financial statements.

Effect: While the necessary adjustments were posted to correct the financial statements and the schedule of expenditures of federal awards, AHCCCS' unadjusted financial statements and schedule of expenditures could be materially misstated and not presented in accordance with accounting principles generally accepted in the United States of America. This could result in conflicting information for management and outside users. This is deemed to be a material weakness in internal control over financial reporting.

Type of Finding: Material weakness in internal control over financial reporting

Current Status: Corrective action taken.

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SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

Item: 2024-003

Subject: Provider Billing Matter

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services in its Medical Assistance Program (noncompliance in a federal program as described in finding 2024-004, that had a direct and material effect on the determination of financial statement amounts). These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud (CAF) payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. See also compliance finding at 2024-004 below.

A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. Therefore, AHCCCS could not determine whether any financial statement adjustments or additional disclosure were necessary as a result of the federal noncompliance.

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Year Ended June 30, 2025

Cause: AHCCCS did not make any financial statement adjustments for potential repayment or recoveries because it lacked evidence to complete the determinations necessary to support the amount of monies it would be required to return to the U.S. government. The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post- payment review of behavioral health claims, as noted in the compliance finding at 2024-004.

Effect: As a result of this matter, we were unable to obtain sufficient appropriate audit evidence for AHCCCS' receivables and other, federal revenue, and due to the federal government line items and have issued a qualified opinion on the basic financial statements as of and for the year ended June 30, 2024. Material unrecorded receivables, federal revenue and due to the federal government may exist.

Type of Finding: Material weakness in internal control over financial reporting

Current Status: Partial corrective action taken. This appears as a repeat finding at 2025-002.

Reason for recurrence: AHCCCS did not make any financial statement adjustments for potential repayment or recoveries because it lacked the evidence to complete the determination necessary to support the amount of monies it would be required to return to the U.S. government. The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner.

Actions taken: In May 2023, AHCCCS announced its findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program.

Actions remaining: AHCCCS is continuing its investigations and refers Credible Allegations of Fraud ("CAF") cases to law enforcement officials. AHCCCS will comply with all federal regulations regarding repayments of federal share and will work with CMS as the CAF cases continues through the law enforcement process.

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SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

Item: 2024-007

Subject: Restatement of financial statements due to identification of errors

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period. State law also requires AHCCCS to submit all necessary financial information to the Arizona Department of Administration ("ADOA") to be used to prepare the State's Annual Comprehensive Financial Report ("ACFR") consistent with generally accepted accounting principles and in accordance with the ADOA's policies and procedures (A.R.S. §35-131[I]).

Condition: Subsequent to the issuance of AHCCCS' fiscal 2024 financial statements, management identified certain errors related to the recognition and classification of certain accruals. Specifically, AHCCCS (a) recorded a portion of their contracted health plan risk reconciliation accruals twice, and (b) recorded an accrual for an amount that had already been paid as of June 30, 2024. These errors resulted in misstatements in the previously reported General Fund balances. Additionally, management identified a misclassification, whereby an accrual originally posted to the General Fund should have been partially allocated to the Other Governmental Fund based on the funding source. As a result, certain amounts have been reclassified between funds to reflect the appropriate allocation.

Cause: The underlying cause of the error was insufficient controls over the journal entry posting process, specifically related to the aggregation and review of year-end accrual entries. AHCCCS aggregated several contracted health plan risk reconciliation journal entry accruals into a single large entry and inadvertently duplicated a portion of the entry. This duplication went undetected due to a review process that lacked sufficient rigor and comprehensiveness. Additionally, the individuals responsible for the review did not possess an adequate understanding of the contracted health plan risk reconciliation accruals, further limiting their ability to identify the error.

Effect: The previously issued fiscal 2024 financial statements and schedule of expenditures of federal awards were misstated and not presented in accordance with U.S. GAAP. Accordingly, as a result of these errors, the financial statements and schedule of expenditures of federal awards were reissued to correct the previously misreported amounts. This could result in conflicting information for management and outside users. The net impact on the entity-wide financial statements was a decrease in assets of $354.3 million, a decrease in liabilities of

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

$344.6 million, a decrease to net position of $9.7 million and a decrease to change in net position of $9.7 million. The net impact to the fund balance on the governmental fund financial statements was an overall decrease of $9.7 million. This consists of a net impact to the General Fund of a decrease in assets of $384.8 million, decrease in liabilities of $350.7 million, a decrease to fund balance of $34.1 million and a decrease to the net change in fund balance of $34.1 million, and a net impact to the Other Governmental Fund consisting of an increase in assets of $30.5 million, an increase in liabilities of $6.1 million, an increase in fund balance of $24.4 million and an increase to the net change in fund balance of $24.4 million. There was also a net increase to the schedule of expenditures of federal awards of $317.0 million, consisting of an increase of $307.2 million to ALN 93.778, Medical Assistance Program (Medicaid; Title XIX), and an increase of $9.8 million to ALN 93.767, Children's Health Insurance Program, (Title XXI). These errors are also in addition to errors detailed in finding 2024-002. This is deemed to be a material weakness in internal control over financial reporting.

Type of Finding: Material weakness in internal control over financial reporting

Current Status: Corrective action taken.

Item: 2024-004

Assistance Listing Number: 93.778

Program: Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Number: 11-W-00275/09

Award Year: July 1, 2023 – June 30, 2024

Compliance Requirement: Special Tests and Provisions – Utilization Control and Program Integrity

Criteria: AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

AHCCCS must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. AHCCCS must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. AHCCCS may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

Condition:

The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud ("CAF") payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. For example, providers billed for:

- Excessive hours of services in a 24-hour period for a single member,
- Multiple services for the same member at the same time,
- AHCCCS members who were not physically present ("ghost billing"),
- Services after a member's date of death, and
- Services that were not medically necessary.

Questioned Costs:

Unknown

Context:

Under 42 C.F.R. § 455.23 and the terms of the Provider Participation Agreement, AHCCCS may suspend payments to a provider if a Credible Allegation of Fraud ("CAF") has been identified. Providers are informed of the reason for their suspension in a Notice of CAF Suspension. CAF suspensions are based on preliminary findings of reliable indicia of fraud and may be lifted if AHCCCS determines there is no fraud occurring and/or good cause has been established under 42 C.F.R. § 455.23. Upon the conclusion of an investigation, AHCCCS may terminate a provider and/or lift their suspension at that time. At the point a referral is made, and payment is suspended, only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation, AHCCCS will terminate a provider's enrollment and require repayment of the identified overpayment. The investigation is on-going and AHCCCS is not currently able to

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

estimate a total overpayment or amount of improper payments made to the providers. Therefore, we are unable to estimate any questioned costs related to the fraud allegations.

Effect:

In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers.

Once a credible allegation of fraud determination is made, AHCCCS is required to suspend all payments to a provider unless there is good cause not to while investigations are conducted. The credible allegation of fraud determination results from the agency's preliminary investigation, and the agency must then make a fraud referral to the Arizona Attorney General's Healthcare Fraud and Abuse Section or a federal law enforcement agency for a full investigation. During this time, providers may continue to bill AHCCCS for services provided, but any reimbursement to these providers is withheld pending the outcome of further investigation. Under state statute, providers are entitled to appeal a suspension placed by AHCCCS. AHCCCS is working closely with the Arizona Attorney General's Healthcare Fraud and Abuse Section, the Federal Bureau of Investigation ("FBI"), the U.S. Department of Health and Human Services ("HHS"), the U.S. Attorney's Office, the Internal Revenue Service ("IRS"), and local and tribal law enforcement to disrupt organized bad actors, apprehend them, and prosecute them to the full extent allowed by law. At present, the investigation is on-going and a determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. As a result, we have issued a qualified opinion on the basic financial statements as of and for the year ended June 30, 2024.

As a result of this matter, we have concluded that AHCCCS did not comply with the compliance requirements and have issued a qualified opinion on compliance. This matter is deemed to be a material weakness in internal control over compliance.

Cause:

The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post- payment review of behavioral health claims. AHCCCS' claims processing system uses the CMS required claim edit protocols to look for improperly billed claims as noted in the National Correct Coding Initiative ("NCCI") and such edit protocols are updated regularly per CMS requirements. However, AHCCCS could have implemented additional controls that may have detected these issues more timely. While not required by CMS, AHCCCS did not have sufficient edits to restrict the inappropriate use of per diem codes or restrict some behavioral health codes from being billed for the same member on the same date of service. Further, AHCCCS did not have sufficient controls in which claims were reviewed by a medical

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

Type of Finding: Material weakness in internal control over compliance

Current Status: Partial corrective action taken. This appears as a repeat finding at 2025-004.

Reason for recurrence: AHCCCS lacked the evidence to complete the determination necessary to support the amount of monies it would be required to return to the U.S. government. The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner. Investigations and law-enforcement processes for CAF cases remain ongoing, which continue to limit the ability to finalize or reliably estimate quantifiable repayment amounts. Furthermore, providers are afforded due process, in which overpayment amounts can be delayed or modified depending on the court's rulings.

Actions taken: In May 2023, AHCCCS announced its findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program.

Actions remaining: AHCCCS is continuing its investigations and refers Credible Allegations of Fraud ("CAF") cases to law enforcement officials. AHCCCS will comply with all federal regulations regarding repayments of federal share and will work with CMS as the CAF cases continues through the law enforcement process. Final determination of the full amount of improper payments, recoveries from providers, and any additional amounts due to the federal government remains pending. The ultimate resolution of these matters is contingent on a variety of factors, including law enforcement actions, administrative and judicial proceedings, appeal rights, and other due process requirements, many of which are outside of AHCCCS's direct control. As a result, these cases may take a significant amount of time to reach final disposition, and final outcomes may differ from preliminary findings or determinations made during the course of the investigations.

Item: 2024-005

Assistance Listing Numbers: 93.778 and 93.767

Program: Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, and Children's Health Insurance Program (CHIP; Title XXI)

Federal Agency: U.S. Department of Health and Human Services

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SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09 and 21-W-00064/09
Award Year:	July 1, 2023 – June 30, 2024
Compliance Requirement:	Special Tests and Provisions – Utilization Control and Program Integrity
Criteria:	AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state MFCU or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21). Additionally, in accordance with AHCCCS policy, the AHCCCS Office of Inspector General is required to regularly follow up on deferred investigations and provide updates at least every 90 days to the State MFCU.
Condition:	AHCCCS did not follow up in a timely manner for certain deferred member investigations.
Questioned Costs:	Unknown
Context:	In a population of 1,494 deferred member and provider cases with identified credible allegations of provider and member fraud assigned during fiscal year 2024, we conducted a non-statistical sample of 40 member and provider investigations to ascertain if AHCCCS performed a preliminary investigation of potential incidents of fraud or abuse committed by members and providers on a timely basis. We also reviewed to ensure AHCCCS was following up on any deferred member and provider cases in a timely manner. In our sample of 40 member and provider investigations, we noted that for 39 of 40 member investigations, in which the investigation had been deferred, AHCCCS did not follow up in a timely manner in accordance with its internal policy on those deferred investigations.
Effect:	Untimely follow up on fraud or abuse incident investigations could result in AHCCCS making unnecessary payments and compromise its ability to investigate cases. This is deemed to be a material weakness in internal control over compliance.
Cause:	Management has reported to us that insufficient investigative staff and increased volumes of provider and member investigations impacted AHCCCS' ability to investigate and follow up on potential fraud or abuse incidents in a timely manner. In fiscal year 2023, the process of holding quarterly reviews of deferred cases did

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

not occur due to resources being diverted to focus on Strike Force activities involved in addressing the Behavioral Health ("BH") crisis. Additionally, OIG announced a re-organization in December 2023 that resulted in permanent transitions to other teams for several staff. Teams were given time to finalize cases and move items to other investigators in order to limit disruption to cases. By April 2024, after the Strike Force initiative had been unwound and the member team structure changes for personnel were finalized, the member team restarted its process of quarterly deferred case reviews. At the first review in April 2024, cases in the deferred backlog that were not completed in the timeframe set for the reviews were postponed to the next quarterly review in July.

Type of Finding: Material weakness in internal control over compliance

Current Status: Partial corrective action taken. This appears as a repeat finding at 2025-005.

Reason for recurrence: A review of the four missed items identified several contributing factors related to process execution, oversight, and tracking mechanisms. First, investigator documentation incorrectly indicated that required actions had been completed, creating the appearance that one case was finalized when outstanding work remained. Second, although some cases were pulled and assigned for review, supervisory verification of completion did not occur, resulting in unresolved deficiencies going undetected. Third, certain cases were not selected as part of AHCCCS' quarterly review process, limiting the opportunity to identify and correct the missed items through internally established quality assurance controls. Finally, reliance on manual spreadsheet tracking and processing introduced the potential for human error, including inaccurate entries, omissions, and tracking inconsistencies that contributed to the missed items. Collectively, these factors reflect gaps in documentation accuracy, supervisory oversight, review selection processes, and manual tracking controls that allowed the four items to remain undetected.

Actions taken: OIG announced a re-organization in December 2023 that resulted in permanent transitions to other teams for several staff. Teams were given time to finalize cases and move items to other investigators in order to limit disruption to cases. By April 2024, after the Strike Force initiative had been unwound and the member team structure changes for personnel were finalized, the member team restarted its process of quarterly deferred case reviews. At the first review in April 2024, cases in the deferred backlog that were not completed in the timeframe set for the reviews were postponed to the next quarterly review in July.

OIG has consistently adapted and refined its quarterly deferred case review process in coordination with auditor feedback and recommendations, with the shared objective of strengthening oversight, increasing accountability, and improving case-tracking accuracy. As enhancements have been implemented, OIG has established progressively higher performance expectations and new operational baselines, reflecting a continuous improvement approach rather than reliance on prior standards. The evolution of the review process demonstrates OIG's commitment to identifying weaknesses, implementing corrective measures, and incorporating lessons learned to reduce the likelihood of future omissions.

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

Actions remaining: AHCCCS OIG commits to a review of the current Deferred Process and will determine areas of improvement to include timeliness for deferred case review completion, quarterly completed deferred case review reports, and required documentation for all deferred case processes.

Item:	2024-006
Assistance Listing Numbers:	93.778 and 93.767
Program:	Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, and Children's Health Insurance Program (CHIP; Title XXI)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09 and 21-W-00064/09
Award Year:	July 1, 2023 – June 30, 2024
Compliance Requirement:	Special Tests and Provisions – Refunding of Federal Share of Medicaid Overpayments to Providers
Criteria:	42 CFR 433 Subpart F outlines the requirements State Medicaid Agencies ("SMAs") are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Act (the Act) (42 USC 1396b), states have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS regardless of whether recovery is made from the provider.
Condition:	AHCCCS did not return the federal share of fraud and abuse recoupments back to CMS in a timely manner.
Questioned Costs:	$5,245,026 for AL#93.778 and $111,638 for AL#93.767
Context:	In a population of 4,117 member and provider cases during fiscal year 2024, we conducted a non-statistical sample of 60 member and 60 provider investigations to ascertain if AHCCCS had properly remitted to CMS any recoupments as a result of the investigations. For 1 of 60 provider fraud cases, we noted AHCCCS did not timely return the federal share of fraud and abuse recoupments back to CMS. We then obtained from AHCCCS OIG a detail of all recoupments received during the period July 1, 2022 through June 30, 2024 noting a total of 392 unique OIG cases for which recoupments were received. Of this total of 392 cases, 136 cases were identified for which the federal share of the total recoupment amount was not

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2025

properly reported on the CMS-64 report and therefore the funds were not properly remitted to CMS for a total of $5,356,664.

Effect: Recoupments were not reported and repaid timely to CMS. This is deemed to be a material weakness in internal control over compliance.

Cause: Management has reported to us that this was a result of staffing turnover as well as a breakdown of inter and intra-departmental communication and collaboration between AHCCCS OIG and the Division of Business and Finance.

Type of Finding: Material weakness in internal control over compliance

Current Status: Corrective action taken.

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CORRECTIVE ACTION PLAN

Item:	2025-001
Subject:	Timeliness in Reporting
Criteria or Specific Requirement:	AHCCCS' close and financial reporting processes involve a significant volume of complex accounting transactions and estimates that require sufficient personnel with the requisite skills, knowledge and expertise to ensure the accuracy and timeliness of the year-end close and financial reporting process as well as the accuracy and timeliness of other quarterly financial reporting. Additionally, State law requires State agencies submit their financial and federal award information to the Arizona Department of Administration ("ADOA") by a specified date to meet the State's financial reporting and single audit deadlines. For fiscal 2025, AHCCCS' financial reporting and federal award information was due to ADOA by November 14, 2025.
Condition:	For fiscal 2025, AHCCCS' financial reporting and federal award information was due to ADOA by November 14, 2025 and was not submitted to ADOA until July 17, 2026.
Name of Contact Person:	Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance
Phone Number:	(602) 767-1580
Anticipated Completion Date:	December 31, 2027
Views of Responsible Officials and Corrective Actions:	The delay in issuing the final financial statements continues to be driven by the residual impact of prior year timing challenges, combined with new requirements and data dependencies. Specifically, GASB Statement No. 101 (Compensated Absences) was effective for State Fiscal Year 2025; however, the required data from the Arizona Department of Administration (ADOA) was not received until December 17, 2025—over a month after the November 14, 2025, due date. Additionally, AHCCCS self-identified certain errors in our state fiscal year 2024 amounts that required a restatement, which further contributed to the timeline for the state fiscal year 2025 report. Actions taken: To improve timeliness and accuracy, AHCCCS has continued to strengthen our financial reporting processes. This includes standardization of workpaper indexing, streamlining of internal audit review procedures, and significant enhancements to the overall accuracy of our deliverables. We have also implemented early and continual notifications to internal stakeholders regarding due dates and information required for audit workpapers. These efforts build on prior improvements, including refined policies, increased documentation, staff development, and ongoing coordination with ADOA.

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Actions remaining: To ensure timely issuance moving forward, AHCCCS will continue to advance internal process efficiencies, enhance coordination with data providers such as internal departments and ADOA, and further strengthen collaboration with auditors. While we remain committed to continuous improvement, challenges persist with the current due dates (given the timing of source data availability).

With these continued improvements, we are confident in achieving further progress toward timely financial statement issuance in the upcoming reporting cycle.

Item: 2025-002

Subject: Provider Billing Matter

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services in its Medical Assistance Program (noncompliance in a federal program as described in finding 2025-004, that had a direct and material effect on the determination of financial statement amounts). These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud (CAF) payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. See also compliance finding at 2025-004 below.

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A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. Therefore, AHCCCS could not determine whether any financial statement adjustments or additional disclosures were necessary as a result of the federal noncompliance.

Name of Contact Person: Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance

Phone Number: (602) 767-1580

Anticipated Completion Date: December 31, 2027

Views of Responsible Officials and Corrective Actions: In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program.

AHCCCS is continuing its investigations and refers Credible Allegations of Fraud (CAF) cases to law enforcement officials. AHCCCS will comply with all federal regulations regarding repayments of federal share and will work with CMS as the CAF cases continue through the law enforcement process.

Item: 2025-003

Subject: Data Breach

Criteria or Specific Requirement: AHCCCS is required to implement administrative, operational, and procedural safeguards to adequately protect the privacy of protected health information and to prevent the breach or disclosure of sensitive data. Per 45 CFR Part 164 Subpart D, AHCCCS is required to notify affected individuals. If a breach affects more than 500 individuals, AHCCCS must also notify the media within 60 calendar days after discovery of the breach. AHCCCS must also notify the U.S. Department of Health and Human Services ("HHS") Secretary of any reportable breaches.

Condition: In August 2025, AHCCCS identified a data breach involving misaddressed member communications. The incident occurred during a routine mailing to members regarding their health plan enrollment. AHCCCS was alerted by a member who received a letter addressed to a different individual. AHCCCS immediately halted its mailing process and launched an internal investigation. Once this data breach was discovered, AHCCCS took the required steps to notify the impacted individuals, the media, and the HHS Secretary in a timely manner.

Name of Contact Person: Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance

Phone Number: (602) 767-1580

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Anticipated Completion Date: December 31, 2026

Views of Responsible Officials and Corrective Actions: Management of AHCCCS concurs with the finding. Upon discovery of the incident, AHCCCS immediately halted the mailing activity and initiated an internal review to determine scope and root cause consistent with its HIPAA Privacy and Security Policy Manual. Additionally, AHCCCS complied with its requirements to complete required notifications to impacted individuals and coordinated applicable external notifications, including media and federal reporting, within required timeframes.

Corrective actions implemented and underway include:

- **Strengthening controls over member communications and data handling.** AHCCCS restricted the use of its mailing system for any communications containing protected health information (PHI) or personally identifiable information (PII) and provided direction to all system administrators and users regarding this requirement.
- **Improved quality assurance review.** AHCCCS implemented additional quality assurance steps for mail merge and outbound communication files, including validation against the source file prior to release, and developed standard work to formalize these controls.
- **Agencywide communications framework development.** AHCCCS is in the process of developing an agency-wide communications framework that includes tiered communication requirements and a documented quality assurance process to improve consistency, oversight, and compliance for all external communications. Once approved, agencywide training will be provided, with more detailed training provided to staff involved in external communications.
- **Training.** AHCCCS will continue to provide regular training and refresher training to employees responsible for outbound communications to reinforce policy requirements, increase awareness of common errors, and promote consistent application of established procedures.

Item: 2025-004

Assistance Listing Number: 93.778

Program: Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster COVID-19 Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Number: 11-W-00275/09

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CORRECTIVE ACTION PLAN

Award Year: July 1, 2024 – June 30, 2025

Compliance Requirement: Special Tests and Provisions – Utilization Control and Program Integrity

Criteria: AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).

AHCCCS must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. AHCCCS must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. AHCCCS may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud ("CAF") payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. For example, providers billed for:

- Excessive hours of services in a 24-hour period for a single member,
- Multiple services for the same member at the same time,
- AHCCCS members who were not physically present ("ghost billing"),
- Services after a member's date of death, and
- Services that were not medically necessary.

Name of Contact Person: Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance

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Phone Number: (602) 767-1580

Anticipated Completion Date: December 31, 2027

Views of Responsible Officials and Corrective Actions: The AHCCCS sober living fraud scheme was an organized Medicaid fraud operation in Arizona that primarily targeted Native American individuals struggling with addiction. Since announcing the scale of the fraud in May 2023, AHCCCS has taken multiple decisive actions to protect members, restore trust, and strengthen oversight. As previously noted in prior reports, AHCCCS self-identified and implemented a broad range of corrective actions and continues to expand and refine its tools and strategies to address emerging risks. These efforts include, but are not limited to, strengthened fraud, waste and abuse detection and review processes, enhanced quality management and care coordination for our members, and ongoing engagement and collaboration initiatives with tribal communities, providers, law enforcement partners, and other stakeholders across Arizona. Through these continued investments and partnerships, AHCCCS remains committed to preventing future misconduct, safeguarding vulnerable populations, and improving the delivery and accountability of services statewide.

- AHCCCS launched a comprehensive response to assist victims, including temporary lodging, transportation, food, hygiene supplies, and most importantly crisis services. Over 11,000 individuals have received direct support, and more than 34,000 calls have been made to the dedicated 211 hotline.
- AHCCCS has implemented over 20 new initiatives to combat fraud, waste, and abuse. These include, but are not limited to:
  - Suspension of over 300 providers and denial of 317 moratorium applications.
  - A forensic audit resulting in 25 methodical recommendations, 24 of which have already been implemented.
  - Enhancements to APEP to track behavioral health professionals and their affiliations
  - Launch of AHCCCS Provider Connect to increase communication with providers regarding their required activities in APEP.
  - Enhanced requirements for provider documentation and licensure verification
  - A new pre/post-payment system utilizing AI to detect irregularities before reimbursements are issued
  - In addition, AHCCCS supports Independent Oversight Committees (IOCs) across Arizona, composed of community members and experts who monitor behavioral health services and ensure human rights protections are upheld.
  - Use of ID.me
  - Updated EFT processes
  - Monthly Operations Analytics Review (MOAR), run by the AHCCCS Office of Data Analytics and Operations (ODAO) Team, in which the high-level utilization and enrollment trends are analyzed across the various AHCCCS lines of business and presented to AHCCCS divisions and leaders. In addition, each month various

CORRECTIVE ACTION PLAN

topics and programs have deep dives performed, analyzed, and trended to give further detailed insights into the given subject. These items are presented to AHCCCS Divisions and leaders.

- To specifically support Tribal communities, AHCCCS developed the "Know the Red Flags" outreach campaign in collaboration with Tribal leaders, Indian Health Services, and the Arizona Advisory Council on American Indian Healthcare. This initiative educates members on identifying fraudulent providers and connects them to trusted, AHCCCS-approved resources.

AHCCCS remains committed to transparency, accountability, and the well-being of our members. AHCCCS will continue working with Tribal Partners, law enforcement, and oversight agencies to ensure impacted individuals receive the care and justice they deserve.

AHCCCS continuously monitors our systems and investigates instances of fraud, waste or abuse or quality of care issues. Any deficiencies or vulnerabilities, areas of concern which are identified are then addressed, and system improvements are made. Furthermore, AHCCCS utilizes data analysis to confirm that these systems improvements are having the intended impacts and that provider networks remain robust.

Item:	2025-005
Assistance Listing Number:	93.778 and 93.767
Program:	Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, COVID-19 Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster and Children's Health Insurance Program (CHIP; Title XXI)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09 and 21-W-00074/09
Award Year:	July 1, 2024 – June 30, 2025
Compliance Requirement:	Special Tests and Provisions – Utilization Control and Program Integrity

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Criteria:	AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit ("MFCU") or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21). Additionally, in accordance with AHCCCS policy, the AHCCCS Office of Inspector General ("OIG") is required to regularly follow up on deferred investigations and provide updates at least every quarter to the State MFCU.
Condition:	AHCCCS did not follow up in a timely manner for certain deferred member investigations.
Name of Contact Person:	Vanessa Templeman, Inspector General, AHCCCS Office of Inspector General; Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance
Phone Number:	(602) 877-9066; (602) 767-1580
Anticipated Completion Date:	December 31, 2026
Views of Responsible Officials and Corrective Actions:	As of July 2026, and in alignment with OIG's modernization efforts and standardized case management practices, enhancements have been implemented within the case management system to strengthen the deferred case review process. Specifically, OIG designed and deployed a dedicated section within the system to document deferred case review notes, improving consistency, visibility, and accountability throughout the review cycle. Since the implementation of the new system in April 2026, OIG has transitioned from manual spreadsheet-based tracking to automated reporting processes that support more reliable identification and monitoring of deferred cases. OIG is currently conducting its first quarterly review utilizing these new capabilities, which include automated reporting, designated deferred case note entries, and documented supervisory review and sign-off requirements. These enhancements are intended to reduce the risk of oversight, improve the accuracy of review documentation, and provide stronger internal controls over the deferred case review process. To ensure the long-term effectiveness of these improvements, OIG will continue to monitor and evaluate the revised process over the next several quarterly review cycles. This monitoring will include assessing the reliability of automated reporting, the consistency of deferred case documentation, and compliance with supervisory review and sign-off requirements. OIG will use the results of these reviews to identify any additional opportunities for refinement and to confirm that the new processes are operating as intended, efficiently supporting case oversight while reducing the risk of errors and omissions.

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Item:	2025-006
Assistance Listing Numbers:	93.778 and 93.767
Program:	Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, COVID-19 Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster and Children's Health Insurance Program (CHIP; Title XXI)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09 and 21-W-00074/09
Award Year:	July 1, 2024 – June 30, 2025
Compliance Requirement:	Special Tests and Provisions – Medicaid Recovery Audit Contractors (RACs)
Criteria:	Under Section 1902(a)(42)(B) of the Social Security Act (42 U.S.C. § 1396a) and 42 CFR part 455, subpart F, states are required to establish and maintain a Medicaid Recovery Audit Contractor (RAC) program to identify underpayments and overpayments and to recoup overpayments for services paid under the State plan and any waivers. The program must be established consistent with State law and generally in the same manner as the Secretary contracts with contingency fee contractors for the Medicare Fee for Service RAC program under Section 1893(h) of the Act (42 U.S.C. § 1395ddd). Subpart F includes requirements related to contracting, conducting post payment reviews, recovery of overpayments, provider notification and appeals, coordination with other auditing entities and the Medicaid Fraud Control Unit (MFCU), and reporting program results to CMS (including reporting on Form CMS 64.9O RAC in accordance with CMS instructions). Under Section 1902(a)(42)(B)(i) of the Act (42 USC 1396a) and 42 CFR section 455 Subpart F, states and territories are required to establish programs to contract with one or more Medicaid RACs to identify underpayments and overpayments, and recoup overpayments under the state plan and under any waiver of the state plan with respect to all services for which payment is made to any entity under such plan or waiver.
Condition:	AHCCCS has executed a contract with a Medicaid RAC consistent with federal requirements (42 CFR section 455.508), and has also developed internal processes with the Medicaid RAC to develop the RAC program. Additionally, AHCCCS maintains meeting minutes of regular communication with the Medicaid RAC to coordinate the program's implementation and progress. However, the RAC program has yet to be fully operational to perform its overall objective to identify under/overpayments and initiate any potential recoupments paid under the State plan and any waivers.

CORRECTIVE ACTION PLAN

Specifically, we noted that AHCCCS:

- Has set limits on the number and frequency of medical records to be reviewed by the RACs, however the program was placed on hold in early fiscal 2025 to reassess the program's system processes, which prevented any further review of medical records by the RAC program through June 30, 2025 as defined by 42 CFR 455.506(e).
- While AHCCCS has policies in place, they have not yet performed procedures under its RAC program to make referrals of suspected fraud
- and/or abuse to the appropriate entities (e.g., the MFCU) as defined by 42 CFR Section 455.506(d).
- Has not completed the required reporting of Medicaid RAC program performance results on the CMS 64.9O RAC form for the applicable quarters, as required by 42 CFR part 455.502, subpart F and CMS 64 reporting instructions. As a result, AHCCCS was not conducting the required RAC activities (e.g., post payment reviews and associated recoveries, provider notifications and appeals processing, coordination, and reporting) during the period under audit.

Name of Contact Person: Vanessa Templeman, Inspector General, AHCCCS Office of Inspector General; Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance

Phone Number: (602) 877-9066; (602) 767-1580

Anticipated Completion Date: July 1, 2027

Views of Responsible Officials and Corrective Actions: AHCCCS has consistently submitted details surrounding AHCCCS' RAC program through the Monthly CMS Operational Report Workbook and has continued to accurately report required RAC metrics to CMS. AHCCCS sought confirmation from CMS regarding its review and oversight of the reported RAC metrics. In response, CMS advised that it had consulted with CMS leadership and noted that Arizona had not reported RAC recoveries on its quarterly CMS-64 expenditure reports and that this matter would be discussed during future reviews. AHCCCS acknowledges CMS' feedback regarding CMS-64 financial reporting. AHCCCS temporarily paused RAC activities to ensure providers were afforded a secondary level of clinical review and due process safeguards. It should also be noted that several Arizona Managed Care Organizations (MCOs) currently perform review activities similar to those identified under the RAC program's initial project.

AHCCCS has demonstrated a longstanding commitment to fully implementing and operationalizing its RAC program. Since program inception, AHCCCS has worked to establish the necessary operational framework, reporting processes, clinical review standards, and oversight mechanisms needed to support a sustainable and effective RAC program. The temporary pause in RAC activities reflects AHCCCS' commitment to ensuring that clinical review workflows, provider protections, and program objectives are appropriately designed and implemented before resuming recovery activities. As such, once the clinical review components, workflows, and program objectives have been finalized and validated, AHCCCS intends to re-implement its RAC program and continue advancing its efforts to strengthen program integrity while maintaining appropriate clinical and administrative safeguards.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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KATIE HOBBS
GOVERNOR

ROBERTA HARRISON
INTERIM DIRECTOR

CORRECTIVE ACTION PLAN

Item:	2025-007
Assistance Listing Number:	93.778
Program:	Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster, COVID-19 Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09
Award Year:	July 1, 2024 – June 30, 2025
Compliance Requirement:	Eligibility
Criteria:	The Office of Management and Budget ("OMB") Compliance Supplement identifies Eligibility as a key compliance requirement, requiring that Medicaid benefits be provided only to eligible individuals and that eligibility determinations, including disenrollments, are performed accurately and timely. States are responsible for ensuring (a) timely termination of eligibility (e.g., upon death), and (b) recovery of payments made on behalf of ineligible individuals.
Condition:	During testing of Medicaid eligibility and enrollment, we identified an instance in which a beneficiary remained enrolled in Medicaid for approximately 18 months after the date of death, resulting in continued capitation payments to the managed care organization (MCO). In addition to the disenrollment issue, we noted deficiencies in the recoupment process. Although AHCCCS initiated recovery efforts after disenrollment, the system was designed to recoup only within the current and one-year prior contract years.
Name of Contact Person:	Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance
Phone Number:	(602) 767-1580
Anticipated Completion Date:	March 31, 2027
Views of Responsible Officials and Corrective Actions:	AHCCCS concurs with the finding. The Agency has implemented and will continue to enhance internal controls to ensure timely disenrollment of deceased members and full recovery of improper payments. Corrective actions address system limitations, manual review processes, data quality, and recovery procedures

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CORRECTIVE ACTION PLAN

Actions taken:

- Enhanced Death Data Matching (PARIS / Do Not Pay): AHCCCS has strengthened its control environment through participation in the federal PARIS match and U.S. Treasury Do Not Pay (DNP) program. Quarterly match files integrate multiple federal death data sources, including the Social Security Administration Death Master File, to identify deceased members. Results are incorporated into eligibility and reconciliation workflows to support automated disenrollment, manual review, improper payment recovery, and prevention of future payments.
- This provides an independent and recurring control that supplements state and SSA data sources.

Actions remaining:

- Recoupment Process Improvements:
  AHCCCS is modifying recoupment processes to ensure recovery of all identified improper payments by removing the 2-contract year restriction.
  Status: In progress
  Completion Date: Q3 SFY27