MEETING NOTICE

- Call to Order

- Approval of Minutes of July 28, 2011.

- DIRECTOR'S REPORT (if necessary).

- EXECUTIVE SESSION
  A. Arizona Department of Administration, Risk Management Services - Consideration of Proposed Settlements under Rule 14.
  B. AHCCCS - Review of RFP to Reduce Erroneous and Fraudulent Payments as Required under A.R.S. § 38-431.03A2.


2. ARIZONA BOARD OF REGENTS - Review of FY 2012 Tuition Revenues.


4. DEPARTMENT OF HEALTH SERVICES - Consider Approval of Nursing Care Facilities Survey.

The Chairman reserves the right to set the order of the agenda.

9/20/11

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People with disabilities may request accommodations such as interpreters, alternative formats, or assistance with physical accessibility. Requests for accommodations must be made with 72 hours prior notice. If you require accommodations, please contact the JLBC Office at (602) 926-5491.
The Chairman called the meeting to order at 10:00 a.m., Thursday, July 28, 2011 in House Hearing Room 4. The following were present:

Members:   Representative Kavanagh, Chairman  Senator Biggs, Vice-Chairman
           Representative Alston  Senator Aboud
           Representative Court  Senator Klein
           Representative Fillmore  Senator Murphy
           Representative Tovar  Senator Yarbrough

Absent:   Representative Harper  Senator Cajero Bedford
           Representative Heinz  Senator Crandall
           Representative Jones

APPROVAL OF MINUTES

Hearing no objections from the members of the Committee to the minutes of June 9, 2011, Chairman John Kavanagh stated that the minutes would stand approved.

EXECUTIVE SESSION

Senator Biggs moved that the Committee go into Executive Session. The motion carried.

At 10:01 a.m. the Joint Legislative Budget Committee went into Executive Session.

Senator Biggs moved that the Committee reconvene into open session. The motion carried.

At 11:42 a.m. the Committee reconvened into open session.


Senator Biggs moved that the Committee give a favorable review with the expectation that 1) the department will give the Committee further information regarding performance bonds, capital improvements, insurance, transportation time and monitoring costs, and 2) in drafting the Request for Proposals, the department will take into consideration the concerns of the Committee as mentioned in the meeting. The motion carried.
Senator Biggs moved that the Committee go back into Executive Session. The motion carried.

At 11:44 a.m. the Joint Legislative Budget Committee went back into Executive Session.

Senator Biggs moved that the Committee reconvene into open session. The motion carried.

At 11:52 a.m. the Committee reconvened into open session.

**B. Litigation Update - Pima County Community College District vs. JLBC (A.R.S. § 38-431.03A3).**

This item was for information only. No Committee action was required.

Without objection, the meeting adjourned at 11:53 a.m.

Respectfully submitted:

__________________________
Sandy Kelley, Secretary

__________________________
Richard Stavneak, Director

__________________________
Representative John Kavanagh, Chairman

NOTE: A full audio recording of this meeting is available at the JLBC Staff Office, 1716 W. Adams. A full video recording of this meeting is available at [http://www.azleg.gov/jlbc/meeting.htm](http://www.azleg.gov/jlbc/meeting.htm).
DATE: September 21, 2011

TO: Representative John Kavanagh, Chairman
Members, Joint Legislative Budget Committee

THRU: Richard Stavneak, Director

FROM: Amy Upston, Principal Fiscal Analyst

SUBJECT: AHCCCS/DHS/DES - Review of Proposed Capitation Rate Changes

Request

Pursuant to footnotes in the FY 2012 General Appropriation Act, the Arizona Health Care Cost Containment System (AHCCCS), the Department of Health Services (DHS), and the Department of Economic Security (DES) are required to report capitation and fee-for-service inflationary rate changes with a budgetary impact to the Committee for review prior to implementation. AHCCCS submitted this item for all 3 agencies.

Recommendation

The Committee has at least the following options:

1. A favorable review.

2. An unfavorable review.

With these capitation rate changes and other policies being implemented, AHCCCS states that the Medicaid system will be able to operate within its available FY 2012 appropriation. While AHCCCS states that Medicaid monies may need to be reallocated between agencies, they are unable to provide the net impact on each individual agency. Since AHCCCS cannot provide the agency-specific impacts, it is unclear as to how they have reached the conclusion that their proposed rates are budget neutral.

Analysis

The FY 2012 budget reduces the Medicaid budgets by $(520) million across the 3 agencies and authorizes AHCCCS to implement a budget within its available appropriation. The FY 2012 Health Budget Reconciliation Bill (Laws 2011, Chapter 31) gives AHCCCS authority to make changes to Medicaid services, eligibility, and reimbursement rates.
Capitation rates are developed by actuaries based on information provided to them by the agency. Rates are set at the beginning of the contract year (October 1) and must be approved by the federal Centers for Medicare and Medicaid Services (CMS). Rates for Medicaid programs are composed of adjustments for utilization, experience, provider reimbursement, and policy changes.

Utilization

Capitation rates are adjusted annually for utilization, or the percentage of eligible individuals who use services and the amount of services each member uses. Utilization changes to capitation rates will be minimal this contract year with the exception of Behavioral Health Services and Children’s Rehabilitative Services (see below).

Experience

In developing capitation rates, the actuaries compare prior rate calculations and assumptions to actual results. This is referred to as experience adjustments.

Provider Reimbursement

Beginning on October 1, 2011, capitation rates will be reduced so that all providers should receive a (5)% rate reduction with the exception of Indian Health Services and tribal 638 facilities (tribally-owned and operated facilities authorized by the federal government), which are funded 100% by the federal government, and hospice services whose rates are set by the federal government. Some changes have also been made to hospitals for outlier payments. Hospitals are paid at a flat per diem rate, regardless of the billed charges for each case. AHCCCS also makes “outlier payments” for cases where the charged amount is above a certain threshold.

Policy Changes

The capitation rates include 2 benefit limitations:

- Members aged 21 years and older will be limited to 25 inpatient days within a 1-year time period (exclusions apply for governmentally operated burn units, days that are part of a transplant stay, and behavioral health-related stays).
- Respite care will be reduced from 720 hours to 600 hours annually; this will impact the ALTCS Elderly and Physically Disabled, Developmentally Disabled, and Behavioral Health programs which are described in more detail below.

Adjustments by Program

**AHCCCS Acute Care**

This population represents members who participate in the Traditional Medicaid, Proposition 204, and KidsCare programs. Overall, the proposed capitation rates for these programs will decline by (7.7)%.

**AHCCCS Long-Term Care (ALTCS) for the Elderly and Physically Disabled**

ALTCS services are provided to the elderly and physically disabled in need of long-term care either in nursing care facilities or in home and community-based settings. The state, counties, and federal government share in the cost of ALTCS services. Unlike the other programs, the AHCCCS ALTCS contracts expire at the end of September 2011 and a Request for Proposal (RFP) was issued earlier in the year. Rates were updated based on bids made through the RFP process. The proposed capitation rates are (9.2)% below the current rates.

**Children’s Rehabilitative Services (CRS)**

The CRS program is administered by AHCCCS and provides services for children with chronic and disabling or potentially disabling conditions. Rates will go up by 1.6%, primarily the result of increases

(Continued)
in utilization and rebases in hospital fees ($0.8 million GF cost), partially offset by provider rate reductions ($1.5 million GF savings).

**Comprehensive Medical and Dental Program (CMDP)**
CMDP provides medical and dental services for children in the foster care system. The proposed capitation rates are reduced by (3.9)% for the remainder of the 2011 calendar year, due mainly to the provider rate reductions ($91,000 GF savings). Unlike the other programs, CMDP’s contract year is from January 1 through December 31.

**Long-Term Care for the Developmentally Disabled (DD)**
DES administers the DD program, providing services for individuals with cognitive disabilities, cerebral palsy, autism, or epilepsy. The largest change to the DD rates result from changes to provider rates ($10.3 million GF savings). Experience adjustments, reduction in respite care hours ($1.2 million GF savings), and the award of new acute care contracts result in minimal changes to the capitation rates. The proposed capitation rates are (5.1)% below current rates.

**Behavioral Health Services (BHS)**
DHS oversees most behavioral health and substance abuse services. The proposed rate is an increase of 3.3% driven largely by expected utilization increases of 6.4%. The largest capitation increase results from the Seriously Mentally Ill (SMI) population. Individuals with an SMI diagnosis who were previously classified as a childless adult have been moved to a different program so they would not be affected by the freeze in the childless adult program. The budget envisioned this shift, which is now estimated to cost $19 million GF. The provider rate reductions ($10.7 million GF savings) offset some of this increase.

**Monthly Capitation Rates**
The table below compares the proposed October 1, 2011 rates to the current rates.

<table>
<thead>
<tr>
<th>Populations</th>
<th>Current Rates</th>
<th>Proposed 10/1/11 Rates</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCCCS Acute</td>
<td>$ 256.53</td>
<td>$ 236.83</td>
<td>(7.7)%</td>
</tr>
<tr>
<td>AHCCCS Elderly &amp; Physically Disabled</td>
<td>3,186.46</td>
<td>2,893.35</td>
<td>(9.2)%</td>
</tr>
<tr>
<td>Children’s Rehabilitative Services</td>
<td>417.35</td>
<td>424.10</td>
<td>1.6</td>
</tr>
<tr>
<td>Comprehensive Medical and Dental Program</td>
<td>232.08</td>
<td>222.98</td>
<td>(3.9)%</td>
</tr>
<tr>
<td>DES Developmentally Disabled</td>
<td>3,387.67</td>
<td>3,217.79</td>
<td>(5.1)%</td>
</tr>
<tr>
<td>DHS Behavioral Health Services</td>
<td>82.41</td>
<td>85.10</td>
<td>3.3</td>
</tr>
</tbody>
</table>
Mr. Richard Stavneak  
Joint Legislative Budget Committee  
1700 West Washington  
Phoenix, Arizona 85007

Dear Mr. Stavneak:

The Arizona Health Care Cost Containment System (AHCCCS), Arizona Department of Health Services (ADHS) and the Arizona Department of Economic Security (DES) respectfully request to be placed on the agenda of the next Joint Legislative Budget Committee (JLBC) meeting to review the capitation rates for Contract Year Ending (CYE) 2012 (October 1, 2011 through September 30, 2012, unless otherwise noted) for the following programs:

- Acute Care
- Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD)
- ALTCS DES/Division of Developmental Disabilities (DDD) (update for October 1, 2011 through June 30, 2012)
- Children’s Rehabilitative Services (CRS)
- Behavioral Health Services (BHS) (update for October 1, 2011 through June 30, 2012)

Additionally, AHCCCS has updated the capitation rates for CYE 2011 (January 1 through December 31, 2011) for the following program:

- Children’s Medical and Dental Program (CMDP) (update for October 1 through December 31, 2011)

Background and Summary

As required by the Federal Balanced Budget Act of 1997, Title XIX Managed Care Programs must have actuarially sound capitation rates. The proposed rate adjustments are awaiting approval by the Centers for Medicare and Medicaid Services (CMS) for an October 1, 2011 implementation. Laws 2011, Chapter 31 authorized AHCCCS to implement a program within its available appropriation, including making changes to services, eligibility and reimbursement rates. The capitation rates reflect many of the changes associated with the State of Arizona Medicaid Reform Plan, proposed by Governor Brewer in March 2011 and built into the budgets passed for AHCCCS, ADHS and DES.

Already approved by CMS is the phase out of the Medical Expense Deduction (MED) program beginning May 1, 2011, effectively eliminating the program October 1, 2011, as it will not be renewed by the State under its revised Waiver Renewal request. CMS has also approved a phase out of the current Childless Adult program, which freezes enrollment for this eligibility category beginning July 8, 2011 and continues the program effective October 1, 2011 based on available funding. Other initiatives included in the Medicaid reform plan and incorporated in the capitation rates include limited benefit changes and reductions in provider reimbursement rates. Details on additional factors contributing to the rate changes are discussed below.
Implementation of the Medicaid Reform Plan requires major changes to AHCCCS’ State Plan also approved by CMS. AHCCCS is still awaiting CMS approval of several significant State Plan Amendments which impact capitation rates. AHCCCS has historically received CMS approval of proposed capitation rates with no changes. However, should CMS withhold approval of any of the pending State Plan Amendments, capitation rates will need to be amended. AHCCCS will promptly notify JLBC of any changes to the proposed rates.

AHCCCS is Arizona’s single state Medicaid agency; however, the Arizona Medicaid system includes state agency subcontractors, ADHS and DES. The budget as passed included assumptions that capitation rates would be held flat. Over the entire Medicaid System that mandate is achieved, with CYE 2012 capitation rates at essentially 0% over the most-recently adjusted rates (April 1, 2011 or July 1, 2011, depending upon the Program). When the policy changes included in the Medicaid Reform Plan are factored in, capitation rates for the entire Medicaid System are (5.53)% below the most-recently adjusted rates (implementation dates noted below), and (7.63)% below the previously-approved annual rates. Table 1 below displays the rate changes by program:

**Table 1**

<table>
<thead>
<tr>
<th>Program</th>
<th>Rate Change</th>
<th>Rate Change (over previously approved annual rates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCCCS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>(7.68)% (over 4/1/11 rates)</td>
<td>(9.99)%</td>
</tr>
<tr>
<td>ALTCS EPD</td>
<td>(9.20)% (over 4/1/11 rates)</td>
<td>(9.69)%</td>
</tr>
<tr>
<td>CRS</td>
<td>1.62% (over 4/1/11 rates)</td>
<td>0.22%</td>
</tr>
<tr>
<td>DES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DDD</td>
<td>(5.10)% (over 7/1/11 rates)</td>
<td>(6.51)%</td>
</tr>
<tr>
<td>CMDP</td>
<td>(3.92)% (over 4/1/11 rates)</td>
<td>(6.09)%</td>
</tr>
<tr>
<td>ADHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHS</td>
<td>3.27% (over 7/1/11 rates)</td>
<td>(0.34)%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>(5.53)%</strong></td>
<td><strong>(7.63)%</strong></td>
</tr>
</tbody>
</table>

The five year average capitation rate adjustment across the Medicaid System is (0.23)%.

**Acute Care Capitation Rates**
The overall rate adjustment for the Acute program for CYE 2012 is a negative (7.68)%.
Mr. Richard Stavneak  
September 9, 2011  

The three largest factors impacting the acute rates are the 5% provider rate reduction, accounting for a (3.64)% decrease; Managed Care Organization (MCO) adjustments of negative (3.60)% due to a “look-back” analysis comparing prior rate calculations and assumptions used therein, versus actual results (referred to as an experience adjustment); and the imposition of a 25 day annual limit on the coverage of inpatient hospital days for adults which further reduces the rate by (1.94)%.

**Elderly and Physically Disabled Long Term Care Capitation Rates**  
The overall rate adjustment for the ALTCS EPD program for CYE 2012 is a negative (9.20)% rate. The largest factor impacting the rates is the 5% provider rate reduction, accounting for a (4.64)% decrease.

The ALTCS EPD contracts went out for bid earlier this year via a Request for Proposal. Interest in the AHCCCS program remained high with a total of nine managed care companies submitting offers to serve at least a portion of the State’s ALTCS EPD population. Three of those companies submitted bids to serve the entire State. This competitive process drove down program costs and accounts for the second largest factor impacting cap rates with a downward adjustment of (4.08)%.

**Developmental Disabilities Long Term Care Capitation Rates**  
The annual update to the ALTCS DDD capitation rates was implemented effective July 1, 2011, at the start of DDD’s CYE 2012. Effective October 1, 2011, rates are updated again for the remaining three-quarters of CYE 2012 with a negative (5.10)% adjustment.

The largest factor impacting the rates is the 5% provider rate reduction, accounting for a (4.11)% decrease. Other changes are minor and include an experience adjustment (decrease of 0.60%), a reduction in the respite hour limit from 720 to 600 hours annually (decrease of 0.51%), and the award of new acute care contracts (increase of 0.33%).

**Children’s Medical and Dental Program Capitation Rates**  
The overall rate adjustment for the Children’s Medical and Dental Program (CMDP) for the remainder of CYE 2011 is a negative (3.92)% rate. The only significant factor impacting the rates is the 5% provider rate reduction.

**Children’s Rehabilitative Services Capitation Rates**  
The overall rate adjustment for the Children’s Rehabilitative Services program for CYE 2012 is an increase of 1.62%.

CRS continues to experience increasing medical trends, resulting in a 3.39% increase to the capitation rate. This increase is offset by the 5% provider rate reduction, which accounts for a (3.47)% decrease. The rebasing of the outpatient fee schedule (which overall to the AHCCCS program is budget neutral) results in increased costs for CRS based on the mix of hospitals utilized and results in a 1.18% increase to the CRS capitation rate. Finally, the transition of pediatric services from St. Joseph’s Hospital to Phoenix Children’s Hospital (PCH) necessitates a 0.72% increase to the CRS capitation rate as services at PCH are paid at a higher rate than at St. Joseph’s Hospital.

**Behavioral Health Services Capitation Rates**  
The annual update to the BHS capitation rates was implemented effective July 1, 2011, at the start of BHS’s CYE 2012. Effective October 1, 2011, rates are updated again for the remaining three-quarters of CYE 2012 with an increase of 3.27%.
The largest factor impacting the BHS rates is a penetration adjustment of 6.40%. The BHS capitation rates are a reflection of the expected costs to the system for people who are using behavioral health services, and are calculated across all AHCCCS Acute Care enrollees. Due to the enrollment freeze for Childless Adults, the Acute Care population is expected to steadily decrease over the course of CYE 2012. However, the number of persons with serious mental illness (SMI) utilizing behavioral health services is expected to remain relatively constant while members with general mental health issues are expected to decline at a lesser rate than the Acute Care population. Therefore, the capitation rates must be adjusted upward in order for the rates to continue to cover the costs in the system and remain actuarially sound.

The other main factor impacting the BHS rates is the 5% provider rate reduction, which accounted for a (3.59)% decrease.

**Overall Fiscal Impact**

Table 2 below displays the fiscal impact of the rate changes.

**Table 2**

<table>
<thead>
<tr>
<th></th>
<th>SFY11</th>
<th>SFY12</th>
<th>FY12 Rate with FY 12 Pop.</th>
<th>SFY12 Rate with FY 12 Pop.</th>
<th>Change Inc. (Dec.)</th>
<th>Percent Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCCCS Acute</td>
<td>$256.53</td>
<td>$236.83</td>
<td>14,365,867</td>
<td>3,736,501,500</td>
<td>(286,936,100)</td>
<td>-7.68%</td>
</tr>
<tr>
<td>AHCCCS EPD</td>
<td>$3,186.46</td>
<td>$2,603.35</td>
<td>321,604</td>
<td>1,024,779,500</td>
<td>(94,266,600)</td>
<td>-9.20%</td>
</tr>
<tr>
<td>CMDP</td>
<td>$232.08</td>
<td>$222.98</td>
<td>124,467</td>
<td>28,891,200</td>
<td>(1,133,600)</td>
<td>-3.92%</td>
</tr>
<tr>
<td>CRS</td>
<td>$417.35</td>
<td>$424.10</td>
<td>307,062</td>
<td>128,151,400</td>
<td>2,073,800</td>
<td>1.62%</td>
</tr>
<tr>
<td>BHS Title XXXXXX</td>
<td>$82.41</td>
<td>$85.10</td>
<td>14,324,942</td>
<td>1,180,460,800</td>
<td>38,588,400</td>
<td>3.27%</td>
</tr>
<tr>
<td>LTC - DD/DES</td>
<td>$3,387.67</td>
<td>$3,214.70</td>
<td>292,002</td>
<td>992,255,700</td>
<td>(50,638,900)</td>
<td>-5.10%</td>
</tr>
<tr>
<td><strong>Total Budget Impact</strong></td>
<td>$454.21</td>
<td>$429.09</td>
<td>15,611,023</td>
<td>7,091,160,100</td>
<td>(392,311,000)</td>
<td>-5.53%</td>
</tr>
</tbody>
</table>

Based on the budgets submitted this week to the Governor’s Office of Strategic Planning and Budgeting, the Medicaid System is currently projecting that with these rate changes, and the implementation of other policy changes, the System will operate within our available resources in CYE 2012. Monies will likely need to be reallocated between the various agencies to better account for the projected spending. AHCCCS will work with OSPB and JLBC to provide necessary information.
Mr. Richard Stavneak  
September 9, 2011  
Page 5

Policy Changes

Per the legislative mandates in ARS 36-2901.06 and 36-2941, AHCCCS has not included any changes beyond those already approved by the Legislature.

The actuarial certifications for the rates are attached. Should you have any questions on any of these issues, please feel free to contact Shelli Silver, DHCM Assistant Director, at (602) 417-4711.

Sincerely,

[Signature]

Thomas J. Betlach  
Director

cc: The Honorable Richard Stavneak, Arizona House of Representatives  
The Honorable Andy Biggs, Arizona State Senate  
John Arnold, Office of Strategic Planning & Budgeting

Enclosures (9)
Acute Care Actuarial Memorandum

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Acute Care capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

The proposed capitation rates incorporate significant portions of Arizona Governor Brewer’s plan to preserve the State’s Medicaid program with reforms that will drive down costs by an estimated $500 million in the State General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget adoption and is subject to Federal approval.

Already approved by CMS is the phase out of the Medical Expense Deduction (MED) program beginning May 1, 2011, effectively eliminating the program October 1, 2011, as it will not be renewed by the State under its revised Waiver Renewal request. CMS has also approved a phase out of the current Childless Adult program (referred to as the Non-MED population in this memorandum), which freezes enrollment for this eligibility category beginning July 8, 2011 and continues the program effective October 1, 2011 based on available funding. Other initiatives included in the Governor’s Medicaid reform plan addressed in this memorandum include limited benefit changes and reductions in provider reimbursement rates.

II. Overview of Rate Setting Methodology

The contract year ending 2012 (CYE12) rates were developed as a rate update from the contract year ending 2011 (CYE11) capitation rates as adjusted April 1, 2011 and previously approved by CMS. The CYE12 rates cover the twelve month contract period of October 1, 2011 through September 30, 2012.

The Acute Care rates were developed from historical Acute Care data including Arizona Medicaid managed care encounter data (via an extract that provides utilization and cost data, referred to as the “databook”), as well as health plan financial statements. Other data sources include programmatic changes, anticipated Arizona Health Care Cost Containment System (AHCCCS) Fee For Service rate changes, anticipated Arizona Department of Health Services (ADHS) transportation increases, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information.

The contract between the AHCCCS and the health plans (HPs) specifies that the HPs may cover additional services. Non-covered services were removed from the databook and not included in the rates.

Trend rates were calculated from the databook and other sources on a unit cost and/or utilization basis by category of service (COS) and a cap was applied to limit the negative and positive trends to a reasonable level. Unit cost trends were further refined by actual and anticipated changes in AHCCCS Fee For Service rates. These adjustments also include state mandates, court ordered programs and other program
changes, if necessary. Additional analysis was performed on all populations due to
shifts in the economy and policy impacts that have caused deviations from the
historical encounter data costs and trends. In order to capture these changes
AHCCCS used more recent encounter data as well as the most recent financial data
and applied an experience adjustment factor to all populations. For more information
on trends and experience adjustments see Section III Projected Trend Adjustments
and Section IV Projected Experience Adjustments.

The Acute Care program has a large membership base, which allows for the
experience data to be analyzed by the different rate cells. These rate cells are
comprised of members with similar risk characteristics. The rate cells were analyzed
by major categories of aid (COA), i.e. risk groups, and COS. In addition, AHCCCS
develops rates by Geographic Service Area (GSA).

The experience data includes only Acute Care Medicaid eligible expenses for Acute
Care Medicaid eligible individuals, as well as reinsurance amounts. The Prior Period
Coverage (PPC) rates and the Non-MED rates are reconciled to a maximum 2% profit or loss. In prior years, the MED rates were reconciled to a maximum 3% profit or loss. Since this population has been phasing out effective May 1, 2011, no reconciliation will be in place for CYE12. Additional payments are made for members giving birth via a Maternity Delivery Payment.

Effective with CYE12, all risk groups other than PPC and non-MED will be
reconciled as follows:

<table>
<thead>
<tr>
<th>Profit</th>
<th>MCO Share</th>
<th>State Share</th>
<th>Maximum MCO Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=3%</td>
<td>100%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>&gt;3% and &lt;=5%</td>
<td>75%</td>
<td>25%</td>
<td>1.5%</td>
</tr>
<tr>
<td>&gt;5% and &lt;=7%</td>
<td>50%</td>
<td>50%</td>
<td>1.0%</td>
</tr>
<tr>
<td>&gt;7% and &lt;=9%</td>
<td>25%</td>
<td>75%</td>
<td>0.5%</td>
</tr>
<tr>
<td>&gt;9%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>0%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loss</th>
<th>MCO Share</th>
<th>State Share</th>
<th>Maximum MCO Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=3%</td>
<td>100%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>&gt;3% and &lt;=6%</td>
<td>50%</td>
<td>50%</td>
<td>1.5%</td>
</tr>
<tr>
<td>&gt;6%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>0%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

The general process in developing the prospective rates involves trending the CYE11
capitation rates to the midpoint of the effective period, which is April 1, 2012. The
next step involves applying programmatic and experience adjustments. This creates a
CYE12 medical PMPM from which the reinsurance offsets are deducted. Following
this calculation, the projected administrative expenses, risk/contingency margin and
premium tax are added to the projected claim PMPMs to obtain the capitation rates.
In the final step, a risk adjustment factor is applied creating budget neutral results.
Each step is described in the sections below. In addition there are sections dedicated
to the development of other rates including, but not limited to, the Maternity Delivery
Payment and PPC rates.
III. Projected Trend Adjustments

The trend analysis includes both the financial data experience and the encounter data experience. Financial data experience is from the contract year ending September 2008 through March 2011. Encounter data experience is from the contract year ending September 2008 through September 2010. Encounter data was used from those plans that provided reasonably complete and accurate encounter submissions for the trend analysis. The resulting data provides an actuarially sound data set for which to trend the CYE11 rates forward. In addition to using encounter and financial data, AHCCCS used information from CMS NHE Report estimates, GI information, and changes in AHCCCS’ Inpatient rates, Professional and Outpatient Fee Schedules, Dental Fee Schedule, Transportation Fee Schedule and other sources. AHCCCS developed utilization and unit cost trend estimates using the encounter data. These trends were developed by major COA and COS, with a cap on the percentage increase and decrease to smooth out exceptional trends.

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors’ Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members’ coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 through SFY 2010, encounter-reported COB cost avoidance grew by greater than 30%, from $391 million in SFY 2008 to $509 million in SFY 10. Additionally, Acute Contractors cost-avoided more than $600 million in additional claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

In addition, unit cost trend estimates were based on AHCCCS fee schedule changes for the majority of the COS trends. As part of the Governor’s Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, AHCCCS is given the authority to reduce fee schedule rates for all providers up to 5%. Therefore, effective October 1, 2011, AHCCCS will reduce all provider reimbursement, with few exceptions, by 5%, including all payment ratios utilized for provider reimbursement (e.g., all Cost-to-Charge Ratios (CCRs), By Report Percentages (BR), etc.). The decreases are included in the trend amounts by category of service as mentioned below and in total are approximately $136 million statewide.

Once these trends were developed they were analyzed by comparing the results to reports and studies (for example the CMS NHE report). The utilization and unit cost trend rates used in projecting the claim costs are summarized in Appendix I. The prospective PMPM trends are shown below in Table I. These trends do not reflect the impact of any program changes.
Table I: Prospective Average Annual PMPM Trends

<table>
<thead>
<tr>
<th>Categories of Service</th>
<th>PMPM Trends</th>
<th>TANF &amp; KidsCare</th>
<th>SSI With Medicare</th>
<th>SSI Without Medicare</th>
<th>Non-MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>-6.2%</td>
<td>-1.5%</td>
<td>-6.7%</td>
<td>-5.3%</td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>-3.2%</td>
<td>-0.3%</td>
<td>0.0%</td>
<td>-3.2%</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>-4.1%</td>
<td>-7.3%</td>
<td>-0.4%</td>
<td>-4.9%</td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>-2.1%</td>
<td>-3.4%</td>
<td>-0.5%</td>
<td>-4.3%</td>
<td></td>
</tr>
<tr>
<td>Referral Physician</td>
<td>-0.4%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>-5.6%</td>
<td></td>
</tr>
<tr>
<td>Other Professional</td>
<td>0.4%</td>
<td>-5.3%</td>
<td>-1.4%</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>7.0%</td>
<td>5.4%</td>
<td>4.9%</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>-5.8%</td>
<td>-4.5%</td>
<td>-3.3%</td>
<td>-4.9%</td>
<td></td>
</tr>
</tbody>
</table>

Hospital Inpatient Trends
Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the inpatient utilization varied from -5.1 to -2.7 percent annually, depending upon risk group. AHCCCS used encounter data, as adjusted for the rate decrease mentioned above, to develop the hospital inpatient unit cost trends. On a combined basis, the per member per month (PMPM) trends for inpatient hospital have been trended at -6.7 to -1.6 percent, depending upon risk group. These ranges are summarized in Appendix I.

Hospital Outpatient and Emergency Room Trends
AHCCCS used encounter data, as adjusted for the rate decrease mentioned above, to develop the hospital outpatient and emergency room unit cost trends. These trends were then adjusted for the rebase of the Outpatient Fee Schedule (OPFS) rates required by the Arizona Administrative Code. This rebase is required every five years and will be effective October 1, 2011. The utilization trends were developed using the data sources mentioned in Section II with emphasis on the AHCCCS encounter data. On a combined basis, the PMPM costs for hospital outpatient and emergency room have been trended at -7.3 to 0.0 percent, depending upon risk group. These ranges are summarized in Appendix I.

Physician and Related Service Trends
Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the assumed utilization for physicians and other professionals ranged from -0.1 to 9.2 percent annually, depending upon risk group and category of service. AHCCCS primarily used encounter data, as adjusted for the rate decrease mentioned above, to develop the physician and other professionals unit cost trends. On a combined basis, the PMPM costs for physicians and other professionals have been trended at -5.6 to 1.4 percent, depending upon risk group. These ranges are summarized in Appendix I.

Pharmacy Trends
Using the data sources mentioned in Section II and emphasizing the AHCCCS encounter data, the assumed pharmacy utilization increased by 1.1 to 7.3 percent, depending upon risk group. Based on a review of the same sources, unit costs have been trended at -2.2 to 4.3 percent. Pharmacy trends are not impacted by the
mandated fee schedule decreases on October 1, 2011. On a combined basis, the PMPM costs for pharmacy have been trended at 3.2 to 7.0 percent, depending upon risk group. These ranges are summarized in Appendix I.

**Smoking Cessation**

Starting October 1, 2008, in accordance with Laws 2008, Chapter 131, AHCCCS added coverage for eligible tobacco cessation products which include nicotine replacement therapy (NRT) and tobacco use medications for eligible Title XIX AHCCCS members who wish to stop tobacco use and who are enrolled in a tobacco cessation program offered by the Arizona Department of Health Services. This program has been effective for almost three years, therefore making it possible to review how actual experience compares to the initial projections. The review is based on encounter utilization and costs data for CYE10 and CYE11 (YTD). AHCCCS determined Acute members utilized less services than included in last year’s projection. Based upon this analysis, AHCCCS is decreasing the amount included for tobacco cessation products in the capitation rates. The statewide impact to the Acute program for CYE12 is a decrease of approximately $742,000.

**IV. Projected Experience Adjustments**

Based on the recent rapid growth in the AHCCCS population resulting from previously unforeseen economic conditions in addition to the freeze of the non-MED risk group effective July 8, 2011, AHCCCS is applying an experience adjustment to the CYE12 capitation rates. The projected experience adjustments are calculated by risk group, by GSA for prospective and PPC populations.

The projected experience adjustments are a function of two components: a financial component and an encounter component. The financial component is based on four different views of the health plans’ submitted financials: reported profit/loss for CYE10; reported profit/loss through March 31, 2011; reported CYE10 medical expense compared to the CYE10 medical expense built into the capitation rates adjusted for the CYE11 changes to medical expense; and reported CYE11 medical expense (for two quarters) compared to the CYE11 medical expense built into the capitation rates. The encounter component is based on three different views: CYE10 databook encounters (PMMIS point-in-time extract) over CYE10 medical expense built into the capitation rates adjusted for CYE11 changes to medical expense; CYE10 Cognos encounters (up-to-date extract from data warehouse) over CYE10 medical expense built into the capitation rates adjusted for CYE11 changes to medical expense; and Cognos encounters for two quarters of CYE11 over CYE11 medical expense in the capitation rates. These components were then analyzed to arrive at the necessary experience adjustments. These experience adjustments are applied to the final medical rate, before reinsurance, admin, risk contingency and premium tax. The impact of the experience adjustment on a statewide basis ranges from -6.3 to 0.4 percent, depending upon prospective and PPC risk group.
V. State Mandates, Court Ordered Programs, Program Changes and Other Changes

Inpatient Day Limit
As part of the Governor’s Medicaid reform plan, effective October 1, 2011 AHCCCS will be limiting inpatient days to 25 days per twelve month period October 1 through September 30 each year for members age 21 and older. Exceptions to this limit include:

- Psychiatric stays;
- Burn diagnoses at a governmentally-operated hospital with a specialized burn unit in Maricopa County;
- Transplant stays at facilities with specialty contracts with AHCCCS, when paid as part of component pricing;
- Same day admit/discharge services; and
- Stays at IHS/638 facilities.

For adult members with Medicare, AHCCCS will continue to pay cost-sharing for Qualified Medicare Beneficiaries (QMB) when the 25 day limit is reached. AHCCCS will not pay cost-sharing for non-QMB Medicare members for days beyond the 25 day limit. The estimated statewide savings is approximately $67.6 million.

Hospital Outliers
As part of the Governor’s Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, language authorizing inpatient outlier payments was eliminated and AHCCCS was provided the authority to establish reimbursement methodologies "notwithstanding any other law." AHCCCS chose to maintain an outlier payment methodology for one year – with modifications – effective October 1, 2011. Those modifications include:

- Increasing cost thresholds by 5 percent; and
- Reducing CCRs by a percentage equal to a hospital’s increase to its charge master based on any/all increases since April 1, 2011.

The impact of these changes is a savings of $28.2 million statewide.

Childless Adult (non-MED) Freeze
As part of the Governor’s Medicaid reform plan, effective CYE12 AHCCCS will change the nature of the Childless Adult (non-MED) program in Arizona from an open-ended entitlement program to one based on available funds. This change provides the State with the flexibility to manage enrollment based on available funding, including adding to enrollment if additional funds are made available. The reform plan includes a phase out of the current Childless Adult program, for which enrollment was frozen beginning July 8, 2011. Individuals enrolled prior to July 8, 2011 will retain their coverage, but no new individuals would be made eligible in this category unless additional funding becomes available. The impact of the freeze on enrollment is a reduction to the non-MED risk group of approximately $433 million. The estimated reduction in member months for CYE12 is approximate 964,360.

The elderly, and individuals meeting the federal definition of disability, were transitioned to either the SSI with or without Medicare risk groups. The CYE12
impact to the SSI with Medicare population is an increase of approximately $12.2 million and 58,300 member months. The impact to the SSI without Medicare population is an increase of approximately $38 million and 54,500 member months.

Elimination of MED Program
As part of the Governor’s Medicaid reform plan, beginning May 1, 2011, enrollment for the MED program was frozen and no new applications are being accepted for this category pursuant to the MED Phase-Out Plan approved by CMS. Since eligibility for MED does not exceed 6 months, the May 1 freeze has the effect of eliminating the MED program by October 1, 2011. There may be rare instances in which an MED member’s enrollment goes slightly beyond September 30, 2011, therefore included herein are MED rates that are equivalent to the CY11 MED rate as adjusted April 1, 2011.

Transition of Pediatric Costs
Effective June 1, 2011, St. Joseph’s Hospital and Phoenix Children’s Hospital (PCH) united the two organizations’ pediatric programs at PCH for patients through age 14. AHCCCS’ outpatient hospital Fee-For-Service rates for PCH are, in aggregate, higher than the payment rates for St. Joseph’s Hospital. AHCCCS used historical utilization data to determine the fiscal impact of this alliance by extracting cost and encounter data to determine the fiscal impact of this alliance by extracting cost and utilization data for pediatric services at St. Joseph’s and repricing them at the PCH rates. Because many of the services may be performed at other Phoenix-area hospitals, AHCCCS included only fifty percent of the increase in the capitation rates. The impact statewide is an increase of $1.5 million.

Transportation
Reductions to transportation rates effective October 1, 2011, are included in the Governor’s Medicaid reform plan and authorized in Laws 2011, Chapter 31. This brings the AHCCCS reimbursement of ADHS-regulated ambulance rates to 68.59% of the approved rates. In accordance with this legislation, ambulance rate increases approved by ADHS after July 1 annually will not be included in AHCCCS’ October 1 fee schedule until the following year in order to provide AHCCCS predictability in expenditures. Since ADHS approved ambulance rate increases (as requested by providers) through July 1, 2011, the impact of this reduction is less than the full 5%, at 4.8% or $243,000.

Institution for Mental Disease (IMD) Waiver and In-Lieu of Services
Included in the base rates is funding for “in lieu of” services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. State approved FFS rates at inpatient non-specialty hospitals are approximately 93.5% more expensive than those provided in alternative inpatient settings. The proposed capitation rates allow for the provision of services in alternative inpatient settings that are licensed by ADHS/ALS/OBHL, in lieu of services in an inpatient non-specialty hospital, thus no increase to cap rates is included.
VI. **Prospective Projected Net Claim PMPM**

The CYE11 utilization, unit costs and net claims PMPMs are trended forward and adjusted for experience trends, state mandates, court ordered programs and program changes to arrive at the CYE12 utilization, unit costs and net claims PMPMs for each COS and COA.

VII. **Prospective Reinsurance Offsets**

The CYE11 reinsurance offsets were reviewed by AHCCCS for appropriateness and reasonableness using reinsurance encounter and payment information. Appropriate adjustments were made to the reinsurance offsets based upon this review. All contractors remained at the same deductible levels as CYE12.

VIII. **Prospective Administrative Expenses and Risk Contingency**

The administrative expense remains at 8.0% for general administration, which was determined to be appropriate to cover the contractors’ average expenses. The risk contingency load also remains the same for all rate cohorts at 1%.

IX. **Prospective Proposed Capitation Rates and Their Impacts**

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VI) less the reinsurance offsets (in section VII) and the projected administrative expenses and risk contingency PMPM (in section VIII), divided by one minus the two percent premium tax. The final adjustment, which is a budget neutral adjustment, is the risk adjustment factor (in Section X). Appendix II contains the proposed capitation rates and the budget impact for all capitation rates using projected CYE12 member months and actual health plan reinsurance deductible levels.

X. **Risk Adjustment Factor**

For CYE12, AHCCCS will be recalculating the risk factors to apply to the CYE 12 capitation rates once the appropriate data is available. It is expected that the adjustment will be applied to the rates on or around April 1, 2012 along with a retroactive adjustment to the rates effective October 1, 2011.

XI. **Maternity Delivery Payment**

The methodology followed in developing the Maternity Delivery Payment is similar to the methodology used in the development of the prospective capitation rates. This methodology involves updating CYE11 rates with utilization and unit cost trends and program changes. The impact is a 7.6% decrease per delivery to the overall global maternity payment rate over the CYE11 rate.
XII. **Extended Family Planning Services (FPS)**

The methodology followed in developing the FPS rate is similar to the methodology used in the development of the prospective capitation rates. This methodology involves updating CYE11 rates with utilization and unit cost trends and program changes. The impact is a 0.2% decrease to the overall global FPS rate over the CYE11 rate.

XIII. **KidsCare Rates**

Continuing with the methodology of previous years, AHCCCS contractors will be paid one blended capitation rate that includes experience from both the traditional TANF Medicaid population and the Title XXI SCHIP population. The rate cohorts whose experience is blended together are detailed as follows:

- TANF < 1 and KidsCare < 1;
- TANF 1–13 M&F and KidsCare 1–13 M&F;
- TANF 14–44 F and KidsCare 14–18 F;
- TANF 14–44 M and KidsCare 14–18 M; and

The related member month, capitation rate and dollar information is as follows:

<table>
<thead>
<tr>
<th>Kidscare Info</th>
<th>CYE12 Projected Member Months</th>
<th>Proj Cap Rate-CYE12</th>
<th>Total Annual Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>KC &lt;1</td>
<td>164</td>
<td>$465.50</td>
<td>$76,229</td>
</tr>
<tr>
<td>KC 1-13</td>
<td>101,070</td>
<td>$99.60</td>
<td>$10,066,537</td>
</tr>
<tr>
<td>KC 14-44F</td>
<td>25,778</td>
<td>$223.03</td>
<td>$5,749,375</td>
</tr>
<tr>
<td>KC 14-44M</td>
<td>27,758</td>
<td>$139.98</td>
<td>$3,885,631</td>
</tr>
</tbody>
</table>

XIV. **Prior Period Coverage Rates (PPC)**

PPC rates cover the period of time from the first day of retroactive eligibility to the date of eligibility determination. PPC rates are established using a similar methodology that was followed in developing the prospective capitation rates. The administration and risk contingency percentages are the same as prospective, i.e. 8% and 1%, respectively. The overall statewide impact is a decrease of 4.7%. The PPC rates are reconciled to a maximum 2.0% profit or loss in CYE12.
XV. **Final Capitation Rates and Their Impact**

Table II below summarizes the adjustments made to the CYE11 rates. The impact to contractors ranges from -8.7% to -5.7%. Individual health plan capitation rates will be impacted as shown in Section B of the contracts.

**Table II: Adjustments to CYE11 Rates**

<table>
<thead>
<tr>
<th>Adjustments to CYE12 Rates</th>
<th>Prospective</th>
<th>PPC</th>
<th>Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Utilization</td>
<td>0.84%</td>
<td>0.22%</td>
<td>0.82%</td>
</tr>
<tr>
<td>2. Inflation</td>
<td>-3.68%</td>
<td>-3.35%</td>
<td>-3.67%</td>
</tr>
<tr>
<td>Experience Adjustment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Total</td>
<td>-3.70%</td>
<td>-0.04%</td>
<td>-3.60%</td>
</tr>
<tr>
<td>Program Changes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. IP 25 Day Limit</td>
<td>-1.96%</td>
<td>-1.19%</td>
<td>-1.94%</td>
</tr>
<tr>
<td>2. Outpatient Fee Schedule Rebase</td>
<td>-0.13%</td>
<td>-0.05%</td>
<td>-0.13%</td>
</tr>
<tr>
<td>3. Smoking Cessation</td>
<td>-0.02%</td>
<td>0.00%</td>
<td>-0.02%</td>
</tr>
<tr>
<td>4. Transition of Pediatric Costs</td>
<td>0.05%</td>
<td>0.00%</td>
<td>0.04%</td>
</tr>
<tr>
<td>Misc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Administration</td>
<td>-0.71%</td>
<td>-0.36%</td>
<td>-0.70%</td>
</tr>
<tr>
<td>2. Risk Contingency</td>
<td>-0.09%</td>
<td>-0.04%</td>
<td>-0.09%</td>
</tr>
<tr>
<td>3. Reinsurance Offset Change</td>
<td>1.42%</td>
<td>n/a</td>
<td>1.38%</td>
</tr>
<tr>
<td>Total Percentage Change</td>
<td>-7.76%</td>
<td>-4.75%</td>
<td>-7.66%</td>
</tr>
</tbody>
</table>
XVI. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.1.0: Overview of rate setting methodology

AHCCCS is performing a rate update from the rates in effect for contract year ending 2011 (CYE11) as adjusted April 1, 2011 and previously approved by CMS, under 42 CFR 438.6(c). Please refer to Section II.

A.A.1.1: Actuarial certification

Please refer to Section XVII.

A.A.1.2: Projection of expenditure

Please refer to Appendix II.

A.A.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

A.A.1.5: Risk contract

AHCCCS limits risk for the Non-MED and all PPC risk groups to 2% profit or loss. The remainder of the risk groups are reconciled as follows:

<table>
<thead>
<tr>
<th>Profit</th>
<th>MCO Share</th>
<th>State Share</th>
<th>Maximum MCO Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=3%</td>
<td>100%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>&gt;3% and &lt;=5%</td>
<td>75%</td>
<td>25%</td>
<td>1.5%</td>
</tr>
<tr>
<td>&gt;5% and &lt;=7%</td>
<td>50%</td>
<td>50%</td>
<td>1.0%</td>
</tr>
<tr>
<td>&gt;7% and &lt;=9%</td>
<td>25%</td>
<td>75%</td>
<td>0.5%</td>
</tr>
<tr>
<td>&gt;9%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>6.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loss</th>
<th>MCO Share</th>
<th>State Share</th>
<th>Maximum MCO Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=3%</td>
<td>100%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>&gt;3% and &lt;=6%</td>
<td>50%</td>
<td>50%</td>
<td>1.5%</td>
</tr>
<tr>
<td>&gt;6%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>4.5%</td>
</tr>
</tbody>
</table>

A.A.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Critical Access Hospitals. GME is paid in accordance with state plan. DSH and Critical Access Hospital payments are paid in accordance with the Waiver Special Terms and
Conditions. None of the additional payments to providers were included in the capitation calculation.

**AA.1.7: Rate modification**

Please refer to Sections II through V, VII, VIII, and X through XIV.
XVII. Actuarial Certification of the Capitation Rates

I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the twelve-month period beginning October 1, 2011.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the health plans and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the health plan auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Windy J. Marks
Fellow of the Society of Actuaries
Member, American Academy of Actuaries

Date 09-01-11
Appendix I

Prospective Trends

### Utilization per 1,000 Trends

<table>
<thead>
<tr>
<th>Categories of Service</th>
<th>TANF &amp; KidsCare Combined</th>
<th>SSI With Medicare</th>
<th>SSI Without Medicare</th>
<th>Non-MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>-3.3%</td>
<td>-5.1%</td>
<td>-2.7%</td>
<td>-4.3%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>0.1%</td>
<td>4.4%</td>
<td>4.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>-1.3%</td>
<td>-0.8%</td>
<td>4.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>2.7%</td>
<td>2.4%</td>
<td>4.4%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Referral Physician</td>
<td>6.0%</td>
<td>9.2%</td>
<td>8.1%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Other Professional</td>
<td>4.4%</td>
<td>3.8%</td>
<td>4.9%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>6.4%</td>
<td>1.1%</td>
<td>7.3%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Other</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Unit Cost Trends

<table>
<thead>
<tr>
<th>Categories of Service</th>
<th>TANF &amp; KidsCare Combined</th>
<th>SSI With Medicare</th>
<th>SSI Without Medicare</th>
<th>Non-MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>-3.0%</td>
<td>3.7%</td>
<td>-4.2%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>-3.3%</td>
<td>-4.5%</td>
<td>-4.7%</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>-2.9%</td>
<td>-6.6%</td>
<td>-4.6%</td>
<td>-5.0%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>-4.7%</td>
<td>-5.6%</td>
<td>-4.6%</td>
<td>-4.2%</td>
</tr>
<tr>
<td>Referral Physician</td>
<td>-6.0%</td>
<td>-8.1%</td>
<td>-7.2%</td>
<td>-8.9%</td>
</tr>
<tr>
<td>Other Professional</td>
<td>-3.8%</td>
<td>-8.8%</td>
<td>-6.0%</td>
<td>-3.3%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0.6%</td>
<td>4.3%</td>
<td>-2.2%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Other</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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</tbody>
</table>

### PMPM Trends

<table>
<thead>
<tr>
<th>Categories of Service</th>
<th>TANF &amp; KidsCare Combined</th>
<th>SSI With Medicare</th>
<th>SSI Without Medicare</th>
<th>Non-MED</th>
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</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>-6.2%</td>
<td>-1.6%</td>
<td>-6.7%</td>
<td>-5.3%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>-3.2%</td>
<td>-0.3%</td>
<td>0.0%</td>
<td>-3.2%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>-4.1%</td>
<td>-7.3%</td>
<td>-0.4%</td>
<td>-4.9%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>-2.1%</td>
<td>-3.4%</td>
<td>-0.5%</td>
<td>-4.3%</td>
</tr>
<tr>
<td>Referral Physician</td>
<td>-0.4%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>-5.6%</td>
</tr>
<tr>
<td>Other Professional</td>
<td>0.4%</td>
<td>-5.3%</td>
<td>-1.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>7.0%</td>
<td>5.4%</td>
<td>4.9%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Other</td>
<td>-5.8%</td>
<td>-4.5%</td>
<td>-3.3%</td>
<td>-4.9%</td>
</tr>
</tbody>
</table>
# Acute Capitation Rate Analysis (Renewal Rates—pending approval)

## Point in Time Comparison—no member growth factor

### CYE '12

#### APPENDIX II

<table>
<thead>
<tr>
<th>Title XIX Waiver Group</th>
<th>Cap Rate '11 (4/4) based on CYE12 Proj Member</th>
<th>Total Annual Dollars CYE12 Proj MMs</th>
<th>Cap Rate CYE12 based on CYE12 Proj MMs</th>
<th>Total Annual Dollars CYE12 based on CYE12 Proj MMs</th>
<th>Difference</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosp-MED</td>
<td>382 $ 1,337.16 $ 510,178 $ 1,337.16 $ 510,178</td>
<td>- $ 0.0%</td>
<td>PPC-MED</td>
<td>100 $ 5,927.52 $ 590,031 $ 5,927.52 $ 590,031</td>
<td>- $ 0.0%</td>
<td></td>
</tr>
<tr>
<td>Total MD</td>
<td>$ 1,100,208</td>
<td>$ 1,100,208</td>
<td>- $ 0.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective-non-MED</td>
<td>1,770,209 $ 451.15 $ 798,629,955 $ 397.17 $ 703,074,503</td>
<td>(95,555,901)</td>
<td>PPP-non-MED</td>
<td>6,000 $ 737.81 $ 4,426,660 $ 737.81 $ 4,426,660</td>
<td>- $ 0.0%</td>
<td></td>
</tr>
<tr>
<td>Total non-MED</td>
<td>$ 803,056,815</td>
<td>$ 707,500,913</td>
<td>(95,555,901)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total TWG</td>
<td>$ 1,776,600</td>
<td>$ 804,157,023</td>
<td>(95,555,901)</td>
<td>% Increase</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TXIX

<table>
<thead>
<tr>
<th>Category</th>
<th>Cap Rate '11 (4/4) based on CYE12 Proj Member</th>
<th>Total Annual Dollars CYE12 Proj MMs</th>
<th>Cap Rate CYE12 based on CYE12 Proj MMs</th>
<th>Total Annual Dollars CYE12 based on CYE12 Proj MMs</th>
<th>Difference</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>575,597 $ 489.94 $ 282,007,781</td>
<td>$ 465.50 $ 267,940,201</td>
<td>(14,067,580)</td>
<td>- $ 5.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-13</td>
<td>5,291,537 $ 105.43 $ 557,886,745</td>
<td>$ 99.60 $ 527,037,084</td>
<td>(30,849,661)</td>
<td>- $ 5.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-44F</td>
<td>2,710,430 $ 237.57 $ 643,916,875</td>
<td>$ 223.03 $ 604,507,222</td>
<td>(39,409,653)</td>
<td>- $ 6.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-44M</td>
<td>1,521,227 $ 151.56 $ 200,245,215</td>
<td>$ 139.98 $ 184,945,402</td>
<td>(15,299,813)</td>
<td>- $ 7.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45+</td>
<td>446,121 $ 361.54 $ 174,874,067</td>
<td>$ 357.88 $ 159,657,647</td>
<td>(15,016,420)</td>
<td>- $ 8.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI w/Med</td>
<td>948,338 $ 137.11 $ 130,026,672</td>
<td>$ 133.19 $ 126,369,185</td>
<td>(3,676,487)</td>
<td>- $ 2.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI w/o Med</td>
<td>802,110 $ 778.35 $ 624,322,397</td>
<td>$ 714.24 $ 572,899,119</td>
<td>(51,423,279)</td>
<td>- $ 8.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFP</td>
<td>48,072 $ 14.46 $ 680,693</td>
<td>$ 14.13 $ 679,250</td>
<td>(1,442)</td>
<td>- $ 0.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery Supplemental Payment</td>
<td>35,196 $ 6,267.19 $ 221,284,469 $ 5,611.78 $ 204,551,917</td>
<td>(16,372,527)</td>
<td>- $ 7.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective non-TWG</td>
<td>$ 12,178,628 $ 2,835,044,933</td>
<td>$ 2,648,527,028</td>
<td>(186,517,906)</td>
<td>- $ 6.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC&lt;1</td>
<td>17,683 $ 931.87 $ 16,478,679</td>
<td>$ 900.43 $ 15,922,711</td>
<td>(555,968)</td>
<td>- $ 3.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC1-13</td>
<td>281,077 $ 54.66 $ 15,363,684</td>
<td>$ 52.97 $ 14,888,663</td>
<td>(475,021)</td>
<td>- $ 3.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC '14-44F</td>
<td>163,911 $ 104.08 $ 31,811,857</td>
<td>$ 184.58 $ 30,254,702</td>
<td>(1,557,155)</td>
<td>- $ 4.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC '14-44M</td>
<td>74,783 $ 156.16 $ 11,678,057</td>
<td>$ 147.78 $ 11,051,378</td>
<td>(626,679)</td>
<td>- $ 5.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC '45+</td>
<td>31,936 $ 318.92 $ 10,185,804</td>
<td>$ 291.04 $ 9,295,361</td>
<td>(890,443)</td>
<td>- $ 8.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC 'SSI w/Med</td>
<td>13,351 $ 130.66 $ 1,744,452</td>
<td>$ 119.82 $ 1,599,726</td>
<td>(144,726)</td>
<td>- $ 8.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC 'SSI w/o Med</td>
<td>27,805 $ 358.44 $ 9,066,595</td>
<td>$ 336.63 $ 9,360,158</td>
<td>(306,563)</td>
<td>- $ 6.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC All non-TWG rate codes</td>
<td>610,549 $ 97,229,128</td>
<td>$ 92,372,700</td>
<td>(4,954,268)</td>
<td>- $ 5.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Title XIX non-TWG</td>
<td>$ 12,789,177 $ 2,932,274,062</td>
<td>$ 2,740,899,728</td>
<td>(191,374,334)</td>
<td>- $ 6.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Grand Total Capitation | $ 3,736,431,085 | $ 3,449,560,849 | (286,830,236) | - $ 7.7% |

1 Population estimates for CYE12 are taken from DBF projections.

2 Reinsurance levels are the same level for plans in CYE12 as CYE11 with two plans at the $35,000 level and the rest at $20,000
Arizona Long Term Care System (ALTCS),
Elderly and Physically Disabled (EPD) Actuarial Memorandum

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD) capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

The proposed capitation rates incorporate portions of Arizona Governor Brewer’s plan to preserve the State’s Medicaid program with reforms that will drive down costs by an estimated $500 million in the State General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget adoption and is subject to Federal approval. Initiatives included in the Governor’s Medicaid reform plan addressed in this memorandum include limited benefit changes and reductions in provider reimbursement rates.

II. Overview of Bid and Rate Setting Methodology

The contract year ending 2012 (CYE12) is the first year of a new cycle for the ALTCS contract. Therefore, the CYE12 rates are the rates awarded as part of the competitive bid process for the CYE12 Request for Proposal (RFP). The awarded rates were then updated for any program and/or fee schedule changes that were not included in the bid process as well as necessary mix change adjustments as mentioned below. These rates represent the twelve month contract period October 1, 2011, through September 30, 2012.

Prospective offerors were required to submit three separate bids: one for the medical component, one for the case management component, and one for the administrative component. For the medical component, AHCCCS’ actuaries developed actuarially sound rate ranges for the CYE12 contract year to be used in the evaluation of the bids submitted. The rate ranges were published for use by the prospective offerors and represented the lower half, or midpoint to minimum, of the actuarially sound rate range. There were no limits imposed for the case management component and an eight percent maximum was enforced for the administrative component. For those rate cohorts for which the offerors were not required to bid (Prior Period Coverage (PPC) and Acute Care Only), AHCCCS’ actuaries developed actuarially sound capitation rates.

Because CYE12 is classified as a rate development year rather than a rate update to the previously approved CYE11 capitation rates, as adjusted April 1, 2011, AHCCCS’ actuaries developed a new base time period to compute CYE12 rates and ranges. Historical Medicaid managed care encounter data was used as the primary data source in development of the base time period. This encounter data was made
available to AHCCCS' actuaries via an extract that provides utilization and cost data, referred to as the "databook". The contract between AHCCCS and the contractors specifies that the contractors may cover additional services. Non-covered services were removed from the databook and excluded from rate development.

Other data sources used in setting the actuarially sound rates and ranges include health plan financial statements, program changes, anticipated AHCCCS Fee For Service rate changes including but not limited to those for nursing facility and home and community based services (HCBS), changes in HCBS placement, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates and Global Insight Prospectve Hospital Market Basket Inflation Index (GI) information.

AHCCCS posted the encounter databook and other supplemental resources such as financial data, analysis of program changes, and enrollment information to its website in order to provide all prospective offerors with the data necessary to submit appropriate bids for CYE12.

Trend rates were calculated from the databook and other sources on a unit cost and/or utilization basis by category of service (COS) and a cap was applied to limit the negative and positive trends to a reasonable level. For more information on trends see Section IV Projected Trend Rates.

Ideally, the experience data should be analyzed by different rate cells which are comprised of members with similar risk characteristics. However, segregating the ALTCS population into different rate cells would lead to a statistical credibility problem due to the statewide disbursement of the relatively small membership base. The ALTCS program has three rate cells: a prospective rate, a prior period coverage (PPC) rate and an Acute Care Only rate. Capitation rates for the ALTCS population do not differ by gender and/or age, but do differ by Geographical Service Area (GSA).

The experience data includes only ALTCS Medicaid eligible expenses for ALTCS Medicaid eligible individuals, as well as reinsurance amounts. The Prior Period Coverage (PPC) rates are reconciled to a maximum 5% profit or loss.

The general process in developing the prospective rates involves trending the base data, adjusted for program changes, to the midpoint of the effective period, which is April 1, 2012, and applying the mix percentage. The next step involves adjustments for share of cost offsets and, if applicable, any program changes. Next is the deduction of the reinsurance offsets. Lastly, the projected case management, administrative expenses, risk/contingency and premium tax are added to the projected claim PMPMs to obtain the capitation rates. Each step is described in the sections below. There are also separate sections describing the PPC population and the Acute Care Only population.
III. Base Period Experience

AHCCCS used historical encounter data for the time period from October 1, 2007 through June 30, 2010. The data was reviewed and audited for accuracy, timeliness and completeness through encounter validation studies as well as studies comparing the encounter data to the contractors’ financial statements. A final adjustment was to apply completion factors to the encounter data for the more recent years.

IV. Projected Trend Rates

The trend analysis includes both the financial and encounter data experiences. Financial data experience is from October 2007 through March 2011. Encounter data experience, as noted above, is from October 2007 through June 2010. The claim PMPMs were computed on a yearly basis and a trend factor was calculated. These encounter and financial trend factors were compared with trend rates from sources such as the changes to the State’s fee-for-service (FFS) schedules and Contractor’s subcontracted rates. The trend rates developed were used to bring the base encounter data to the effective midpoint of the contract year.

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors’ Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members’ coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 through SFY 2010, encounter-reported COB cost avoidance grew by greater than 83%, from $130 million in SFY 2008 to $239 million in SFY 10. Additionally, ALTCS EPD Contractors cost-avoided more than $108 million in additional claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

As part of the Governor’s Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, AHCCCS is given the authority to reduce fee schedule rates for all providers up to 5%. Therefore, effective October 1, 2011, AHCCCS will reduce all provider reimbursement, with few exceptions, by 5%, including all payment ratios utilized for provider reimbursement (e.g., all Cost-to-Charge Ratios (CCRs), By Report Percentages (BR), etc.). The decreases are included in the trend amounts by category of service and in total are approximately $47.5 million statewide. In addition, the historical cost trends were selected using past encounter data, Contractor financial statements, and changes to the FFS schedules over the last several years that are not reflected in the encounter data. Utilization trends for both the NF and HCBS components were based on encounter data experience. For the Acute Care component, the trends were developed using both the encounter data and financial information and future FFS schedule changes.
The trend rates used in projecting the claim costs, which include RFP rebase impacts as well as reductions to fee schedule rates, are identified in Table I.

Table I: Average Annual Trend Rate before Mix and SOC

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Combine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility</td>
<td>-3.4%</td>
</tr>
<tr>
<td>HCBS</td>
<td>-13.0%</td>
</tr>
<tr>
<td>Acute</td>
<td>-6.9%</td>
</tr>
</tbody>
</table>

Smoking Cessation
Starting October 1, 2008, in accordance with Laws 2008, Chapter 131, AHCCCS added coverage for eligible tobacco cessation products which include nicotine replacement therapy (NRT) and tobacco use medications for eligible Title XIX AHCCCS members who wish to stop tobacco use and who are enrolled in a tobacco cessation program offered by the Arizona Department of Health Services. This program has been effective for almost two years, therefore making it possible to review how actual experience matches up with the initial projections. The review is based on encounter utilization and costs data for CYE09, CYE10 and CYE11 (YTD). AHCCCS determined EPD members were utilizing services at a lesser extent than included in last year’s projection. Based upon this review AHCCCS is decreasing the amount included for tobacco cessation products in the capitation rates. The statewide impact to the EPD program for CYE12 is a decrease of approximately $13,000.

V. Projected Gross Claim PMPM

The contract period for CYE12 rates is October 1, 2011, through September 30, 2012, so the midpoint is April 1, 2012. The claims’ PMPMs from the base data were trended to the midpoint of the CYE12 rate period.

VI. Mix Percentage

The CYE12 combined mix percentages are set using a combination of current placement percentages, program growth/saturation and the number of ALTCS members. These sources were reviewed by contractor and by county, over a 21-month period. The HCBS and NF placement percentages can be found in Table II.

Table II: Combined Mix Percentages Weighted

<table>
<thead>
<tr>
<th>GSA</th>
<th>CYE12 Mix</th>
<th>CYE12 Mix</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NF Mix</td>
<td>HCBS Mix</td>
<td>NF Mix</td>
</tr>
<tr>
<td>GSA 40 (Pinal, Gila)</td>
<td>24.55%</td>
<td>75.45%</td>
<td>24.58%</td>
</tr>
<tr>
<td>GSA 42 (LaPaz, Yuma)</td>
<td>40.65%</td>
<td>59.35%</td>
<td>39.91%</td>
</tr>
<tr>
<td>GSA 44 (Apache, Cochise, Mohave, Navajo)</td>
<td>33.30%</td>
<td>66.70%</td>
<td>32.56%</td>
</tr>
<tr>
<td>GSA 46 (Cochise, Graham, Greenlee)</td>
<td>39.30%</td>
<td>60.70%</td>
<td>38.60%</td>
</tr>
<tr>
<td>GSA 48 (Yavapai)</td>
<td>40.13%</td>
<td>59.87%</td>
<td>36.62%</td>
</tr>
<tr>
<td>GSA 50 (Pima, Santa Cruz)</td>
<td>33.40%</td>
<td>66.60%</td>
<td>32.86%</td>
</tr>
<tr>
<td>GSA 52 (Maricopa)</td>
<td>27.26%</td>
<td>72.74%</td>
<td>25.66%</td>
</tr>
<tr>
<td>Statewide</td>
<td>29.84%</td>
<td>70.16%</td>
<td>28.56%</td>
</tr>
</tbody>
</table>
VII. State Mandates, Court Ordered Programs, Program Changes and Other Changes

Inpatient Day Limit
As part of the Governor’s Medicaid reform plan, effective October 1, 2011 AHCCCS will be limiting inpatient days to 25 days per the twelve month period of October 1 through September 30 each year for members age 21 and older. Exceptions to this limit include:
• Psychiatric stays;
• Burn diagnoses at a governmentally-operated hospital with a specialized burn unit in Maricopa County;
• Transplant stays at facilities with specialty contracts with AHCCCS, when paid as part of component pricing;
• Same day admit/discharge services; and
• Stays at IHS/638 facilities.

For adult members with Medicare, AHCCCS will continue to pay cost-sharing for Qualified Medicare Beneficiaries (QMB) when the 25 day limit is reached. AHCCCS will not pay cost-sharing for non-QMB Medicare members for days beyond the 25 day limit. The estimated statewide savings is approximately $12.6 million.

Hospital Outliers
As part of the Governor’s Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, language authorizing inpatient outlier payments was eliminated and AHCCCS was provided the authority to establish reimbursement methodologies "notwithstanding any other law." AHCCCS chose to maintain an outlier payment methodology for one year – with modifications – effective October 1, 2011. Those modifications include:
• Increasing cost thresholds by 5 percent; and
• Reducing CCRs by a percentage equal to a hospital’s increase to its charge master based on any/all increases since April 1, 2011.

The impact of these changes is a savings of approximately $675,000 statewide.

Transportation
Reductions to transportation rates effective October 1, 2011, are included in the Governor’s Medicaid reform plan and authorized in Laws 2011, Chapter 31. This brings the AHCCCS reimbursement of ADHS-regulated ambulance rates to 68.59% of the approved rates. In accordance with this legislation, ambulance rate increases approved by ADHS after July 1 annually will not be included in AHCCCS’ October 1 fee schedule until the following year in order to provide AHCCCS predictability in expenditures. Since ADHS approved ambulance rate increases (as requested by providers) through July 1, 2011, the impact of this reduction is less than the full 5%, at 4.8% or $466,000.
Reduction in Respite Hours
As part of the Governor’s Medicaid reform plan, effective October 1, 2011, the number of respite hours for adults and children receiving ALTCS Services will be reduced from 720 to 600 hours per the twelve month period of October 1 through September 30 each year. The statewide impact of this change is a reduction of $48,600.

Institution for Mental Disease (IMD) Waiver and In-Lieu of Services
Included in the base rates is funding for “in lieu of” services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. State approved FFS rates at inpatient non-specialty hospitals are approximately 93.5% more expensive than those provided in alternative inpatient settings. The proposed capitation rates allow for the provision of services in alternative inpatient settings that are licensed by ADHS/ALS/OBHL, in lieu of services in an inpatient non-specialty hospital, thus no increase to cap rates is included.

Movement of High Cost Member and Change in Related Costs
The EPD program has one extremely high cost member due to a rare medical condition who, during CYE11, relocated from one GSA to another. In addition, AHCCCS added the pharmaceutical product used by this member to its specialty contract with Phoenix Children’s Hospital and is now able to obtain this drug at 340B discounted pricing. The result of the discounted pricing is a reduction of approximately $190,000 in pharmacy expense. The impact of the member’s move, net of the pharmacy savings, is approximately $802,000.

VIII. Projected Net Claim PMPM
The Nursing Facility and Home and Community Based Services projected gross claim PMPMs were adjusted for the mix percentages. The projected gross claims PMPMs were then discounted for the recipients’ Share of Cost. The SOC component is fully reconciled with each Contractor. (The reinsurance offset is already included in the acute care component of the rates for the EPD population.)

IX. Case Management, Administrative Expenses and Risk Contingency
The Case Management rates represent those rates awarded as part of the CYE12 RFP process which are reduced 3.8% over CYE11 rates. The administrative expenses range from 2.6% to 7.4% of medical expenses plus case management. The risk contingency percentage remains the same as CYE11 at 1%.
X. Proposed Capitation Rates and Their Impacts

The proposed capitation rates for the EPD population equal the sum of the projected net claim PMPM (in Section VIII) and the projected case management, administrative expenses and risk contingency PMPM (in section IX) divided by one minus the two percent premium tax. Table III shows the proposed capitation rates for the EPD population statewide.

Table III: Statewide Projected Net Capitation PMPM EPD Combined

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Gross CYE12 Rate</th>
<th>Mix</th>
<th>Net CYE12 Rate</th>
<th>Mix</th>
<th>Net Gross Change</th>
<th>Mix</th>
<th>Net Net Change</th>
<th>Mix</th>
<th>Gross CYE12 Rate</th>
<th>Mix</th>
<th>Net CYE12 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility</td>
<td>$5,419.37</td>
<td>29.64%</td>
<td>$1,677.14</td>
<td>-3.4%</td>
<td>-7.6%</td>
<td>$5,234.52</td>
<td>26.56%</td>
<td>$1,409.98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Share of Cost</td>
<td>(249.40)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(224.50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Nursing Facility</td>
<td>$1,367.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,270.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home and Community (HCS)</td>
<td>$1,608.95</td>
<td>70.16%</td>
<td>$1,128.84</td>
<td>-13.0%</td>
<td>-11.4%</td>
<td>$1,399.54</td>
<td>71.44%</td>
<td>$999.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>$114.56</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$110.19</td>
<td></td>
<td></td>
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<tr>
<td>Acute Care</td>
<td>$389.86</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$362.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>$201.95</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$162.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Contingency</td>
<td>$32.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$30.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Tax</td>
<td>$66.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$59.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Capitation PMPM</td>
<td>$3,300.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2,996.85</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

XI. Acute Care Only Members

As in prior years, for members who are only eligible for acute care services in the ALTCS program, Contractors will be paid the acute care component plus the case management and administrative components. Since the reinsurance policy is the same for these members as for the other ALTCS members, the same reinsurance offset is appropriate.

XII. Prior Period Coverage (PPC) Rates

PPC rates cover the period of time from the effective date of eligibility to the day a member is enrolled with the Contractor. PPC rates are reconciled to a five percent profit/loss corridor.

AHCCCS used the actual PPC cost and PPC enrollment data for CYE08, CYE09 and CYE10 as the base in the development of the CYE12 PPC rates. Historical trends were developed and reviewed for appropriateness. Due to the relatively short PPC time period, AHCCCS’ actuaries analyzed the data by combining rate cohorts or geographic regions to enhance statistical credibility when needed.

XIII. Proposed Capitation Rates and Budget Impact

Table IV includes the net capitation rates on a statewide basis for all rate cells as well as the estimated budget impact based off of CYE12 projected member months. The adjustments impact contractors ranging from -13.1% to -5.0%. Appendix I shows EPD rates by geographical service area and Contractor.
Table IV: Proposed Capitation Rates and Budget Impact

<table>
<thead>
<tr>
<th></th>
<th>CYE12 Rate</th>
<th>CYE11 Rate</th>
<th>CYE12:Rate</th>
<th>Based on CYE12:Annualized Projected Member-Months</th>
<th>Estimated CYE11 Capitation</th>
<th>Estimated CYE12 Capitation</th>
<th>Dollar Impact</th>
<th>Percentage Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPD</td>
<td>306.539</td>
<td>$3,300.80</td>
<td>$2,996.85</td>
<td>$1,611,825,310</td>
<td>$918,652,854</td>
<td>$(93,172,856)</td>
<td>-9.2%</td>
<td></td>
</tr>
<tr>
<td>PPC</td>
<td>10,436</td>
<td>$995.99</td>
<td>$908.41</td>
<td>$10,394,509</td>
<td>$9,480,493</td>
<td>$(914,016)</td>
<td>-8.8%</td>
<td></td>
</tr>
<tr>
<td>Acute Only</td>
<td>4,629</td>
<td>$553.03</td>
<td>$514.15</td>
<td>$2,559,705</td>
<td>$2,379,749</td>
<td>$(179,957)</td>
<td>-7.0%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>$1,624,779,524</td>
<td>$930,512,896</td>
<td>$(94,266,625)</td>
<td>-9.2%</td>
<td></td>
</tr>
</tbody>
</table>
XIV. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.0: Overview of rate setting methodology

AHCCCS is performing a rebase from the previously approved contract year ending 2011 (CYE11) rates under 42 CFR 438.6(c). Please refer to Section II.

AA.1.1: Actuarial certification

Please refer to Section XV.

AA.1.2: Projection of expenditure

Please refer to Section XIII.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

AA.1.5: Risk contract

The contract is an at risk contract.

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to the providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Critical Access Hospitals. GME is paid in accordance with state plan. DSH and Critical Access Hospital payments are paid in accordance with Waiver Special Terms and Conditions. None of the additional payments to the providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Sections III, IV, VI, VII, VIII, XI, XII, and XIII.

2. Base Year Utilization and Cost Data

AA.2.0: Base year utilization and cost data

Please refer to Sections II, III and IV.

AA.2.1: Medicaid eligibles under the contract

There are dual eligibles.

AA.2.2: Spenddown

Not applicable, not covered under this contract.
AA.2.3: State plan services only

The contract between AHCCCS and the Contractors specifies that Contractors may cover additional services. Non-covered services were not included in the encounter data used to set the rates.

AA.2.4: Services that can be covered by a capitated entity out of contract savings.

Same as AA.2.3

3. Adjustments to the Base Year Data

AA.3.0 Adjustments to base year data

Please refer to Sections II, III, IV, V and VII.

AA.3.1 Benefit differences

Please refer to Section VII for benefit changes to inpatient hospital days for adults and respite changes for all members.

AA.3.2 Administrative cost allowance calculation

Please refer to Section IX.

AA.3.3 Special populations’ adjustment

It is anticipated that the risk characteristics of this population will not change materially from the base period to the effective period of the capitation rates. Therefore, no adjustment was made.

AA.3.4 Eligibility Adjustments

No adjustment was made.

AA.3.5 DSH Payments

No DSH payment was included in the capitation development

AA.3.6 Third party Liability (TPL)

This is a contractual arrangement between AHCCCS and the Contractors.

AA.3.7 Copayments, coinsurance and deductible in the capitated rates

EPD members do not pay any copays, coinsurance or deductibles, but some do pay SOC. See Section VIII.

AA.3.8 Graduate Medical Education (GME)

The experience excludes any payment for GME.

AA.3.9 FQHC and RHC reimbursement
The experience excludes any additional payments that FQHCs may receive from the State.

AA.3.10 Medical cost/trend inflation
Please refer to Section IV.

AA.3.11 Utilization adjustment
Other than trend, no specific adjustment was made to utilization.

AA.3.12 Utilization and cost assumptions
Not applicable, since actual experience was used.

AA.3.13 Post-eligibility treatment of income (PETI)
Not applicable, not required to consider PETI.

AA.3.14 Incomplete data adjustment.
The CYE10 encounter data was not fully complete. AHCCCS assumed the data was approximately 95% complete and applied the appropriate completion factor to complete the CYE10 data. The audited financial statements may include outstanding claim liabilities, which were audited and believed to be reasonable by AHCCCS auditors.

4. Establish Rate Category Groupings

AA.4.0: Establish rate category groupings
Please refer to Section II.

AA.4.1: Age
Please refer to Section II.

AA.4.2: Gender
Please refer to Section II.

AA.4.2: Locality/region
Please refer to Section II.

AA.4.2: Eligibility category
Please refer to Section II.

5. Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0: Data smoothing
Please refer to Sections II, III and IV.

AA.5.1: Special populations and assessment of the data for distortions
Data was not adjusted for special populations.

AA.5.2: Cost-neutral data smoothing adjustments
There was no cost-neutral data smoothing adjustments

AA.5.3: Risk-adjustment
No risk adjustment methodology is currently in place for the EPD population.

6. Stop Loss, Reinsurance, or Risk-Sharing arrangements

AA.6.1: Commercial reinsurance
There is no commercial reinsurance.

AA.6.2: Simple stop loss program
AHCCCS has a reinsurance program. Please refer to Section VIII and XI.

AA.6.3: Risk corridor program
There are reconciliations for PPC, HCBS and SOC.

7. Incentive Arrangements

At this time there are no incentive arrangements.
XV. **Actuarial Certification of the Capitation Rates**

I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the twelve-month period beginning October 1, 2011.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the Program Contractors and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the Program Contractors auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Windy J. Marks

Fellow of the Society of Actuaries
Member, American Academy of Actuaries

Date: 09-01-11
## Appendix I

<table>
<thead>
<tr>
<th>GSA</th>
<th>Contractor</th>
<th>EPD Rate</th>
<th>Acute Only Rate</th>
<th>PPC Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 (Pinal, Gila)</td>
<td>Bridgeway</td>
<td>$3,050.80</td>
<td>$612.00</td>
<td>$959.55</td>
</tr>
<tr>
<td>42 (LaPaz, Yuma)</td>
<td>Evercare</td>
<td>$2,882.98</td>
<td>$423.93</td>
<td>$959.55</td>
</tr>
<tr>
<td>44 (Apache, Coconino, Mohave, Navajo)</td>
<td>Evercare</td>
<td>$2,602.94</td>
<td>$526.66</td>
<td>$959.55</td>
</tr>
<tr>
<td>46 (Cochise, Graham, Greenlee)</td>
<td>Bridgeway</td>
<td>$2,786.23</td>
<td>$578.00</td>
<td>$959.55</td>
</tr>
<tr>
<td>48 (Yavapai)</td>
<td>Evercare</td>
<td>$3,075.52</td>
<td>$485.64</td>
<td>$959.55</td>
</tr>
<tr>
<td>50 (Pima, Santa Cruz)</td>
<td>Evercare</td>
<td>$3,182.00</td>
<td>$502.36</td>
<td>$838.89</td>
</tr>
<tr>
<td>50 (Pima, Santa Cruz)</td>
<td>Mercy Care</td>
<td>$3,148.03</td>
<td>$451.16</td>
<td>$838.89</td>
</tr>
<tr>
<td>52 (Maricopa)</td>
<td>Bridgeway</td>
<td>$2,981.95</td>
<td>$634.03</td>
<td>$903.73</td>
</tr>
<tr>
<td>52 (Maricopa)</td>
<td>Evercare</td>
<td>$3,323.83</td>
<td>$359.12</td>
<td>$903.73</td>
</tr>
<tr>
<td>52 (Maricopa)</td>
<td>Mercy Care</td>
<td>$2,941.11</td>
<td>$532.43</td>
<td>$903.73</td>
</tr>
<tr>
<td>52 (Maricopa)</td>
<td>Scan</td>
<td>$2,946.12</td>
<td>$452.09</td>
<td>$903.73</td>
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</tbody>
</table>
Arizona Long Term Care System (ALTCS),
Department of Economic Security /Division of Developmental Disabilities (DES/DDD) Actuarial Memorandum

I. Purpose

This memorandum presents a revision to the capitation rates for the Arizona Long Term Care System (ALTCS)/Division of Developmental Disabilities (DDD) program, for the period October 1, 2011 to June 30, 2012. The purpose of this actuarial memorandum is to demonstrate that the updated capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

The proposed capitation rates incorporate portions of Arizona Governor Brewer’s plan to preserve the State's Medicaid program with reforms that will drive down costs by an estimated $500 million in the State General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget adoption and is subject to Federal approval. Initiatives included in the Governor’s Medicaid reform plan addressed in this memorandum include limited benefit changes and reductions in provider reimbursement rates.

II. Overview of Changes

Inpatient Day Limit
As part of the Governor’s Medicaid reform plan, effective October 1, 2011 AHCCCS will be limiting inpatient days to 25 days per the twelve month period of October 1 through September 30 each year for members age 21 and older. Exceptions to this limit include:

- Psychiatric stays;
- Burn diagnoses at a governmentally-operated hospital with a specialized burn unit in Maricopa County;
- Transplant stays at facilities with specialty contracts with AHCCCS, when paid as part of component pricing;
- Same day admit/discharge services; and
- Stays at IHS/638 facilities.

For adult members with Medicare, AHCCCS will continue to pay cost-sharing for Qualified Medicare Beneficiaries (QMB) when the 25 day limit is reached. AHCCCS will not pay cost-sharing for non-QMB Medicare members for days beyond the 25 day limit. The estimated statewide savings is approximately $412,700.

Hospital Outliers
As part of the Governor’s Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, language authorizing inpatient outlier payments was eliminated and AHCCCS was provided the authority to establish reimbursement methodologies "notwithstanding any other law.” AHCCCS chose to maintain an outlier payment
methodology for one year – with modifications – effective October 1, 2011. Those modifications include:

- Increasing cost thresholds by 5 percent; and
- Reducing CCRs by a percentage equal to a hospital’s increase to its charge master based on any/all increases since April 1, 2011.

The impact of these changes is a savings of $163,400 statewide.

**Reduction in Provider Reimbursement**

As part of the Governor’s Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, AHCCCS is given the authority to reduce fee schedule rates for all providers up to 5%. Therefore, effective October 1, 2011, AHCCCS will reduce all provider reimbursement, with few exceptions, by 5%, including all payment ratios utilized for provider reimbursement (e.g., all Cost-to-Charge Ratios (CCRs), By Report Percentages (BR), etc.). The decreases are included in the trend amounts by category of service as mentioned below and in total are approximately $30.5 million statewide.

**Reduction in Respite Hours**

As part of the Governor’s Medicaid reform plan, effective October 1, 2011, the number of respite hours for adults and children receiving ALTCS Services will be reduced from 720 to 600 hours per the twelve month period of October 1 through September 30 each year. The statewide impact of this change is $3.7 million.

**Transportation**

Reductions to transportation rates effective October 1, 2011, are included in the Governor’s Medicaid reform plan and authorized in Laws 2011, Chapter 31. This brings the AHCCCS reimbursement of ADHS-regulated ambulance rates to 68.59% of the approved rates. In accordance with this legislation, ambulance rate increases approved by ADHS after July 1 annually will not be included in AHCCCS’ October 1 fee schedule until the following year in order to provide AHCCCS predictability in expenditures. Since ADHS approved ambulance rate increases (as requested by providers) through July 1, 2011, the impact of this reduction is less than the full 5%, at 4.8% or $5,000.

**Acute Services Request for Proposal (RFP)**

The acute services component of the DDD program is subcontracted to health plans via a competitive RFP process every five years. CYE12 represents an RFP year for these subcontracts. Through the competitive process, contracts were awarded with new rates for an effective date of October 1, 2011. All previous acute subcontractors were awarded contracts for the same counties in which they previously served. The result of this RFP is a 3% increase in the acute component of the capitation rates.

**Projected Experience Adjustment**

The projected experience adjustments are based on a comparison of YTD financial statements submitted by DDD and the July 1, 2011 capitation rates by component (i.e. institutional, HCBS, administrative expense, etc.). Any component with a differential greater than 5% was reviewed. Per this review it was determined that two components (institutional and administrative) warranted an experience adjustment. The impact of the experience adjustment on a statewide basis is -6.3% for
institutional services and -8.3% for administrative expenses, or a reduction of $4.4 million overall.

**Coordination of Benefits**

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 through SFY 2010, encounter-reported COB cost avoidance grew by greater than 123%, from $16 million in SFY 2008 to $36 million in SFY 10. Additionally, DDD cost-avoided more than $23 million in additional claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

**III. Proposed Capitation Rates and Their Impacts**

Table I below summarizes the changes from the current approved CYE12 capitation rates and the estimated budget impact, effective for the period October 1, 2011 through June 30, 2012 on a statewide basis.

<table>
<thead>
<tr>
<th>Rate Cell Category</th>
<th>CYE12 Current Rate</th>
<th>CYE12 Updated Rate</th>
<th>Estimated CYE12 Current Capitation</th>
<th>Estimated CYE12 Updated Capitation</th>
<th>Dollar Impact</th>
<th>Percentage Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDD</td>
<td>218,510</td>
<td>$3,265.75</td>
<td>3,065.90</td>
<td>713,601,218</td>
<td>676,463,250</td>
<td>($37,137,960)</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>218,510</td>
<td>$106.23</td>
<td>103.31</td>
<td>23,212,317</td>
<td>22,574,269</td>
<td>($638,049)</td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>40,077</td>
<td>$85.96</td>
<td>$85.96</td>
<td>3,445,024</td>
<td>3,445,024</td>
<td>$0.00</td>
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<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td>$740,258,559</td>
<td>$702,482,550</td>
<td>($37,776,009)</td>
</tr>
</tbody>
</table>

*DDD rates reflect full premium tax*

*BH does not reflect premium tax*
IV. Actuarial Certification of the Capitation Rates

I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the nine-month period beginning October 1, 2011.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by DES/DDD and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the DES/DDD auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Windy J. Marks
Date

Fellow of the Society of Actuaries
Member, American Academy of Actuaries
Children’s Rehabilitative Services (CRS)
Actuarial Memorandum for CYE 2012

I. Purpose

This memorandum presents a discussion of the revision to the capitation rates for the Children’s Rehabilitative Services (CRS) program, for the period October 1, 2011 to September 30, 2012. This revision to the rates is required primarily due to changes effective October 1, 2011 resulting from the Governor’s Medicaid Reform Plan. The purpose of this actuarial memorandum is to demonstrate that the updated capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

II. Overview of Rate Setting Methodology

The contract year ending 2012 (CYE12) rates were developed as a rate update from the contract year ending 2011 (CYE11) capitation rates as adjusted April 1, 2011 and previously approved by CMS. The CYE12 rates cover the twelve month contract period of October 1, 2011 through September 30, 2012.

The assumed trend rates were developed from an internal data extract (“databook”) that tracks historical enrollment, as well as utilization counts and unit costs for encounters adjudicated by AHCCCS. Other data sources include health plan financial statements, anticipated Arizona Health Care Cost Containment System (AHCCCS) Fee For Service rate changes, anticipated Arizona Department of Health Services (ADHS) transportation increases, programmatic changes, and BLS statistics on medical inflation.

CRS enrollees are classified into three different risk groups, high, medium and low, based on the medical condition that drives their initial eligibility for CRS enrollment. Prior to CYE12, separate capitation rates were developed for each risk group. Beginning in CYE12, a single PMPM capitation rate will be implemented, using a member-weighted average of the current CYE11 rates as a starting point. AHCCCS believes this adjustment to a single capitation rate will add to the credibility of the CRS capitation rates. The average CYE11 rate is then trended forward to the midpoint of the contract year, or April 1, 2012 and adjusted for provider reimbursement changes and other changes. In the final step, the projected administrative expenses, risk/contingency margin, reinsurance offset and premium tax are added to the projected claim per member per month values (PMPMs) to obtain the capitation rates. Each step is described in the sections below.
III. Projected Trend Assumptions and Provider Reimbursement Adjustments

Utilization and unit cost trend rates were calculated from the encounter data experience for CYE09 and CYE10 dates of service. CYE09, CYE10 and CYE11 (YTD) Financials were used to validate encounter data and trends. Adjustments to the encounter data were made for the observed change in enrollment distribution between the risk groups. The resulting average PMPM trend of 4.1% was applied to all categories of service, except Clinic Fees as they represent overhead expenses and infrastructure costs which are not expected to follow this trend.

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors’ Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 through SFY 2010, encounter-reported COB cost avoidance grew from $34,000 in SFY 2008 to $889,000 in SFY 10. Additionally, the CRS Contractor cost-avioded almost $9 million in additional claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

As part of the Governor’s Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, AHCCCS is given the authority to reduce fee schedule rates for all providers up to 5%. Therefore, effective October 1, 2011, AHCCCS will reduce all provider reimbursement, with few exceptions, by 5%, including all payment ratios utilized for provider reimbursement (e.g., all Cost-to-Charge Ratios (CCRs), By Report Percentages (BR), etc.). The decreases total approximately $4.4 million statewide.

The Hospital Outpatient and Emergency Room trend rate was then adjusted for the rebase of the Outpatient Fee Schedule (OPFS) rates required by the Arizona Administrative Code. This rebase is required every five years and will be effective October 1, 2011. The rebase results in an inccrease of approximately $1,516,000.

IV. State Mandates, Court Ordered Programs, Program Changes and Other Changes

Transition of Pediatric Costs
Effective June 1, 2011, St. Joseph’s Hospital and Phoenix Children’s Hospital (PCH) united the two organizations’ pediatric programs at PCH for patients through age 14. AHCCCS’ outpatient hospital Fee-For-Service rates for PCH are, in aggregate, higher than the payment rates for St. Joseph’s Hospital. AHCCCS used historical encounter data to determine the fiscal impact of this alliance by extracting cost and utilization data for pediatric services at St. Joseph’s and repricing them at the PCH rates.
Because many of the services may be performed at other Phoenix-area hospitals, AHCCCS included only fifty percent of the increase in the capitation rates. The impact is an increase of approximately $925,000.

**Hospital Outliers**
As part of the Governor's Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, language authorizing inpatient outlier payments was eliminated and AHCCCS was provided the authority to establish reimbursement methodologies "notwithstanding any other law." AHCCCS chose to maintain an outlier payment methodology for one year – with modifications – effective October 1, 2011. Those modifications include:
- Increasing cost thresholds by 5 percent;
- Reducing CCRs by a percentage equal to a hospital's increase to its charge master based on any/all increases since April 1, 2011.

The impact of these changes is a savings of approximately $815,600.

**Transportation**
Reductions to transportation rates effective October 1, 2011, are included in the Governor's Medicaid reform plan and authorized in Laws 2011, Chapter 31. This brings the AHCCCS reimbursement of ADHS-regulated ambulance rates to 68.59% of the approved rates. In accordance with this legislation, ambulance rate increases approved by ADHS after July 1 annually will not be included in AHCCCS' October 1 fee schedule until the following year in order to provide AHCCCS predictability in expenditures. Since ADHS approved ambulance rate increases (as requested by providers) through July 1, 2011, the impact of this reduction is less than the full 5%, at 4.8%.

**V. Prospective Projected Net Claim PMPM**
The CYE11 utilization, unit costs and net claims PMPMs are trended forward and adjusted for AHCCCS fee schedule changes, state mandates, court ordered programs and program changes to arrive at the CYE12 utilization, unit costs and net claims PMPMs.

**VI. Projected Reinsurance Offsets**
The CYE11 reinsurance offsets were reviewed by AHCCCS for appropriateness and reasonableness using reinsurance encounter and payment information. Appropriate adjustments were made to the reinsurance offsets based upon this review.

**VII. Proposed Administrative Expenses and Risk Contingency**
The administrative expense remains at 9.64% for general administration, which was determined to be appropriate to cover the contractors' average expenses. The risk contingency load also remains the same at 2%.
VIII. Proposed Revised Capitation Rates and Their Impact

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section V) less the reinsurance offsets (in section VI) and the projected administrative expenses and risk contingency PMPM (in section VII), divided by one minus two percent for premium tax. Table I below summarizes the changes from the current approved CYE11 capitation rates and the estimated budget impact, effective for CYE12 on a statewide basis.

Table I. Proposed Statewide Capitation Rates and Budget Impact

<table>
<thead>
<tr>
<th></th>
<th>Based on Projected Member Months October 1, 2011</th>
<th>Based on Projected Member Months September 30, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYE11 (4/1) Current Rate</td>
<td>$417.35</td>
<td>$424.10</td>
</tr>
<tr>
<td>CYE12 (4/1) Current Rate</td>
<td>$128,151,376</td>
<td>$130,225,219</td>
</tr>
<tr>
<td>Based on Projected Member Months October 1, 2011</td>
<td>$417.35</td>
<td>$424.10</td>
</tr>
<tr>
<td>Based on Projected Member Months September 30, 2012</td>
<td>$128,151,376</td>
<td>$130,225,219</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>CYE11 (4/1) Current Rate</th>
<th>CYE12 (4/1) Current Rate</th>
<th>Estimated CYE12 (4/1) Current Rate</th>
<th>Projected CYE12 (4/1) Updated Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Totals</td>
<td>$417.35</td>
<td>$424.10</td>
<td>$128,151,376</td>
<td>$130,225,219</td>
</tr>
<tr>
<td>Dollar Impact</td>
<td>$2,073,843</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage Impact</td>
<td></td>
<td></td>
<td>1.62%</td>
<td></td>
</tr>
</tbody>
</table>
IX. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.1.0: Overview of rate setting methodology

AHCCCS is performing a rate update from the rates in effect for contract year ending 2011 (CYE11) as adjusted April 1, 2011 and previously approved by CMS, under 42 CFR 438.6(c). Please refer to Section II.

AA.1.1: Actuarial certification

Please refer to Section X.

AA.1.2: Projection of expenditure

Please refer to Section VIII.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Sole Source contracting method.

AA.1.5: Risk contract

The contract is an at risk contract, however there are some provisions for reinsurance.

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Critical Access Hospitals. GME is paid in accordance with state plan. DSH and Critical Access Hospital payments are paid in accordance with the Waiver Special Terms and Conditions. None of the additional payments to providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Sections II through IV, VI and VI.
X. **Actuarial Certification of the Capitation Rates**

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

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the twelve month period beginning October 1, 2011.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the health plan and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the health plan auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations and analyses promulgated from time-to-time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Matthew C. Varitek

Fellow of the Society of Actuaries
Member, American Academy of Actuaries
Comprehensive Medical and Dental Program (CMDP)
Updated Actuarial Memorandum for CYE 2011

I. Purpose

This memorandum presents a discussion of the revision to the capitation rates for the Comprehensive Medical and Dental Program (CMDP) program, for the period October 1, 2011 to December 31, 2011. This update to the rates is required primarily due to changes effective October 1, 2011 resulting from the Governor's Medicaid Reform Plan. The purpose of this actuarial memorandum is to demonstrate that the updated capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

II. Overview of Changes

Provider Reductions and OPFS Rebase
As part of the Governor's Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, AHCCCS is given the authority to reduce fee schedule rates for all providers up to 5%. Therefore, effective October 1, 2011, AHCCCS will reduce all provider reimbursement, with few exceptions, by 5%, including all payment ratios utilized for provider reimbursement (e.g., all Cost-to-Charge Ratios (CCRs), By Report Percentages (BR), etc.). The decreases are included in the trend assumptions by category of service and total approximately $269,340 statewide.

The Hospital Outpatient and Emergency Room trend rate was then adjusted for the rebase of the Outpatient Fee Schedule (OPFS) rates required by the Arizona Administrative Code. This rebase is required every five years and will be effective October 1, 2011. The rebase results in a decrease of approximately $19,600.

Hospital Outliers
As part of the Governor's Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, language authorizing inpatient outlier payments was eliminated and AHCCCS was provided the authority to establish reimbursement methodologies "notwithstanding any other law." AHCCCS chose to maintain an outlier payment methodology for one year – with modifications – effective October 1, 2011. Those modifications include:
- Increasing cost thresholds by 5 percent; and
- Reducing CCRs by a percentage equal to a hospital's increase to its charge master based on any/all increases since April 1, 2011.

The impact of these changes is a savings of approximately $9,200.

Transition of Pediatric Costs
Effective June 1, 2011, St. Joseph's Hospital and Phoenix Children's Hospital (PCH) united the two organizations' pediatric programs at PCH for patients through age 14. AHCCCS' outpatient hospital Fee-For-Service rates for PCH are, in aggregate, higher
than the payment rates for St. Joseph's Hospital. AHCCCS used historical encounter data to determine the fiscal impact of this alliance by extracting cost and utilization data for pediatric services at St. Joseph’s and repricing them at the PCH rates. Because many of the services may be performed at other Phoenix-area hospitals, AHCCCS included only fifty percent of the increase in the capitation rates. The impact is an increase of approximately $3,300.

Transportation
Reductions to transportation rates effective October 1, 2011, are included in the Governor’s Medicaid reform plan and authorized in Laws 2011, Chapter 31. This brings the AHCCCS reimbursement of ADHS-regulated ambulance rates to 68.59% of the approved rates. In accordance with this legislation, ambulance rate increases approved by ADHS after July 1 annually will not be included in AHCCCS’ October 1 fee schedule until the following year in order to provide AHCCCS predictability in expenditures. Since ADHS approved ambulance rate increases (as requested by providers) through July 1, 2011, the impact of this reduction is less than the full 5%, at 4.8%.

Coordination of Benefits
Inherent in the encounter and financial data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 through SFY 2010, encounter-reported COB cost avoidance grew from $7,500 in SFY 2008 to $575,000 in SFY 10. Additionally, CMDP cost-avoided more than $208,000 in additional claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

III. Proposed Revised Capitation Rates and Their Impact

Table 1 below summarizes the changes from the current approved CYE11 capitation rates and the estimated budget impact, effective for the period October 1, 2011 through December 31, 2011 on a statewide basis.

Table I: Proposed Statewide Capitation Rates and Budget Impact

<table>
<thead>
<tr>
<th>Rate Cell</th>
<th>Projected Member Months</th>
<th>CYE11 Current Rate</th>
<th>CYE11 Updated Rate</th>
<th>Estimated CYE11 Current Capitation</th>
<th>Estimated CYE11 Updated Capitation</th>
<th>Dollar Impact</th>
<th>Percentage Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective</td>
<td>30,043</td>
<td>$227.46</td>
<td>$218.60</td>
<td>$6,833,543</td>
<td>$6,567,363</td>
<td>$(266,180)</td>
<td>-3.9%</td>
</tr>
<tr>
<td>PPC</td>
<td>735</td>
<td>$421.03</td>
<td>$401.87</td>
<td>$309,389</td>
<td>$295,309</td>
<td>$(14,080)</td>
<td>-4.6%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>$7,142,932</td>
<td>$6,862,672</td>
<td>$(280,260)</td>
<td>-3.9%</td>
</tr>
</tbody>
</table>
IV. Actuarial Certification of the Capitation Rates

I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the three month period beginning October 1, 2011.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by CMDP and AHCCCS internal database. I have accepted the data without audit and have relied upon the CMDP auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations and analyses promulgated from time-to-time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Windy J. Marks  
Fellow of the Society of Actuaries  
Member, American Academy of Actuaries  

09-01-11  
Date
Ms. Cynthia Layne  
Interim Chief Financial Officer  
Arizona Department of Health Services  
Division of Behavioral Health Services  
150 N. 18th Avenue, Suite 200  
Phoenix, AZ 85007

September 1, 2011

FINAL

Subject: Revised Behavioral Health Services last three quarters of State fiscal year 2012 capitation rates for the Title XXI Program

Dear Ms. Layne:

The State of Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS), has worked closely with Mercer Government Human Services Consulting (Mercer) to develop revisions to the actuarially-sound capitation rates for each of its Regional Behavioral Health Authorities (RBHAs) for the last three quarters of State fiscal year 2012 (SFY12). These rates will be effective from October 1, 2011 to June 30, 2012.

I. Purpose

Updated rates for the last three quarters of SFY12 have been developed to reflect changes/updated analyses to the program:

A. Implementation of a provider fee schedule (rate) reduction effective October 1, 2011.
B. Reduction in the number of covered hours for respite care effective October 1, 2011.

The following certification letter is a supplement to the prior SFY12 letter issued on April 15, 2011, and includes background and adjustments for the development of the last three quarters of SFY12 actuarially-sound capitation rates.

II. Overview of the changes/updated analyses

The changes/updated analyses impact on the Title XIX RBHA capitation rates is described in our certification letter dated September 1, 2011. An update to the Title XXI capitation rates is necessary due to the use of Title XIX capitation rates as a base for Title XXI capitation rate development.
The statewide impact to the program is a decrease of approximately $120,233 for the last three quarters of SFY12.

**Coordination of Benefits**

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides the RBHAs with verified commercial and Medicare coverage information for their members which the RBHAs utilize to ensure payments are not made for medical services that are covered by the other carriers. When the RBHAs make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. For state fiscal years (SFY) 2009 and 2010, encounter-reported COB cost avoidance averaged approximately $7 million (Title XIX and Title XXI combined). Additionally, in SFY10, BHS RBHAs cost-avoided more than $34 million (Title XIX and Title XXI combined) in additional claims for which the RBHA had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

**III. Proposed revised capitation rates**

Actuarially-sound capitation rates were developed for the following population and RBHA combinations, shown in the table below:

<table>
<thead>
<tr>
<th>Title XXI</th>
<th>Cenpatico 3</th>
<th>CPSA</th>
<th>Cenpatico 2</th>
<th>NARBHA</th>
<th>Cenpatico 4</th>
<th>MHS</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$22.02</td>
<td>$37.22</td>
<td>$22.81</td>
<td>$24.14</td>
<td>$28.13</td>
<td>$18.69</td>
<td>$22.58</td>
</tr>
</tbody>
</table>

The rate development schedules are shown in Attachment A.

**IV. Certification of final rates**

In preparing the rates shown above and in the attached, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design and financial data, and information supplied by BHS and the RBHAs. BHS and the RBHAs are responsible for the validity and completeness of this supplied data and information. We have
reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the above and the attached rates, including risk-sharing mechanisms, incentive arrangements or other payments, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates developed by Mercer are actuarial projections of future contingent events. Actual RBHA costs will differ from these projections. Mercer has developed these rates on behalf of BHS to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

RBHAs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by the RBHAs for any purpose. Mercer recommends that any RBHA considering contracting with BHS should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rates before deciding whether to contract with BHS.

This certification letter assumes the reader is familiar with the BHS program, Medicaid eligibility rules and actuarial rating techniques. It is intended for BHS and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.
If you have any questions concerning our rate-setting methodology, please feel free to contact me at +1 602 522 6510 or mike.nordstrom@mercer.com.

Sincerely,

[Signature]

Michael E. Nordstrom, ASA, MAAA
Partner

MN/vh

Attachments

Copy:
Sundee Easter, Mercer
Mike Miner, Mercer
Rob O'Brien, Mercer
<table>
<thead>
<tr>
<th></th>
<th>Cenpatico 3</th>
<th>CPSA</th>
<th>Cenpatico 2</th>
<th>NARBHA</th>
<th>Cenpatico 4</th>
<th>Magellan</th>
<th>Total</th>
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<tr>
<td>1. SFY10 Adjusted BHS Service Expenses</td>
<td>$7,406,236</td>
<td>$39,662,311</td>
<td>$10,716,347</td>
<td>$30,345,406</td>
<td>$13,624,889</td>
<td>$104,784,611</td>
<td>$208,836,010</td>
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<tr>
<td>2. SFY10 Member Months</td>
<td>268,628</td>
<td>986,765</td>
<td>291,770</td>
<td>931,498</td>
<td>338,629</td>
<td>4,055,036</td>
<td>6,865,527</td>
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<tr>
<td>3. SFY10 PMPM</td>
<td>$28.07</td>
<td>$40.50</td>
<td>$36.73</td>
<td>$32.58</td>
<td>$40.47</td>
<td>$25.84</td>
<td>$30.37</td>
</tr>
<tr>
<td>4. Relational Modeling</td>
<td>1.019</td>
<td>1.000</td>
<td>1.000</td>
<td>0.975</td>
<td>1.021</td>
<td>1.000</td>
<td>0.998</td>
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<tr>
<td>5. SFY10 Adjusted Claim Cost</td>
<td>$28.60</td>
<td>$40.50</td>
<td>$36.73</td>
<td>$31.73</td>
<td>$41.31</td>
<td>$26.84</td>
<td>$30.08</td>
</tr>
<tr>
<td>6. Claim Cost Trend Factor</td>
<td>4.0%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>4.0%</td>
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<tr>
<td>7. SFY12 Tended Base Claim Cost</td>
<td>$30.93</td>
<td>$43.00</td>
<td>$36.73</td>
<td>$34.35</td>
<td>$44.68</td>
<td>$27.93</td>
<td>$32.53</td>
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<td>8. PPC</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<td>9. 1st 72 Hours</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<tr>
<td>10. Provider Fee Schedule (Rate) Reduction - 4/1/2011</td>
<td>$1.34</td>
<td>$1.68</td>
<td>$1.88</td>
<td>$1.52</td>
<td>$1.80</td>
<td>$1.14</td>
<td>$1.37</td>
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<tr>
<td>11. Provider Fee Schedule (Rate) Reduction - 10/1/2011</td>
<td>$1.35</td>
<td>$1.89</td>
<td>$1.80</td>
<td>$1.55</td>
<td>$1.81</td>
<td>$1.16</td>
<td>$1.38</td>
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<td>12. Respite Hour Reduction</td>
<td>$0.02</td>
<td>$0.07</td>
<td>$0.07</td>
<td>$0.05</td>
<td>$0.04</td>
<td>$0.01</td>
<td>$0.03</td>
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<tr>
<td>13. SFY12 Claim Cost With Above Adjustments</td>
<td>$28.82</td>
<td>$39.98</td>
<td>$35.97</td>
<td>$31.23</td>
<td>$41.03</td>
<td>$25.65</td>
<td>$29.79</td>
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<tr>
<td>14. Penetration Factor</td>
<td>1.028</td>
<td>1.014</td>
<td>1.046</td>
<td>1.006</td>
<td>1.019</td>
<td>1.013</td>
<td>1.015</td>
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<tr>
<td>15. Pool Penetration Factor PMPM</td>
<td>$29.01</td>
<td>$40.54</td>
<td>$37.61</td>
<td>$31.43</td>
<td>$41.82</td>
<td>$25.99</td>
<td>$30.20</td>
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<td>16. Acuity Factor</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
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<td>17. Base SFY12 Claim Costs</td>
<td>$29.01</td>
<td>$40.54</td>
<td>$37.61</td>
<td>$31.43</td>
<td>$41.82</td>
<td>$25.99</td>
<td>$30.20</td>
</tr>
<tr>
<td>18. Interpretive Services Administrative Load</td>
<td>1.06%</td>
<td>1.06%</td>
<td>1.06%</td>
<td>1.06%</td>
<td>1.06%</td>
<td>1.06%</td>
<td>1.06%</td>
</tr>
<tr>
<td>19. Non-Interpretive Services Administrative Load</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
</tr>
<tr>
<td>20. 10/1/2011 Capitation Rates</td>
<td>$32.47</td>
<td>$45.38</td>
<td>$42.10</td>
<td>$35.18</td>
<td>$43.61</td>
<td>$29.90</td>
<td>$33.81</td>
</tr>
<tr>
<td>21. 7/1/2011 Capitation Rates</td>
<td>$34.01</td>
<td>$47.64</td>
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# Attachment A

## 10/1/2011 DBHS Capitation Rates

**Title XIX**  
**GMH/SA**

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<th>Cerpatico 4</th>
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<td>$38.25</td>
<td>$24.45</td>
<td>$47.85</td>
<td>$29.76</td>
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<tr>
<td>6. Claim Cost Trend Factor</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.1%</td>
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<tr>
<td>7. SFY12 Trended Base Claim Cost</td>
<td>$28.24</td>
<td>$43.88</td>
<td>$39.87</td>
<td>$25.49</td>
<td>$49.86</td>
<td>$31.02</td>
<td>$33.44</td>
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<td>8. PPC</td>
<td>$0.30</td>
<td>$1.29</td>
<td>$0.13</td>
<td>$0.14</td>
<td>$0.16</td>
<td>$0.54</td>
<td>$0.55</td>
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<tr>
<td>9. Copay Adjustment</td>
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<td>$(0.17)</td>
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<tr>
<td>10. 1st 72 Hours</td>
<td>$0.01</td>
<td>$0.18</td>
<td>$0.02</td>
<td>$0.01</td>
<td>$0.05</td>
<td>$0.11</td>
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<tr>
<td>11. Provider Fee Schedule (Rate) Reduction - 4/1/2011</td>
<td>$(0.99)</td>
<td>$(1.58)</td>
<td>$(1.62)</td>
<td>$(0.89)</td>
<td>$(1.62)</td>
<td>$(0.98)</td>
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<td>12. Provider Fee Schedule (Rate) Reduction - 10/1/2011</td>
<td>$(1.07)</td>
<td>$(1.86)</td>
<td>$(1.87)</td>
<td>$(0.99)</td>
<td>$(1.92)</td>
<td>$(1.20)</td>
<td>$(1.33)</td>
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<tr>
<td>13. Respite Hour Reduction</td>
<td>$(0.00)</td>
<td>$(0.00)</td>
<td>$(0.01)</td>
<td>-</td>
<td>$(0.00)</td>
<td>$(0.00)</td>
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<tr>
<td>14. SFY12 Claim Cost With Above Adjustments</td>
<td>$24.32</td>
<td>$41.56</td>
<td>$36.55</td>
<td>$23.58</td>
<td>$46.37</td>
<td>$29.32</td>
<td>$31.45</td>
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<tr>
<td>15. Penetration Factor</td>
<td>1.058</td>
<td>1.107</td>
<td>1.078</td>
<td>1.081</td>
<td>1.077</td>
<td>1.087</td>
<td>1.079</td>
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<td>16. Post Penetration Factor PMPM</td>
<td>$25.97</td>
<td>$46.00</td>
<td>$39.32</td>
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<td>$49.92</td>
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<td>17. Acuity Factor</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
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<tr>
<td>18. Base SFY12 Claim Costs</td>
<td>$25.86</td>
<td>$46.45</td>
<td>$38.84</td>
<td>$25.17</td>
<td>$49.33</td>
<td>$30.92</td>
<td>$33.83</td>
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<td>19. Interpretive Services Administrative Load</td>
<td>0.45%</td>
<td>0.45%</td>
<td>0.45%</td>
<td>0.45%</td>
<td>0.45%</td>
<td>0.45%</td>
<td>0.45%</td>
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<tr>
<td>20. Non-Interpretive Services Administrative Load</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
</tr>
<tr>
<td>21. 10/1/2011 Capitation Rates</td>
<td>$28.34</td>
<td>$50.19</td>
<td>$42.90</td>
<td>$27.80</td>
<td>$54.47</td>
<td>$34.14</td>
<td>$37.00</td>
</tr>
<tr>
<td>22. 7/1/2011 Capitation Rates</td>
<td>$27.81</td>
<td>$48.72</td>
<td>$42.06</td>
<td>$27.13</td>
<td>$53.20</td>
<td>$33.42</td>
<td>$36.16</td>
</tr>
<tr>
<td>23. % Change</td>
<td>1.9%</td>
<td>3.0%</td>
<td>2.0%</td>
<td>2.4%</td>
<td>2.4%</td>
<td>2.2%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

*Source: Mercer Government Human Services Consulting*
### Statewide TXIX Rate for Non-CMDP Children

<table>
<thead>
<tr>
<th>RBHA</th>
<th>Proj. 9 mos. Eligibility Member Months</th>
<th>Col. 1</th>
<th>Proposed 10/1 Rates</th>
<th>Col. 1 x Col. 2 Total Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cenpatico 3</td>
<td>195,915</td>
<td>$32.47</td>
<td>$6,361,586</td>
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</tr>
<tr>
<td>CPSA</td>
<td>785,699</td>
<td>$45.38</td>
<td>$35,649,229</td>
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<tr>
<td>Cenpatico 2</td>
<td>217,543</td>
<td>$42.10</td>
<td>$9,158,426</td>
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<tr>
<td>NARBHA</td>
<td>687,799</td>
<td>$35.18</td>
<td>$24,199,979</td>
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</tr>
<tr>
<td>Cenpatico 4</td>
<td>270,325</td>
<td>$46.81</td>
<td>$12,655,064</td>
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</tr>
<tr>
<td>Magellan</td>
<td>3,317,303</td>
<td>$29.09</td>
<td>$96,500,196</td>
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</tbody>
</table>

Tribes

Subtotal 5,474,494 $204,820,205

BHS Administration/R/C of 3.46%

Total with BHS Administration/R/C $212,160,344

Statewide Capitation Rate $38.75

### Statewide TXIX Rate for CMDP Children

<table>
<thead>
<tr>
<th>RBHA</th>
<th>Proj. 9 mos. Eligibility Member Months</th>
<th>Col. 1</th>
<th>Proposed 10/1 Rates</th>
<th>Col. 1 x Col. 2 Total Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cenpatico 3</td>
<td>2,313</td>
<td>$1,468.80</td>
<td>$3,397,337</td>
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<tr>
<td>CPSA</td>
<td>20,012</td>
<td>$1,153.57</td>
<td>$23,085,273</td>
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<tr>
<td>Cenpatico 2</td>
<td>1,076</td>
<td>$1,099.41</td>
<td>$1,182,970</td>
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</tr>
<tr>
<td>NARBHA</td>
<td>7,105</td>
<td>$1,511.70</td>
<td>$10,740,617</td>
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</tr>
<tr>
<td>Cenpatico 4</td>
<td>6,160</td>
<td>$680.88</td>
<td>$4,194,191</td>
<td></td>
</tr>
<tr>
<td>Magellan</td>
<td>55,339</td>
<td>$679.44</td>
<td>$37,599,339</td>
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</table>

Tribes

Subtotal 92,005 $88,992,899

BHS Administration/R/C of 3.46%

Total with BHS Administration/R/C $92,182,136

Statewide Capitation Rate $1,001.93
## Statewide TXIX Rate for SMI

<table>
<thead>
<tr>
<th>RBHIA</th>
<th>Proj. 9 mos. Eligibility Member Months</th>
<th>Col. 1 Proposed 10/1 Rates</th>
<th>Col. 2 Total Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cenpatico 3</td>
<td>223,137</td>
<td>$48.60</td>
<td>$10,843,833</td>
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<tr>
<td>CPSA</td>
<td>863,858</td>
<td>$65.74</td>
<td>$56,789,858</td>
</tr>
<tr>
<td>Cenpatico 2</td>
<td>219,423</td>
<td>$33.36</td>
<td>$7,320,298</td>
</tr>
<tr>
<td>NARBHA</td>
<td>810,100</td>
<td>$42.57</td>
<td>$34,485,321</td>
</tr>
<tr>
<td>Cenpatico 4</td>
<td>267,290</td>
<td>$47.09</td>
<td>$12,586,210</td>
</tr>
<tr>
<td>Magellan</td>
<td>2,680,292</td>
<td>$94.94</td>
<td>$254,461,515</td>
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<td>Tribes</td>
<td></td>
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<tr>
<td>Subtotal</td>
<td>5,064,100</td>
<td></td>
<td>$382,698,808</td>
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<tr>
<td>BHS Administration/R/C of 3.46%</td>
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<td></td>
<td>$13,714,772</td>
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<td>Total with BHS Administration/R/C</td>
<td></td>
<td></td>
<td>$396,413,580</td>
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<tr>
<td>Statewide Capitation Rate</td>
<td></td>
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<td>$78.28</td>
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</table>

## Statewide TXIX Rate for GMH/SA

<table>
<thead>
<tr>
<th>RBHIA</th>
<th>Proj. 9 mos. Eligibility Member Months</th>
<th>Col. 1 Proposed 10/1 Rates</th>
<th>Col. 2 Total Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cenpatico 3</td>
<td>223,137</td>
<td>$28.34</td>
<td>$6,322,859</td>
</tr>
<tr>
<td>CPSA</td>
<td>863,858</td>
<td>$50.19</td>
<td>$43,354,103</td>
</tr>
<tr>
<td>Cenpatico 2</td>
<td>219,423</td>
<td>$42.90</td>
<td>$9,412,510</td>
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<tr>
<td>NARBHA</td>
<td>810,100</td>
<td>$27.80</td>
<td>$22,518,884</td>
</tr>
<tr>
<td>Cenpatico 4</td>
<td>267,290</td>
<td>$54.47</td>
<td>$14,559,744</td>
</tr>
<tr>
<td>Magellan</td>
<td>2,680,292</td>
<td>$34.14</td>
<td>$91,509,596</td>
</tr>
<tr>
<td>Tribes</td>
<td></td>
<td></td>
<td>$14,764,874</td>
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<tr>
<td>Subtotal</td>
<td>5,064,100</td>
<td></td>
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<tr>
<td>BHS Administration/R/C of 3.46%</td>
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<td></td>
<td>$7,254,932</td>
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<tr>
<td>Total with BHS Administration/R/C</td>
<td></td>
<td></td>
<td>$209,697,502</td>
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<tr>
<td>Statewide Capitation Rate</td>
<td></td>
<td></td>
<td>$41.41</td>
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</table>
Note: This section uses 10/1/2011-6/30/2012 (9 month) Projected Member Months applied to both 7/1/2011 and 10/1/2011 Rates.

<table>
<thead>
<tr>
<th></th>
<th>Statewide Rates</th>
<th>9 Month Projected MM</th>
<th>9 Month Projected Expenditures</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7/1/2011 Rates</td>
<td>10/1/2011 Rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TXIX</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>$57.85</td>
<td>$54.67</td>
<td>$322,002,604</td>
<td>-5.5%</td>
</tr>
<tr>
<td>SMI</td>
<td>$70.11</td>
<td>$78.28</td>
<td>$355,053,780</td>
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<tr>
<td>GMH/SA</td>
<td>$40.35</td>
<td>$41.41</td>
<td>$204,336,444</td>
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<tr>
<td>Total</td>
<td>$</td>
<td>$</td>
<td>$881,392,828</td>
<td>3.3%</td>
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</table>

<table>
<thead>
<tr>
<th>TXIX Children</th>
<th>Statewide Rates</th>
<th>9 Month Projected MM</th>
<th>9 Month Projected Expenditures</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7/1/2011 Rates</td>
<td>10/1/2011 Rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-CMDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>$40.95</td>
<td>$38.75</td>
<td>$224,174,852</td>
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<td>CMDP Children</td>
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<td>$1,001.93</td>
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<tr>
<td>Total</td>
<td>$57.85</td>
<td>$54.67</td>
<td>$322,002,604</td>
<td>-5.5%</td>
</tr>
<tr>
<td>Title XXI</td>
<td>Cenpatico 3</td>
<td>CPSA</td>
<td>Cenpatico 2</td>
<td>NARHIA</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>------</td>
<td>------------</td>
<td>--------</td>
</tr>
<tr>
<td>1. SFY10 Member Months</td>
<td>17,486</td>
<td>71,162</td>
<td>23,475</td>
<td>62,783</td>
</tr>
<tr>
<td>2. T-19 SFY12 Claim Costs</td>
<td>$41.62</td>
<td>$70.34</td>
<td>$43.11</td>
<td>$42.13</td>
</tr>
<tr>
<td>3. Penetration Factor</td>
<td>0.475</td>
<td>0.475</td>
<td>0.475</td>
<td>0.515</td>
</tr>
<tr>
<td>4. Base SFY12 Claim Costs</td>
<td>$19.78</td>
<td>$33.43</td>
<td>$20.48</td>
<td>$21.89</td>
</tr>
<tr>
<td>5. Interpretive Services Administrative Load</td>
<td>1.18%</td>
<td>1.18%</td>
<td>1.18%</td>
<td>1.18%</td>
</tr>
<tr>
<td>6. Non-interpretive Services Administrative Load</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>9.0%</td>
</tr>
<tr>
<td>8. 7/1/2011 Capitation Rates</td>
<td>$23.10</td>
<td>$39.07</td>
<td>$24.01</td>
<td>$25.34</td>
</tr>
<tr>
<td>9. Change in Rates</td>
<td>-4.7%</td>
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<td>-5.0%</td>
<td>-4.7%</td>
</tr>
<tr>
<td>RBHA</td>
<td>Proj. 9 mos. Eligibility Member Months</td>
<td>Col. 1 Proposed 10/1 Rates</td>
<td>Col. 2 Total Dollars</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Cenpatico 3</td>
<td>3,997</td>
<td>$22.02</td>
<td>$88,004</td>
<td></td>
</tr>
<tr>
<td>CPSA</td>
<td>15,291</td>
<td>$37.22</td>
<td>$569,076</td>
<td></td>
</tr>
<tr>
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<tr>
<td>NARBHA</td>
<td>12,260</td>
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<td>$296,007</td>
<td></td>
</tr>
<tr>
<td>Cenpatico 4</td>
<td>5,003</td>
<td>$28.13</td>
<td>$140,711</td>
<td></td>
</tr>
<tr>
<td>Magellan</td>
<td>70,650</td>
<td>$18.69</td>
<td>$1,320,296</td>
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</tr>
<tr>
<td>Tribes</td>
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</tr>
<tr>
<td>Subtotal</td>
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</tr>
<tr>
<td>BHS Administration/R/C of 3.46%</td>
<td></td>
<td></td>
<td>$133,033</td>
<td></td>
</tr>
<tr>
<td>Total with BHS Administration/R/C</td>
<td></td>
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<td>$3,845,215</td>
<td></td>
</tr>
<tr>
<td>Statewide Capitation Rate</td>
<td></td>
<td></td>
<td>$34.13</td>
<td></td>
</tr>
</tbody>
</table>
State of Arizona

Attachment C
10/1/2011 DBHS Capitation Rates
Projection of Expenditures
Title XXI

Note: This section uses 10/1/2011-6/30/2012 (9 month) Projected Member Months applied to both 7/1/2011 and 10/1/2011 Rates.

<table>
<thead>
<tr>
<th></th>
<th>Statewide Rates</th>
<th>9 Month Projected Expenditures</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7/1/2011 Rates</td>
<td>10/1/2011 Rates</td>
<td></td>
</tr>
<tr>
<td>TXXI</td>
<td>$</td>
<td>35.06</td>
<td>34.13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-2.7%</td>
</tr>
</tbody>
</table>
Ms. Cynthia Layne  
Interim Chief Financial Officer  
Arizona Department of Health Services  
Division of Behavioral Health Services  
150 N. 18th Avenue, Suite 200  
Phoenix, AZ 85007  

September 1, 2011  

FINAL  

Subject: Revised Behavioral Health Services last three quarters of State fiscal year 2012 capitation rates for the Title XIX Program  

Dear Ms. Layne:  

The State of Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS), has worked closely with Mercer Government Human Services Consulting (Mercer) to develop revisions to the actuarially-sound capitation rates for each of its Regional Behavioral Health Authorities (RBHAs) for the last three quarters of State fiscal year 2012 (SFY12). These rates will be in effect from October 1, 2011 through June 30, 2012.  

I. Purpose  

Updated rates for the last three quarters of SFY12 have been developed to reflect four changes/updated analyses to the program:  

A. Implementation of a provider fee schedule (rate) reduction effective October 1, 2011.  
B. Reduction in the number of covered hours for respite care effective October 1, 2011.  
C. Change in the penetration rate (comparison of BHS members who are enrolled as defined by having an open episode of care, to those who are Arizona Health Care Cost Containment System (AHCCCS) eligible) for the Seriously Mentally Ill (SMI) and General Mental Health/Substance Abuse (GMH/SA) populations, given the Childless Adults (CA) program changes and enrollment freeze, and the Medical Expense Deduction (MED) program phase-out.  
D. Change in the underlying acuity (risk) mix for the last three quarters of SFY12 for the GMH/SA population given the CA and MED changes.
The following certification letter is a supplement to the prior SFY12 letter issued on April 15, 2011, and includes the adjustments for the development of the last three quarters of SFY12 actuarially-sound capitation rates.

II. Overview of the changes/updated analyses

A. BHS is implementing a 5% provider rate decrease effective October 1, 2011, for all provider types, excluding pharmacy. The updated last three quarters of SFY12 rates reflect these provider fee schedule decreases.

The per member per month (PMPM) decreases applied to the Title XIX populations for this unit cost adjustment are as follows.

<table>
<thead>
<tr>
<th>Population</th>
<th>Cenpatico 3</th>
<th>CPSA</th>
<th>Cenpatico 2</th>
<th>NARBHA</th>
<th>Cenpatico 4</th>
<th>MHS</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-CMDP</td>
<td>($1.35)</td>
<td>($1.89)</td>
<td>($1.80)</td>
<td>($1.55)</td>
<td>($1.81)</td>
<td>($1.16)</td>
<td>($1.38)</td>
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<tr>
<td>CMDP</td>
<td>($68.63)</td>
<td>($54.64)</td>
<td>($63.77)</td>
<td>($65.15)</td>
<td>($29.79)</td>
<td>($30.37)</td>
<td>($40.41)</td>
</tr>
<tr>
<td>SMI</td>
<td>($1.80)</td>
<td>($2.27)</td>
<td>($1.25)</td>
<td>($1.40)</td>
<td>($1.68)</td>
<td>($3.60)</td>
<td>($2.69)</td>
</tr>
<tr>
<td>GMH/SA</td>
<td>($1.07)</td>
<td>($1.86)</td>
<td>($1.67)</td>
<td>($0.99)</td>
<td>($1.92)</td>
<td>($1.20)</td>
<td>($1.33)</td>
</tr>
</tbody>
</table>

The statewide impact to the program for the October 1, 2011 provider rate reduction adjustment is a decrease of approximately $31,808,458 for the last three quarters of SFY12.

In addition, because of the multiplicative nature of many of the capitation rate components (for example RBHA administration), the reduction in assumed claim dollars impacts total administrative dollars to the RBHAs. The RBHA administration percentage did not change.

B. As part of the Governor's Medicaid reform plan, effective October 1, 2011, the number of respite hours for adults and children receiving BHS Services will be reduced from 720 to 600 hours per twelve month period October 1 through September 30 each year.

The PMPM decreases applied to the Title XIX populations for this utilization adjustment are as follows.
<table>
<thead>
<tr>
<th>Population</th>
<th>Cenpatico 3</th>
<th>CPSA</th>
<th>Cenpatico 2</th>
<th>NARBHA</th>
<th>Cenpatico 4</th>
<th>MHS</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-CMMP</td>
<td>($0.02)</td>
<td>($0.07)</td>
<td>($0.07)</td>
<td>($0.05)</td>
<td>($0.04)</td>
<td>($0.01)</td>
<td>($0.03)</td>
</tr>
<tr>
<td>CMMP</td>
<td>($1.10)</td>
<td>($0.54)</td>
<td>($1.17)</td>
<td>($1.64)</td>
<td>($0.35)</td>
<td>($0.11)</td>
<td>($0.38)</td>
</tr>
<tr>
<td>SMI</td>
<td>($0.00)</td>
<td>($0.00)</td>
<td>($0.00)</td>
<td>($0.00)</td>
<td>($0.02)</td>
<td>($0.00)</td>
<td>($0.00)</td>
</tr>
<tr>
<td>GMH/SA</td>
<td>($0.00)</td>
<td>($0.00)</td>
<td>($0.01)</td>
<td>($0.00)</td>
<td>($0.00)</td>
<td>($0.00)</td>
<td>($0.00)</td>
</tr>
</tbody>
</table>

The statewide impact to the program for the October 1, 2011 respite hour reduction adjustment is a decrease of approximately $194,610 for the last three quarters of SFY12.

In addition, because of the multiplicative nature of many of the capitation rate components (for example RBHA administration), the reduction in assumed claim dollars impacts total administrative dollars to the RBHAs. The RBHA administration percentage did not change.

C. For the SMI and GMH/SA populations, an update to the penetration rate (in prior certifications, also referred to as the acuity adjustment or acuity factor, but we have now reserved “acuity” for the fourth change under “D” below) was required, given the Childless Adults (CA) program changes and enrollment freeze (approved by the Centers for Medicare and Medicaid Services (CMS) on July 1, 2011), and the MED program phase-out (CMS approval received on April 29, 2011). BHS and the RBHAs are reimbursed by AHCCCS based on AHCCCS eligibles. So while the reductions in AHCCCS eligibles from these two changes will reduce revenue, it is believed that significant and varying percentages of these SMI or GMH/SA individuals will actually be redetermined to be eligible via another aid category, and hence, the underlying risk and costs will not decrease nearly as much as the revenue. Therefore, an adjustment, incorporating the most recently available data, is required.
The penetration factors that were applied to the Title XIX populations for this utilization adjustment are as follows.

<table>
<thead>
<tr>
<th>Population</th>
<th>Cenpatico 3</th>
<th>CPSA</th>
<th>Cenpatico 2</th>
<th>NARBHA</th>
<th>Cenpatico 4</th>
<th>MHS</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMI</td>
<td>1.161</td>
<td>1.158</td>
<td>1.101</td>
<td>1.162</td>
<td>1.156</td>
<td>1.144</td>
<td>1.148</td>
</tr>
<tr>
<td>GMH/SA</td>
<td>1.068</td>
<td>1.107</td>
<td>1.076</td>
<td>1.081</td>
<td>1.077</td>
<td>1.067</td>
<td>1.079</td>
</tr>
</tbody>
</table>

The statewide impact to the program for the penetration rate adjustment is approximately $56,622,255 for the last three quarters of SFY12.

In addition, because of the multiplicative nature of many of the capitation rate components (for example RBHA administration), the change in assumed claim dollars impacts total administrative dollars to the RBHAs. The RBHA administration percentage did not change.

D. For the GMH/SA population, the distribution of CA, MED and the other aid categories making up the population, changes from the full SFY12 distribution to the last three quarters of SFY12 (October 1, 2011 – June 30, 2012) distribution require analysis. Because the CA, MED and “All Other” costs are different, when distribution changes occur, the underlying risk or acuity changes as well.

The acuity factors that were applied to the Title XIX populations for this adjustment are as follows.

<table>
<thead>
<tr>
<th>Population</th>
<th>Cenpatico 3</th>
<th>CPSA</th>
<th>Cenpatico 2</th>
<th>NARBHA</th>
<th>Cenpatico 4</th>
<th>MHS</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMH/SA</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
<td>0.988</td>
</tr>
</tbody>
</table>

The statewide impact to the program for the acuity adjustment is a decrease of approximately $2,064,138 for the last three quarters of SFY12.

In addition, because of the multiplicative nature of many of the capitation rate components (for example RBHA administration), the change in assumed claim dollars impacts total administrative dollars to the RBHAs. The RBHA administration percentage did not change.
Coordination of Benefits

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides the RBHAs with verified commercial and Medicare coverage information for their members which the RBHAs utilize to ensure payments are not made for medical services that are covered by the other carriers. When the RBHAs make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. For state fiscal years (SFY) 2009 and 2010, encounter-reported COB cost avoidance averaged approximately $7 million (Title XIX and Title XXI combined). Additionally, in SFY10, BHS RBHAs cost-avoided more than $34 million (Title XIX and Title XXI combined) in additional claims for which the RBHA had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

III. Proposed revised capitation rates

The end result of this capitation rate development update, completed jointly by BHS and Mercer, is actuarially-sound capitation rates for the last three quarters of SFY12.

Actuarially-sound capitation rates were developed for each of the following populations and RBHA combinations, shown in the next table.

<table>
<thead>
<tr>
<th>Population</th>
<th>Cenpatico 3</th>
<th>CPSA</th>
<th>Cenpatico 2</th>
<th>NARBHA</th>
<th>Cenpatico 4</th>
<th>MHS</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children — non-CMDP</td>
<td>$32.47</td>
<td>$45.38</td>
<td>$42.10</td>
<td>$35.18</td>
<td>$46.81</td>
<td>$29.09</td>
<td>$33.81</td>
</tr>
<tr>
<td>Children — CMDP</td>
<td>$1,468.80</td>
<td>$1,153.57</td>
<td>$1,099.41</td>
<td>$1,511.70</td>
<td>$680.88</td>
<td>$679.44</td>
<td>$883.95</td>
</tr>
<tr>
<td>SMI</td>
<td>$48.60</td>
<td>$65.74</td>
<td>$33.36</td>
<td>$42.57</td>
<td>$47.09</td>
<td>$94.94</td>
<td>$73.20</td>
</tr>
<tr>
<td>GMH/SA</td>
<td>$28.34</td>
<td>$50.19</td>
<td>$42.90</td>
<td>$27.80</td>
<td>$54.47</td>
<td>$34.14</td>
<td>$37.03</td>
</tr>
</tbody>
</table>

The rate development schedules are shown in Attachment A.
IV. Certification of final rates

In preparing the rates shown above and in the attached, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design and financial data, and information supplied by BHS and the RBHAs. BHS and the RBHAs are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the above and the attached rates, including risk-sharing mechanisms, incentive arrangements or other payments, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates developed by Mercer are actuarial projections of future contingent events. Actual RBHA costs will differ from these projections. Mercer has developed these rates on behalf of BHS to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

RBHAs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by the RBHAs for any purpose. Mercer recommends that any RBHA considering contracting with BHS should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rates before deciding whether to contract with BHS.

This certification letter assumes the reader is familiar with the BHS program, Medicaid eligibility rules and actuarial rating techniques. It is intended for BHS and CMS and
should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions concerning our rate setting methodology, please feel free to contact me at +1 602 522 6510 or mike.nordstrom@mercer.com.

Sincerely,

Michael E. Nordstrom, ASA, MAAA
Partner

MEN/vh

Enclosures

Copy:
Sundee Easter, Mercer
Mike Miner, Mercer
Rob O'Brien, Mercer
DATE: September 21, 2011

TO: Representative John Kavanagh, Chairman
   Members, Joint Legislative Budget Committee

THRU: Richard Stavneak, Director

FROM: Leatta McLaughlin, Assistant Director

SUBJECT: Arizona Board of Regents - Review of FY 2012 Tuition Revenues

Request

The Arizona Board of Regents (ABOR) requests Committee review of its expenditure plan for tuition revenue amounts greater than the amounts appropriated by the Legislature, and all non-appropriated tuition and fee revenue expenditures for the current fiscal year. This review is required by the FY 2012 General Appropriation Act.

Recommendation

The Committee has at least the following 2 options:

1. A favorable review.
2. An unfavorable review.

Total FY 2012 tuition and fee collections are projected to be $1.49 billion, or $229.0 million higher than FY 2011. These collections are divided into appropriated and non-appropriated funds.

Appropriated FY 2012 tuition collections are estimated to be $910.1 million. This amount is $110.8 million above the original FY 2012 budget and $138.3 million above FY 2011. ASU plans on using about half of the additional $110.8 million on backfilling prior year General Fund budget reductions and backfilling expired federal stimulus monies. A majority of the remaining additional monies will be spent on fringe benefits costs for ASU and enrollment growth funding for all of the universities. To a lesser extent, these monies will also cover miscellaneous academic and support planning priorities.

(Continued)
Non-appropriated locally retained tuition and fees for FY 2012 are estimated at $577.1 million, $90.6 million higher than FY 2011. Of the $577.1 million amount, about $408.1 million will be spent on financial aid, $86.0 million on debt service, $64.0 million on operating budgets, and $19.0 million on plant funds. Statute allows the universities to retain a portion of tuition collections for expenditures, as approved by ABOR. These “locally” retained tuition monies are considered non-appropriated. Any remaining tuition collections are then submitted as part of each university’s operating budget request and are available for appropriation by the Legislature.

Analysis

Appropriated Tuition

Attachment 1 shows ABOR changes to resident and non-resident undergraduate tuition from FY 2011 to FY 2012. Prior to April 2011, ABOR policy was to set undergraduate resident tuition at the top of the bottom one-third of all senior public universities. Their current policy is to set tuition and fees based on certain factors, such as the cost of university attendance, tuition costs at peer universities, debt service payments, and Arizona’s median family income levels.

Table 1 displays FY 2011 and FY 2012 General Fund and tuition/fee monies for the Arizona University System. The FY 2012 budget includes $799.3 million in appropriated tuition monies, which reflects tuition growth from new students but not tuition rate increases. The higher tuition rates generated $110.8 million more in appropriated monies than budgeted, for a total of $910.1 million. The universities have set aside $577.1 million of the $1.49 billion for non-appropriated purposes.

In total, General Fund and tuition/fee resources will increase by $21.3 million from $2,131.4 million in FY 2011 to $2,152.7 million in FY 2012 after the tuition/fee increase.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Arizona University System FY 2011 and FY 2012 General Fund and Tuition/Fee Revenues (in Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriations</td>
<td>FY 2011</td>
</tr>
<tr>
<td>General Fund</td>
<td>$ 873.1</td>
</tr>
<tr>
<td>Tuition/Fees</td>
<td>771.8</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$1,644.9</td>
</tr>
<tr>
<td>Non-Appropriated</td>
<td></td>
</tr>
<tr>
<td>Tuition/Fees</td>
<td>$ 486.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$2,131.4</td>
</tr>
</tbody>
</table>

\( ^{1/} \) The FY 2012 General Fund appropriation includes a $(198.0) million lump sum reduction and statewide adjustments.

Tables 2 and 3 present FY 2012 appropriated and non-appropriated estimates of ABOR’s tuition and fee revenues, and resulting additional revenues by campus. Table 2 shows that of the $110.8 million in additional appropriated tuition, Arizona State University (ASU) – Tempe/Downtown Phoenix received $82.7 million, ASU – East $2.9 million, ASU – West $6.0 million, Northern Arizona University (NAU) $11.1 million, the University of Arizona (UA) – Main $7.7 million, and UA – Health Sciences Center –
## Table 2
Arizona University System  
### FY 2012 Appropriated Tuition/Fee Revenues by Campus

<table>
<thead>
<tr>
<th>Campus</th>
<th>FY 2012 Appropriation</th>
<th>Additional Tuition</th>
<th>FY 2012 After Tuition Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASU-Tempe/DPC</td>
<td>$371,241,700</td>
<td>$82,652,600</td>
<td>$453,894,300</td>
</tr>
<tr>
<td>ASU-East</td>
<td>34,635,000</td>
<td>2,937,700</td>
<td>37,572,700</td>
</tr>
<tr>
<td>ASU-West</td>
<td>26,261,700</td>
<td>6,017,000</td>
<td>32,278,700</td>
</tr>
<tr>
<td>NAU</td>
<td>86,613,200</td>
<td>11,125,700</td>
<td>97,738,900</td>
</tr>
<tr>
<td>UofA-Main</td>
<td>255,188,900</td>
<td>(7,685,900)</td>
<td>247,503,000</td>
</tr>
<tr>
<td>UofA-Health Sciences Center</td>
<td>25,381,800</td>
<td>15,772,200</td>
<td>41,154,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$799,322,300</strong></td>
<td><strong>$110,819,300</strong></td>
<td><strong>$910,141,600</strong></td>
</tr>
</tbody>
</table>

## Table 3
Arizona University System  
### FY 2011 & FY 2012 Non-Appropriated Tuition/Fee Revenues by Campus

<table>
<thead>
<tr>
<th>Campus</th>
<th>FY 2011 Non-Appropriated</th>
<th>Additional Tuition</th>
<th>FY 2012 After Tuition Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASU-Tempe/DPC</td>
<td>$198,910,300</td>
<td>$56,719,700</td>
<td>$255,630,000</td>
</tr>
<tr>
<td>ASU-East</td>
<td>11,164,700</td>
<td>2,200,800</td>
<td>13,365,500</td>
</tr>
<tr>
<td>ASU-West</td>
<td>21,695,000</td>
<td>2,541,500</td>
<td>24,236,500</td>
</tr>
<tr>
<td>NAU</td>
<td>68,418,200</td>
<td>5,340,700</td>
<td>73,758,900</td>
</tr>
<tr>
<td>UofA-Main</td>
<td>183,685,600</td>
<td>23,546,100</td>
<td>207,231,700</td>
</tr>
<tr>
<td>UofA-Health Sciences Center</td>
<td>2,594,500</td>
<td>309,900</td>
<td>2,904,400</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$486,468,300</strong></td>
<td><strong>$90,658,700</strong></td>
<td><strong>$577,127,000</strong></td>
</tr>
</tbody>
</table>

(Continued)
$15.8 million. The decrease in appropriation tuition revenues for UA – Main is due to the movement of the Outreach College activity from state funds to locally retained tuition collections. Table 3 shows that of the $90.7 million in additional non-appropriated tuition and fees, ASU received $61.5 million, NAU $5.3 million, and UA $23.9 million.

Table 4 provides some information on the uses of additional appropriated tuition revenues by university. Attached, ABOR has provided further detail.
<table>
<thead>
<tr>
<th>Arizona University System</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2011 to FY 2012 Undergraduate Tuition and Fees Changes 2/</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Resident 2/</th>
<th>Non-Resident 2/</th>
<th></th>
<th>Non-Resident 2/</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY 2011</td>
<td>FY 2012</td>
<td>$ Change</td>
<td>% Change</td>
</tr>
<tr>
<td>ASU-Tempe/DPC</td>
<td>$6,942 to</td>
<td>$8,355 to</td>
<td>$1,413 to</td>
<td>20.4% to</td>
</tr>
<tr>
<td></td>
<td>$8,128</td>
<td>$9,716</td>
<td>$1,588</td>
<td>19.5%</td>
</tr>
<tr>
<td>ASU-East/West</td>
<td>$6,708 to</td>
<td>$8,077 to</td>
<td>$1,369 to</td>
<td>20.4% to</td>
</tr>
<tr>
<td></td>
<td>$8,128</td>
<td>$9,716</td>
<td>$1,588</td>
<td>19.5%</td>
</tr>
<tr>
<td>NAU</td>
<td>$5,848 to</td>
<td>$5,960 to</td>
<td>$112 to</td>
<td>1.9% to</td>
</tr>
<tr>
<td></td>
<td>$7,667</td>
<td>$8,824</td>
<td>$1,157</td>
<td>15.1%</td>
</tr>
<tr>
<td>NAU-Distance Ed.</td>
<td>$4,500 to</td>
<td>$4,803 to</td>
<td>$303 to</td>
<td>6.7% to</td>
</tr>
<tr>
<td></td>
<td>$6,131</td>
<td>$6,317</td>
<td>$186</td>
<td>3.0%</td>
</tr>
<tr>
<td>UofA-Main/HSC</td>
<td>$8,237</td>
<td>$10,035</td>
<td>$1,798</td>
<td>21.8%</td>
</tr>
<tr>
<td>UofA-South</td>
<td>$6,652</td>
<td>$7,941</td>
<td>$1,289</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

1/ The amounts represent combined full-time tuition for fall and spring semesters, as well as mandatory fees. Undergraduates must take at least 12 credit hours to qualify for full-time status. Mandatory fees include Arizona Financial Aid Trust and student recreation charges, but do not include special class or program fees.

2/ NAU provides a guaranteed tuition rate for each resident cohort. ASU and UA have no tuition guarantee.
August 24, 2011

The Honorable John Kavanagh, Chairman
Joint Legislative Budget Committee
Arizona House of Representatives
1700 West Washington
Phoenix, Arizona 85007

Dear Representative Kavanagh:

A footnote included in the General Appropriations Act requires that the Arizona Board of Regents report to the Joint Legislative Budget Committee of any tuition revenue amounts which are different from the amounts appropriated by the legislature, and all tuition and fee revenues retained locally by the universities.

Enclosed for your information is a summary report of tuition revenues that support the FY 2012 state operating budget as reported to the Board at its August 2011 meeting. The increase in tuition and fees revenues can be attributed to a combination of increased student enrollments from the estimates made last fall during the budget process, and tuition and fee rate increases approved by the Board of Regents in April 2011.

Compared to the $1.486 billion tuition revenue estimate presented in the FY 2012 Appropriations Report, the current system estimate is $1.487 billion. These revenues are allocated between state appropriated funds and the universities’ local funds as shown on the attached schedules.

If you have any questions, please do not hesitate to call me at 229-2505.

Sincerely,

Thomas Anderes, PhD
President

xc: Richard Stavneak, Director, JLBC
    John Arnold, Director, OSPB
## Arizona University System

### Tuition and Fees in Support of the 2011-12 State Operating Budget

<table>
<thead>
<tr>
<th>State Collections</th>
<th>As Reported in the 2011-12 Initial All Funds Operating Budget Report</th>
<th>2011-12 Appropriations Report</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona State University Tempe</td>
<td>453,894,300</td>
<td>371,241,700</td>
<td>82,652,600</td>
</tr>
<tr>
<td>Arizona State University Polytechnic</td>
<td>37,572,700</td>
<td>34,635,000</td>
<td>2,937,700</td>
</tr>
<tr>
<td>Arizona State University West</td>
<td>32,278,700</td>
<td>26,261,700</td>
<td>6,017,000</td>
</tr>
<tr>
<td><strong>TOTAL ASU</strong></td>
<td>523,745,700</td>
<td>432,138,400</td>
<td>91,607,300</td>
</tr>
<tr>
<td>Northern Arizona University</td>
<td>97,738,900</td>
<td>86,613,200</td>
<td>11,125,700</td>
</tr>
<tr>
<td>University of Arizona</td>
<td>247,503,000</td>
<td>255,188,900</td>
<td>-7,685,900</td>
</tr>
<tr>
<td>University of Arizona Health Sciences Center</td>
<td>41,154,000</td>
<td>25,381,800</td>
<td>15,772,200</td>
</tr>
<tr>
<td><strong>TOTAL UA</strong></td>
<td>288,657,000</td>
<td>280,570,700</td>
<td>8,086,300</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>910,141,600</td>
<td>799,322,300</td>
<td>110,819,300</td>
</tr>
</tbody>
</table>

Reconciliation to FY 2012 Appropriations Report

<table>
<thead>
<tr>
<th>Description</th>
<th>Initial Report</th>
<th>Reconciliation Report</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total State Collections</td>
<td>910,141,600</td>
<td>799,322,300</td>
<td>110,819,300</td>
</tr>
<tr>
<td>Total Locally Retained Collections</td>
<td>577,126,900</td>
<td>509,639,900</td>
<td>67,487,000</td>
</tr>
<tr>
<td>To Be Allocated Tuition Collections (Table 5 - FY 2012 Appropriations Report)</td>
<td>0</td>
<td>177,067,300</td>
<td>-177,067,300</td>
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<tr>
<td>Total Estimated Tuition Revenue</td>
<td>1,487,268,500</td>
<td>1,486,029,500</td>
<td>1,239,000</td>
</tr>
</tbody>
</table>

0.08%
## ARIZONA STATE UNIVERSITY at the TEMPE Campus

**FY12 PLANNED USES OF ESTIMATED STATE COLLECTIONS AND LOCALLY RETAINED TUITION AND FEE REVENUES INITIAL ALL FUNDS BUDGET vs. APPROPRIATIONS REPORT**

<table>
<thead>
<tr>
<th>Description</th>
<th>State Collections</th>
<th>Local Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Collections As Reported in the Initial All Funds Report</td>
<td>$453,894,300</td>
<td>$255,630,000</td>
</tr>
<tr>
<td>Collections As Reported in the FY12 Appropriations Report</td>
<td>371,241,700</td>
<td></td>
</tr>
<tr>
<td>Base Collections Increase/(Decrease) from FY12 Appropriations Report</td>
<td>82,652,600</td>
<td>255,630,000</td>
</tr>
</tbody>
</table>

### ALLOCATIONS BY PROGRAM

- **All Programs**
  - Fringe Benefits Costs
  - Instruction
    - Backfill State Appropriation Reduction
    - Backfill Expiration of Stimulus Funding
    - College/School Support from Special Program Fees/Differential Tuition
    - Enrollment Growth Support to Colleges
    - Faculty and Other Academic Investments
    - ASU Online/Extended Campus Support
    - ASU Online Expense
    - Local Account Operating Support
  - Organized Research
    - Local Account Operating Support
  - Public Service
    - Local Account Operating Support
  - Academic Support
    - Enrollment and Transfer Student Services Support
    - UTO Support from Mandatory Student Technology Fee
    - Local Operating Budget Support
  - Student Services
    - Local Account Operating Support
  - Institutional Support
    - Local Account Operating Support
  - Scholarships/Fellowships/Financial Aid
    - Financial Aid
  - Auxiliary Enterprises
    - Auxiliary Operating Support
  - Debt Service
    - Debt Service Payments
  - Plant Funds
    - Minor Capital Projects

<table>
<thead>
<tr>
<th></th>
<th>State Collections</th>
<th>Local Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$82,652,600</td>
<td>$255,630,000</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>INITIAL 2011-12</td>
<td>FINAL 2010-11</td>
</tr>
<tr>
<td>----------</td>
<td>----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>American English and Cultural Program - ITA</td>
<td>87,500</td>
<td>87,500</td>
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<tr>
<td>Associated Students - ASASU</td>
<td>869,100</td>
<td>869,100</td>
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<tr>
<td>Child &amp; Family Services</td>
<td>62,700</td>
<td>62,700</td>
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<tr>
<td>Constituent Advocacy</td>
<td>124,500</td>
<td>124,500</td>
</tr>
<tr>
<td>Distance Learning Technology</td>
<td>970,200</td>
<td>970,200</td>
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<tr>
<td>Environmental Health &amp; Safety</td>
<td>162,200</td>
<td>162,200</td>
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<tr>
<td>Federal Direct Loan Administration</td>
<td>144,000</td>
<td>144,000</td>
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<tr>
<td>Fine Arts Activities</td>
<td>367,900</td>
<td>367,900</td>
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<tr>
<td>Forensics</td>
<td>605,900</td>
<td>605,900</td>
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<tr>
<td>Graduate Support Program</td>
<td>37,800</td>
<td>37,800</td>
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<tr>
<td>Interpreters Theatre</td>
<td>20,700</td>
<td>20,700</td>
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<tr>
<td>KASR Radio</td>
<td>22,000</td>
<td>22,000</td>
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<tr>
<td>Library Support</td>
<td>312,000</td>
<td>312,000</td>
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<tr>
<td>Local Support for Academic/Administrative Units</td>
<td>0</td>
<td>10,025,200</td>
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<tr>
<td>Mona Plumer Aquatic Center</td>
<td>141,900</td>
<td>141,900</td>
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<tr>
<td>Online Partnership/Management Payments</td>
<td>0</td>
<td>7,200,100</td>
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<tr>
<td>Registrar Services</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Special Events</td>
<td>176,800</td>
<td>176,800</td>
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<tr>
<td>Student Affairs Initiatives</td>
<td>228,800</td>
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<tr>
<td>Student Financial Assistance Administration</td>
<td>351,000</td>
<td>351,000</td>
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<tr>
<td>Summer Bridge Program</td>
<td>355,200</td>
<td>355,200</td>
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<tr>
<td>Teaching Assistant/Graduate Teaching Assistant - Tuition Benefit</td>
<td>11,624,000</td>
<td>2,569,700</td>
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<tr>
<td>University Minority Cultural Program</td>
<td>113,800</td>
<td>113,800</td>
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<tr>
<td>University Recycling Program</td>
<td>83,000</td>
<td>83,000</td>
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<tr>
<td>Employee Benefit Adjustments/Contingencies</td>
<td>166,000</td>
<td>166,000</td>
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</tbody>
</table>

**Subtotal Designated:** 17,412,100 19,895,000 37,307,100

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>INITIAL 2011-12</th>
<th>FINAL 2010-11</th>
<th>INCREASE/DECREASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASU Public Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intercollegiate Athletics</td>
<td>1,975,300</td>
<td>1,975,300</td>
<td>0</td>
</tr>
<tr>
<td>Memorial Union</td>
<td>1,129,200</td>
<td>1,129,200</td>
<td>0</td>
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<tr>
<td>Recreational Sports</td>
<td>827,100</td>
<td>827,100</td>
<td>0</td>
</tr>
<tr>
<td>Student Media</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Subtotal Auxiliary:** 3,901,600 0 3,901,600

**Total Operating Funds:** 21,343,700 19,895,000 41,238,700

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>INITIAL 2011-12</th>
<th>FINAL 2010-11</th>
<th>INCREASE/DECREASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regents Financial Aid Set-Aside</td>
<td>55,020,300</td>
<td>15,032,500</td>
<td>70,052,800</td>
</tr>
<tr>
<td>Other F.A. - Institutional FA</td>
<td>60,106,300</td>
<td>11,106,300</td>
<td>71,212,600</td>
</tr>
<tr>
<td>Other Financial Aid - CRESTEM/CONACYTHEEP</td>
<td>308,200</td>
<td>308,200</td>
<td>0</td>
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<tr>
<td>CONACYT Fellowship Program</td>
<td>122,500</td>
<td>122,500</td>
<td>0</td>
</tr>
<tr>
<td>Other F.A. - Graduate Scholars Program</td>
<td>507,600</td>
<td>507,600</td>
<td>0</td>
</tr>
<tr>
<td>Graduate Fellowship Program</td>
<td>1,522,700</td>
<td>1,522,700</td>
<td>0</td>
</tr>
<tr>
<td>Law Scholarships</td>
<td>1,500,000</td>
<td>1,500,000</td>
<td>0</td>
</tr>
<tr>
<td>Student Technology Fee FA Set-Aside</td>
<td>1,243,700</td>
<td>32,500</td>
<td>1,276,200</td>
</tr>
<tr>
<td>Other F.A. - School of Engineering Program</td>
<td>60,000</td>
<td>800,000</td>
<td>680,000</td>
</tr>
<tr>
<td>College of Business FA Set-Aside</td>
<td>712,400</td>
<td>16,900</td>
<td>729,300</td>
</tr>
<tr>
<td>Walter Cronkite School of Journalism FA Set-Aside</td>
<td>44,500</td>
<td>32,100</td>
<td>77,000</td>
</tr>
<tr>
<td>School of Engineering FA Set-Aside</td>
<td>499,600</td>
<td>236,700</td>
<td>736,500</td>
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<tr>
<td>College of Law FA Set-Aside</td>
<td>1,226,200</td>
<td>180,500</td>
<td>1,406,700</td>
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<tr>
<td>College of Liberal Arts FA Set-Aside</td>
<td>84,300</td>
<td>1,993,700</td>
<td>1,989,400</td>
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<tr>
<td>College of Nursing FA Set-Aside</td>
<td>412,900</td>
<td>352,100</td>
<td>765,000</td>
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<tr>
<td>University College FA Set-Aside</td>
<td>97,700</td>
<td>6,900</td>
<td>104,600</td>
</tr>
</tbody>
</table>

**Subtotal Financial Aid:** 127,509,500 29,700,200 157,209,700

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>INITIAL 2011-12</th>
<th>FINAL 2010-11</th>
<th>INCREASE/DECREASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plant Fund - Minor Capital Projects/energy Management Contract</td>
<td>14,000,000</td>
<td>3,500,000</td>
<td>17,500,000</td>
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<tr>
<td>Debt Service</td>
<td>36,677,000</td>
<td>3,614,500</td>
<td>39,291,500</td>
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</table>

**TOTAL LOCAL RETENTION:** 198,910,300 56,719,700 255,630,000
<table>
<thead>
<tr>
<th>Description</th>
<th>State Collections</th>
<th>Local Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Collections As Reported in the Initial All Funds Report</td>
<td>$37,572,700</td>
<td>$13,365,500</td>
</tr>
<tr>
<td>Collections As Reported in the FY12 Appropriations Report</td>
<td>34,635,000</td>
<td></td>
</tr>
<tr>
<td>Base Collections Increase/(Decrease) from FY11 Appropriations Report</td>
<td>2,937,700</td>
<td>13,365,500</td>
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</tbody>
</table>

**ALLOCATIONS BY PROGRAM**

<table>
<thead>
<tr>
<th>Program</th>
<th>State Collections</th>
<th>Local Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Programs</td>
<td>778,400</td>
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<tr>
<td>Fringe Benefit Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Backfill State Appropriation Reduction</td>
<td>1,378,800</td>
<td></td>
</tr>
<tr>
<td>Enrollment Growth Support to Colleges</td>
<td>780,500</td>
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<tr>
<td>ASU Online Expense</td>
<td></td>
<td>1,080,700</td>
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<td>Local Account Operating Support</td>
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</tr>
<tr>
<td>Organized Research</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Public Service</td>
<td></td>
<td></td>
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<tr>
<td>Local Account Operating Support</td>
<td></td>
<td>11,000</td>
</tr>
<tr>
<td>Academic Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic Advising, Enrollment Services and Classroom Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Account Operating Support</td>
<td>28,400</td>
<td></td>
</tr>
<tr>
<td>Student Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Account Operating Support</td>
<td></td>
<td>1,325,700</td>
</tr>
<tr>
<td>Institutional Support</td>
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<td>Local Account Operating Support</td>
<td>38,000</td>
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</tr>
<tr>
<td>Scholarships/Fellowships/Financial Aid</td>
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</tr>
<tr>
<td>Financial Aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auxiliary Enterprises</td>
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<td></td>
</tr>
<tr>
<td>Auxiliary Operating Support</td>
<td>253,800</td>
<td></td>
</tr>
<tr>
<td>Debt Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt Service Payments</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Plant Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Capital Projects</td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>$2,937,700</td>
<td>$13,365,500</td>
</tr>
<tr>
<td>Designated</td>
<td>Final Budget 2010-11</td>
<td>Increase/Decrease</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>AECF - International Teaching Assistants</td>
<td>8,000</td>
<td>0</td>
</tr>
<tr>
<td>Associated Students - ASU</td>
<td>78,200</td>
<td>78,200</td>
</tr>
<tr>
<td>Career Services</td>
<td>48,900</td>
<td>48,900</td>
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<tr>
<td>Child &amp; Family Services</td>
<td>5,700</td>
<td>5,700</td>
</tr>
<tr>
<td>Constituent Advocacy</td>
<td>11,000</td>
<td>11,000</td>
</tr>
<tr>
<td>Dining Services Management</td>
<td>38,000</td>
<td>38,000</td>
</tr>
<tr>
<td>Distance Learning Technology</td>
<td>88,300</td>
<td>88,300</td>
</tr>
<tr>
<td>Environmental Health &amp; Safety</td>
<td>16,100</td>
<td>16,100</td>
</tr>
<tr>
<td>Federal Direct Loan Administration</td>
<td>13,100</td>
<td>13,100</td>
</tr>
<tr>
<td>Graduate Support Program</td>
<td>16,200</td>
<td>16,200</td>
</tr>
<tr>
<td>Intercampus Shuttle Services</td>
<td>36,000</td>
<td>36,000</td>
</tr>
<tr>
<td>Learning Communities</td>
<td>6,500</td>
<td>6,500</td>
</tr>
<tr>
<td>Library Support</td>
<td>28,400</td>
<td>28,400</td>
</tr>
<tr>
<td>Online Partnership/Management Payments</td>
<td>0</td>
<td>1,089,700</td>
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<td>Student Affairs Initiatives</td>
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<td>5,000</td>
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<td>Student Health Services</td>
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<td>225,000</td>
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<tr>
<td>Student Organizations</td>
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<td>21,000</td>
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<tr>
<td>Student Orientation and Forums</td>
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<td>10,600</td>
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<tr>
<td>Student Recreation/Recreational Activities</td>
<td>301,500</td>
<td>301,500</td>
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<tr>
<td>Student Union Activities</td>
<td>558,700</td>
<td>558,700</td>
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<tr>
<td>Undergraduate Business Program</td>
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<td>0</td>
</tr>
<tr>
<td>Teaching Assistant Tuition Benefit</td>
<td>253,900</td>
<td>80,800</td>
</tr>
<tr>
<td>University Minority Cultural Program</td>
<td>5,300</td>
<td>5,300</td>
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<tr>
<td>University Recycling Program</td>
<td>7,300</td>
<td>7,300</td>
</tr>
<tr>
<td>Employee Benefit Adjustments/Contingencies</td>
<td>14,600</td>
<td>14,600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subtotal Designated</th>
<th>1,859,000</th>
<th>1,161,500</th>
<th>3,011,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercollegiate Athletics</td>
<td>179,800</td>
<td>179,800</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subtotal Auxiliary</th>
<th>179,800</th>
<th>0</th>
<th>179,800</th>
</tr>
</thead>
</table>

| Total Operating Funds | 2,029,800 | 1,161,500 | 3,191,300 |

<table>
<thead>
<tr>
<th>Financial Aid</th>
<th>Final Budget 2010-11</th>
<th>Increase/Decrease</th>
<th>Initial Budget 2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regents Financial Aid Set-Aside</td>
<td>9,450,400</td>
<td>811,800</td>
<td>7,262,200</td>
</tr>
<tr>
<td>Other F.A. - Institutional FA</td>
<td>2,562,300</td>
<td>227,500</td>
<td>2,789,800</td>
</tr>
<tr>
<td>Other Financial Aid - CRISMET/CONACYT/NEEP</td>
<td>28,000</td>
<td>28,000</td>
<td></td>
</tr>
<tr>
<td>CONACYT Fellowship Program</td>
<td>5,400</td>
<td>5,400</td>
<td></td>
</tr>
<tr>
<td>Other F.A. - Graduate Scholars Program</td>
<td>22,200</td>
<td>22,200</td>
<td></td>
</tr>
<tr>
<td>Graduate Fellowship Program</td>
<td>66,600</td>
<td>66,600</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Subtotal Financial Aid</th>
<th>9,134,900</th>
<th>1,059,300</th>
<th>10,174,200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plant Fund</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt Service</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| TOTAL LOCAL RETENTION | 11,164,700 | 2,206,800 | 13,365,500 |
### ARIZONA STATE UNIVERSITY at the WEST Campus

**FY12 PLANNED USES OF ESTIMATED STATE COLLECTIONS AND LOCALLY RETAINED TUITION AND FEE REVENUES
INITIAL ALL FUNDS BUDGET vs. APPROPRIATIONS REPORT**

<table>
<thead>
<tr>
<th>Description</th>
<th>State Collections</th>
<th>Local Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Collections As Reported in the Initial All Funds Report</td>
<td>$32,278,700</td>
<td>$24,236,400</td>
</tr>
<tr>
<td>Collections As Reported in the FY12 Appropriations Report</td>
<td>26,261,700</td>
<td></td>
</tr>
<tr>
<td>Base Collections Increase/(Decrease) from FY12 Appropriations Report</td>
<td>6,017,000</td>
<td>24,236,400</td>
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</table>

### ALLOCATIONS BY PROGRAM

<table>
<thead>
<tr>
<th>Program</th>
<th>State Collections</th>
<th>Local Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fringe Benefit Costs</td>
<td>2,503,800</td>
<td></td>
</tr>
<tr>
<td>Instruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Backfill State Appropriation Reduction</td>
<td>2,687,600</td>
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</tr>
<tr>
<td>Enrollment Growth Support to Colleges</td>
<td>94,000</td>
<td></td>
</tr>
<tr>
<td>Faculty and Other Academic Investments</td>
<td>731,600</td>
<td></td>
</tr>
<tr>
<td>ASU Online Expense</td>
<td></td>
<td>1,008,900</td>
</tr>
<tr>
<td>Local Account Operating Support</td>
<td></td>
<td>255,600</td>
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**Total**                                               | **$6,017,000**    | **$24,236,400**   |
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## Northern Arizona University

### FY12 Planned Uses of Estimated State Collections and Locally Retained Tuition and Fee Revenues

**Initial All Funds Budget vs. Appropriations Report**

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<tr>
<th>Description</th>
<th>State Collections</th>
<th>Local Collections</th>
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<td>Base Collections Increase/(Decrease) from FY11 Appropriations Report</td>
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<td>73,758,900</td>
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### Allocation by Program

**Instruction**
- Undergraduate Enrollment Growth and Course Support: 7,251,500
- Health Care Program Continuation and Expansion: 2,040,000
- College/School Support from Special Program Fees: 454,000

**Academic Support**
- Student Advising: 460,200
- Library Technology Replacement and Online Materials: 650,000

**Student Services**
- Student Recruitment and Retention: 270,000

**Local Funds Student Operating Support**
- 8,128,400

**Scholarships/Fellowships/Financial Aid**
- Regent's Financial Aid Set-Aside: 20,100,000
- Institutional Financial Aid: 29,100,000
- All Other Financial Aid: 604,600

**Plant Funds**
- 1,378,200

**Debt Service Payments**
- 14,447,700

**Total**
- $11,125,700
- $73,758,900
### Northern Arizona University

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UNIVERSITY OF ARIZONA
FY12 PLANNED USES OF ESTIMATED STATE COLLECTIONS AND
LOCALLY RETAINED TUITION AND FEE REVENUES
INITIAL ALL FUNDS BUDGET vs. APPROPRIATIONS REPORT

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<th>STATE COLLECTIONS</th>
<th>LOCAL COLLECTIONS</th>
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DATE: September 21, 2011

TO: Representative John Kavanagh
   Members, Joint Legislative Budget Committee

THRU: Richard Stavneak, Director

FROM: Marge Zylla, Senior Fiscal Analyst

SUBJECT: Attorney General - Review of Allocation of Settlement Monies

Request

The General Appropriation Act (Laws 2011, Chapter 24) contains a footnote that requires Joint Legislative Budget Committee (JLBC) review of the expenditure plan for settlement monies over $100,000 received by the Office of the Attorney General (AG), or any other person on behalf of the State of Arizona, prior to expenditure of the monies. Settlements that are deposited in the General Fund pursuant to statute do not require JLBC review.

This request is for review of a $1,363,900 allocation to the AG from a consent judgment with GlaxoSmithKline (Glaxo), a pharmaceutical company.

Recommendation

The JLBC Staff recommends that the Committee give a favorable review of the allocation plan from the Glaxo consent judgment. The allocation plan is consistent with A.R.S. § 44-1531.01, which relates to the distribution of monies recovered as a result of enforcing consumer protection or consumer fraud statutes.

Analysis

In June 2011, the AG and 36 other states and the District of Columbia entered into a consent judgment with Glaxo as a result of their consumer fraud investigation of Glaxo’s subsidiary, SB Pharmco. The investigation determined that SB Pharmco, which has since ceased to exist as a corporation, had substandard drug manufacturing practices at its Cidra facility, which has been closed since 2009.

The settlement requires Glaxo to pay $1,363,900 to the AG. This amount will be deposited into the Consumer Fraud Revolving Fund for attorneys fees, investigation costs, and to support consumer fraud investigations, consumer education, and enforcement of the Consumer Fraud Act.

The settlement also requires that Glaxo not make misleading claims about any drugs that were manufactured at the Cidra plant.

RS/MZ:mt
The Honorable Russell Pearce  
President of the Senate  
1700 West Washington Street  
Phoenix, AZ 85007

The Honorable Andy Tobin  
Speaker of the House  
1700 West Washington Street  
Phoenix, AZ 85007

The Honorable John Kavanagh  
Chairman, Joint Legislative Budget Committee  
1700 West Washington Street  
Phoenix, AZ 85007

Re:  State ex rel Horne v. GlaxoSmithKline, LLC and SB Pharmco Puerto Rico, Inc.  
     C2011-4602 (Ariz. Sup. Ct., Pima County)

The State of Arizona recently settled a multi-state case against GlaxoSmithKline, LLC ("Glaxo") resolving allegations that the subsidiary of Glaxo, SB Pharmco Puerto Rico, Inc. ("SB Pharmco") violated the Arizona Consumer Fraud Act, A.R.S. § 44-1521 et seq., in its promotion, sale, and manufacturing of pharmaceuticals.

Arizona recently joined with 36 other state Attorneys General and the District of Columbia to settle a multi-state action against Glaxo’s subsidiary, SB Pharmco. Between 2001 and 2004, Glaxo and SB Pharmco manufactured and put into the stream of commerce certain lots of Kytril, Bactroban, Paxil, and Avandia that were adulterated because the manufacturing processes used to produce these lots were substandard. The settlement, in the form of a Consent Judgment, resolves the States’ two year investigation of SB Pharmco’s manufacturing practices.

GSK and SB Pharmco are no longer manufacturing drugs at their Cidra facility, which has been closed since 2009. Because that facility has closed and because SB Pharmco ceased to exist as a corporation shortly before the settlement, the injunctive terms contained in the Consent Judgment apply only to Glaxo, the surviving entity.
Among other things, the Consent Judgment requires the following:

- Glaxo shall not, as a result of the manner in which the Covered Products are manufactured, make any written or oral claim for these Products that is false, misleading, or deceptive.

- Glaxo shall not, as a result of the manner in which the Covered Products are manufactured, represent that these Products have sponsorship, approval, characteristics, ingredients, uses, benefits, quantities, or qualities that they do not have.

- Glaxo shall not, as a result of the manner in which the Covered Products are manufactured, cause likelihood of confusion or of misunderstanding as to these Products' source, sponsorship, approval, or certification.

The settlement provides a total payment of $40,750,000 to the States, of which $1,363,884 was paid to Arizona. Those funds were deposited into the Consumer Fraud Revolving Fund pursuant to A.R.S. §44-1531.01.

Our notification to you of this settlement is made without prejudice to this office's long-standing position that it is not under any legal obligation to provide notices of settlements to the Joint Legislative Budget Committee. We are providing this notification to you as a courtesy so that you will be aware of this important settlement.

Thank you for your consideration of this matter. If you have any questions, please feel free to contact me at dena.epstein@azag.gov or (602) 542-7717.

Sincerely,

[Signature]

Dena Rosen Epstein
Section Chief Counsel
Consumer Protection and Advocacy Section

cc: The Honorable Andy Biggs
    The Honorable Chad Campbell
    The Honorable David Schapira
    Mr. Richard S. Stavneak

1 "Covered Products" are all drugs that were manufactured at the Cidra plant no matter where they may now be produced.
Ms. Marge Zylla (Settlement Agreement enclosed)
Mr. Joe Sciarotta
Mr. Art Harding
Ms. Vicki Salazar
Mr. John T. Stevens, Jr.
DATE: September 21, 2011

TO: Representative John Kavanagh, Chairman
Members, Joint Legislative Budget Committee

THRU: Richard Stavneak, Director

FROM: Art Smith, Senior Fiscal Analyst

SUBJECT: Department of Health Services – Consider Approval of Nursing Care Facilities Survey

Request

Pursuant to a FY 2012 General Appropriation Act footnote, the Department of Health Services (DHS) is submitting its proposal for a $400,000 expenditure from the Nursing Care Institution Resident Protection Revolving Fund to the Committee for its approval. Pending Committee approval, DHS will award a contract for a client satisfaction survey contractor to conduct quality improvement studies of nursing care facilities statewide.

Recommendation

The Committee has at least the following options:

1. Approve the DHS request.
2. Not approve the DHS request.

Analysis

Background
The Nursing Care Institution Resident Protection Revolving Fund, established under A.R.S. § 36-431.02, receives its revenue from civil money penalties assessed to certified nursing care facilities by DHS on behalf of the Centers for Medicaid and Medicare Services (CMS). Since DHS is the state agency contractor for the CMS survey and certification, the civil money penalties charged by CMS are federal Medicare monies; these monies are deposited into the Nursing Care Institution Resident Protection Revolving Fund. DHS also assesses state-based civil penalties, which are deposited into the General Fund.
A.R.S. § 36-431.01 permits DHS to use monies in the Nursing Care Institution Resident Protection Fund for federally-approved quality assessment and assurance of nursing facilities. The Legislature appropriated $400,000 in one-time monies in the FY 2012 budget with the inclusion of a footnote that allows DHS to implement a 2-year nursing care quality improvement program. The footnote states that the appropriation may be used for, but is not limited to, contracting with a survey contractor for a study of selected nursing care facilities statewide.

In addition, the use of these monies must be approved by both CMS and the Committee. An amount of $400,000 was previously appropriated to the department in the FY 2008 budget for a similar study. The department has determined that quality of care issues concerning patient falls, sores and infections could be addressed through a statewide survey that would be conducted using monies from the fund. CMS concurs that this would be a proper use of monies collected for federal violations.

There is an existing nursing facility comparison called Nursing Home Compare, which is produced by CMS, that uses information collected from annual reports required by both state governments and the federal government. Information collected for Nursing Home Compare is used to determine a 1-to-5 star rating for certified nursing facilities and is used by members of the public. Nursing facility associations suggest that the additional survey tool would benefit nursing care facilities because participants would receive direct client feedback that would allow them to make quality improvements in advance of existing federal and state surveys. Additionally, stakeholders state that nursing facilities would benefit from the proposed client satisfaction surveys because it is anticipated that a number of new Medicare pay-for-performance programs in 2012 will be based on customer satisfaction.

Survey Application Costs and Agency Administration
DHS issued a request-for-proposals (RFP) this summer with responses due August 23rd. It currently has 4 respondents. The department has established a tentative contract award date of October 6th. In addition to project management by the contractor, the scope of work requires:

1. A survey application developed by the contractor that has been used to provide similar services in the last 2 years in conjunction with marketing tools, descriptive literature and training so that nursing facilities can utilize the application.
2. A survey application in a format that can be accessed via the internet using PCs, which would be accessed by nursing facilities. The survey application will allow individual nursing homes to set quality of care benchmarks, which can then be compared against other participating facilities.
3. User manuals available by CD, hard copy or link to a customer service website.
4. Provision of customer support during normal business hours.

The survey application would be available to all licensed nursing facilities; however, DHS states that the exact level of participation in the survey could not be determined. The survey will be administered either by phone interview by the contractor or by questionnaires to clients. The contractor would determine how frequently survey results are reported, depending on the survey tool that is used. It is expected that the primary respondents will be residents or their appointed legal representative.

The department estimates that approximately 75 out of 136 facilities would participate statewide. The department also estimates that the application would cost between $3,500 and $4,500 per facility, which yields a total cost range of $262,500 to $337,500 for the 2-year period of the survey.

The General Appropriation Act footnote allows up to 8% of the $400,000 appropriation, or $32,000, to be spent by DHS for administrative costs. According to the department, administrative costs include monitoring the use of the survey, tracking survey results and agency interaction with nursing facilities.

RS/AS:sk
September 2, 2011

The Honorable John Kavanagh
Chairman
Joint Legislative Budget Committee
1700 West Washington Street
Phoenix, AZ 85007

Chairman Kavanagh:

Pursuant to Laws 2011, 1st Regular Session, Chapter 24 (Senate Bill 1612), the Arizona Department of Health Services (ADHS) respectfully requests to be placed on the Joint Legislative Budget Committee’s (JLBC) agenda for its next scheduled meeting to review and approve ADHS’s plan to expend monies appropriated from the nursing care institution resident protection revolving fund (A.R.S. 36-431.02). ADHS was appropriated the funds as follows:

"Contingent on federal and Joint Legislative Budget Committee approval of the use of these monies, of the monies appropriated from the Nursing Care Institution Resident Protection Revolving Fund, $400,000 shall be used by the department to improve the operation of nursing care institutions. The funding may be used for, but is not limited to, a contract with a survey contractor or contractors to conduct surveys of selected nursing care institution facilities in Arizona over a two year period beginning July 1, 2011. Monies appropriated for this purpose are exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations until June 30, 2013. Any unused and unallocated monies remaining on June 30, 2013, shall revert to the Nursing Care Institution Resident Protection Revolving Fund. Up to eight per cent of this appropriation may be used by the department for administrative purposes."

The nursing care institution resident protection revolving fund consists of monies from civil penalties that are collected for various violations of federal laws and regulations. The monies in the fund must be used for improvement of the quality of care of patients in skilled nursing facilities. The specific use of the monies is restricted by federal regulation.

ADHS is proposing to contract with a satisfaction survey contractor to conduct quality improvement surveys of facilities in order to improve health outcomes and quality of life for residents. This scope of work and project has been approved by the Centers for Medicaid and Medicare Services.

Leadership for a Healthy Arizona
The scope of work for the project includes:

- Provide a satisfaction survey application that the Contractor has developed and that has been used to provide these services within the last two (2) years nationally or within the State of Arizona.
- Provide marketing tools and descriptive literature for the nursing homes to engage them in using the satisfaction survey application.
- Provide training to each nursing home that requests assistance in the use of the satisfaction survey application.
- Provide the satisfaction survey application in a format that is able to be installed on or accessed through the internet using Personal Computers provided by a variety of companies, including but not limited to IBM, Lenovo, Hewlett Packard, and Dell.

ADHS has been working collaboratively with stakeholders in the community over the past 18 months to determine how these monies could be spent to improve health outcomes while adhering to federal guidelines. Through this extensive process, it was determined that a quality improvement survey project would meet the requirements of CMS and would also benefit residents of skilled nursing facilities.

Stakeholders will additionally benefit from a comprehensive and standard evaluation of various facilities throughout Arizona in areas of quality improvement. Some of the quality of care issues the Department anticipates being addressed includes:

- Pressure sores
- Patient falls
- Healthcare associated infections

Many facilities monitor problem areas but have no way of determining if they are doing better or worse than similar facilities in Arizona. These satisfaction surveys are the first step facilities can take in order to begin addressing problem areas that impact quality of life and health outcomes. As a result of these satisfaction surveys, the Department expects facilities to focus training and improvement resources on eliminating problem areas within their facilities that impact quality of life.

The project’s appropriated budget is $400,000, of which, ADHS may use up to eight per cent for administrative purposes ($32,000). Administrative costs would include:

- Monitoring use of the satisfaction survey
- Tracking of various results of the survey
- Interaction with facilities/users

The Department is currently in the procurement process and has established a tentative date for completion of the evaluation and notification of award on October 6, 2011. ADHS had 4 offerors respond to the RFP. ADHS anticipates awarding a contract shortly after JLBC review.
The survey tool is open to all skilled nursing facilities; however, the exact level of participation is difficult to estimate. While this program is completely voluntary, the Department anticipates adequate funding for approximately 75 facilities. This estimate is based on average bid costs between $3,500 and $4,500 dollars per facility at a total cost between $262,500 and $337,500.

A copy of the Request for Proposal is attached for your review. If you need additional information, please contact Colby Bower, Chief Legislative Liaison at (602) 542-1032.

Sincerely,

Will Humble
Director

WH/jh

C: Senator Andy Biggs, Senate Appropriations Chairman
Richard Stavneak, Director, Joint Legislative Budget Committee
Eileen Klein, Chief of Staff, Finance/Budget, Governor’s Office
John Arnold, Budget Director, Office of Strategic Planning and Budgeting
Arthur Smith, Financial Analyst, Joint Legislative Budget Committee
Don Hughes, Policy Advisor for Health, Governor’s Office
James Humble, Assistant Director, CFO, ADHS
Mary Wiley, Assistant Director, DLS, ADHS
Kris Okazaki, Budget Analyst, Governor’s Office of Strategic Planning and Budgeting