STATE OF ARIZONA

Joint Legislative Budget Committee

STATE SENATE

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LORI KLEIN
RICK MURPHY
STEVEN B. YARBROUGH

1716 WEST ADAMS
PHOENIX, ARIZONA 85007

PHONE (602) 926-5491

FAX (602) 926-5416

http://www.azleg.gov/jlbc.htm

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JOINT LEGISLATIVE BUDGET COMMITTEE
Wednesday, September 28, 2011
1:00 P.M.
Senate Appropriations, Room 109

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.

1. AHCCCS/DEPARTMENT OF HEALTH SERVICES/DEPARTMENT OF ECONOMIC SECURITY - Review of Proposed Capitation Rate Changes.

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

3. ATTORNEY GENERAL - Review of Allocation of Settlement Monies.

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
sk

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.

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VACANT

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MINUTES OF THE MEETING

JOINT LEGISLATIVE BUDGET COMMITTEE

July 28, 2011

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.

A. State Department of Corrections - Review of the Request for Information Responses on Privatization of Prison Health Care (A.R.S. § 38-431.03A2).

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.

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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.

(Continued)

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)%. The main factors influencing these changes are provider rate reductions ($45.7 million General Fund (GF) savings), experience adjustments, and the 25-day hospital inpatient limit ($22.7 million GF savings).

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 1

Monthly Regular Capitation Rates

Populations	Current Rates	Proposed 10/1/11 Rates	% Change
AHCCCS Acute	$ 256.53	$ 236.83	(7.7)%
AHCCCS Elderly & Physically Disabled	3,186.46	2,893.35	(9.2)
Children's Rehabilitative Services	417.35	424.10	1.6
Comprehensive Medical and Dental Program	232.08	222.98	(3.9)
DES Developmentally Disabled	3,387.67	3,217.79	(5.1)
DHS Behavioral Health Services	82.41	85.10	3.3

RS/AU:sk

Janice K. Brewer, Governor
Thomas J. Betlach, Director

801 East Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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

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

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)%.

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)%. 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)%. 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 rebase 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

	Statewide Rates SFY11	Statewide Rates SFY12	FY12 Population	SFY11 Rate with FY 12 Pop.	SFY12 Rate with FY 12 Pop.	Change Inc. (Dec.)	Percent Impact
AHCCCS Acute	$ 256.53	$ 236.83	14,565,867	3,736,601,500	3,449,665,400	(286,936,100)	-7.68%
AHCCCS EPD	$ 3,186.46	$ 2,893.35	321,604	1,024,779,500	930,512,900	(94,266,600)	-9.20%
CMDP	$ 232.08	$ 222.98	124,487	28,891,200	27,757,600	(1,133,600)	-3.92%
CRS	$ 417.35	$ 424.10	307,062	128,151,400	130,225,200	2,073,800	1.62%
BHS Title XIX/XXI	$ 82.41	$ 85.10	14,324,942	1,180,480,800	1,219,069,200	38,588,400	3.27%
LTC - DD/DES	$ 3,387.67	$ 3,214.79	292,902	992,255,700	941,618,800	(50,636,900)	-5.10%
Total Budget Impact	$ 454.21	$ 429.09	15,611,923	7,091,160,100	6,698,849,100	(392,311,000)	-5.53%

AHCCCS Total Fund Impact	(380,262,500)	96.9%
Pass-through Total Fund Impact	(12,048,500)	3.1%
AHCCCS State Impact	(125,586,300)	96.9%
Pass-through State Impact	(3,969,000)	3.1%
Total State Impact	(129,555,300)	
AHCCCS Federal Impact	(254,676,200)	96.9%
Pass-through Federal Impact	(8,079,500)	3.1%
Total Federal Impact	(262,755,700)	

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.

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,

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:

Profit	MCO Share	State Share	Maximum MCO Profit
<=3%	100%	0%	3%
>3% and <=5%	75%	25%	1.5%
>5% and <=7%	50%	50%	1.0%
>7% and <=9%	25%	75%	0.5%
>9%	0%	100%	0%
Total			6.0%

Loss	MCO Share	State Share	Maximum MCO Loss
<=3%	100%	0%	3%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%
Total			4.5%

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

	PMPM Trends			
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-6.2%	-1.6%	-6.7%	-5.3%
Outpatient Facility	-3.2%	-0.3%	0.0%	-3.2%
Emergency Room	-4.1%	-7.3%	-0.4%	-4.9%
Primary Care	-2.1%	-3.4%	-0.5%	-4.3%
Referral Physician	-0.4%	0.4%	0.3%	-5.6%
Other Professional	0.4%	-5.3%	-1.4%	1.4%
Pharmacy	7.0%	5.4%	4.9%	3.2%
Other	-5.8%	-4.5%	-3.3%	-4.9%

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 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:

Kidscare Info	CYE12 Projected Member Months	Proj Cap Rate-CYE12	Total Annual Dollars CYE12 based CYE12 Proj MMs
KC <1	164	$ 465.50	$ 76,229
KC 1-13	101,070	$ 99.60	$ 10,066,537
KC 14-44F	25,778	$ 223.03	$ 5,749,375
KC 14-44M	27,758	$ 139.98	$ 3,885,631

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

AHCCCS Medicaid Managed Care Summary			
Adjustments to CYE12 Rates	Prospective	PPC	Weighted Average
Trend:			
1. Utilization	0.84%	0.22%	0.82%
2. Inflation	-3.68%	-3.35%	-3.67%
Experience Adjustment			
1. Total	-3.70%	-0.04%	-3.60%
Program Changes			
1. IP 25 Day Limit	-1.96%	-1.19%	-1.94%
2. Outpatient Fee Schedule Rebase	-0.13%	-0.05%	-0.13%
3. Smoking Cessation	-0.02%	0.00%	-0.02%
4. Transition of Pediatric Costs	0.05%	0.00%	0.04%
Misc			
1. Administration	-0.71%	-0.36%	-0.70%
2. Risk Contingency	-0.09%	-0.04%	-0.09%
3. Reinsurance Offset Change	1.42%	n/a	1.38%
Total Percentage Change	-7.76%	-4.75%	-7.68%

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.

AA.1.1: Actuarial certification

Please refer to Section XVII.

AA.1.2: Projection of expenditure

Please refer to Appendix II.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

AA.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:

Profit	MCO Share	State Share	Maximum MCO Profit
<=3%	100%	0%	3%
>3% and <=5%	75%	25%	1.5%
>5% and <=7%	50%	50%	1.0%
>7% and <=9%	25%	75%	0.5%
>9%	0%	100%	0%
Total			6.0%

Loss	MCO Share	State Share	Maximum MCO Loss
<=3%	100%	0%	3%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%
Total			4.5%

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 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 — 09-01-11

Windy J. Marks — Date

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

Appendix I

Prospective Trends

Utilization per 1,000 trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-3.3%	-5.1%	-2.7%	-4.3%
Outpatient Facility	0.1%	4.4%	4.9%	2.1%
Emergency Room	-1.3%	-0.8%	4.4%	0.2%
Primary Care	2.7%	2.4%	4.4%	-0.1%
Referral Physician	6.0%	9.2%	8.1%	3.7%
Other Professional	4.4%	3.8%	4.9%	4.8%
Pharmacy	6.4%	1.1%	7.3%	3.4%
Other	n/a	n/a	n/a	n/a

Unit Cost Trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-3.0%	3.7%	-4.2%	-1.0%
Outpatient Facility	-3.3%	-4.5%	-4.7%	-5.2%
Emergency Room	-2.9%	-6.6%	-4.6%	-5.0%
Primary Care	-4.7%	-5.6%	-4.6%	-4.2%
Referral Physician	-6.0%	-8.1%	-7.2%	-8.9%
Other Professional	-3.8%	-8.8%	-6.0%	-3.3%
Pharmacy	0.6%	4.3%	-2.2%	-0.2%
Other	n/a	n/a	n/a	n/a

PMPM Trends				
Categories of Service	TANF & KidsCare Combined	SSI With Medicare	SSI without Medicare	Non-MED
Hospital Inpatient	-6.2%	-1.6%	-6.7%	-5.3%
Outpatient Facility	-3.2%	-0.3%	0.0%	-3.2%
Emergency Room	-4.1%	-7.3%	-0.4%	-4.9%
Primary Care	-2.1%	-3.4%	-0.5%	-4.3%
Referral Physician	-0.4%	0.4%	0.3%	-5.6%
Other Professional	0.4%	-5.3%	-1.4%	1.4%
Pharmacy	7.0%	5.4%	4.9%	3.2%
Other	-5.8%	-4.5%	-3.3%	-4.9%

Acute Capitation Rate Analysis (Renewal Rates--pending approval)
Point in Time Comparison--no member growth factor
CYE '12
APPENDIX II

		CYE12 Projected Member Months [1]	Cap Rate- '11 (4/1) based on CYE12 Proj Member Months	Total Annual Dollars CYE '11 (4/1) based on CYE12 Proj MMs	Cap Rate- CYE12 based on CYE12 Proj Member Months	Total Annual Dollars CYE12 based on CYE12 Proj MMs	Difference	% Increase
Title XIX Waiver Group								
	Prospective-MED	382	$ 1,337.16	$ 510,178	$ 1,337.16	$ 510,178	$ -	0.0%
	PPC-MED	100	$ 5,927.52	$ 590,031	$ 5,927.52	$ 590,031	$ -	0.0%
	Total MED	481		$ 1,100,208		$ 1,100,208	$ -	0.0%
	Prospective-non-MED	1,770,209	$ 451.15	$ 798,629,955	$ 397.17	$ 703,074,053	$ (95,555,901)	-12.0%
	PPC -non-MED	6,000	$ 737.81	$ 4,426,860	$ 737.81	$ 4,426,860	$ -	0.0%
	Total non-MED	1,776,209		$ 803,056,815		$ 707,500,913	$ (95,555,901)	-11.9%
	Total TWG	1,776,690		$ 804,157,023		$ 708,601,122	$ (95,555,901)	-11.9%
TXIX								
	<1	575,597	$ 489.94	$ 282,007,781	$ 465.50	$ 267,940,201	$ (14,067,580)	-5.0%
	1-13	5,291,537	$ 105.43	$ 557,886,745	$ 99.60	$ 527,037,084	$ (30,849,661)	-5.5%
	14-44F	2,710,430	$ 237.57	$ 643,916,875	$ 223.03	$ 604,507,222	$ (39,409,653)	-6.1%
	14-44M	1,321,227	$ 151.56	$ 200,245,215	$ 139.98	$ 184,945,402	$ (15,299,813)	-7.6%
	45+	446,121	$ 391.54	$ 174,674,067	$ 357.88	$ 159,657,647	$ (15,016,420)	-8.6%
	SSI w/Med	948,338	$ 137.11	$ 130,026,672	$ 133.19	$ 126,309,185	$ (3,717,486)	-2.9%
	SSI w/o Med	802,110	$ 778.35	$ 624,322,397	$ 714.24	$ 572,899,119	$ (51,423,279)	-8.2%
	SFP	48,072	$ 14.16	$ 680,693	$ 14.13	$ 679,250	$ (1,442)	-0.2%
	Delivery Supplemental Payment	35,196	$ 6,287.19	$ 221,284,489	$ 5,811.78	$ 204,551,917	$ (16,732,572)	-7.6%
	Total Prospective-non-TWG	12,178,628		$ 2,835,044,933		$ 2,648,527,028	$ (186,517,906)	-6.6%
	PPC'<1	17,683	$ 931.87	$ 16,478,679	$ 900.43	$ 15,922,711	$ (555,968)	-3.4%
	PPC'1-13	281,077	$ 54.66	$ 15,363,684	$ 52.97	$ 14,888,663	$ (475,021)	-3.1%
	PPC '14-44F	163,911	$ 194.08	$ 31,811,857	$ 184.58	$ 30,254,702	$ (1,557,155)	-4.9%
	PPC '14-44M	74,783	$ 156.16	$ 11,678,057	$ 147.78	$ 11,051,378	$ (626,679)	-5.4%
	PPC '45+	31,938	$ 318.92	$ 10,185,804	$ 291.04	$ 9,295,361	$ (890,443)	-8.7%
	PPC 'SSI w/Med	13,351	$ 130.66	$ 1,744,452	$ 119.82	$ 1,599,726	$ (144,726)	-8.3%
	PPC 'SSI w/o Med	27,805	$ 358.44	$ 9,966,595	$ 336.63	$ 9,360,158	$ (606,437)	-6.1%
	PPC All non-TWG rate codes	610,549		$ 97,229,128		$ 92,372,700	$ (4,856,428)	-5.0%
	Total Title XIX-non-TWG	12,789,177		$ 2,932,274,062		$ 2,740,899,728	$ (191,374,334)	-6.5%
Grand Total Capitation				**$ 3,736,431,085**		**$ 3,449,500,849**	**$ (286,930,236)**	-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 Prospective 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

Service Category	Combine
Nursing Facility	-3.4%
HCBS	-13.0%
Acute	-6.9%

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

GSA	CYE11		CYE12		Difference HCBS Mix
	NF Mix	HCBS Mix	NF Mix	HCBS Mix	
GSA 40 (Pinal, Gila)	24.55%	75.45%	24.58%	75.42%	-0.03%
GSA 42 (LaPaz, Yuma)	40.65%	59.35%	39.91%	60.09%	0.74%
GSA 44 (Apache, Coconino, Mohave, Navajo)	33.30%	66.70%	32.56%	67.44%	0.74%
GSA 46 (Cochise, Graham, Greenlee)	39.30%	60.70%	38.60%	61.40%	0.70%
GSA 48 (Yavapai)	40.13%	59.87%	36.62%	63.38%	3.51%
GSA 50 (Pima, Santa Cruz)	33.40%	66.60%	32.86%	67.14%	0.54%
GSA 52 (Maricopa)	27.26%	72.74%	25.66%	74.34%	1.60%
Statewide	29.84%	70.16%	28.56%	71.44%	1.28%

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

Service Category	Gross CYE11 Rate	Mix	Net CYE11 Rate	% Gross Change	% Net Change	Gross CYE12 Rate	Mix	Net CYE12 Rate
Nursing Facility	$ 5,419.37	29.84%	$ 1,617.14	-3.4%	-7.6%	$ 5,234.52	28.56%	$ 1,494.98
Share of Cost			$ (249.40)		-9.9%			$ (224.60)
Net Nursing Facility			$ 1,367.74		-7.1%			$ 1,270.38
Home and Community (HCBS)	$ 1,608.95	70.16%	$ 1,128.84	-13.0%	-11.4%	$ 1,399.54	71.44%	$ 999.83
Case Management			$ 114.56		-3.8%			$ 110.19
Acute Care			$ 389.66		-6.9%			$ 362.90
Administration			$ 201.95		-19.4%			$ 162.72
Risk Contingency			$ 32.03		-3.6%			$ 30.89
Premium Tax			$ 66.02		-9.2%			$ 59.94
Net Capitation PMPM			$ 3,300.80		-9.2%			$ 2,996.85

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

Rate Cell	CYE12 Projected MMs	CYE11 Rate (4/1)	CYE12 Rate	Based on CYE12 Annualized Projected Member Months: Estimated CYE11 Capitation	Estimated CYE12 Capitation	Dollar Impact	Percentage Impact
EPD	306,539	$ 3,300.80	$ 2,996.85	$ 1,011,825,310	$ 918,652,654	$ (93,172,656)	-9.2%
PPC	10,436	$ 995.99	$ 908.41	$ 10,394,509	$ 9,480,493	$ (914,016)	-8.8%
Acute Only	4,629	$ 553.03	$ 514.15	$ 2,559,705	$ 2,379,749	$ (179,957)	-7.0%
Total				$ 1,024,779,524	$ 930,512,896	$ (94,266,629)	-9.2%

XIV. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.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 — 09-01-11

Windy J. Marks — Date

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

Appendix I

GSA	Contractor	EPD Rate	Acute Only Rate	PPC Rate
GSA 40 (Pinal, Gila)	Bridgeway	$ 3,050.80	$ 612.00	$ 959.55
GSA 42 (LaPaz, Yuma)	Evercare	$ 2,882.98	$ 423.93	$ 959.55
GSA 44 (Apache, Coconino, Mohave, Navajo)	Evercare	$ 2,602.94	$ 526.66	$ 959.55
GSA 46 (Cochise, Graham, Greenlee)	Bridgeway	$ 2,786.23	$ 578.00	$ 959.55
GSA 48 (Yavapai)	Evercare	$ 3,075.52	$ 485.64	$ 959.55
GSA 50 (Pima, Santa Cruz)	Evercare	$ 3,182.00	$ 502.36	$ 838.89
GSA 50 (Pima, Santa Cruz)	Mercy Care	$ 3,148.03	$ 451.16	$ 838.89
GSA 52 (Maricopa)	Bridgeway	$ 2,981.95	$ 634.03	$ 903.73
GSA 52 (Maricopa)	Evercare	$ 3,323.83	$ 359.12	$ 903.73
GSA 52 (Maricopa)	Mercy Care	$ 2,941.11	$ 532.43	$ 903.73
GSA 52 (Maricopa)	Scan	$ 2,946.12	$ 452.09	$ 903.73

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 I: Proposed Capitation Rates and Budget Impact

	Based on Projected Member Months			Based on Projected Member Months October 1, 2011 - June 30, 2012			
Rate Cell	October 1, 2011 - June 30, 2012	CYE12 Current Rate	CYE12 Updated Rate	Estimated CYE12 Current Capitation	Estimated CYE12 Updated Capitation	Dollar Impact	Percentage Impact
DDD	218,510	$ 3,265.76	$ 3,095.80	$ 713,601,218	$ 676,463,258	$ (37,137,960)	-5.20%
Behavioral Health	218,510	$ 106.23	$ 103.31	$ 23,212,317	$ 22,574,268	$ (638,049)	-2.75%
Targeted Case Management	40,077	$ 85.96	$ 85.96	$ 3,445,024	$ 3,445,024	$ -	0.00%
Total				$ 740,258,559	$ 702,482,550	$ (37,776,009)	-5.10%

DDD rate reflect full premium tax
BH does not reflect premium tax

IV. Actuarial Certification of the Capitation Rates

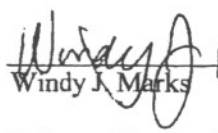
I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by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

09-01-11
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-avoided 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 increase 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; 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 $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

	Based on Projected Member Months October 1, 2011 - September 30, 2012	CYE11 (4/1) Current Rate	CYE12 Updated Rate	Based on Projected Member Months October 1, 2011 - September 30, 2012	
				Estimated CYE11 (4/1) Current Capitation	Estimated CYE12 Updated Capitation
Statewide Totals	307,062	$417.35	$424.10	$128,151,376	$130,225,219
Dollar Impact					$2,073,843
Percentage Impact					1.62%

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 — 09-01-2011

Matthew C. Varitek — Date

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 I 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

Rate Cell	Projected Member Months	CYE11 Current Rate	CYE11 Updated Rate	Estimated CYE11 Current Capitation	Estimated CYE11 Updated Capitation	Dollar Impact	Percentage Impact
Prospective	30,043	$227.46	$218.60	$6,833,543	$6,567,363	($266,180)	-3.9%
PPC	735	$421.03	$401.87	$309,389	$295,309	($14,080)	-4.6%
Total				$7,142,932	$6,862,672	($280,260)	-3.9%

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 — 09-01-11

Windy J. Marks — Date

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

Mike Nordstrom
Partner

Government Human Services Consulting
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6500
mike.nordstrom@mercer.com
www.mercer.com

MERCER

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:

Title XXI

Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
$22.02	$37.22	$22.81	$24.14	$28.13	$18.69	$22.58

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

Michael E. Nordstrom, ASA, MAAA
Partner

MN/vh

Attachments

Copy:
Sundee Easter, Mercer
Mike Miner, Mercer
Rob O'Brien, Mercer

Attachment A
10/1/2011 DBHS Capitation Rates
Title XIX
Non-CMDP Children

	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	Magellan	Total
1. SFY10 Adjusted BHS Service Expenses	$ 7,406,236	$ 39,962,311	$ 10,716,347	$ 30,345,406	$ 13,624,699	$ 104,781,911	$ 206,836,910
2. SFY10 Member Months	263,829	986,765	291,770	931,498	336,629	4,055,036	6,865,527
3. SFY10 PMPM	$ 28.07	$ 40.50	$ 36.73	$ 32.58	$ 40.47	$ 25.84	$ 30.13
4. Relational Modeling	1.019	1.000	1.000	0.975	1.021	1.000	0.998
5. SFY10 Adjusted Claim Cost	$ 28.60	$ 40.50	$ 36.73	$ 31.76	$ 41.31	$ 25.84	$ 30.08
6. Claim Cost Trend Factor	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
7. SFY12 Trended Base Claim Cost	$ 30.93	$ 43.80	$ 39.73	$ 34.35	$ 44.68	$ 27.95	$ 32.53
8. PPC	$ -	$ -	$ -	$ -	$ -	$ 0.01	$ 0.01
9. 1st 72 Hours	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Provider Fee Schedule (Rate) Reduction - 4/1/2011	$ (1.34)	$ (1.86)	$ (1.88)	$ (1.52)	$ (1.80)	$ (1.14)	$ (1.37)
11. Provider Fee Schedule (Rate) Reduction - 10/1/2011	$ (1.35)	$ (1.89)	$ (1.80)	$ (1.55)	$ (1.81)	$ (1.16)	$ (1.38)
12. Respite Hour Reduction	$ (0.02)	$ (0.07)	$ (0.07)	$ (0.05)	$ (0.04)	$ (0.01)	$ (0.03)
13. SFY12 Claim Cost With Above Adjustments	$ 28.22	$ 39.98	$ 35.97	$ 31.23	$ 41.03	$ 25.65	$ 29.76
14. Penetration Factor	1.028	1.014	1.046	1.006	1.019	1.013	1.015
15. Post Penetration Factor PMPM	$ 29.01	$ 40.54	$ 37.61	$ 31.43	$ 41.82	$ 25.99	$ 30.20
16. Acuity Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000
17. Base SFY12 Claim Costs	$ 29.01	$ 40.54	$ 37.61	$ 31.43	$ 41.82	$ 25.99	$ 30.20
18. Interpretive Services Administrative Load	1.66%	1.66%	1.66%	1.66%	1.66%	1.66%	1.66%
19. Non-Interpretive Services Administrative Load	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
20. 10/1/2011 Capitation Rates	$ 32.47	$ 45.38	$ 42.10	$ 35.18	$ 46.81	$ 29.09	$ 33.81
21. 7/1/2011 Capitation Rates	$ 34.01	$ 47.54	$ 44.24	$ 36.94	$ 48.88	$ 30.38	$ 35.37
22. % Change	-4.5%	-4.5%	-4.8%	-4.8%	-4.2%	-4.2%	-4.4%

	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	Magellan	Total
1. SFY10 Adjusted BHS Service Expenses	$ 3,635,045	$ 33,748,234	$ 2,289,658	$ 10,237,228	$ 4,220,903	$ 43,719,380	$ 97,850,447
2. SFY10 Member Months	2,572	30,071	1,677	7,479	6,748	65,020	113,567
3. SFY10 PMPM	$ 1,413.31	$ 1,122.29	$ 1,365.33	$ 1,368.80	$ 625.50	$ 672.40	$ 861.61
4. Relational Modeling	1.000	1.000	0.800	1.081	1.000	1.000	1.004
5. SFY10 Adjusted Claim Cost	$ 1,413.31	$ 1,122.29	$ 1,092.26	$ 1,479.15	$ 625.50	$ 672.40	$ 864.85
6. Claim Cost Trend Factor	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
7. SFY12 Trended Base Claim Cost	$ 1,450.30	$ 1,151.65	$ 1,120.85	$ 1,517.86	$ 641.87	$ 689.99	$ 887.48
8. PPC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. 1st 72 Hours	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Provider Fee Schedule (Rate) Reduction - 4/1/2011	$ (63.32)	$ (53.27)	$ (61.35)	$ (61.37)	$ (29.05)	$ (26.91)	$ (37.62)
11. Provider Fee Schedule (Rate) Reduction - 10/1/2011	$ (68.63)	$ (54.64)	$ (63.77)	$ (65.15)	$ (29.79)	$ (30.37)	$ (40.41)
12. Respite Hour Reduction	$ (1.10)	$ (0.54)	$ (1.17)	$ (1.64)	$ (0.35)	$ (0.11)	$ (0.38)
13. SFY12 Claim Cost With Above Adjustments	$ 1,317.25	$ 1,043.21	$ 994.56	$ 1,389.70	$ 582.69	$ 632.61	$ 809.07
14. Penetration Factor	1.013	1.005	1.005	0.989	1.062	0.976	0.993
15. Post Penetration Factor PMPM	$ 1,334.88	$ 1,048.39	$ 999.17	$ 1,373.86	$ 618.79	$ 617.49	$ 803.36
16. Acuity Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000
17. Base SFY12 Claim Costs	$ 1,334.88	$ 1,048.39	$ 999.17	$ 1,373.86	$ 618.79	$ 617.49	$ 803.36
18. Interpretive Services Administrative Load	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%
19. Non-Interpretive Services Administrative Load	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
20. 10/1/2011 Capitation Rates	$ 1,468.80	$ 1,153.57	$ 1,099.41	$ 1,511.70	$ 680.88	$ 679.44	$ 883.95
21. 7/1/2011 Capitation Rates	$ 1,546.41	$ 1,214.47	$ 1,171.09	$ 1,584.21	$ 716.02	$ 712.10	$ 928.46
22. % Change	-5.0%	-5.0%	-6.1%	-4.6%	-4.9%	-4.6%	-4.8%

	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	Magellan	Total
1. SFY10 Adjusted BHS Service Expenses	$ 11,041,282	$ 73,710,545	$ 13,006,004	$ 40,582,634	$ 17,845,602	$ 148,501,291	$ 304,687,357
2. SFY10 Member Months	266,401	1,016,836	293,447	938,977	343,377	4,120,056	6,979,094
3. SFY10 PMPM	$ 41.45	$ 72.49	$ 44.32	$ 43.22	$ 51.97	$ 36.04	$ 43.66
4. Relational Modeling	1.013	1.000	0.965	1.002	1.016	1.000	1.000
5. SFY10 Adjusted Claim Cost	$ 41.97	$ 72.49	$ 42.76	$ 43.29	$ 52.79	$ 36.04	$ 43.66
6. Claim Cost Trend Factor	3.1%	2.8%	3.6%	3.3%	3.4%	3.2%	3.1%
7. SFY12 Trended Base Claim Cost	$ 44.64	$ 76.57	$ 45.90	$ 46.17	$ 56.42	$ 38.40	$ 46.44
8. PPC	$ -	$ -	$ -	$ -	$ -	$ 0.01	$ 0.01
9. 1st 72 Hours	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Provider Fee Schedule (Rate) Reduction - 4/1/2011	$ (1.93)	$ (3.38)	$ (2.22)	$ (2.00)	$ (2.33)	$ (1.55)	$ (1.96)
11. Provider Fee Schedule (Rate) Reduction - 10/1/2011	$ (2.00)	$ (3.45)	$ (2.15)	$ (2.06)	$ (2.36)	$ (1.62)	$ (2.02)
12. Respite Hour Reduction	$ (0.03)	$ (0.08)	$ (0.08)	$ (0.06)	$ (0.05)	$ (0.01)	$ (0.03)
13. SFY12 Claim Cost With Above Adjustments	$ 40.67	$ 69.65	$ 41.45	$ 42.05	$ 51.67	$ 35.23	$ 42.44
14. Penetration Factor	1.023	1.010	1.040	1.002	1.029	1.003	1.008
15. Post Penetration Factor PMPM	$ 41.62	$ 70.34	$ 43.11	$ 42.13	$ 53.16	$ 35.32	$ 42.79
16. Acuity Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000
17. Base SFY12 Claim Costs	$ 41.62	$ 70.34	$ 43.11	$ 42.13	$ 53.16	$ 35.32	$ 42.79
18. Interpretive Services Administrative Load	1.19%	0.99%	1.46%	1.27%	1.31%	1.24%	1.20%
19. Non-Interpretive Services Administrative Load	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
20. 10/1/2011 Capitation Rates	$ 46.34	$ 78.15	$ 48.14	$ 46.95	$ 59.27	$ 39.35	$ 47.64
21. 7/1/2011 Capitation Rates	$ 48.62	$ 82.05	$ 50.68	$ 49.27	$ 61.99	$ 41.14	$ 49.90
22. % Change	-4.7%	-4.8%	-5.0%	-4.7%	-4.4%	-4.3%	-4.5%

	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	Magellan	Total
1. SFY10 Adjusted BHS Service Expenses	$ 13,333,283	$ 65,366,349	$ 9,732,004	$ 42,617,605	$ 14,904,460	$ 286,424,397	$ 432,378,099
2. SFY10 Member Months	329,466	1,203,326	331,598	1,217,055	378,224	3,563,471	7,023,140
3. SFY10 PMPM	$ 40.47	$ 54.32	$ 29.35	$ 35.02	$ 39.41	$ 80.38	$ 61.56
4. Relational Modeling	1.000	1.000	1.000	1.000	1.000	1.000	1.000
5. SFY10 Adjusted Claim Cost	$ 40.47	$ 54.32	$ 29.35	$ 35.02	$ 39.41	$ 80.38	$ 61.56
6. Claim Cost Trend Factor	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
7. SFY12 Trended Base Claim Cost	$ 41.28	$ 55.41	$ 29.94	$ 35.72	$ 40.20	$ 81.99	$ 62.80
8. PPC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. 1st 72 Hours	$ -	$ 0.07	$ -	$ 0.00	$ 0.01	$ 0.05	$ 0.04
10. Provider Fee Schedule (Rate) Reduction - 4/1/2011	$ (1.48)	$ (1.68)	$ (1.19)	$ (1.06)	$ (1.53)	$ (3.11)	$ (2.26)
11. Provider Fee Schedule (Rate) Reduction - 10/1/2011	$ (1.80)	$ (2.27)	$ (1.25)	$ (1.40)	$ (1.68)	$ (3.60)	$ (2.69)
12. Respite Hour Reduction	$ (0.00)	$ -	$ (0.00)	$ (0.00)	$ (0.02)	$ (0.00)	$ (0.00)
13. SFY12 Claim Cost With Above Adjustments	$ 38.00	$ 51.54	$ 27.50	$ 33.26	$ 36.98	$ 75.33	$ 57.89
14. Penetration Factor	1.161	1.158	1.101	1.162	1.156	1.144	1.148
15. Post Penetration Factor PMPM	$ 44.12	$ 59.68	$ 30.29	$ 38.65	$ 42.75	$ 86.19	$ 66.46
16. Acuity Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000
17. Base SFY12 Claim Costs	$ 44.12	$ 59.68	$ 30.29	$ 38.65	$ 42.75	$ 86.19	$ 66.46
18. Interpretive Services Administrative Load	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%
19. Non-Interpretive Services Administrative Load	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
20. 10/1/2011 Capitation Rates	$ 48.60	$ 65.74	$ 33.36	$ 42.57	$ 47.09	$ 94.94	$ 73.20
21. 7/1/2011 Capitation Rates	$ 43.84	$ 59.15	$ 30.58	$ 38.20	$ 42.46	$ 86.05	$ 66.20
22. % Change	10.9%	11.1%	9.1%	11.4%	10.9%	10.3%	10.6%

	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	Magellan	Total
1. SFY10 Adjusted BHS Service Expenses	$ 8,292,832	$ 50,418,515	$ 12,682,523	$ 29,754,344	$ 18,097,710	$ 106,043,870	$ 225,289,794
2. SFY10 Member Months	329,466	1,203,326	331,598	1,217,055	378,224	3,563,471	7,023,140
3. SFY10 PMPM	$ 25.17	$ 41.90	$ 38.25	$ 24.45	$ 47.85	$ 29.76	$ 32.08
4. Relational Modeling	1.000	1.000	1.000	1.000	1.000	1.000	1.000
5. SFY10 Adjusted Claim Cost	$ 25.17	$ 41.90	$ 38.25	$ 24.45	$ 47.85	$ 29.76	$ 32.08
6. Claim Cost Trend Factor	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%
7. SFY12 Trended Base Claim Cost	$ 26.24	$ 43.68	$ 39.87	$ 25.49	$ 49.88	$ 31.02	$ 33.44
8. PPC	$ 0.30	$ 1.29	$ 0.13	$ 0.14	$ 0.16	$ 0.54	$ 0.55
9. Copay Adjustment	$ (0.17)	$ (0.17)	$ (0.17)	$ (0.17)	$ (0.17)	$ (0.17)	$ (0.17)
10. 1st 72 Hours	$ 0.01	$ 0.18	$ 0.02	$ 0.01	$ 0.05	$ 0.11	$ 0.09
11. Provider Fee Schedule (Rate) Reduction - 4/1/2011	$ (0.99)	$ (1.56)	$ (1.62)	$ (0.89)	$ (1.62)	$ (0.98)	$ (1.13)
12. Provider Fee Schedule (Rate) Reduction - 10/1/2011	$ (1.07)	$ (1.86)	$ (1.67)	$ (0.99)	$ (1.92)	$ (1.20)	$ (1.33)
13. Respite Hour Reduction	$ (0.00)	$ (0.00)	$ (0.01)	$ -	$ (0.00)	$ (0.00)	$ (0.00)
14. SFY12 Claim Cost With Above Adjustments	$ 24.32	$ 41.56	$ 36.55	$ 23.58	$ 46.37	$ 29.32	$ 31.45
15. Penetration Factor	1.068	1.107	1.076	1.081	1.077	1.067	1.079
16. Post Penetration Factor PMPM	$ 25.97	$ 46.00	$ 39.32	$ 25.48	$ 49.92	$ 31.29	$ 33.94
17. Acuity Factor	0.988	0.988	0.988	0.988	0.988	0.988	0.988
18. Base SFY12 Claim Costs	$ 25.66	$ 45.45	$ 38.84	$ 25.17	$ 49.33	$ 30.92	$ 33.53
19. Interpretive Services Administrative Load	0.45%	0.45%	0.45%	0.45%	0.45%	0.45%	0.45%
20. Non-Interpretive Services Administrative Load	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
21. 10/1/2011 Capitation Rates	$ 28.34	$ 50.19	$ 42.90	$ 27.80	$ 54.47	$ 34.14	$ 37.03
22. 7/1/2011 Capitation Rates	$ 27.81	$ 48.72	$ 42.06	$ 27.13	$ 53.20	$ 33.42	$ 36.16
23. % Change	1.9%	3.0%	2.0%	2.4%	2.4%	2.2%	2.4%

Statewide TXIX Rate for Non-CMDP Children

RBHA	Col. 1 Proj. 9 mos. Eligibility Member Months	Final Estimate Col. 2 Proposed 10/1 Rates	Col. 1 x Col. 2 Total Dollars
Cenpatico 3	195,915	$ 32.47	$ 6,361,586
CPSA	785,609	$ 45.38	$ 35,649,229
Cenpatico 2	217,543	$ 42.10	$ 9,158,426
NARBHA	687,799	$ 35.18	$ 24,199,979
Cenpatico 4	270,325	$ 46.81	$ 12,655,064
Magellan	3,317,303	$ 29.09	$ 96,500,196
Tribes			$ 20,295,725
Subtotal	5,474,494		$ 204,820,205
BHS Administration/R/C of 3.46%			$ 7,340,139
Total with BHS Administration/R/C			$ 212,160,344
Statewide Capitation Rate			$ 38.75

Statewide TXIX Rate for CMDP Children

RBHA	Col. 1 Proj. 9 mos. Eligibility Member Months	Final Estimate Col. 2 Proposed 10/1 Rates	Col. 1 x Col. 2 Total Dollars
Cenpatico 3	2,313	$ 1,468.80	$ 3,397,337
CPSA	20,012	$ 1,153.57	$ 23,085,273
Cenpatico 2	1,076	$ 1,099.41	$ 1,182,970
NARBHA	7,105	$ 1,511.70	$ 10,740,617
Cenpatico 4	6,160	$ 680.88	$ 4,194,191
Magellan	55,339	$ 679.44	$ 37,599,339
Tribes			$ 8,793,172
Subtotal	92,005		$ 88,992,899
BHS Administration/R/C of 3.46%			$ 3,189,237
Total with BHS Administration/R/C			$ 92,182,136
Statewide Capitation Rate			$ 1,001.93

Statewide TXIX Rate for SMI

RBHA	Col. 1 Proj. 9 mos. Eligibility Member Months	Final Estimate Col. 2 Proposed 10/1 Rates	Col. 1 x Col. 2 Total Dollars
Cenpatico 3	223,137	$ 48.60	$ 10,843,833
CPSA	863,858	$ 65.74	$ 56,789,858
Cenpatico 2	219,423	$ 33.36	$ 7,320,298
NARBHA	810,100	$ 42.57	$ 34,485,321
Cenpatico 4	267,290	$ 47.09	$ 12,586,210
Magellan	2,680,292	$ 94.94	$ 254,461,515
Tribes			$ 6,211,773
Subtotal	5,064,100		$ 382,698,808
BHS Administration/R/C of 3.46%			$ 13,714,772
Total with BHS Administration/R/C			$ 396,413,580
Statewide Capitation Rate			$ 78.28

Statewide TXIX Rate for GMH/SA

RBHA	Col. 1 Proj. 9 mos. Eligibility Member Months	Final Estimate Col. 2 Proposed 10/1 Rates	Col. 1 x Col. 2 Total Dollars
Cenpatico 3	223,137	$ 28.34	$ 6,322,859
CPSA	863,858	$ 50.19	$ 43,354,103
Cenpatico 2	219,423	$ 42.90	$ 9,412,510
NARBHA	810,100	$ 27.80	$ 22,518,884
Cenpatico 4	267,290	$ 54.47	$ 14,559,744
Magellan	2,680,292	$ 34.14	$ 91,509,596
Tribes			$ 14,764,874
Subtotal	5,064,100		$ 202,442,570
BHS Administration/R/C of 3.46%			$ 7,254,932
Total with BHS Administration/R/C			$ 209,697,502
Statewide Capitation Rate			$ 41.41

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.

	Statewide Rates 7/1/2011 Rates	Statewide Rates 10/1/2011 Rates	9 Month Projected MMs	9 Month Projected Expenditures 7/1/2011 Rates	9 Month Projected Expenditures 10/1/2011 Rates	Percent Change
TXIX						
Children	$ 57.85	$ 54.67	5,566,499	$ 322,002,604	$ 304,342,480	-5.5%
SMI	$ 70.11	$ 78.28	5,064,100	$ 355,053,780	$ 396,413,580	11.6%
GMH/SA	$ 40.35	$ 41.41	5,064,100	$ 204,336,444	$ 209,697,502	2.6%
Total				**$ 881,392,828**	**$ 910,453,562**	**3.3%**

	Statewide Rates 7/1/2011 Rates	Statewide Rates 10/1/2011 Rates	9 Month Projected MMs	9 Month Projected Expenditures 7/1/2011 Rates	9 Month Projected Expenditures 10/1/2011 Rates	Percent Change
TXIX Children						
Non-CMDP Children	$ 40.95	$ 38.75	5,474,494	$ 224,174,852	$ 212,160,344	-5.4%
CMDP Children	$ 1,063.29	$ 1,001.93	92,005	$ 97,827,752	$ 92,182,136	-5.8%
Total	**$ 57.85**	**$ 54.67**	**5,566,499**	**$ 322,002,604**	**$ 304,342,480**	**-5.5%**

Title XXI	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	Magellan	Total
1. SFY10 Member Months	17,489	71,182	23,475	62,793	21,268	321,958	518,165
2. T-19 SFY12 Claim Costs	$ 41.62	$ 70.34	$ 43.11	$ 42.13	$ 53.16	$ 35.32	$ 42.26
3. Penetration Factor	0.475	0.475	0.475	0.515	0.475	0.475	0.480
4. Base SFY12 Claim Costs	$ 19.78	$ 33.43	$ 20.48	$ 21.69	$ 25.26	$ 16.79	$ 20.28
5. Interpretive Services Administrative Load	1.18%	1.18%	1.18%	1.18%	1.18%	1.18%	1.18%
6. Non-Interpretive Services Administrative Load	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
7. 10/1/2011 Capitation Rates	$ 22.02	$ 37.22	$ 22.81	$ 24.14	$ 28.13	$ 18.69	$ 22.58
8. 7/1/2011 Capitation Rates	$ 23.10	$ 39.07	$ 24.01	$ 25.34	$ 29.41	$ 19.54	$ 23.65
9. Change in Rates	-4.7%	-4.7%	-5.0%	-4.7%	-4.4%	-4.3%	-4.5%

Statewide TXXI Rate

RBHA	Col. 1 Proj. 9 mos. Eligibility Member Months	Final Estimate Col. 2 Proposed 10/1 Rates	Col. 1 x Col. 2 Total Dollars
Cenpatico 3	3,997	$ 22.02	$ 88,004
CPSA	15,291	$ 37.22	$ 569,076
Cenpatico 2	5,457	$ 22.81	$ 124,449
NARBHA	12,260	$ 24.14	$ 296,007
Cenpatico 4	5,003	$ 28.13	$ 140,711
Magellan	70,650	$ 18.69	$ 1,320,296
Tribes			$ 1,173,639
Subtotal	112,658		$ 3,712,182
BHS Administration/R/C of 3.46%			$ 133,033
Total with BHS Administration/R/C			$ 3,845,215
Statewide Capitation Rate			$ 34.13

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.

	Statewide Rates		9 Month	9 Month Projected Expenditures		Percent
	7/1/2011 Rates	10/1/2011 Rates	Projected MMs	7/1/2011 Rates	10/1/2011 Rates	Change
TXXI	$ 35.09	$ 34.13	112,658	$ 3,953,465	$ 3,845,215	-2.7%

Mike Nordstrom
Partner

Government Human Services Consulting
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6500
mike.nordstrom@mercer.com
www.mercer.com

MERCER

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.

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

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.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Non-CMDP	($0.02)	($0.07)	($0.07)	($0.05)	($0.04)	($0.01)	($0.03)
CMDP	($1.10)	($0.54)	($1.17)	($1.64)	($0.35)	($0.11)	($0.38)
SMI	($0.00)	($0.00)	($0.00)	($0.00)	($0.02)	($0.00)	($0.00)
GMH/SA	($0.00)	($0.00)	($0.01)	($0.00)	($0.00)	($0.00)	($0.00)

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.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
SMI	1.161	1.158	1.101	1.162	1.156	1.144	1.148
GMH/SA	1.068	1.107	1.076	1.081	1.077	1.067	1.079

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.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
GMH/SA	0.988	0.988	0.988	0.988	0.988	0.988	0.988

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.

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

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

Michael E. Nordstrom, ASA, MAAA
Partner

MEN/vh

Enclosures

Copy:
Sundee Easter, Mercer
Mike Miner, Mercer
Rob O'Brien, Mercer

STATE OF ARIZONA

Joint Legislative Budget Committee

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1716 WEST ADAMS
PHOENIX, ARIZONA 85007

PHONE (602) 926-5491

FAX (602) 926-5416

http://www.azleg.gov/jlbc.htm

HOUSE OF REPRESENTATIVES

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ANNA TOVAR

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 1

Arizona University System
FY 2011 and FY 2012 General Fund and Tuition/Fee Revenues
(in Millions)

	FY 2011	FY 2012 Before Tuition Increase	FY 2012 After Tuition Increase
Appropriations			
General Fund	$ 873.1	$ 665.5 1/	$ 665.5 1/
Tuition/Fees	771.8	799.3	910.1
Subtotal	**$1,644.9**	**$1,464.8**	**$1,575.6**
Non-Appropriated			
Tuition/Fees	$ 486.5	$ 509.6	$ 577.1
TOTAL	**$2,131.4**	**$1,974.4**	**$2,152.7**

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 –

(Continued)

Table 2

Arizona University System
FY 2012 Appropriated Tuition/Fee Revenues by Campus

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

Table 3

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

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

Table 4

Arizona University System
Use of Additional Appropriated Tuition/Fee Revenues by Campus

		$ in Millions
ASU	Fringe Benefits Costs	$16.5
	Backfill for Prior Year General Fund Cuts	26.9
	Backfill for ARRA Expiration	29.3
	College/School Support from Special Program Fees	7.8
	Enrollment Growth Support to Colleges	5.0
	Faculty & Other Academic Investments	0.7
	Online/Extended Campus Support	5.3
	UTO Support from Mandatory Student Technology Fee	0.1
	Subtotal	**$91.6**
NAU	Undergraduate Enrollment Growth & Course Support	$ 7.2
	Health Care Program Continuation/Expansion	2.0
	College/School Support from Special Program Fees	0.5
	Student Advising	0.5
	Library Technology Replacement & Online Materials	0.6
	Student Recruitment & Retention	0.3
	Subtotal	**$11.1**
UA	Enrollment Growth & General Education Support	$4.9
	College of Medicine Tucson Marginal Tuition	0.3
	College of Medicine Phoenix Marginal Tuition	0.9
	Support to Colleges from Differential Tuition Revenue	2.0
	Subtotal	**$8.1**
	TOTAL	**$110.8**

(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.

RS/LMc:mt
Attachment

Attachment 1

Arizona University System
FY 2011 to FY 2012 Undergraduate Tuition and Fees Changes [1/]

	Resident [2/]				Non-Resident [2/]			
	FY 2011	**FY 2012**	**$ Change**	**% Change**	**FY 2011**	**FY 2012**	**$ Change**	**% Change**
ASU-Tempe/DPC	$6,942 to $8,128	$8,355 to $9,716	$1,413 to $1,588	20.4% to 19.5%	$20,592	$22,315	$1,723	8.4%
ASU-East/West	$6,708 to $8,128	$8,077 to $9,716	$1,369 to $1,588	20.4% to 19.5%	$20,592	$22,315	$1,723	8.4%
NAU	$5,848 to $7,667	$5,960 to $8,824	$112 to $1,157	1.9% to 15.1%	$16,946 to $20,067	$17,058 to $20,179	$112	0.6%
NAU-Distance Ed.	$4,500 to $6,131	$4,803 to $6,317	$303 to $186	6.7% to 3.0%	$13,887 to $17,264	$14,283 to $17,650	$396 to $386	2.9% to 2.2%
UofA-Main/HSC	$8,237	$10,035	$1,798	21.8%	$24,596	$25,494	$898	3.7%
UofA-South	$6,652	$7,941	$1,289	19.4%	$24,382	$25,071	$689	2.8%

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.

Arizona Board of Regents
2020 North Central Avenue, Suite 230
Phoenix, AZ 85004-4593
602-229-2500
Fax 602-229-2555
www.azregents.edu

Arizona State University *Northern Arizona University* *University of Arizona*

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

	STATE COLLECTIONS		
	AS REPORTED IN THE 2011-12 INITIAL ALL FUNDS OPERATING BUDGET REPORT	2011-12 APPROPRIATIONS REPORT	CHANGE
Arizona State University Tempe	453,894,300	371,241,700	82,652,600
Arizona State University Polytechnic	37,572,700	34,635,000	2,937,700
Arizona State University West	32,278,700	26,261,700	6,017,000
TOTAL ASU	523,745,700	432,138,400	91,607,300
Northern Arizona University	97,738,900	86,613,200	11,125,700
University of Arizona	247,503,000	255,188,900	-7,685,900
University of Arizona Health Sciences Center	41,154,000	25,381,800	15,772,200
TOTAL UA	288,657,000	280,570,700	8,086,300
TOTAL	910,141,600	799,322,300	110,819,300

Reconciliation to FY 2012 Appropriations Report

Total State Collections	910,141,600	799,322,300	110,819,300
Total Locally Retained Collections	577,126,900	509,639,900	67,487,000
To Be Allocated Tuition Collections (Table 5 - FY 2012 Appropriations Report)	*0*	*177,067,300*	*-177,067,300*
Total Estimated Tuition Revenue	**1,487,268,500**	**1,486,029,500**	**1,239,000**
			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

	STATE COLLECTIONS	LOCAL COLLECTIONS
Base Collections As Reported in the Initial All Funds Report	$453,894,300	$255,630,000
Collections As Reported in the FY12 Appropriations Report	371,241,700	
Base Collections Increase/(Decrease) from FY12 Appropriations Report	**82,652,600**	**255,630,000**
ALLOCATIONS BY PROGRAM		
All Programs		
Fringe Benefits Costs	13,217,800	
Instruction		
Backfill State Appropriation Reduction	22,872,700	
Backfill Expiration of Stimulus Funding	29,365,400	
College/School Support from Special Program Fees/Differential Tuition	7,577,300	
Enrollment Growth Support to Colleges	4,132,400	
Faculty and Other Academic Investments		10,025,200
ASU Online/Extended Campus Support	5,333,900	
ASU Online Expense		7,200,100
Local Account Operating Support		2,842,300
Organized Research		
Local Account Operating Support		0
Public Service		
Local Account Operating Support		301,300
Academic Support		
Enrollment and Transfer Student Services Support		
UTO Support from Mandatory Student Technology Fee	153,100	
Local Operating Budget Support		312,000
Student Services		
Local Account Operating Support		1,901,300
Institutional Support		
Local Account Operating Support		431,200
Scholarships/Fellowships/Financial Aid		
Financial Aid		171,503,400
Auxiliary Enterprises		
Auxiliary Operating Support		3,931,600
Debt Service		
Debt Service Payments		43,181,600
Plant Funds		
Minor Capital Projects		14,000,000
	$82,652,600	**$255,630,000**

2011-12

LOCALLY RETAINED COLLECTIONS

ARIZONA STATE UNIVERSITY - TEMPE/DOWNTOWN CAMPUS

		FINAL BUDGET 2010-11	INCREASE/ (DECREASE)	INITIAL BUDGET 2011-12
DESIGNATED	American English and Cultural Program - ITA	87,500		87,500
	Associated Students - ASASU	859,100		859,100
	Child & Family Services	62,700		62,700
	Constituent Advocacy	124,500		124,500
	Distance Learning Technology	970,200		970,200
	Environmental Health & Safety	182,200		182,200
	Federal Direct Loan Administration	144,000		144,000
	Fine Arts Activities	307,900		307,900
	Fine Arts Theatres	605,900		605,900
	Forensics	106,100		106,100
	Graduate Support Program	371,800		371,800
	Interpreters Theatre	35,700		35,700
	KASR Radio	22,000		22,000
	Library Support	312,000		312,000
	Local Support for Academic/Administrative Units	0	10,025,200	10,025,200
	Mona Plummer Aquatic Center	141,900		141,900
	Online Partnership/Management Payments	0	7,200,100	7,200,100
	Registrar Services	0		0
	Special Events	176,800		176,800
	Student Affairs Initiatives	228,800		228,800
	Student Financial Assistance Administration	351,000		351,000
	Summer Bridge Program	335,200		335,200
	Teaching Assistant Tuition Benefit	11,624,000	2,669,700	14,293,700
	University Minority Culture Program	113,800		113,800
	University Recycling Program	83,000		83,000
	Employee Benefit Adjustments/Contingencies	166,000		166,000
	Subtotal Designated	17,412,100	19,895,000	37,307,100
AUXILIARY	ASU Public Events	0		0
	Intercollegiate Athletics	1,975,300		1,975,300
	Memorial Union	1,129,200		1,129,200
	Recreational Sports	827,100		827,100
	Student Media	0		0
	Subtotal Auxiliary	3,931,600	0	3,931,600
	Total Operating Funds	21,343,700	19,895,000	41,238,700
FIN AID	Regents Financial Aid Set-Aside	59,060,300	15,032,500	74,092,800
	Other F.A.- Institutional FA	60,106,300	11,106,300	71,212,600
	Other Financial Aid - CRESMET/CONACY/NEEP	308,200		308,200
	CONACYT Fellowship Program	122,500		122,500
	Other F.A.- Graduate Scholars Program	507,600		507,600
	Graduate Fellowship Program	1,522,700		1,522,700
	Law Scholarhips	1,500,000		1,500,000
	Student Technology Fee FA Set-Aside	1,243,700	32,500	1,276,200
	Other F.A - School of Engineering Program	60,000	800,000	860,000
	College of Business FA Set-Aside	712,400	16,900	729,300
	Walter Cronkite School of Journalism FA Set-Aside	44,900	32,100	77,000
	School of Engineering FA Set-Aside	499,800	236,700	736,500
	College of Law FA Set-Aside	1,226,200	180,500	1,406,700
	College of Liberal Arts FA Set-Aside	84,300	1,903,700	1,988,000
	College of Nursing FA Set-Aside	412,900	352,100	765,000
	University College FA Set-Aside	97,700	6,900	104,600
	Subtotal Financial Aid	127,509,500	29,700,200	157,209,700
	Plant Fund - Minor Capital Projects/Energy Management Contrac	14,000,000	3,506,000	17,506,000
	Debt Service	36,057,100	3,618,500	39,675,600
TOTAL LOCAL RETENTION		198,910,300	56,719,700	255,630,000

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

	STATE COLLECTIONS	LOCAL COLLECTIONS
Base Collections As Reported in the Initial All Funds Report	$37,572,700	$13,365,500
Collections As Reported in the FY12 Appropriations Report	34,635,000	
Base Collections Increase/(Decrease) from FY11 Appropriations Report	2,937,700	13,365,500
ALLOCATIONS BY PROGRAM		
All Programs		
Fringe Benefit Costs	778,400	
Instruction		
Backfill State Appropriation Reduction	1,378,800	
Enrollment Growth Support to Colleges	780,500	
ASU Online Expense		1,080,700
Local Account Operating Support		119,000
Organized Research		
n/a		0
Public Service		
Local Account Operating Support		11,000
Academic Support		
Academic Advising, Enrollment Services and Classroom Support		
Local Account Operating Support		28,400
Student Services		
Local Account Operating Support		1,325,700
Institutional Support		
Local Account Operating Support		38,000
Scholarships/Fellowships/Financial Aid		
Financial Aid		10,508,900
Auxiliary Enterprises		
Auxiliary Operating Support		253,800
Debt Service		
Debt Service Payments		0
Plant Funds		
Minor Capital Projects		0
	$2,937,700	$13,365,500

2011-12

LOCALLY RETAINED COLLECTIONS

ARIZONA STATE UNIVERSITY - POLYTECHNIC CAMPUS

		FINAL BUDGET 2010-11	INCREASE/ (DECREASE)	INITIAL BUDGET 2011-12
DESIGNATED	AECP - International Teaching Assistants	8,000		8,000
	Associated Students - ASU	78,200		78,200
	Career Services	48,900		48,900
	Child & Family Services	5,700		5,700
	Constituent Advocacy	11,000		11,000
	Dining Services Management	38,000		38,000
	Distance Learning Technology	88,300		88,300
	Environmental Health & Safety	16,100		16,100
	Federal Direct Loan Administration	13,100		13,100
	Graduate Support Program	16,200		16,200
	Intercampus Shuttle Services	36,000		36,000
	Learning Communities	6,500		6,500
	Library Support	28,400		28,400
	Online Partnership/Management Payments	0	1,080,700	1,080,700
	Student Affairs Initiatives	20,800		20,800
	Student Counseling	5,000		5,000
	Student Financial Assistance Administration	31,900		31,900
	Student Health Services	225,000		225,000
	Student Organizations	21,000		21,000
	Student Orientation and Forums	10,600		10,600
	Student Recreation/Intramurals	301,500		301,500
	Student Union/Activities	558,700		558,700
	Undergraduate Business Program	0		0
	Teaching Assistant Tuition Benefit	253,900	80,800	334,700
	University Minority Cultural Program	5,300		5,300
	University Recycling Program	7,300		7,300
	Employee Benefit Adjustments/Contingencies	14,600		14,600
	Subtotal Designated	1,850,000	1,161,500	3,011,500
AUXILIARY	Intercollegiate Athletics	179,800		179,800
	Subtotal Auxiliary	179,800	0	179,800
	Total Operating Funds	2,029,800	1,161,500	3,191,300
FIN AID	Regents Financial Aid Set-Aside	6,450,400	811,800	7,262,200
	Other F.A.- Institutional FA	2,562,300	227,500	2,789,800
	Other Financial Aid - CRESMET/CONACY/NEEP	28,000		28,000
	CONACYT Fellowship Program	5,400		5,400
	Other F.A.- Graduate Scholars Program	22,200		22,200
	Graduate Fellowship Program	66,600		66,600
	Subtotal Financial Aid	9,134,900	1,039,300	10,174,200
	Plant Fund			
	Debt Service			
TOTAL LOCAL RETENTION		11,164,700	2,200,800	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

	STATE COLLECTIONS	LOCAL COLLECTIONS
Base Collections As Reported in the Initial All Funds Report	$32,278,700	$24,236,400
Collections As Reported in the FY12 Appropriations Report	26,261,700	
Base Collections Increase/(Decrease) from FY12 Appropriations Report	**6,017,000**	**24,236,400**
ALLOCATIONS BY PROGRAM		
All Programs		
Fringe Benefit Costs	2,503,800	
Instruction		
Backfill State Appropriation Reduction	2,687,600	
Enrollment Growth Support to Colleges	94,000	
Faculty and Other Academic Investments	731,600	
ASU Online Expense		1,008,900
Local Account Operating Support		255,600
Organized Research		
n/a		0
Public Service		
Local Account Operating Support		34,500
Academic Support		
Local Account Operating Support		35,700
Student Services		
Local Account Operating Support		260,400
Institutional Support		
Local Account Operating Support		55,200
Scholarships/Fellowships/Financial Aid		
Financial Aid		21,360,300
Auxiliary Enterprises		
Auxiliary Operating Support		225,800
Debt Service		
Debt Service Payments		0
Plant Funds		
Minor Capital Projects		1,000,000
	$6,017,000	**$24,236,400**

2011-12

LOCALLY RETAINED COLLECTIONS

ARIZONA STATE UNIVERSITY - WEST CAMPUS

		FINAL BUDGET 2010-11	INCREASE/ (DECREASE)	INITIAL BUDGET 2011-12
DESIGNATED	Academic Affairs	5,200		5,200
	AECP - International Teaching Assistants	10,000		10,000
	Alumni Association - Devil's West	0		0
	Arts & Sciences Support	0		0
	Associated Students - ASU	98,300		98,300
	ASU West Commencement	15,000		15,000
	ASUW Film Series	0		0
	ASUW Fine Arts Program	60,000		60,000
	Campus Environment Team	4,800		4,800
	Child and Family Services	7,200		7,200
	Child Development & Visual Perception Lab	0		0
	Constituent Advocacy	14,500		14,500
	Distance Learning Technology	111,000		111,000
	Environmental Health & Safety	21,300		21,300
	Federal Direct Loan Administration	16,500		16,500
	Graduate Support Program	51,400		51,400
	Honors College	3,000		3,000
	Library Support	35,700		35,700
	Online Partnership/Management Payments	0	1,008,900	1,008,900
	Special Events	20,000		20,000
	Student Affairs Initiative	26,200		26,200
	Student Financial Assistance Administration	40,100		40,100
	University Minority Cultural Program	7,100		7,100
	University Recycling Program	9,700		9,700
	Student Government	65,000		65,000
	Teaching Assistant Tuition Benefit	234,100	175,600	409,700
	Employee Benefit Adjustments/Contingencies	19,400		19,400
	Subtotal Designated	875,500	1,184,500	2,060,000
AUXILIARY	Intercollegiate Athletics	225,800		225,800
	Subtotal Auxiliary	225,800	0	225,800
	Total Operating Funds	1,101,300	1,184,500	2,285,800
FIN AID	Regents Financial Aid Set-Aside	7,596,500	713,200	8,309,700
	Other F.A.- Institutional FA	7,364,100	643,700	8,007,800
	Other F.A. - CRESMET/CONACYT/NEEP	35,200		35,200
	Other FA - Teach for America	4,300,000		4,300,000
	Other F.A. - Graduate Scholars Program	70,200		70,200
	Business Financial Aid Set-Aside	0		0
	CONACYT Fellowship Program	17,000		17,000
	Graduate Fellowship Program	210,700		210,700
	Subtotal Financial Aid	19,593,700	1,356,900	20,950,600
	Plant Fund	1,000,000	0	1,000,000
	Debt Service/Lease Purchase	0	0	0
TOTAL LOCAL RETENTION		21,695,000	2,541,400	24,236,400

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

	STATE COLLECTIONS	LOCAL COLLECTIONS
Base Collections As Reported in the FY12 Initial All Funds Report	$97,738,900	$73,758,900
Collections As Reported in the FY12 JLBC Appropriations Report	86,613,200	
Base Collections Increase/(Decrease) from FY11 Appropriations Report	11,125,700	73,758,900
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
	$11,125,700	$73,758,900

2011-12

LOCALLY RETAINED COLLECTIONS

NORTHERN ARIZONA UNIVERSITY

		FINAL BUDGET 2010-11	INCREASE/ (DECREASE)	INITIAL BUDGET 2011-12
DESIGNATED	ADA Services	180,000	70,000	250,000
	Art Gallery	10,900		10,900
	Child Care	43,900		43,900
	Employee Benefit Adjustments/Contingencies	100,000		100,000
	Financial Aid Office Operations	337,300		337,300
	Graduate Assistant Tuition Remission	1,747,400	552,600	2,300,000
	Graduate Operations Support	0		0
	Honors Forum	11,200		11,200
	International Studies	260,000	(260,000)	0
	NAU-Yuma	19,900		19,900
	Operations - Credit Card Fees	500,800		500,800
	Performing Arts Series	39,900		39,900
	Performing Arts - Music	58,900		58,900
	Registrar Office	112,400		112,400
	School of Comm Student Radio, Cable & Forensics	30,200		30,200
	Special Events	28,300		28,300
	Stateside Expansion	1,000,000	800,000	1,800,000
	Student Activities	285,100		285,100
	SUN (Student Union Network)	65,800		65,800
	Program Fee - MAdm	349,400	(349,400)	0
	Program Fee - MBA	124,500	(124,500)	0
	Program Fee - MEng	0		0
	Program Fee - MSN	7,500	(7,500)	0
	Program Fee - Doctor of Physical Therapy (DPT)	124,500	(124,500)	0
	Program Fee - Bachelor BA	149,400	(149,400)	0
	Program Fee - Bachelor Dental Hygiene	29,100	(29,100)	0
	Program Fee - BSN	31,500	(31,500)	0
	Program Fee - UG Engineering/Construction	130,300	(130,300)	0
	Yuma Enrollment Support	183,500		183,500
		0		0
	Subtotal Designated	5,961,700	216,400	6,178,100
AUXILIARY				
	Associated Students (ASNAU)	0		0
	Intercollegiate Athletics	1,665,500		1,665,500
	Intramurals/Recreation	63,700		63,700
	Skydome	207,900		207,900
	Mountain Campus ID	13,200		13,200
	Subtotal Auxiliary	1,950,300	0	1,950,300
	Total Operating Funds	7,912,000	216,400	8,128,400
FIN AID				
	Regents Financial Aid Set-Aside	18,200,000	1,900,000	20,100,000
	Set-Aside for Academically Meritorious AZ Residents	15,000		15,000
	DPT- FA Set-Aside	25,500	2,900	28,400
	MAdm - FA Set-Aside	71,600	(6,100)	65,500
	MBA - FA Set-Aside	25,500	5,400	30,900
	MEng - FA Set-Aside	0		0
	MSN - FA Set-Aside	1,500	2,800	4,300
	BBA - FA Set-Aside	30,600	40,000	70,600
	BDH - FA Set-Aside	6,000	(1,700)	4,300
	BSN - FA Set-Aside	6,500	5,400	11,900
	UG Eng/Constrct FA Set-Aside	26,700	15,800	42,500
	GIS - FA Set-Aside	0		0
	UG Honors Program		12,800	12,800
	Student Financial Aid Match (SSIG, SEOG, etc.)	318,400		318,400
	Other Financial Aid - (formerly tuition waivers)	24,000,000	5,100,000	29,100,000
	Subtotal Financial Aid	42,727,300	7,077,300	49,804,600
	Plant Fund	1,378,200	0	1,378,200
	Debt Service	16,400,700	(1,953,000)	14,447,700
TOTAL LOCAL RETENTION		68,418,200	5,340,700	73,758,900

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

	STATE COLLECTIONS	LOCAL COLLECTIONS
Base Collections as Reported in the Initial All Funds Report	$288,657,000	$210,136,100
Collections As Reported in the FY12 Appropriations Report	280,570,700	
Base Collections Increase/(Decrease) from FY12 Appropriations Report	8,086,300	210,136,100
ALLOCATION BY PROGRAM		
Instruction		
Enrollment Growth and General Education Support	4,899,700	
College of Medicine Tucson Marginal Tuition	316,700	
College of Medicine Phoenix Marginal Tuition	912,400	
Support to Colleges from Differential Tuition Revenue	1,957,500	
Local Account Operating Support		9,435,900
Organized Research		
n/a		
Public Service		
Local Account Operating Support		40,300
Academic Support		
Local Account Operating Support		3,910,900
Student Services		
Local Account Operating Support		2,812,500
Institutional Support		
Local Account Operating Support		8,463,500
Scholarships/Fellowships/Financial Aid		
ABOR Financial Aid Set Aside		34,823,900
Student Aid Awards (formerly waivers)		98,285,800
Graduate Assistant Tuition Remission		12,208,500
All Other Financial Aid		9,558,500
Auxiliary Enterprises		
n/a		
Debt Service		
Debt Service Payments		28,472,400
Plant Funds		
Minor Capital Project Set Aside		2,123,900
	$8,086,300	$210,136,100

2011-12

LOCALLY RETAINED COLLECTIONS

UNIVERSITY OF ARIZONA

		FINAL BUDGET 2010-11	INCREASE/ (DECREASE)	INITIAL BUDGET 2011-12
DESIGNATED	AZ Outreach College	0	7,500,000	7,500,000
	College of Nursing - Accelerated BSN	390,000	(208,000)	182,000
	Eller Evening MBA	907,100	674,500	1,581,600
	Multicultural Affairs and Student Success (M.A.S.S.)			
	Admissions Recruiting	501,500	263,800	765,300
	Early Outreach	36,500	200	36,700
	Minority Student Recruitment	180,300	1,300	181,600
	Minority Summer Institute for Writing	13,200	100	13,300
	FM Student Recreation O&M	252,800	2,200	255,000
	Graduate Teaching Assistants -Tuition Remission	8,393,400	3,815,100	12,208,500
	Graduate College	153,100	189,400	342,500
	Graduate and Professional Student Council	63,300	100	63,400
	Honors College	80,000	248,500	328,500
	Interpreting/Disabilities (ADA)	164,200		164,200
	Law College Special Fee	1,367,400	988,600	2,356,000
	Learning Disabilities Mandated Services	128,700	1,000	129,700
	Library Acquisitions	461,200		461,200
	Merchant Credit Card Banking Fees	1,733,200	800,000	2,533,200
	Special Education Fee Waiver	564,500	(564,500)	0
	Student Child Care Voucher Program	83,100		83,100
	Student Travel Support	53,000		53,000
	Student Services	191,300	3,200	194,500
	Sustainability Projects	600,000		600,000
	UA Presents	0	40,300	40,300
	Utility Costs Reserve	2,624,800	(700)	2,624,100
	Subtotal Designated	18,942,600	13,755,100	32,697,700
AUXILIARY	Associated Students (ASUA)	274,700	3,200	277,900
	Campus Health Service	3,532,400	(1,328,100)	2,204,300
	Campus Recreation and Intramurals	444,000	(398,500)	45,500
	Student-Related Activities	24,800	200	25,000
	Student Programs	369,300	109,700	479,000
	Student Union	1,134,000	8,200	1,142,200
	Subtotal Auxiliary	5,779,200	(1,605,300)	4,173,900
	Total Operating Funds	24,721,800	12,149,800	36,871,600
FIN AID	Regents Financial Aid Set-Aside	32,033,300	2,394,600	34,427,900
	UAS (SV) - Regents FA Set-Aside	385,300	10,700	396,000
	Undergraduate Scholars	3,619,300		3,619,300
	Other Financial Aid - (formerly tuition waivers)	89,577,100	8,708,700	98,285,800
	Architecture (Grad) FA Set-Aside	33,100	2,300	35,400
	Architecture (UG) FA Set-Aside	71,200	(5,700)	65,500
	COM FA Set-Aside	883,600	64,900	948,500
	COM - Phoenix - FA Set-Aside	326,500	121,900	448,400
	Eller MBA FA Set-Aside	425,200	16,800	442,000
	Eller (UG) FA Set-Aside	265,200	40,800	306,000
	Engineering (UG) FA Set-Aside	142,300	68,500	210,800
	FCS FA Set-Aside	38,000	(1,800)	36,200
	Fine Arts FA Set-Aside	92,600		92,600
	Geography FA Set-Aside	1,800	1,300	3,100
	Graduate Scholarships	635,200		635,200
	Honor College FA Set-Aside	191,300	37,200	228,500
	Journalism (UG) FA Set-Aside	19,100	(4,700)	14,400
	Journalism (Grad) FA Set-Aside	2,100		2,100
	Law School FA Set-Aside	909,500	229,500	1,139,000
	Linguistic Differential Tuition FA	0	200	200
	Nursing Accl BSN FA Set-Aside	158,800	11,200	170,000
	Nursing (Grad) Special Fee FA	27,500	4,800	32,300
	Nursing (UG) Special Fee FA	73,100	(16,600)	56,500
	Optical Science FA Set-Aside	32,000		32,000
	Pharmacy FA Set-Aside	746,300	1,800	748,100
	Philosophy FA Set-Aside	300	1,000	1,300
	Planning FA Set-Aside	8,500	2,100	10,600
	Public Health FA Set-Aside	13,600	6,800	20,400
	Public Health FA Set-Aside (UG)	1,700	1,700	3,400
	School of Art - FA Set-Aside	11,200		11,200
	School of Dance - FA Set-Aside	1,000		1,000
	School of Music - FA Set-Aside	20,400		20,400
	SGAPP - MPA Differential Tuition FA	20,300	8,900	29,200
	SGAPP - (UG) Differential Tuition FA	29,300	14,000	43,300
	SIRLS FA Set-Aside	166,300	(14,700)	151,600
	Subtotal Financial Aid	130,962,000	11,706,200	142,668,200
	Plant Funds/Utility Infrastructure	2,123,900	0	2,123,900
	Debt Service	28,472,400	0	28,472,400
TOTAL LOCAL RETENTION		186,280,100	23,856,000	210,136,100

STATE OF ARIZONA

Joint Legislative Budget Committee

STATE SENATE

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STEVEN B. YARBROUGH

1716 WEST ADAMS
PHOENIX, ARIZONA 85007

PHONE (602) 926-5491

FAX (602) 926-5416

http://www.azleg.gov/jlbc.htm

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ANNA TOVAR

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

TOM HORNE
ATTORNEY GENERAL

OFFICE OF THE ARIZONA ATTORNEY GENERAL
PUBLIC ADVOCACY DIVISION
CONSUMER PROTECTION & ADVOCACY SECTION

DENA ROSEN EPSTEIN
SECTION CHIEF COUNSEL
DIRECT PHONE NO. (602) 542-7717
DENA.EPSTEIN@AZAG.GOV

August 22, 2011

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[1]* 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,

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.

#2052397

STATE OF ARIZONA

Joint Legislative Budget Committee

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ANNA TOVAR

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.

(Continued)

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

Arizona Department of Health Services

Office of the Director

150 N. 18th Avenue, Suite 500
Phoenix, Arizona 85007-3247
(602) 542-1025
(602) 542-1062 FAX
Internet: www.azdhs.gov

JANICE K. BREWER, GOVERNOR
WILL HUMBLE, DIRECTOR

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.

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, Goveror's Office of Strategic Planning and Budgeting