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FINAL

June 6, 2012

Subject: Behavioral Health Services July 2012 through September 2013 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) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates for each of its Regional Behavioral Health Authorities (RBHAs) for the contract period 2013 (CP13) time period. The CP13 time period begins on July 1, 2012 and ends on September 30, 2013. Rates were developed for the Title XIX program. The overall statewide Title XIX weighted capitation rate change was -0.9% when compared to the BHS capitation rates effective October 1, 2011 through June 30, 2012.

Provider Reimbursement and Other Benefit Adjustments

ADHS intends to update these capitation rates effective January 1, 2013 to include changes to the physician fee schedule resulting from health care reform requirements and the change in requirement for Part D plans to cover benzodiazepines on their formularies and barbiturates to treat epilepsy, cancer or a chronic mental health disorder for dual eligible members effective January 1, 2013. In addition, ADHS may, at that time, also update the rates for provider increases due to a 2% behavioral health provider reimbursement increase appropriated by the Arizona Legislature to begin April 1, 2013. For clarity, none of the potential adjustments described within this paragraph are included in what follows.

I. Introduction/Background

There are four RBHAs for which actuarially sound capitation rates were developed, covering six geographic service areas. They include:

RBHA	Area(s) Served
Community Partnership of Southern Arizona (CPSA)	Pima County
Cenpatico Behavioral Health of Arizona (Cenpatico 2, Cenpatico 3 and Cenpatico 4)	Yuma, LaPaz, Graham, Greenlee, Santa Cruz, Cochise, Pinal and Gila Counties
Northern Arizona Regional Behavioral Health Authority (NARBHA)	Mohave, Coconino, Apache, Navajo and Yavapai Counties
Magellan Health Services (MHS)	Maricopa County

II. Overview of Rate Setting Methodology

Mercer assisted BHS with the development of a risk-based capitation rate setting methodology for RBHAs that complies with the Centers for Medicare & Medicaid Services (CMS) requirements and the regulations under the Balanced Budget Act of 1997. As it relates to the rate setting methodology checklist and Medicaid managed care regulations (42 CFR 438.6) effective August 13, 2002, CMS requires that capitation rates be "actuarially sound." CMS defines actuarially sound rates as meeting the following criteria:

- Have been developed in accordance with generally accepted actuarial principles and practices.
- Are appropriate for the populations to be covered and the services to be furnished under the contract.
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

Actuarially sound capitation rates were developed for the contract period July 1, 2012, through September 30, 2013. Mercer has utilized actuarially sound principles and practices in the development of these capitation rates.

The goal of capitation rate development is to take experience that is available during the base period and convert that experience, using actuarial principles, into appropriate baseline data for the contract period. Once the baseline data is determined, adjustments including trend, any unusual service utilization changes and provisions for administration and underwriting profit/risk/contingency are applied in order to determine actuarially sound capitation rates. The capitation rate development process was divided into the following steps:

1. Calculate base data:
   - Collect, analyze and adjust state fiscal year 2011 (SFY11) RBHA financial statements, as well as SFY11 RBHA-submitted encounter data.
   - Utilize actual member months from SFY11 and the adjusted SFY11 total claim costs to calculate adjusted SFY11 per-member-per-month (PMPM) values.
   - Apply any budget-neutral relational modeling factors (see Section IV).
2. Calculate CP13 actuarially sound rates:
   - Apply trend factors to bring base SFY11 claim costs forward to CP13.
   - Adjust for any changes occurring between the base period and prior to the contract period (such as the October 1, 2011 provider fee schedule (rate) reduction, respite hour reduction, best for babies, 340B pricing, psych consults and emergency room (ER) transportation).
   - Apply a penetration adjustment (if necessary) to account for changes in behavioral health penetration rates.
   - Certify actuarial equivalence of the populations.
   - Add provisions for administration and underwriting profit/risk/contingency.

The end result of this capitation rate development process, completed jointly by BHS and Mercer, is actuarially sound capitation rates for CP13.

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

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Children – non-CMDP	$39.58	$48.26	$41.57	$35.84	$49.12	$28.91	$34.59
Children – CMDP	$1,636.44	$1,303.88	$1,096.99	$1,585.40	$721.82	$615.58	$893.10
Seriously mentally ill (SMI)	$45.22	$73.74	$34.88	$45.42	$44.93	$89.11	$72.26
General mental health/substance abuse (GMH/SA)	$31.70	$53.45	$49.23	$29.40	$56.70	$35.78	$39.28

The rate development schedules are shown in Attachment A.

III. Base Data

The base data consisted of adjusted financial statements from all RBHAs for the July 1, 2010 through June 30, 2011 time period. The financial statement expenses were reduced by 0.5% for assumed RBHA increased efficiency and effectiveness in the management of service utilization. This 0.5% reduction decreased total SFY11 base costs by $5,037,242.

Four changes, which took place during SFY11, needed to be incorporated within the SFY11 base costs since their financial impact was not fully reflected within the RBHA SFY11 financial statements due to the timing of these changes. These four changes are listed below.

First 72 Hours Coverage

Effective October 1, 2010, the first 72 hours of inpatient coverage became the financial responsibility of the contracted RBHAs. Historically, the Arizona Health Care Cost Containment System (AHCCCS) acute care health plans had been financially responsible for the first 72 hours of inpatient coverage. This adjustment represents a shift of dollars from the AHCCCS program contractors to the RBHAs. No material child dollars (non-CMDP or CMDP) were found in the data, so no adjustment was made for those populations.

The PMPM increases applied to the SMI and GMH/SA populations for this utilization adjustment are as follows:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
SMI	$0.00	$0.02	$0.00	$0.00	$0.00	$0.01	$0.01
GMH/SA	$0.00	$0.04	$0.01	$0.00	$0.01	$0.03	$0.02

The statewide impact to the base data due to this adjustment is an increase of approximately $239,563.

Prior Period Coverage

Effective October 1, 2010, AHCCCS acute care health plans were no longer responsible for behavioral health services provided during the prior period coverage timeframe. These services became the responsibility of ADHS and are now part of the BHS capitation rate. The PMPM increases applied to the GMH/SA population for this utilization adjustment are as follows (this change also affected non-CMDP children, but the amount is negligible):

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
GMH/SA	$0.07	$0.32	$0.03	$0.04	$0.04	$0.13	$0.14

The statewide impact to the base data due to this adjustment is an increase of approximately $1,042,072.

Copayments

Effective October 1, 2010, AHCCCS implemented hard (mandatory) copayments on certain services for adults in the Transitional Medical Assistance (TMA) Program. In addition, AHCCCS modified soft copayments (non-mandatory) for adults in the non-TMA/non-Title XIX Waiver Group (TWG) population. These copayments were minimal, and no adjustments were made as a result. However, effective November 1, 2010, AHCCCS reinstated hard copays for adults in the Medical Spend Down Program (MED) and non-MED populations (collectively TWG), after a long-standing court injunction on TWG copays was lifted. There are a myriad of exclusions for adult copays related to both specific services and specific members as detailed in the contract.

The PMPM decreases applied for this unit cost adjustment are as follows:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
GMH/SA	($0.06)	($0.06)	($0.06)	($0.06)	($0.06)	($0.06)	($0.06)

The statewide impact to the base data due to this unit cost adjustment is a decrease of approximately $425,511.

4/1/2011 Provider Fee Schedule (Rate) Reduction

BHS implemented a 5% provider rate decrease effective April 1, 2011 for all provider types, excluding inpatient and pharmacy. The 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	($1.20)	($1.28)	($1.22)	($0.99)	($1.41)	($0.77)	($0.94)
CMDP	($62.47)	($40.53)	($31.52)	($45.30)	($19.53)	($16.71)	($26.17)
SMI	($1.01)	($1.41)	($0.82)	($0.84)	($0.99)	($2.19)	($1.65)
GMH/SA	($0.58)	($1.17)	($1.27)	($0.67)	($1.45)	($0.64)	($0.81)

The statewide impact to the base data due to the April 1, 2011 provider rate reduction is a decrease of approximately $28,117,461.

Encounter Data Completeness

ADHS/BHS has for several years stressed the importance of timely and accurate encounter data submission by the RBHAs for capitation rate setting (among other valuable uses). An adjustment to the base data was made which incorporated the relative level of completeness of the encounter data submitted by the RBHAs. Two geographic service area (GSAs) were found to have relatively low encounter data dollar amounts submitted. As a result, a 0.98 factor was applied to one of these GSA's adjusted base data and a 0.99 factor was applied to the other GSA's adjusted base data. This adjustment was uniform across all four populations. No encounter data adjustments were made to the remaining four GSAs. The total statewide dollar impact of the adjustment was a decrease of $6,194,921.

"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 fee-for-service (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 Arizona Department of Health Services/Arizona Licensing Services/Office of Behavioral Health Licensure, in lieu of services in an inpatient non-specialty hospital, with unit cost savings of approximately 48.3% and total yearly cost savings of approximately $2.6 million. These savings are already reflected in the base data.

The following table shows the base data PMPM for in lieu of services by RBHA:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS
Title XIX	$0.06	$0.10	$0.02	$0.09	$0.07	$0.14

BHS has periodically performed reviews of the RBHA-submitted data and has determined that the data does not include any other non-covered services.

IV. Budget Neutral Relational Modeling

While, in aggregate, the population and adjusted financial data were fully credible in the base period, there were distortions between one RBHA's costs in different GSAs in the CMDP and GMH/SA populations that required additional smoothing. Mercer applied budget neutral relational modeling to account for these variances. No dollars were gained or lost through this process.

V. Trend

Trend is an estimate of the change in the cost of providing a specific set of benefits over time, resulting from both unit cost (price) and utilization changes. Trend factors are used to estimate the cost of providing services in some future year (contract year) based on the cost incurred in a prior (base) year.

In order to determine actuarially sound capitation rates, Mercer projected the base data forward to reflect utilization and unit cost trend by population. Mercer calculated trends from the historical financial and encounter data. The historical data that was used as a basis for trend development did not appropriately reflect the costs related to the separate service utilization and fee schedule changes described below. Mercer also utilized its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs. Although the trends were developed using several years of historical data, the trend factors were applied only to the SFY11 base data, bringing it forward 25.5 months to CP13. The following trend estimates were used for the capitation rates.

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Children — non-CMDP	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%
Children — CMDP	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
SMI	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
GMH/SA	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%

VI. Service Utilization and Fee Schedule Changes

BHS and Mercer reviewed changes made subsequent to the base data period, SFY11, which would unusually affect service utilization or provider unit cost. It was determined that due to expected changes in utilization or unit cost of specific existing covered services, prospective adjustments would need to be made to account for these changes.

Prospective Adjustments

The following adjustments have taken place after the SFY11 base data period.

October 1, 2011 Provider Fee Schedule (Rate) Reduction

BHS implemented a 5% provider rate decrease effective October 1, 2011 for all provider types, excluding pharmacy. The 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	($1.72)	($1.89)	($1.69)	($1.46)	($2.05)	($1.13)	($1.38)
CMDP	($89.02)	($56.22)	($46.64)	($67.97)	($26.47)	($24.73)	($37.61)
SMI	($1.54)	($2.38)	($1.28)	($1.47)	($1.54)	($3.30)	($2.56)
GMH/SA	($0.89)	($1.81)	($1.82)	($1.02)	($2.19)	($1.14)	($1.31)

The estimated impact due to this adjustment is a decrease of $47,418,335 for the CP13 period.

This adjustment was also applied within the development of the October 1, 2011 rates. When the estimated impact from the October 1, 2011 rates is adjusted to be on a 15-month basis, the incremental change from last year's estimated impact to this year's estimated impact is an increase of approximately $5.6 million (i.e., less projected dollars are being taken out of the rates for CP13).

Respite Hour Reduction

Effective October 1, 2011, the number of respite hours for adults and children receiving BHS services was 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	($0.04)	($0.06)	($0.02)	($0.06)	($0.03)	($0.02)	($0.03)
CMDP	($1.26)	($0.66)	$0.00	($1.57)	($0.22)	($0.12)	($0.39)
SMI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
GMH/SA	$0.00	$0.00	$0.00	$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 $327,303 for CP13.

This adjustment was also applied within the development of the October 1, 2011 rates. When the estimated impact from the October 1, 2011 rates is adjusted to be on a 15-month basis, the incremental change from last year's estimated impact to this year's estimated impact is a decrease of approximately $3,000 (i.e., more projected dollars are being taken out of the rates for CP13).

Best for Babies

Effective July 1, 2011, the Best for Babies initiative was introduced in Maricopa County. The Best for Babies/Court Team Project is a national initiative sponsored by Zero to Three, targeting children from birth to three years of age involved with dependency court. This project is based on best practices in infant mental health to improve outcomes for young dependent children exposed to trauma and separation through greater judicial oversight of their services and time to permanency. Timely assessment and services for both children and parents, emotional care of infants in foster care, addressing health issues and developmental delays, frequent visitation which supports security and skill building for parents and improving child-centered court procedures are all emphasized in the national initiative. This initiative only affects capitation rates for Maricopa County. The cost of this initiative results in an increase to the capitation rates of $3,154,930 for the CP13 contract period.

The PMPM increases only apply to the CMDP population and are as follows:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
CMDP	$0.00	$0.00	$0.00	$0.00	$0.00	$23.48	$13.65

340B Pricing

Beginning in April 2012, the RBHAs began reimbursing claims for 340B drugs, consistent with the requirements in AHCCCS Rule A.A.C. R9-22-710 C. In general, this provision requires that claims for drugs identified on the 340 B pricing file dispensed by federally qualified health centers (FQHCs) and FQHC Look Alike pharmacies be reimbursed at the lesser of the actual acquisition cost or the 340 B ceiling price, plus a dispensing fee listed in the AHCCCS capped FFS schedule. For more detail regarding reimbursement of 340B drugs, please refer to the AHCCCS Rule. The statewide impact due to this adjustment is a decrease of approximately $332,071 for the CP13 contract period.

The PMPM impacts applied to the TXIX populations due to this unit cost adjustment are as follows:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Non-CMDP	$0.00	($0.02)	$0.00	($0.01)	($0.12)	$0.00	($0.01)
CMDP	($0.01)	($0.20)	$0.00	($0.08)	($0.97)	$0.00	($0.12)
SMI	$0.00	($0.04)	$0.00	($0.01)	($0.11)	$0.00	($0.01)
GMH/SA	$0.00	($0.03)	$0.00	($0.01)	($0.21)	$0.00	($0.02)

Psych Consults

Effective at the start of the CP13 contract period, the RBHAs are responsible for payment of medically necessary psychiatric consultations and evaluations provided to acute care members in inpatient facilities in medical/surgical beds regardless of the bed or floor where the member is placed, including emergency departments, even if the member is being treated for other co-morbid physical conditions. Historically, the AHCCCS Acute Health Plans were financially responsible for these psychiatric consultations/evaluations. This adjustment represents a shift of dollars from the AHCCCS Acute Health Plans to the RBHAs. The statewide impact due to this adjustment is an increase of $336,683 for the CP13 contract period.

The PMPM increases as a result of this adjustment are as follows (this adjustment applies to the CMDP children, SMI and GMH/SA populations):

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
CMDP	$0.00	$0.01	$0.00	$0.03	$0.02	$0.01	$0.01
SMI	$0.01	$0.03	$0.00	$0.01	$0.01	$0.04	$0.03
GMH/SA	$0.01	$0.01	$0.00	$0.00	$0.02	$0.03	$0.02

ER Transportation

Effective July 1, 2012, the AHCCCS Acute Health Plans will pay for all emergency transportation for a behavioral health member, unless the emergency transport is to a behavioral health facility. Historically, the RBHAs were financially responsible for emergency transportation for a behavioral health member. This adjustment represents a shift of dollars out of the RBHAs and into the AHCCCS Acute Health Plans. The statewide impact due to this adjustment is a decrease of $511,049 for the CP13 contract period.

The PMPM increases as a result of this adjustment are as follows (this adjustment applies to the CMDP children, SMI and GMH/SA populations):

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS	Statewide
Non-CMDP	($0.01)	$0.00	($0.09)	$0.00	($0.10)	($0.01)	($0.02)
CMDP	($0.28)	($0.04)	($1.58)	($0.10)	($1.20)	($0.11)	($0.18)
SMI	($0.02)	($0.01)	($0.07)	$0.00	($0.12)	($0.04)	($0.03)
GMH/SA	$0.00	$0.00	($0.06)	$0.00	($0.06)	($0.01)	($0.01)

VII. Behavioral Health Penetration Adjustment

An adjustment was made in the rate development to account for any projected increases or decreases in penetration rate of members utilizing BHS services compared to the entire AHCCCS population for each RBHA and population, since BHS capitation rates are paid for each AHCCCS eligible individual. For the SMI and GMH/SA populations, a phase out of the MED program began on May 1, 2011, and an enrollment freeze in the childless adult population began on July 8, 2011. 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.

For the children populations (non-CMDP and CMDP), the most recent observed penetration rate trends were analyzed and estimated for the contract period. The increases/decreases observed in these populations have contributed to the overall projected increase/decrease in utilization for these populations and are reflected in overall claim costs. These changes were applied as a penetration adjustment to the CP13 PMPM claim costs and represent a difference due to increased or decreased penetration (those enrolled compared to those eligible). This component of the rate development does not adjust for any normal unit cost or utilization trends, which are handled above.

The penetration factors that were applied are as follows:

Population	Cenpatico 3	CPSA	Cenpatico 2	NARBHA	Cenpatico 4	MHS
Children – non-CMDP	0.992	1.043	1.061	1.045	0.998	1.011
Children – CMDP	0.952	1.008	1.036	1.024	0.988	1.006
SMI	1.205	1.203	1.144	1.207	1.200	1.188
GMH/SA	1.085	1.124	1.093	1.098	1.093	1.084

The statewide impact to the program for the penetration adjustment is an increase of approximately $105,599,690 for the CP13 period.

This adjustment was also applied within the development of the October 1, 2011 rates. When the estimated impact from the October 1, 2011 rates is adjusted to be on a 15-month basis, the incremental change from last year's estimated impact to this year's estimated impact is an increase of approximately $8.2 million (i.e., more projected dollars are being added to the rates for CP13).

VIII. Interpretive Services Administration

The actuarially sound capitation rates developed include provisions for RBHA interpretive services administration. Interpretive services are covered by TXIX and are provided by the RBHAs to TXIX members. The interpretive services administrative factors were determined based on aggregate RBHA SFY11 financial experience. A consistent percentage by population was applied to each RBHA.

Population	Children – non-CMDP	Children -CMDP	SMI	GMH/SA
All TXIX	2.09%	0.20%	0.29%	0.58%

The statewide impact to the program for interpretive services is an increase of approximately $9,642,221.

This adjustment was also applied within the development of the October 1, 2011 rates. When the estimated impact from the October 1, 2011 rates is adjusted to be on a 15-month basis, the incremental change from last year's estimated impact to this year's estimated impact is an

increase of approximately $1.6 million (i.e., more projected dollars are being added to the rates for CP13).

IX. Administration and Underwriting Profit/Risk/Contingency

The actuarially sound capitation rates developed include provisions for RBHA administration. Mercer used its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs in determining appropriate loads for administration and underwriting profit/risk/contingency. Mercer also reviewed current RBHA financial reports. The component for administration and underwriting profit/risk/contingency is calculated as a percentage of the final capitation rate. A 9% load was added across all populations, which is the same as was applied to the SFY12 rates.

X. Risk Corridors and Performance Incentive

BHS has in place a risk corridor arrangement with the RBHAs that provides motivation for the RBHAs to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for the RBHAs to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

The proposed CP13 BHS risk corridor approach provides for gain/loss risk-sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. The RBHAs' contracts also provide for a potential 1% performance incentive. In Mercer's professional opinion, the risk corridor and performance incentive methodologies utilized by BHS are actuarially sound.

XI. Tribal FFS Claims Estimate

Mercer received and reviewed projected CP13 tribal claims data from BHS. Effective April 1, 2012, AHCCCS assumed responsibility for payment of tribal claims for non-emergency medical transportation and emergency medical transportation services for specific members with diagnosis code 799.9. This adjustment represents a shift of dollars from the BHS capitation rates to AHCCCS in the amount of $46 million. Based on the information received from BHS and the change in transportation responsibility, Mercer and BHS project that Title XIX tribal claim costs for CP13 will be approximately $62 million.

XII. BHS Administration/Risk/Contingency

AHCCCS has placed BHS administration at financial risk for the provision of BHS covered services for CP13. Accordingly, the capitation rates were developed to include compensation to BHS for the cost of ensuring the delivery of all BHS covered services. The capitation rates paid to BHS include a 3.67% load, which was negotiated between AHCCCS and BHS administration. The

load represents 2% premium tax and a 1.67% administrative load for the BHS costs of ensuring the efficient delivery of services in a managed care environment.

XIII. Development of Statewide Capitation Rates

Statewide capitation rates were developed by blending the CP13 capitation rates for each RBHA using projected CP13 member months, the estimated dollar amount of CP13 tribal claims and the administrative percentage add-on component for BHS.

The statewide capitation rates are shown in Attachment B.

XIV. CMS Rate Setting Checklist (July 22, 2003)

Item #/Description	Reference to Certification Letter Language
AA.1.0 Overview of rate setting methodology	Sections I – II
AA.1.1 Actuarial certification	Section XV
AA.1.2 Projection of expenditures	Attachment C
AA.1.3 Procurement, prior approval and rate setting	Contract
AA.1.5 Risk contracts	Contract
AA.1.6 Limit on payment to other providers	Contract
AA.1.7 Rate modifications	N/A
AA.2.0 Base year utilization and cost data	Sections III and IV
AA.2.1 Medicaid eligibles under the contract	Section III
AA.2.2 Dual eligibles	Contract
AA.2.3 Spend-down	N/A
AA.2.4 State Plan services only	Section III
AA.2.5 Services that may be covered by a capitated entity out of contract savings	N/A
AA.3.0 Adjustments to the base year data	Sections III – XII
AA.3.1 Benefit differences	N/A
AA.3.2 Administrative cost allowance calculations	Sections VIII, IX and XII
AA.3.3 Special populations' adjustments	Section XI
AA.3.4 Eligibility adjustments	N/A
AA.3.5 DSH payments	N/A

Item #/Description	Reference to Certification Letter Language
AA.3.6 Third party liability	Contract
AA.3.7 Copayments, coinsurance and deductibles in capitated rates	Contract
AA.3.8 Graduate medical education	N/A
AA.3.9 FQHC and RHC reimbursement	Contract
AA.3.10 Medical cost/trend inflation	Section V
AA.3.11 Utilization adjustments	Sections VI and VII
AA.3.12 Utilization and cost assumptions	N/A
AA.3.13 Post-eligibility treatment of income	N/A
AA.3.14 Incomplete data adjustment	Section III
AA.4.0 Establish rate category groupings	Section II
AA.4.1 Age	Section II
AA.4.2 Gender	N/A
AA.4.3 Locality/Region	Section I
AA.4.4 Eligibility categories	Section II
AA.5.0 Data smoothing	Section III
AA.5.1 Special populations and assessment of the data for distortions	Section IV
AA.5.2 Cost-neutral data smoothing adjustment	Section IV
AA.5.3 Risk adjustment	N/A
AA.6.0 Stop loss, reinsurance or risk-sharing arrangements	Section X
AA.6.1 Commercial reinsurance	N/A
AA.6.2 Simple stop loss program	N/A
AA.6.3 Risk corridor program	Section X
AA.7.0 Incentive arrangements	Section X

XV. Certification of Final Rates

In preparing the rates shown above and 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 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 CMS requirements under 42 CFR 438.6(c) and in 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 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.

Sincerely,

Michael E. Nordstrom, ASA, MAAA
Partner

MEN:beb

Enclosures

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