PROGRAM AND FEE SCHEDULE CHANGES

Introduction

This document contains historical and future program changes as well as historical changes to the AHCCCS Fee For Service rates to aid in capitation rate development and/or review.

Program Changes

These program changes individually had a statewide impact to rates of at least $150,000, not specific to the population in this Request for Proposal (RFP). Some of the program changes will only impact those Offerors bidding on Children's Rehabilitative Services (CRS). Additional information can be found in the actuarial certifications which are posted on the Arizona Health Care Cost Containment System (AHCCCS) website. Note: Fiscal impact estimates in the actuarial certifications will be specific to the program addressed by the certification and not necessarily specific to the population targeted in this RFP.

There are three Attachments which contain the impacts for the majority of the program change items described below.

- Attachment A: impacts for Acute Care Services (prospective only)
- Attachment B: impacts for Behavioral Health Services (BHS)
- Attachment C: impacts for Children's Rehabilitative Services (CRS)

Attachment A should be used by those Offerors bidding on the Acute Care and/or CRS program(s). Attachments B and C only pertain to those Offerors bidding on CRS. Any program change item described below that is not displayed in the Attachments is noted in Table I or II as Not Applicable (NA) and the Offeror should review the detailed description for that program change for more information.

The program change items in the Attachments are displayed on a per member per month (PMPM) basis. For Attachment A they are displayed by geographical service area (GSA) and risk group; for Attachments B and C they are displayed on a statewide basis. The program change items are grouped by the suggested service matrix categories that they impact. For Attachment A, if a program change impacts multiple service matrix categories, the adjustments were made to appropriately "split" to the suggested service matrix categories; this adjustment was not made for Attachments B and C. The program change PMPMs in the Attachments are estimates that were computed at the time the capitation rates were updated for the specific program change. Although they have not been re-calculated for actual experience, AHCCCS reserves the right to adjust the PMPMs used in the rate ranges. If AHCCCS makes an adjustment to reflect actual experience, that information will be noted along with the rate ranges.

Table I – Program Change Items Considered in Development of Capitation Rate Ranges Published with RFP

Program Change Item	Effective Date	Suggested Service Matrix Categories Impacted	Acute Care Bid	CRS Bid	Attachment
Dental Sealants	May 2009	Dental	X	X	A
DDD State Only Transfers	May 2009	Other Professional	X		A
High Needs Children	July 2009	Case Management Services		X	B
Transition Age Youth	July 2009	Case Management Services and All Other Support Services		X	B
H1N1	October 2009	Physician	X	X	NA
Outlier Hospital Reimbursement Rates	October 2009	Hospital Inpatient	X	X	A
Dental Service Changes	October 2009	Dental	X	X	A
Medical Management Changes	October 2009	Physician	X	X	A
ADHS Regulated Transportation	October 2009	Transportation	X	X	NA
Elimination of HIFA Parents	October 2009	All	X	X	NA
KidsCare Freeze	January 2010	All	X	X	NA
HPV	July 2010	Physician	X	X	A
Benefit Redesign Change	October 2010	Outpatient, Physician, Other Professional, DME, Dental	X	X	A
Copayments	October 2010	Outpatient, Emergency Room, Physician, Pharmacy	X	X	A
Shift to Ambulatory Surgical Centers	October 2010	Outpatient	X	X	A
First 72 Hours of Coverage	October 2010	Hospital Inpatient	X	X	A
Behavioral Health Services in Prior Period Coverage Timeframe	October 2010	Hospital Inpatient	X	X	NA
Cochlear Implants	October 2010	Physician, DME and Other Professional		X	C
Elimination of MED program	May 2011	All	X	X	NA
Transition of Pediatric Costs	June 2011	Outpatient	X	X	A and C
Best for Babies	July 2011	Treatment Services and All Other Support Services		X	B
Childless Adult Freeze	July 2011	All	X	X	NA
Inpatient Day Limit	October 2011	Hospital Inpatient	X	X	A
Hospital Outliers	October 2011	Hospital Inpatient	X	X	NA
Transportation	October 2011	Transportation	X	X	NA
Outpatient Fee Schedule (OPFS) Rebase	October 2011	Outpatient and Emergency Room	X	X	NA
Hepatitis C	October 2011	Pharmacy	X	X	A
Claims Processing	January 2012	Hospital Inpatient	X	X	A
Family Planning Services	February 2012	Physician	X	X	A
Taxi Copay	April 2012	Transportation	X	X	A
340B Pricing	April 2012	Pharmacy	X	X	A
Psychiatric Consultations	July 2012	Hospital Inpatient	X	X	A
ER Transportation	July 2012	Transportation	X	X	A

Program Change Item	Effective Date	Suggested Service Matrix Categories Impacted	Acute Care Bid	CRS Bid	Attachment
KidsCare II	May 2012	All	X	X	NA
BCCTP	August 2012	All	X		NA
Shift to Ambulatory Surgical Centers	October 2012	Outpatient	X	X	A
Transition of Clinic Services	October 2012	Clinic		X	C
Out of Network QMB Duals	January 2013	Hospital Inpatient, Outpatient and Physician	X	X	A

Table II: Program Change Items NOT Considered in Development of Capitation Rate Ranges Published with RFP, But Will Be Included When Capitation Rates Are Adjusted For 10/01/2013

Program Change Item	Effective Date	Suggested Service Matrix Categories Impacted	Acute Care Bid	CRS Bid	Attachment
Medicare Parity	January 2013	Physician	X	X	NA
Benzodiazepine and Barbiturate Part D	January 2013	Pharmacy	X	X	NA
BHS Provider Rate Change	April 2013	Possibly All		X	NA
Medicare Dual Demonstration	January 2014	All	X		NA
Health Insurer Fees	January 2014	All	X	X	NA
Other Program Changes to be Determined	Multiple	All	X	X	NA

Detailed Descriptions: For Table I Program Change Items

Dental Sealants
AHCCCS no longer covers dental sealants for primary teeth effective May 1, 2009.

Division of Developmental Disabilities (DDD) State Only Transfers
DDD referred all nursing, therapy and other clinical service requests for members under the age of 21 enrolled in the state-only DDD program who are also AHCCCS Acute enrolled members, to the Acute Care program effective May 2009.

High Needs Children
Effective July 1, 2009, the High Needs Children service expansion added additional case managers throughout the State to continue progress towards the goal of one case manager for every fifteen high needs children. Of these case managers, the vast majority were behavioral health technicians and the remainder were behavioral health professionals. Adequate case management was required to coordinate the variety of necessary covered behavioral health services especially for children with complex needs. This adjustment applied to the Non-CMDP and CMDP Child population. This was the last year of this service utilization adjustment.

Transition Age Youth
Effective July, 1, 2009, the Jason K. Settlement Agreement stipulated that class members should have services through age 20. In Arizona, at age 18, young adults enrolled in the public behavioral health system were transferred from the children's system to the adult system. While enrolled in the children's behavioral health system, members had the benefit of a case manager to assist in the service planning and coordination of services and were able to utilize an array of covered services to support them and their families in learning to cope with their behavioral health issues. This settlement allows for these services to be more fully utilized by the individual in the adult system by providing case managers and generalist support services similar to those received in the children's system. This adjustment applied to the Seriously Mentally Impaired (SMI) and GMH/SA population.

H1N1 Influenza
A new influenza A, H1N1, was detected in the U.S. in April 2009. In June 2009, the World Health Organization signaled that a pandemic of H1N1 flu was underway. AHCCCS Contractors urged members to get immunized against H1N1 once the vaccine was available. The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommended that certain groups at highest risk for infection or complications be the initial targets for vaccination. Pregnant women and children were in the initial target group thus it was anticipated that vaccination-related costs would rise in Contract Year Ending (CYE) 10 because they made up a significant portion of the AHCCCS membership. AHCCCS also expected increased utilization for those members infected with H1N1 and those who had flu-like symptoms. This impact is not reflected in the Attachments due to a rerun of the data to review actual impact. AHCCCS estimated a fiscal impact of approximately $15 million for CYE 10. Actual data showed an increase of approximately $2.5 million from CYE 09 to CYE 10 followed by a decrease of approximately $2.5 million from CYE 10 to CYE 11.

Outlier Hospital Reimbursement Rates
This amendment of State law, passed in the 2007 legislative session, changed the methodology for the payment of claims with extraordinary operating costs per day. It stipulated that effective October 1, 2007, AHCCCS should phase in over a three year period the use of the most recent statewide urban and rural average Medicare or Medicare approved cost-to-charge ratios to qualify and pay extraordinary operating costs. October 1, 2009, was the third year of the three-year phase-in. Once fully-phased in, these cost-to-charge ratios would be updated annually. Routine maternity charges were excluded from outlier consideration.

Dental Service Changes
AHCCCS modified the following dental services effective October 1, 2009:

- Eliminated behavior management as a reimbursable dental service.
- Modified some dental radiograph (x-ray) services making them age appropriate.
- Established a maximum age limitation for dental sealants on permanent teeth.

Medical Management Changes
AHCCCS implemented the following medical management changes effective October 1, 2009:

- Established medical necessity criteria for genetic testing.
- Eliminated coverage of allergic immunotherapy (testing, treatment, injections) for adults except where therapy may be lifesaving.
- Adopted more restrictive medical necessity criteria for negative pressure wound therapy.
- Limited somnography to one study per contract year unless clinical circumstances require additional studies.

ADHS Regulated Transportation
State law allowed AHCCCS to reduce the ADHS-regulated transportation rates by 5% effective October 1, 2009. This impact is not reflected in the Attachments. Offerors may consider this adjustment when setting the unit cost trends.

Elimination of Health Insurance Flexibility and Accountability Act (HIFA) Parents
HIFA parents are no longer covered by AHCCCS effective October 1, 2009. This impact is not reflected in the Attachments nor is there any data regarding HIFA parents in the databook. .

KidsCare Freeze
Pursuant to Arizona Revised Statutes (A.R.S.) § 36-2985(A), the AHCCCS Administration instituted an enrollment cap on the KidsCare program due to insufficient funding effective January 1, 2010. Per this statute, no new applications would be processed until such time that the AHCCCS Administration would be able to verify that funding was sufficient and the Governor would agree that the AHCCCS Administration might begin processing new applications. This impact is not reflected in the Attachments. The Offeror may choose to consider how this information impacts its bid.

Human Papillomavirus (HPV) Vaccine Administration
- December 1, 2006: Federal law required states to cover the human papillomavirus (HPV) vaccine as part of the EPSDT benefit package for all females aged 11-20. Contractors are only responsible for the administration costs through age 18, but are responsible for both vaccine and administration expenses above age 18.
- October 1, 2007: AHCCCS also covered the HPV vaccine for women aged 21-26, paying for both the vaccine and administration costs.
- July 1, 2010: The law was revised to include males aged 11-20. Contractors are only responsible for the administration costs through age 18, but are responsible for both vaccine and administration above age 18.
- July 1, 2010: AHCCCS discontinued coverage of this vaccine for women aged 21-26.

Benefit Redesign Change
AHCCCS implemented the following benefit changes for adult members effective October 1, 2010:
- Eliminated coverage of insulin pumps, percussive vests, bone-anchored hearing aids, cochlear implants and orthotics. Supplies, equipment maintenance and repair of component parts remain a covered benefit.
- Eliminated coverage of well visits, microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs.
- Eliminated emergency dental except for medical and surgical oral services, that can be provided by a physician or dentist, when those services would be considered a physician service if furnished by a physician.
- Eliminated services provided by a podiatrist.
- Limited outpatient physical therapy to fifteen visits per contract year.

For adult members with Medicare, AHCCCS continues to pay cost-sharing for Qualified Medicare Beneficiaries (QMB) when the services noted above were covered by Medicare. AHCCCS does not pay cost-sharing for excluded services for non-QMB Medicare members.

Copayments
AHCCCS implemented mandatory copayments on certain services for adults in the Transitional Medical Assistance Program (TMA) effective October 1, 2010. At the same time, AHCCCS reinstated mandatory copays for adults in the AHCCCS Care population. In addition, AHCCCS modified non-mandatory copayments for adults in the non-TMA/non-TWG Title XIX population. There were a myriad of exclusions for adult copays related to both specific services and specific members as detailed in contract.

Shift to Ambulatory Surgical Centers
Capitation rates effective October 1, 2010, included an adjustment to recognize savings that might be generated by transitioning certain procedures that were currently performed in hospital outpatient settings to more cost-effective Ambulatory Surgical Centers (ASC). AHCCCS reviewed the utilization and costs of services that might be performed in both of these outpatient settings and determined the savings that could be realized by shifting 3% of outpatient hospital claims to ASCs.

First 72-Hours Coverage
The first 72 hours of inpatient psychiatric coverage is the financial responsibility of the contracted Regional Behavioral Health Authorities (RBHAs) effective October 1, 2010. Historically, AHCCCS Acute Care Contractors were responsible for payment of these costs.

Behavioral Health Services during the Prior Period Coverage Timeframe
AHCCCS Acute Care Contractors are no longer responsible for behavioral health services provided during the Prior Period Coverage timeframe effective October 1, 2010. These services are the responsibility of the contracted RBHAs. This impact is not reflected in the Attachments since Offerors are not bidding on PPC capitation rates.

Cochlear Implants Expanded Coverage
The standard of care for cochlear implants was expanded to include both ears effective October 1, 2010. Previous to that date, the standard provided for an implant in only one ear.

Elimination of Medical Expense Deduction (MED) Program
As part of the Governor's Medicaid reform plan, enrollment for the MED program was frozen and no new applications were accepted for this category pursuant to the MED Phase-Out Plan approved by the Center for Medicare and Medicaid Services (CMS) effective May 1, 2011. Since eligibility for MED does not exceed six months, the May 1 freeze had the effect of eliminating the MED program by October 1, 2011. There were rare instances in which an MED member's enrollment went slightly beyond September 30, 2011. This impact is not reflected in the Attachments. The Offeror may choose to consider how this information impacts its bid.

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 PMPM impact to the rates.

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. This national initiative emphasizes timely assessment and services for both children and parents, emotional care of infants in foster care, addressing health issues and developmental delays in children, frequent visitation which supports security and skill building for parents and improving child-centered court procedures. This adjustment applies to the CMDP Child population.

Childless Adult (AHCCCS Care) Freeze
As part of the Governor's Medicaid reform plan, effective October 1, 2011, AHCCCS changed the nature of the Childless Adult (AHCCCS Care) program in Arizona from an open-ended entitlement program to one based on available funds. This change provided the State with the flexibility to manage enrollment based on available funding, including adding to enrollment if additional funds were made available. The reform plan included 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, retained their coverage but no new individuals would be made eligible in this category unless additional funding becomes available. The elderly and individuals meeting the federal definition of disability (including SMI members) were transitioned to either the SSI with or without Medicare risk groups. This impact is not reflected in the Attachments, but the table below displays the estimated percentage impact for the Acute Care program on a PMPM basis by risk group and GSA for those risk groups involved.

GSA	SSI	SSIWO	AHCCCS Care
2	2.55%	-0.96%	-0.60%
4	8.57%	-0.43%	-1.01%
6	5.68%	-1.04%	-0.28%
8	4.15%	-0.40%	-0.06%
10	3.04%	-1.71%	-2.32%
12	5.85%	0.25%	-0.83%
14	2.37%	-0.68%	-0.99%

Inpatient Day Limit
As part of the Governor's Medicaid reform plan effective October 1, 2011, AHCCCS would limit 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.
- Treatment for burns and burn late effects at an American College of Surgeons-verified burn center.
- Transplant stays at facilities with specialty contracts with AHCCCS, when paid as part of component pricing.

- Same day admit/discharge services.
- Stays at IHS/638 facilities.

For adult members with Medicare, AHCCCS would continue to pay cost-sharing for QMB dual members when the 25 day limit is reached. AHCCCS does not pay cost-sharing for non-QMB Medicare members for days beyond the 25 day limit.

Hospital Outliers

As part of the Governor's Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, language authorizing inpatient outlier payments would be eliminated and AHCCCS would be 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 included:

- Increased cost thresholds by 5%.
- Reduced CCRs by a percentage equal to a hospital's increase to its charge master based on any/all increases since April 1, 2011.

This impact is not reflected in the Attachments. Offerors may consider this adjustment when setting the unit cost trends.

Transportation

Reductions to transportation rates were effective October 1, 2011, as included in the Governor's Medicaid reform plan and authorized in Laws 2011, Chapter 31. This brought 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 would not be included in AHCCCS' October 1 fee schedule until the following year in order to provide AHCCCS predictability in expenditures. This impact is not reflected in the Attachments. Offerors may consider this adjustment when setting the unit cost trends.

Outpatient Fee Schedule (OPFS) Rebase

Pursuant to Arizona Administrative Code (A.A.C.) R9-22-712.40, which requires that the fee schedule for outpatient hospital reimbursement be rebased every five years, OPFS rates were rebased effective October 1, 2011. The rebase resulted in a variety of changes including, but not limited to:

- Adjustment to the peer group modifiers (specific multipliers to the base payments otherwise payable to certain type of hospitals as described under A.A.C. R9-22-712.35).
- Elimination of separate payment for outpatient observation.
- Change in the grouping methodology to bundle codes per episode of care rather than by calendar date (that is, a single capped fee schedule payment is intended to cover the cost of associated services regardless of whether all the services are provided on one or more days as described under A.A.C. R9-22-712.25).
- Clarification of settings that qualify for payment as outpatient hospital settings.

This impact is not reflected in the Attachments as it was budget neutral.

Hepatitis C

In May 2011, the FDA granted approval for two new drug therapies for hepatitis C (Incivek and Victrelis). Both drugs were made available to AHCCCS members at that time. Since becoming available, utilization of the drug therapies grew steadily until October 2011. It is expected that these therapies will reduce the need for liver transplants for hepatitis C patients.

Claims Processing Standards
Effective January 1, 2012, Contractors were required to adjust their claims processing systems to recognize two cost-saving standards including multiple surgery occurrences and bundled services. When multiple surgeries occur on the same day, the surgery with the lowest cost is valued at 50% of the standard allowed amount for that surgery. Encounter data identified with status code B reflects bundled services where no additional payment is allowed for certain services that are performed together (e.g. anesthesia provided during an outpatient surgery).

Family Planning Devices
Effective February 1, 2012, AHCCCS increased the reimbursement rates for certain family planning services. Rates for two devices, Paragard and Mirena, and for the Essure procedure were adjusted to address providers' costs related to these cost-effective services.

Taxi Copay
Beginning April 1, 2012, Childless Adult (AHCCCS Care) members in Maricopa and Pima counties became subject to a $2 mandatory copayment for taxi services per one-way trip. Mandatory copayments permit taxi providers to deny services due to lack of member payment.

340B Pharmacy Pricing
Effective April 2012, all Contractors were required to reimburse claims for 340B drugs consistent with the requirements in A.A.C. R9-22-710 C. In general, this provision requires that claims for drugs identified on the 340B pricing file dispensed by Federally Qualified Healthcare Centers (FQHCs) and FQHC Look Alike pharmacies be reimbursed at the lesser of: 1) the actual acquisition cost or 2) the 340B ceiling price, plus a dispensing fee listed in the AHCCCS capped fee-for-service (FFS) schedule. For more detail regarding reimbursement of 340B drugs, please refer to A.A.C. R9-22-710 C.

Psychiatric Consultations
Effective July 1, 2012, the RBHAs became responsible for payment for 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. This includes emergency departments, even when the member is being treated for other co-morbid physical conditions. Historically, the Acute Contractors were financially responsible for these psychiatric consultations and evaluations

ER Transportation
Effective July 1, 2012, the Acute Contractors became responsible for payment 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

KidsCare II
On April 6, 2012, CMS approved a new 2012 Waiver Amendment which included funding for KidsCare II. KidsCare II provides coverage to children who have income up to 175% of the federal poverty level (FPL) and meet other eligibility requirements. Coverage for KidsCare II began May 1, 2012. This impact is not reflected in the Attachments. The Offeror may choose to consider how this information impacts its bid.

Breast and Cervical Cancer Treatment Program (BCCTP)
Effective August 2, 2012, a change in Arizona law (A.R.S. § 36.2901.85) modified the definition of an eligible person for BCCTP by expanding the number of providers recognized by the Arizona Well Woman Healthcheck Program (WWHP). Prior to this change, only women who were screened and diagnosed through the WWHP qualified for the BCCTP. The new law allows for all women who meet the qualification of the BCCTP, but are diagnosed outside of WWHP, to enroll in the treatment program provided they meet the BCCTP eligibility requirements. This impact is not reflected in the Attachments, but the table below displays the estimated percentage impact for the Acute Care program on a PMPM basis by risk group and GSA for those risk groups involved.

GSA	TANF 14-44 F	TANF 45+
2	0.10%	2.80%
4	0.08%	2.11%
6	0.07%	2.01%
8	0.07%	2.03%
10	0.10%	2.56%
12	0.09%	2.18%
14	0.09%	2.33%

Shift to Ambulatory Surgical Centers
Capitation rates effective October 1, 2012 include an adjustment to recognize savings that may be generated by transitioning certain procedures that are currently performed in hospital outpatient settings to more cost-effective Ambulatory Surgical Centers (ASC). AHCCCS reviewed the utilization and costs of services that may be performed in both of these outpatient settings, as well as data from ASCs on their available capacity, and determined that such savings could be realized if Contractors increase ASC service utilization by 20% statewide.

Transition of Clinic Services
Effective October 1, 2012, CRS clinic services were moved from St. Joseph's Hospital to a new clinic in Maricopa County. The new clinic, District Medical Group (DMG), began operations October 1, 2012. The contracted clinic fee per visit with DMG is higher than that previously paid to St. Joseph's.

Out of Network QMB Duals
CMS published new guidance regarding Medicare cost-sharing for QMB dual eligible members. The guidance clarifies that AHCCCS Contractors are required to pay cost-sharing for all services provided to QMB dual members regardless of a provider's network status as long as the provider is registered with AHCCCS. This is effective January 5, 2013.

Detailed Descriptions: For Table II Program Change Items

Medicare Parity
Effective January 1, 2013, AHCCCS and its Contractors will be required to implement provisions of the Affordable Care Act of 2010 (ACA) regarding Medicare rate parity. Contractors will utilize the published AHCCCS primary care services fee schedule for AHCCCS identified primary care providers and select primary care services and meet all other requirements as stipulated. CMS has stated its intent to publish a final Rule in November 2012. Due to the short time to implement system and rate changes from a November publishing date, AHCCCS is developing policy decisions based on the proposed Rule. Changes to AHCCCS policy may be necessary based on the final Rule.

Benzodiazepine and Barbiturate Part D Changes
Effective January 1, 2013, Medicare will be required to include barbiturates (limited to treatment for epilepsy, cancer or chronic mental health conditions) and benzodiazepines as part of its Part D benefit. AHCCCS and its Contractors will no longer cover barbiturates used for these conditions or benzodiazepines prescribed for any condition for dual eligible members.

BHS Provider Rate Change
Pursuant to Laws 2012, Chapter 249, monies were appropriated to the Arizona Department of Health Services to increase behavioral health provider reimbursement effective April 1, 2013.

Medicare Dual Demonstration
Approximately 120,000 AHCCCS members are dually eligible for both the Medicaid and Medicare programs. AHCCCS has been concerned about the challenges in achieving quality of care and good health outcomes for dual eligible individuals when they are asked to navigate two complex and distinct systems of care. AHCCCS is working with CMS to implement a Dual Demonstration program beginning January 1, 2014, to find effective ways of integrating these two programs to produce better health care outcomes, streamline the delivery of care, and reduce costs. This Demonstration is pending Federal approval and the Demonstration approach is subject to change until a Memorandum of Understanding (MOU) is finalized and approved by CMS. This is going to be covered in other areas.

Health Insurer Fees
Effective January 1, 2014, the Affordable Care Act will impose an annual fee on the health insurance industry. The fee is to be collected from commercial insurers and Medicaid plans nationwide. The fee due from each insurer or Medicaid plan will be calculated by the Treasury Department and will consider the market share of applicable revenue that each plan receives. Exclusions apply to nonprofit county health plans, small plans with less than $25 million in revenue, and nonprofit entities that receive at least 80% of their revenue from Medicare, Medicaid, SCHIP, or dual-eligible members.

Other Program Changes to be Determined
As AHCCCS learns of additional program changes impacting Contractors' expenditures in CYE 14, cost/savings estimates will be evaluated to determine if capitation rates should be adjusted. These adjustments will occur after the capitation rate ranges are published with this RFP and effective on or after October 1, 2013, as appropriate.

Fee Schedule Changes

To aid in capitation rate development and/or review, the following AHCCCS/BHS fee schedule changes should be considered in addition to the encounter and financial statement information provided in the data supplement. These changes may impact the historical unit cost trends. This table outlines the fee schedule changes by year and service matrix categories. Additional information can be found in the actuarial certifications which are posted on the AHCCCS website:

Contract Year	2008	2009	2009 [1]	2010	2011 [2]	2011	2012
date of rate change	10/1/2007	10/1/2008	2/1/2009 5/1/2009 10/1/2009	10/1/2009	10/1/2010	4/1/2011	10/1/2011
Hospital Inpatient	3.5%	0.0%	0.0%	0.0%	0.0%	-5.0%	-5.0%
Hospital Outpatient	3.5%	0.0%	0.0%	0.0%	0.0%	-5.0%	-5.0%
Nursing Facility	7.0%	4.0%	0.0%	0.0%	0.0%	0.0%	-5.0%
HCBS	6.0%	4.6%	0.0%	-5.0%	-2.5%	-2.5%	-5.0%
Behavioral Health [3]	9.1%	3.8%					
Inpatient Psych			-5.0%	0.0%	0.0%	0.0%	-5.0%
Outpatient Psych			-5.0%	0.0%	0.0%	-5.0%	-5.0%
Tiered per diem at acute hospital			0.0%	0.0%	0.0%	-5.0%	-5.0%
Physician Fee Schedule -- Excluding categories below	-0.3%	-0.3%	-5.0%	0.7%	0.4%	-5.0%	-4.9%
DME/Med Supplies/Orthotics	0.0%	0.8%	-5.0%	-1.1%	-0.13%	-5.0%	-5.0%
Drugs and Injectables	0.0%	1.4%	-5.0%	2.8%	1.26%	0.0%	0.0%
Anesthesia	0.0%	0.0%	-5.0%	0.0%	0.0%	-5.0%	-5.0%
Free-Standing Dialysis	0.0%	0.0%	-5.0%	0.0%	0.0%	-5.0%	-5.0%
Transportation	3.5%						
Emergency Ground (ADHS)		6.9%	0.0%	0.0%	0.0%	-5.0%	-5.0%
Emergency Ground (Tribal, OOS)		4.3%	-5.0%	0.0%	0.0%	-5.0%	-5.0%
Non Emergency Ground		3.4%	-5.0%	0.0%	0.0%	-5.0%	-5.0%
Emergency Air		4.3%	-5.0%	0.0%	0.0%	-5.0%	-5.0%
Dental	5.3%	0.0%	0.0%	-5.0%	0.0%	-5.0%	-5.0%
Hospice	3.8%	2.0%	0.0%	3.0%	4.1%	0.0%	2.3%
ASCs	0.0%	0.0%	0.0%	-5.0%	0.0%	0.0%	-5.0%

[1] The fee schedule was changed effective 2/1/09 but the capitation rates were not changed until 2/1/09 for CMDP, 5/1/09 for Acute, 10/01/09 for EPD and DDD.

[2] The HCBS service matrix category for 10/1/10 reflects a rebase of the HCBS fee schedule.

[3] The behavioral Health changes for 2008 through 2009 are the overall fee schedule impact.

Outlier Hospital Reimbursement Rates (effective October 2009)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ (1.30)	$ (0.04)	$ (0.12)	$ (0.07)	$ (0.18)	$ (0.09)	$ (1.32)	$ (0.45)
GSA 4	$ (1.34)	$ (0.04)	$ (0.13)	$ (0.08)	$ (0.27)	$ (0.13)	$ (1.05)	$ (0.33)
GSA 6	$ (1.31)	$ (0.04)	$ (0.15)	$ (0.09)	$ (0.28)	$ (0.09)	$ (0.96)	$ (0.33)
GSA 8	$ (1.22)	$ (0.04)	$ (0.13)	$ (0.09)	$ (0.36)	$ (0.12)	$ (0.91)	$ (0.38)
GSA 10	$ (3.47)	$ (0.11)	$ (0.35)	$ (0.23)	$ (0.73)	$ (0.28)	$ (2.57)	$ (0.97)
GSA 12	$ (10.57)	$ (0.35)	$ (1.52)	$ (1.03)	$ (3.95)	$ (1.55)	$ (11.01)	$ (5.08)
GSA 14	$ (1.27)	$ (0.04)	$ (0.13)	$ (0.09)	$ (0.25)	$ (0.08)	$ (0.90)	$ (0.37)

First 72 Hours of Coverage (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.08)
GSA 4	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.03)
GSA 6	$ -	$ -	$ (0.31)	$ -	$ -	$ -	$ -	$ -
GSA 8	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.24)
GSA 10	$ -	$ -	$ (0.11)	$ (0.05)	$ -	$ (0.22)	$ (0.21)	$ (0.41)
GSA 12	$ -	$ -	$ (0.05)	$ (0.03)	$ (0.06)	$ (0.19)	$ (0.07)	$ (0.20)
GSA 14	$ -	$ -	$ (0.09)	$ -	$ -	$ -	$ -	$ -

Inpatient Day Limit (effective October 2011)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (1.87)	$ (0.88)	$ (5.45)	$ (0.93)	$ (24.20)	$ (9.98)
GSA 4	$ -	$ -	$ (2.75)	$ (1.60)	$ (11.48)	$ (0.28)	$ (38.11)	$ (19.69)
GSA 6	$ -	$ -	$ (2.35)	$ (1.69)	$ (8.47)	$ (0.53)	$ (29.22)	$ (14.42)
GSA 8	$ -	$ -	$ (2.64)	$ (1.72)	$ (8.68)	$ (0.89)	$ (29.06)	$ (16.64)
GSA 10	$ -	$ -	$ (1.99)	$ (1.24)	$ (6.56)	$ (1.10)	$ (29.04)	$ (11.54)
GSA 12	$ -	$ -	$ (2.60)	$ (1.63)	$ (10.01)	$ (1.51)	$ (31.30)	$ (17.25)
GSA 14	$ -	$ -	$ (2.05)	$ (1.59)	$ (5.77)	$ (1.02)	$ (27.25)	$ (10.39)

Claims Processing (effective January 2012)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)
GSA 4	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)
GSA 6	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)
GSA 8	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)
GSA 10	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)
GSA 12	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)
GSA 14	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)

Psychiatric Consultations (effective July 2012)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ (0.02)	$ -	$ (0.01)
GSA 4	$ -	$ -	$ (0.01)	$ -	$ -	$ (0.03)	$ -	$ (0.02)
GSA 6	$ -	$ -	$ (0.02)	$ -	$ -	$ (0.04)	$ -	$ -
GSA 8	$ -	$ (0.01)	$ -	$ -	$ -	$ (0.07)	$ -	$ (0.04)
GSA 10	$ -	$ -	$ (0.01)	$ -	$ (0.02)	$ (0.05)	$ -	$ (0.04)
GSA 12	$ -	$ (0.00)	$ (0.02)	$ (0.02)	$ (0.02)	$ (0.08)	$ (0.01)	$ (0.06)
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.04)

Out of Network for QMB Duals (effective January 2013)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ 0.55	$ -	$ -
GSA 4	$ -	$ -	$ -	$ -	$ -	$ 3.06	$ -	$ -
GSA 6	$ -	$ -	$ -	$ -	$ -	$ 0.90	$ -	$ -
GSA 8	$ -	$ -	$ -	$ -	$ -	$ 3.20	$ -	$ -
GSA 10	$ -	$ -	$ -	$ -	$ -	$ 0.83	$ -	$ -
GSA 12	$ -	$ -	$ -	$ -	$ -	$ 0.93	$ -	$ -
GSA 14	$ -	$ -	$ -	$ -	$ -	$ 1.18	$ -	$ -

Acute Care\CRS RFP CYE 14
Section B - Program and Fee Schedule Changes
Impacts to Acute Care Services

Attachment A
Outpatient

Benefit Redesign (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ (1.34)	$ -	$ -	$ (0.83)
GSA 4	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.78)
GSA 6	$ -	$ -	$ (0.48)	$ -	$ -	$ -	$ (1.94)	$ (1.80)
GSA 8	$ -	$ -	$ -	$ -	$ -	$ -	$ (1.09)	$ (0.64)
GSA 10	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.32)	$ (0.38)
GSA 12	$ -	$ -	$ (0.14)	$ (0.12)	$ (0.73)	$ (0.07)	$ (0.55)	$ (0.81)
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.26)

Copayments (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (0.01)	$ (0.01)	$ (0.01)	$ -	$ (0.01)	$ -
GSA 4	$ -	$ -	$ (0.01)	$ (0.01)	$ (0.01)	$ -	$ (0.01)	$ -
GSA 6	$ -	$ -	$ (0.01)	$ (0.01)	$ (0.01)	$ -	$ (0.01)	$ -
GSA 8	$ -	$ -	$ (0.01)	$ (0.01)	$ (0.01)	$ -	$ (0.01)	$ -
GSA 10	$ -	$ -	$ (0.01)	$ (0.01)	$ (0.01)	$ -	$ (0.01)	$ -
GSA 12	$ -	$ -	$ (0.01)	$ (0.01)	$ (0.01)	$ -	$ (0.01)	$ -
GSA 14	$ -	$ -	$ (0.01)	$ (0.01)	$ (0.01)	$ -	$ (0.01)	$ -

Ambulatory Surgical Centers Shift (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (0.58)	$ -	$ -	$ -	$ -	$ (0.88)
GSA 4	$ -	$ -	$ (0.38)	$ -	$ -	$ -	$ (0.75)	$ (0.49)
GSA 6	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (1.13)
GSA 8	$ -	$ -	$ (0.44)	$ -	$ -	$ -	$ (1.43)	$ (0.68)
GSA 10	$ -	$ -	$ (0.15)	$ -	$ (0.44)	$ -	$ (0.71)	$ (0.30)
GSA 12	$ -	$ -	$ (0.18)	$ (0.09)	$ (0.40)	$ (0.09)	$ (0.60)	$ (0.38)
GSA 14	$ -	$ -	$ (0.82)	$ -	$ -	$ -	$ -	$ (1.08)

Transition of Pediatric Costs (effective June 2011)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSIW	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 4	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 6	$ -	$ 0.12	$ -	$ -	$ -	$ -	$ -	$ -
GSA 8	$ -	$ 0.09	$ -	$ -	$ -	$ -	$ -	$ -
GSA 10	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 12	$ 0.52	$ 0.36	$ -	$ 0.02	$ -	$ -	$ 0.19	$ -
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Ambulatory Surgical Centers Shift (effective October 2012)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 4	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 6	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 8	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 10	$ -	$ (0.25)	$ (0.80)	$ (0.43)	$ (1.45)	$ (0.55)	$ (2.67)	$ (1.47)
GSA 12	$ (0.47)	$ (0.24)	$ (0.78)	$ (0.42)	$ (1.41)	$ (0.54)	$ (2.60)	$ (1.44)
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Out of Network for QMB Duals (effective January 2013)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ 0.54	$ -	$ -
GSA 4	$ -	$ -	$ -	$ -	$ -	$ 1.56	$ -	$ -
GSA 6	$ -	$ -	$ -	$ -	$ -	$ 0.82	$ -	$ -
GSA 8	$ -	$ -	$ -	$ -	$ -	$ 1.70	$ -	$ -
GSA 10	$ -	$ -	$ -	$ -	$ -	$ 0.64	$ -	$ -
GSA 12	$ -	$ -	$ -	$ -	$ -	$ 0.28	$ -	$ -
GSA 14	$ -	$ -	$ -	$ -	$ -	$ 0.79	$ -	$ -

Copayments (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.07)
GSA 4	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.19)
GSA 6	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.22)
GSA 8	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.30)
GSA 10	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.24)
GSA 12	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.08)
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.08)

Medical Management Changes (effective October 2009)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (0.33)	$ (0.23)	$ (0.55)	$ -	$ (0.59)	$ (0.55)
GSA 4	$ -	$ -	$ (0.30)	$ (0.22)	$ (0.47)	$ -	$ (0.73)	$ (0.69)
GSA 6	$ -	$ -	$ (0.31)	$ -	$ -	$ -	$ (0.77)	$ (0.70)
GSA 8	$ -	$ -	$ (0.28)	$ -	$ -	$ -	$ (0.54)	$ (0.54)
GSA 10	$ -	$ (0.02)	$ (0.30)	$ (0.08)	$ (0.49)	$ -	$ (0.49)	$ (0.54)
GSA 12	$ -	$ (0.02)	$ (0.35)	$ (0.20)	$ (0.66)	$ -	$ (0.60)	$ (0.68)
GSA 14	$ -	$ -	$ (0.24)	$ -	$ -	$ -	$ (0.70)	$ (0.31)

HPV (effective July 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ 0.04	$ (0.25)	$ 0.27	$ -	$ -	$ -	$ -
GSA 4	$ -	$ 0.04	$ (0.25)	$ 0.27	$ -	$ -	$ -	$ -
GSA 6	$ -	$ 0.04	$ (0.25)	$ 0.27	$ -	$ -	$ -	$ -
GSA 8	$ -	$ 0.04	$ (0.25)	$ 0.27	$ -	$ -	$ -	$ -
GSA 10	$ -	$ 0.04	$ (0.25)	$ 0.27	$ -	$ -	$ -	$ -
GSA 12	$ -	$ 0.04	$ (0.25)	$ 0.27	$ -	$ -	$ -	$ -
GSA 14	$ -	$ 0.04	$ (0.25)	$ 0.27	$ -	$ -	$ -	$ -

Benefit Redesign (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (2.66)	$ -	$ -	$ -	$ -	$ (2.52)
GSA 4	$ -	$ -	$ (1.67)	$ -	$ -	$ -	$ -	$ (1.37)
GSA 6	$ -	$ -	$ (2.55)	$ -	$ -	$ -	$ -	$ (2.59)
GSA 8	$ -	$ -	$ (1.95)	$ -	$ -	$ -	$ -	$ (1.66)
GSA 10	$ -	$ -	$ (1.81)	$ -	$ (2.07)	$ -	$ (1.05)	$ (1.63)
GSA 12	$ -	$ -	$ (1.84)	$ (0.46)	$ (2.45)	$ -	$ (1.08)	$ (1.95)
GSA 14	$ -	$ -	$ (3.07)	$ -	$ -	$ -	$ -	$ -

Copayments (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (0.06)	$ (0.06)	$ (0.06)	$ -	$ (0.06)	$ (1.63)
GSA 4	$ -	$ -	$ (0.06)	$ (0.06)	$ (0.06)	$ -	$ (0.06)	$ (1.61)
GSA 6	$ -	$ -	$ (0.06)	$ (0.06)	$ (0.06)	$ -	$ (0.06)	$ (1.57)
GSA 8	$ -	$ -	$ (0.06)	$ (0.06)	$ (0.06)	$ -	$ (0.06)	$ (1.52)
GSA 10	$ -	$ -	$ (0.06)	$ (0.06)	$ (0.06)	$ -	$ (0.06)	$ (1.26)
GSA 12	$ -	$ -	$ (0.06)	$ (0.06)	$ (0.06)	$ -	$ (0.06)	$ (1.56)
GSA 14	$ -	$ -	$ (0.06)	$ (0.06)	$ (0.06)	$ -	$ (0.06)	$ (1.60)

Family Planning Services (February 2012)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ 0.92	$ -	$ -	$ -	$ -	$ -
GSA 4	$ -	$ -	$ 1.06	$ -	$ -	$ -	$ -	$ 0.08
GSA 6	$ -	$ -	$ 1.05	$ -	$ -	$ -	$ -	$ 0.08
GSA 8	$ -	$ -	$ 1.41	$ -	$ -	$ -	$ -	$ 0.16
GSA 10	$ -	$ -	$ 1.10	$ -	$ -	$ -	$ 0.07	$ 0.10
GSA 12	$ -	$ -	$ 1.19	$ -	$ 0.04	$ 0.02	$ 0.05	$ 0.12
GSA 14	$ -	$ -	$ 1.25	$ -	$ -	$ -	$ -	$ 0.09

Out of Network for QMB Duals (effective January 2013)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ 0.72	$ -	$ -
GSA 4	$ -	$ -	$ -	$ -	$ -	$ 3.31	$ -	$ -
GSA 6	$ -	$ -	$ -	$ -	$ -	$ 1.40	$ -	$ -
GSA 8	$ -	$ -	$ -	$ -	$ -	$ 3.86	$ -	$ -
GSA 10	$ -	$ -	$ -	$ -	$ -	$ 1.06	$ -	$ -
GSA 12	$ -	$ -	$ -	$ -	$ -	$ 0.85	$ -	$ -
GSA 14	$ -	$ -	$ -	$ -	$ -	$ 1.81	$ -	$ -

DDD State Only Transfers (effective May 2009)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ 0.04	$ -	$ -	$ -	$ -	$ 1.09	$ -
GSA 4	$ 0.09	$ 0.19	$ -	$ -	$ -	$ -	$ 1.15	$ -
GSA 6	$ 0.20	$ 0.13	$ -	$ -	$ -	$ -	$ 1.71	$ -
GSA 8	$ 0.70	$ 0.39	$ -	$ -	$ -	$ -	$ 1.55	$ -
GSA 10	$ 0.12	$ 0.18	$ -	$ -	$ -	$ -	$ 0.70	$ -
GSA 12	$ 0.10	$ 0.09	$ -	$ -	$ -	$ -	$ 0.59	$ -
GSA 14	$ 0.56	$ 0.21	$ -	$ -	$ -	$ -	$ 1.07	$ -

Benefit Redesign (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (0.17)	$ -	$ (0.61)	$ -	$ (0.76)	$ (0.46)
GSA 4	$ -	$ -	$ (0.09)	$ -	$ -	$ -	$ (0.43)	$ (0.28)
GSA 6	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.32)
GSA 8	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.70)	$ (0.55)
GSA 10	$ -	$ -	$ (0.11)	$ -	$ (0.35)	$ -	$ (0.48)	$ (0.30)
GSA 12	$ -	$ -	$ (0.11)	$ (0.06)	$ (0.37)	$ -	$ (0.37)	$ (0.37)
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.66)

Copayments (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (0.12)	$ (0.12)	$ (0.12)	$ -	$ (0.12)	$ (6.19)
GSA 4	$ -	$ -	$ (0.12)	$ (0.12)	$ (0.12)	$ -	$ (0.12)	$ (5.87)
GSA 6	$ -	$ -	$ (0.12)	$ (0.12)	$ (0.12)	$ -	$ (0.12)	$ (5.69)
GSA 8	$ -	$ -	$ (0.12)	$ (0.12)	$ (0.12)	$ -	$ (0.12)	$ (5.63)
GSA 10	$ -	$ -	$ (0.12)	$ (0.12)	$ (0.12)	$ -	$ (0.12)	$ (5.18)
GSA 12	$ -	$ -	$ (0.12)	$ (0.12)	$ (0.12)	$ -	$ (0.12)	$ (5.27)
GSA 14	$ -	$ -	$ (0.12)	$ (0.12)	$ (0.12)	$ -	$ (0.12)	$ (6.58)

Hepatitis C ("ramp-up completed" October 2011)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ 0.31	$ 3.85	$ -	$ 2.27	$ 6.17
GSA 4	$ -	$ -	$ -	$ -	$ -	$ -	$ 2.98	$ 3.27
GSA 6	$ -	$ -	$ -	$ 0.26	$ 1.72	$ -	$ -	$ 3.39
GSA 8	$ -	$ -	$ -	$ 0.45	$ 1.06	$ -	$ 1.16	$ 1.19
GSA 10	$ -	$ -	$ 0.19	$ 1.18	$ 2.44	$ -	$ 5.06	$ 3.34
GSA 12	$ -	$ -	$ 0.29	$ 0.47	$ 2.25	$ -	$ 2.85	$ 2.74
GSA 14	$ -	$ -	$ 0.24	$ -	$ 1.41	$ -	$ 2.55	$ 2.06

340B Pharmacy Pricing (effective April 2012)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ (0.19)	$ (0.35)	$ (0.32)	$ (2.67)	$ -	$ (4.19)	$ (1.77)
GSA 4	$ -	$ -	$ (0.21)	$ -	$ (0.89)	$ -	$ (1.41)	$ (0.73)
GSA 6	$ -	$ -	$ -	$ -	$ -	$ -	$ (1.77)	$ -
GSA 8	$ -	$ (0.21)	$ (0.44)	$ (0.44)	$ (2.79)	$ -	$ (4.45)	$ (2.20)
GSA 10	$ -	$ (0.27)	$ (0.42)	$ (0.43)	$ (1.97)	$ -	$ (6.36)	$ (3.20)
GSA 12	$ -	$ (0.06)	$ (0.09)	$ (0.09)	$ (0.66)	$ -	$ (1.96)	$ (0.48)
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.37)

Copayments (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ (0.67)	$ -	$ -	$ -	$ -	$ (1.90)
GSA 4	$ -	$ -	$ (0.47)	$ -	$ -	$ -	$ (1.57)	$ (1.03)
GSA 6	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (3.12)
GSA 8	$ -	$ -	$ (0.47)	$ -	$ -	$ -	$ (1.45)	$ (1.24)
GSA 10	$ -	$ -	$ (0.34)	$ (0.22)	$ (0.71)	$ -	$ (1.12)	$ (0.82)
GSA 12	$ -	$ -	$ (0.44)	$ (0.35)	$ (1.07)	$ -	$ (1.08)	$ (1.32)
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (1.29)

Taxi Copay (effective April 2012)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 4	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 6	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 8	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GSA 10	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.37)
GSA 12	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (0.37)
GSA 14	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

ER Transportation Shift (effective July 2012)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ 0.02	$ -	$ -	$ -	$ 0.65	$ 0.26
GSA 4	$ -	$ 0.01	$ -	$ -	$ -	$ -	$ 0.06	$ 0.01
GSA 6	$ -	$ -	$ 0.04	$ -	$ -	$ -	$ -	$ 0.03
GSA 8	$ -	$ 0.02	$ 0.10	$ 0.08	$ -	$ -	$ 0.69	$ 0.29
GSA 10	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.00
GSA 12	$ -	$ 0.00	$ 0.02	$ 0.01	$ 0.02	$ 0.01	$ 0.11	$ 0.09
GSA 14	$ -	$ -	$ -	$ 0.23	$ -	$ -	$ -	$ -

Dental Sealants (effective May 2009)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ (0.46)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 4	$ -	$ (0.16)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 6	$ -	$ (0.74)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 8	$ -	$ (0.00)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 10	$ -	$ (0.12)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 12	$ -	$ (0.43)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 14	$ -	$ (0.09)	$ -	$ -	$ -	$ -	$ -	$ -

Dental Service Changes (effective October 2009)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ (0.56)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 4	$ -	$ (0.25)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 6	$ -	$ (0.74)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 8	$ -	$ (0.10)	$ -	$ -	$ -	$ -	$ -	$ -
GSA 10	$ -	$ (0.19)	$ (0.07)	$ (0.14)	$ -	$ -	$ -	$ -
GSA 12	$ -	$ (0.46)	$ (0.07)	$ (0.13)	$ -	$ -	$ (0.08)	$ -
GSA 14	$ -	$ (0.19)	$ -	$ -	$ -	$ -	$ -	$ -

Benefit Redesign (effective October 2010)	TANF < 1	TANF 1-13	TANF 14-44 F	TANF 14-44 M	TANF 45+	SSI W	SSI Without	AHCCCS Care
GSA 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (1.50)
GSA 4	$ -	$ -	$ (0.89)	$ (0.66)	$ -	$ (0.94)	$ (1.40)	$ (1.46)
GSA 6	$ -	$ -	$ (1.66)	$ -	$ -	$ -	$ -	$ (2.95)
GSA 8	$ -	$ -	$ (1.16)	$ -	$ -	$ -	$ -	$ (2.01)
GSA 10	$ -	$ -	$ (0.52)	$ (0.31)	$ -	$ (0.76)	$ (0.77)	$ (0.93)
GSA 12	$ -	$ -	$ (0.61)	$ (0.36)	$ (0.90)	$ (0.93)	$ (0.80)	$ (1.08)
GSA 14	$ -	$ -	$ (1.28)	$ -	$ -	$ -	$ -	$ (2.16)

Acute Care\CRS RFP CYE 14
Section B - Program and Fee Schedule Changes
Impacts to BH Services

Attachment B

Program Change	Effective Date	Suggested Service Matrix Categories Impacted	PMPM
High Needs Children	July 2009	Case Management Services	$ 1.08
Transition Age Youth	July 2009	Case Management Services and All Other Support Services	$ 0.05
Best for Babies	July 2011	Treatment Services and All Other Support Services	$ 0.18

Acute Care\CRS RFP CYE 14
Section B - Program and Fee Schedule Changes
Impacts to CRS Services

Attachment C

Program Change	Effective Date	Suggested Service Matrix Categories Impacted	PMPM
Cochlear Implants	October 2010	Physician, DME and Other Professional	$ 3.53
Transition of Pediatric Services	June 2011	Outpatient	$ 3.01
Transition of Clinic Services	October 2012	Clinic	$ 5.14