Mission:

- Reaching across Arizona to provide comprehensive, quality health care for those in need.

Vision:

- Shaping tomorrow’s managed health care…from today’s experience, quality and innovation.

Customer:

- Depending on the changing role of AHCCCS we recognize different internal and external customers, but we have only one fundamental focus that inspires our efforts:

  Our primary customers are AHCCCS members.
AHCCCS Overview

Kari Price
Assistant Deputy Director
Introduction to AHCCCS

Product Lines
- Acute Care (Medicaid & KidsCare)
- Long Term Care
- Healthcare Group
- Premium Sharing

- Acute Health Plans
- LTC Program Contractors
- State Agencies
  - DHS
    - Behavioral Health & CRS
  - DES
    - Eligibility
- Fee-For-Service
  - Native Americans
  - Non-Qualified Persons

AHCCCS Administration

• Policy
• Eligibility (Special Populations)
• Contract for Care
• Monitor Care and Financial Viability
• Information Services
• Budget and Claims Processing
• Legal
• Intergovernmental Relations

Funding
• Federal
• State
• County
• Private
  ➢ Premiums

• Funding Sources
  ➢ Federal
  ➢ State
  ➢ County
  ➢ Private

February 21, 2003
AHCCCS Organizational Structure

- Office of Managed Care (OMC)
- Office of Medical Management (OMM)
- Office of Policy Analysis and Coordination (OPAC)
- Office of the Director (OOD)
- Office of Legal Assistance (OLA)
- Division of Business and Finance (DBF)
- Division of Member Services (DMS)
- Information Service Division (ISD)
### Who Does AHCCCS Serve?

<table>
<thead>
<tr>
<th>Program</th>
<th>Enrolled Members</th>
<th>Member Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medicaid</td>
<td>794,925</td>
<td>Primarily children and women with children. (Includes 86,453 from Proposition 204)</td>
</tr>
<tr>
<td>KidsCare</td>
<td>48,915</td>
<td>Children through the age of 18.</td>
</tr>
<tr>
<td>ALTCS (Long Term Care)</td>
<td>36,485</td>
<td>Individuals with developmental disabilities, physical disabilities, or over 65 years of age.</td>
</tr>
<tr>
<td>Premium Sharing</td>
<td>4,600</td>
<td>Individuals without insurance.</td>
</tr>
<tr>
<td>Healthcare Group</td>
<td>13,100</td>
<td>Employees of small businesses.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>898,025</strong></td>
<td></td>
</tr>
</tbody>
</table>
2003 Annual Income Standards

100% Federal Poverty Limit

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Income Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$8,860</td>
</tr>
<tr>
<td>2</td>
<td>$11,940</td>
</tr>
<tr>
<td>3</td>
<td>$15,020</td>
</tr>
<tr>
<td>4</td>
<td>$18,100</td>
</tr>
<tr>
<td>5</td>
<td>$21,180</td>
</tr>
<tr>
<td>6</td>
<td>$24,260</td>
</tr>
</tbody>
</table>
Acute Eligibility Levels

- KidsCare: 200%
- SOBRA Pregnant Women: 133%
- Medicaid 0-5 years: 133%
- Medicaid >6 years (exc. SOBRA and MED): 100%
- MED: 40%
Percentage of Arizonans on AHCCCS

![Bar chart showing percentage of Arizonans on AHCCCS from 1982 to 2002. The percentages range from 3.1% to 17.0% with specific years and percentages marked on the chart.](chart.png)
<table>
<thead>
<tr>
<th>GSA Number</th>
<th>Health Plan Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>39,404</td>
</tr>
<tr>
<td>4</td>
<td>63,048</td>
</tr>
<tr>
<td>6</td>
<td>22,343</td>
</tr>
<tr>
<td>8</td>
<td>33,050</td>
</tr>
<tr>
<td>10</td>
<td>137,699</td>
</tr>
<tr>
<td>12</td>
<td>397,265</td>
</tr>
<tr>
<td>14</td>
<td>29,879</td>
</tr>
</tbody>
</table>

Total Health Plan Enrollment = 722,688
### AHCCCS Appropriation SFY ’03

<table>
<thead>
<tr>
<th></th>
<th>FY 02-03</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>$1,496,850,000</td>
</tr>
<tr>
<td>Federal</td>
<td>$2,962,273,000</td>
</tr>
<tr>
<td>Total</td>
<td>$4,459,123,000</td>
</tr>
</tbody>
</table>

Federal Medical Assistance Percentage

- Administration: 50%
- Program: 67.25%
AHCCCS’ Partnership Strategy

The success of Arizona’s Medicaid Program is dependent on the success of our contractors ... therefore, partnership is vital.

- Set clear and reasonable expectations with Contractor involvement
- Respect for each other
- Commitment to each other
- Understanding each other’s challenges
- Feedback/Listening
- Ongoing communication
- Mutual accountability
- Flexibility
- Striving for a long-term relationship
Health Plan Oversight – Ongoing

Conducted by the Office of Managed Care (OMC) & the Office of Medical Management (OMM):

- On-site Operational and Financial Review (OFR)
- Financial monitoring
- Quality Management/Improvement Plan
- Clinical performance measures
- Provider network monitoring
- Claims payment timeliness
- Grievance and Appeal monitoring
- Quality Improvement Projects
Health Plan Oversight - Focused

Conducted by OMC and OMM due to:

- Non-compliance with financial viability standards
- Changes in ownership
- Numerous changes in management
- Failure to meet minimum network standards
- New contractor
- Contractor serving new geographic service area
- Other contractual non-compliance
Health Plan Enrollment

Member Assignment Hierarchy:

I. Reenrollment within 90 days
II. Newborn of an existing member
III. Choice
IV. Family Continuity
V. Auto-Assignment Algorithm
Members enrolled as of 12/31/02

- Re-enrolls 30%
- Choosers 30%
- Newborns 8%
- Family Continuity 5%
- Auto-Assigns 19%
- Other 8%

Out of 723,000 members
Source of Enrollment

6 Months ending 1/31/03

- Choosers: 36%
- Re-enrolls: 26%
- Auto-Assigns: 18%
- Family Continuity: 7%
- Newborns: 8%
- Other: 5%

Out of 332,500 members
Source of Enrollment

Members with Choice Only
6 months ending 1/31/03

- Choosers: 52%
- Auto-Assigns: 26%
- Family Continuity: 10%
- Newborns: 12%

Out of 229,000 members
## Members Exercising Choice

Percent by Risk Group (6 months ending 1/31/03)

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANF &lt;1</td>
<td>6%</td>
</tr>
<tr>
<td>TANF 1-13</td>
<td>52%</td>
</tr>
<tr>
<td>TANF 14-44F</td>
<td>58%</td>
</tr>
<tr>
<td>TANF 14-44M</td>
<td>42%</td>
</tr>
<tr>
<td>TANF 45+</td>
<td>48%</td>
</tr>
<tr>
<td>SSI w/ Med</td>
<td>55%</td>
</tr>
<tr>
<td>SSI w/o Med</td>
<td>27%</td>
</tr>
<tr>
<td>KidsCare</td>
<td>100%</td>
</tr>
<tr>
<td>TWG MED</td>
<td>55%</td>
</tr>
<tr>
<td>TWG non-MED</td>
<td>55%</td>
</tr>
<tr>
<td>HIFA</td>
<td>100%</td>
</tr>
</tbody>
</table>
Health Plan Enrollment

- Members select a plan prior to being made eligible
- Members assigned to a plan on date of eligibility determination
- Plans notified one day after assignment
- Members retroactively eligible - prior period coverage (PPC)
- Plans responsible for retroactive eligibility period
Compensation Overview

Anne Winter
Reimbursement and Projects
Administrator
Reimbursement

- Prospective Capitation
  - Monthly payment per member for the provision of medical services for enrolled members.

- PPC Capitation
  - Capitation payment for the period from the effective date of eligibility to the date of determination
Reimbursement

- **Mid Month Adjustment**
  - Newly enrolled members—health plans receive a prorated capitation rate for the number of days in a month that a member is prospectively enrolled.
  - Disenrolled members—prorated capitation is recouped from the health plans for the period that a member is no longer enrolled in the health plan.
Reimbursement

- Risk Sharing Arrangements
  - PPC Capitation
    - Health plans’ risk is limited for PPC medical expenses to 2%
    - Annual reconciliation
  - Title XIX Waiver Group (TWG)
    - Health plans’ risk is limited for TWG medical expenses to 2%
    - Annual reconciliation for both prospective and PPC time period
Compensation

Rate Categories

– TANF/SOBRA/KidsCare <1
– TANF/SOBRA/KidsCare 1-13
– TANF/SOBRA/KidsCare/BCCTP/14-44F
– TANF/SOBRA/KidsCare 14-44M
– TANF/BCCTP 45+
Compensation

Rate Categories (cont.)

– SSI With Medicare
– SSI Without Medicare/Freedom to Work
– Title XIX Waiver Group (TWG)-non-MED
– Title XIX Waiver Group (TWG)-MED
– SOBRA Family Planning
Compensation

Supplemental Payments

– Delivery Supplement
– Hospitalized Supplement—MED only
– HIV/AIDS Supplement
Compensation

Reinsurance

- Inpatient
- Catastrophic
- Transplant
### Reinsurance - Inpatient

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Deductible—all non-Title XIX Waiver Group Members</th>
<th>Title XIX Waiver Group Deductible</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-34,999</td>
<td>$20,000</td>
<td>$15,000</td>
<td>75%</td>
</tr>
<tr>
<td>35,000-49,000</td>
<td>$35,000</td>
<td>$15,000</td>
<td>75%</td>
</tr>
<tr>
<td>50,000+</td>
<td>$50,000</td>
<td>$15,000</td>
<td>75%</td>
</tr>
</tbody>
</table>
Reinsurance – Catastrophic

- Hemophilia, von Willebrand’s disease, Gaucher’s disease
- No Deductible
- 85% Coinsurance
Reinsurance – Transplants

- No Deductible
- 85% Coinsurance
- New RFP for Transplant providers
- Effective October 1, 2003
• Contractor’s will be reimbursed 100% for reinsurance cases after a case reaches $650,000 (except for transplants)
Financial Standards

- **Performance Bond**
  - 75% of one month’s capitation
  - Initial amount 80%
  - Amount of security may fall to 70% before it must be increased to 80%
### Minimum Capitalization

<table>
<thead>
<tr>
<th>GSA</th>
<th>Capitalization—New Contractors</th>
<th>Capitalization—Existing Contractors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mohave/Coconino/Apache/Navajo</td>
<td>$4,400,000</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>La Paz/Yuma</td>
<td>$3,000,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Maricopa</td>
<td>$5,000,000</td>
<td>$4,000,000</td>
</tr>
<tr>
<td>Pima/Santa Cruz</td>
<td>$4,500,000</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>Cochise/Graham/Greenlee</td>
<td>$2,150,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Pinal/Gila</td>
<td>$2,150,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Yavapai</td>
<td>$1,600,000</td>
<td>$1,600,000</td>
</tr>
</tbody>
</table>
Financial Standards

- **Minimum Capitalization**
  - $10,000,000 statewide ceiling
  - Required in addition to Performance Bonding requirements
  - May be applied to meeting the equity per member requirement
  - Existing Contractors must be meeting their equity per member requirement
  - Existing Contractors are considered incumbent for all GSA’s bid
Financial Standards

- Financial Viability Standards/Performance Guidelines
  - Current Ratio: 1.00
  - Equity Per Member:
    - $150 for enrollment 0-99,999
    - $100 for enrollment 100,000 and greater
  - Medical Expense Ratio: at least 80%
Financial Standards

- Financial Viability Standards/Performance Guidelines
  - Administrative Cost Percentage: 10%
  - RBUC Days Out: No more than 30 Days

- Stricter monitoring and compliance with ease of standards
Medical Management Overview

CJ Hindman, MD
Chief Medical Officer
Assistant Deputy Director
Chief Medical Officer
Assistant Deputy Director

- AHCCCS Medical Director
  - Debra Brown, M.D.
- Pharmacy Program
- Provider Development
- Community Relations
- Office of Special Programs
- Office of Medical Management
Office of Special Programs

Debi Wells

- Medical Policy & Clinical Technology
- School – Based Services (MIPS, SHAPE)
- Balanced Budget Act Compliance
- Medical Foods
- Border Health
- Healthcare Group
- Employer Sponsored Insurance Pilot
- Long Term Care Strategy
- Medicaid Coordination with Department of Corrections
AHCCCS Medical Policy Manual

- Information on covered health care services
- Quality and utilization management requirements
  - Chapters 400 and 900
- Medical and program policies and requirements
- Manual on AHCCCS Website [www.ahcccs.state.az.us](http://www.ahcccs.state.az.us)
  - Go to Information Types and select:
    - Policy
    - Manuals
    - AHCCCS Medical Policy Manual
Office of Medical Management (OMM)

Kate Aurelius

- Clinical Quality Management
- Clinical Services Management
- Clinical Research and Data
- Provider Registration
Clinical Quality Management

- Oversight of contractual requirements including EPSDT, Maternity/Family Planning, and Quality Management Standards
- Monitoring of Sentinel Quality Issues
- Member Issue/Complaint Resolution
- Operational and Financial Reviews
- Program Development, Technical Assistance, Best Practices
- Performance Indicators
- Medical Audits
- Quality Improvement Projects
- Governmental Reporting of Quality and Performance Indicators
Performance Indicators

Annual Measure

- Adult access to Preventive / Ambulatory Care
- Children’s access to Primary Care Practitioner
- Immunization of two year-olds
Performance Indicators

Measure During Even Years
- Timeliness of Prenatal Care
- Breast Cancer Screening
- Cervical Cancer Screening
Performance Indicators

Measure During Odd Years

- Dental visits
- Well-Child visits (first 15 months of life)
- Well-Child visits – three through six years of life
- Adolescent Well-Care visits
Clinical Services Management

Kate Aurelius (Acting)

- Medical management of the Fee For Service population
- Authorizations of reinsurance – transplants, catastrophic programs
- Oversight of utilization management programs via OFRs
Clinical Research & Data

Tina Trout

- Data Collection, Analysis and Reporting
- Methodology Development and Review
- Technical Assistance to Contractors
- OMM Databases – Design, Build, Maintain
- Update / Maintain Claims Codes Tables
Provider Registration

Valerie Noor

- Registration of Providers
- Maintenance of Provider Subsystem
Encounters

Brent Ratterree
Encounter Administrator
What Is An Encounter?

- A record of a medically related service rendered by a registered AHCCCS provider to an AHCCCS member enrolled with a capitated contractor (MCO).
  - Submitted electronically by MCO
  - Includes capitated services and fee-for-service

- Encounter data = post-adjudicated claims data
Encounter Data Uses

- MCO capitation/fee-for-service rate setting
- Prior Period Coverage reconciliation
- Reinsurance calculation and payment
- Disproportionate Share Hospital rate calculations
- MCO evaluation (expected vs. actual)
- Utilization review and reporting
- Quality of care and outcome measurements
QISMC/HEDIS reporting and clinical performance measurements

Medical record audits

CMS reports

Fraud and abuse analysis & reporting

General information management

Decision support and “what-if” analysis
Submission Standards

- Encounter files submitted to AHCCCS’ server
- Files undergo file and syntax checks
- Data is processed with claims-type edits resulting in:
  - Finalized encounters – no errors found
  - Pended encounters – errors found
    - MCOs must correct errors in order to finalize encounters
    - Errors not timely corrected are sanctionable
MCOs retrieve files and reports from AHCCCS’ server

Information identifies finalized and pended encounter data
  – Data clues are provided to assist with pended encounter error resolution

MCOs reconcile data submitted with data retrieved
CMS requires AHCCCS to collect complete, accurate and timely encounter data from MCOs.

AHCCCS validation study evaluates completeness, accuracy and timeliness:
- When errors exceed thresholds - sanctions applied.

Ongoing review of encounter submission trends and data quality.
Additional Information

- RFP and Attachment I
- Encounter Reporting User Manual
- Encounter Validation Technical Document
Questions

Kari Price
Assistant Deputy Director