AHCCCS Acute Care RFP

Prospective Offerors Orientation
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.
What’s New in the RFP

Part I:  Kari Price
Assistant Deputy Director

Part II:  Anne Winter
Reimbursement and Projects
Administrator
What’s New in the RFP - Part I

- Geographic Service Area changes
- Algorithm changes
- Network Development & Management Plan
- Technological advancement
- Performance Incentives schedule
- Member ID cards
- Extra credit
Geographic Service Areas

Acute Enrollment As of February 1, 2003

<table>
<thead>
<tr>
<th>GSA Number</th>
<th>Health Plan Enrollment</th>
</tr>
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<tbody>
<tr>
<td>2</td>
<td>39,404</td>
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<tr>
<td>4</td>
<td>63,048</td>
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<td>6</td>
<td>22,343</td>
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<td>8</td>
<td>33,050</td>
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<td>10</td>
<td>137,699</td>
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<td>397,265</td>
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<td>14</td>
<td>29,879</td>
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</tbody>
</table>

Total Health Plan Enrollment = 722,688
GSA Changes

- Reduced from 9 to 7 GSAs
- Matches ALTCS GSAs
- Practice patterns considered
- Larger rural GSAs contribute more membership
Auto-Assignment Algorithm

- Target percentage by risk group by GSA
- Used to assign a member or a household
- Developed using the following:
  - Final rate bid - 30%
  - Final awarded rate - 30%
  - Program Section Score - 40%
- Points awarded for above components (Attachment G)
- Adjustment for Contractors <25,000 members
  - Must be in Maricopa and/or Pima/Santa Cruz
  - Utilize adjustment until statewide target membership met
Ensures provision of covered services as required in contract
Outlines status of Contractor’s network
Projects future needs
Identifies network gaps and short-term interventions
Evaluation of interventions
Ongoing network development activities
Coordination - internal and external
Due 45 days after start of each contract year
Technological Advancement

- By April 1, 2004
  
  Contractor website to include:
  - Formulary
  - Provider Manual
  - Policies
  - Member Handbook
  - Provider network listing
  - Enrollment verification
  - Claims inquiry
Performance Incentives

- Publication of clinical performance indicators on AHCCCS website

- For October 1, 2005
  - Recalculate algorithm target percentages
    - Prenatal care timeliness and well-child visits 3-6 years
    - Clinical performance may replace program component

- Incentive fund may be used in future - Not CYE’04
Member Identification Cards

- Issued to members:
  - Initial enrollment with AHCCCS
  - When members change contractors
  - Re-enrolls > 90 day break
  - Change in RBHA
  - Change in program
- Currently 72¢ per card
- Averaged 40,000 cards/mo statewide - last 6 mos.
- Monthly invoicing directly from vendor
- Cost included in capitation rate development
Extra Credit

- Optional (but *encouraged*)
- Above and beyond contractual requirements
- Incentive for innovation
  - Use of technology
  - Reduce provider hassle factor
  - Community involvement
- Submit up to three programs/initiatives
- Points significant - may determine award outcome
- Initiatives to become contract special provision
- Scoring by national experts in managed care
What’s New in the RFP - Part II

- Changes due to BBA
- Prescription drug carve-out
- Financial Standards
- Compensation
BBA Changes

- Definitions
  - Emergency Medical Service
  - Post Stabilization of Services
  - Special Health Care Needs
Emergency Services

- ED’s have 10 days to notify the Contractor that a member received screening and treatment. Claims cannot be denied for lack of 12 hour notification.

- Attending or treating provider is solely responsible for determining when the member is stabilized and ready for transfer. This decision is binding on the contractor for payment.
Post-stabilization Care Services—Payment cannot be denied under the following circumstances:

- Post-stabilization care services were pre-approved
- Post-stabilization care services were not pre-approved by the Contractor because they did not respond to the treating physician within one hour for pre-approval, or could not be contacted
- The Contractor’s representative and the treating provider cannot reach agreement regarding the member’s care, and the Contractor’s physician is unavailable for consultation.
Special Health Care Needs

- AMPM update—April 2003
- The Contractor must implement mechanisms to assess each member identified as having special health care needs to determine if they need a specialized course of treatment
- Members must have direct access to specialists for their specialized course of treatment or regular care monitoring
BBA Changes (cont.)

- Member Information
  - Marketing Attestation Statement
  - Oral Interpretation services for member choosing a plan must be provided free of charge
  - Definition of vital written materials has expanded
  - Member handbook has expanded
  - More comprehensive description of network
Grievance and Request for Hearing

- Attachment H(1) and H(2)
- Responsibility for resolution of expedited grievances/hearings
Network

- Communication of network changes to members
- Provider Network Development and Management Plan
- Languages spoken by physicians must be actively tracked
- Network must provide access at least equal to community norm
BBA Changes (cont.)

- Compensation
  - Description of factors considered in capitation rate setting
  - Statement that non-State Plan services are not covered
  - Rates must be actuarially sound

- Sanctions
  - Policy under development
  - Specific amounts and process delineated
Governor Napolitano’s Executive Order

Submission of capitation rates both assuming pharmacy is a capitated service and assuming it is carved out of capitation

Carved out bid submission will not be scored

Carved out bid submission must be actuarially sound based on best estimates

Estimated October 1, 2004 implementation date, if determined more cost effective
Financial Standards - What’s New

- 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>$2,400,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Yavapai</td>
<td>$1,600,000</td>
<td>$1,600,000</td>
</tr>
</tbody>
</table>
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
Financial Standards (cont.)

- 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 (cont.)

- 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
Prospective Capitation

- Title XIX Waiver Group
  - Separate rates for MED and non-MED
  - No hospitalized supplemental payment for non-MED’s
  - These rates will be set, not bid
  - Risk sharing corridor of 2% profits and losses
Prospective Capitation (cont.)

- **HIFA Parents**
  - These rates will be set as a percentage of the TANF capitation rates, not bid

- **Breast and Cervical Cancer Treatment Program**
  - No longer covered under special reinsurance
  - Members included in the TANF 14-44F and TANF 45+ rate categories
**Compensation - What’s New**

Prospective Capitation (cont.)

- **TANF Rate Categories**
  - These rate categories will include TANF (1931), SOBRA, KidsCare, and BCCPT members

- **SSI Without Medicare**
  - This rate category will include the Freedom to Work members
Compensation - What’s New

PPC Capitation

- The rates will be set, not bid
- Reinstate the risk sharing corridor with 2% for profits and losses
- Roll the former FFS choice plus notification utilization into the prospective capitation rates
- Eliminate PPC Reinsurance
Data Supplement

- Data provided to Mercer to rebase capitation rates (not all inclusive)

- Encounter Utilization Reports
  - Structure
    - What’s new
    - Utilization—units per 1,000
    - Unit cost
    - Information is presented by contract year, service category, county, GSA, and statewide
Other supplemental data

- Health Plan pmpm’s by service category for last two contract years
- Service matrix crosswalk between CRCS, encounter utilization reports, and financial pmpm’s
- Service selection criteria
Other supplemental data (cont.)

- Maternity data
- SFP utilization and cost data
- Reinsurance payments
- Enrollment and demographic statistics
Data Supplement (cont.)

- New data information
  - Maternity costs
  - C-Section versus vaginal deliveries by County
  - SFP utilization and cost data
  - Enrollment growth trends
Capitation Rate-Setting Process

- Rates to be developed for three county groupings
- Trend(s)
- Rate Ranges
  - Statistical credibility
  - Ranges for each GSA
Actuarial Certifications under the New BBA Regulations

- Actuarial certifications from bidders to AHCCCS

- Actuarial certification from Mercer to CMS
  - Data requirements
  - Actuarial rate development techniques
Bidding Process

- Initial bid submissions
- Technical assistance session
- Best and final offers
- Final bid submissions
- Rate offers - under what circumstances?
Pending Issues

Kari Price
Assistant Deputy Director
Pending Issues

- Prescription drug carve-out
- Member cost sharing
- Hospital Reimbursement Pilot Program
- Changes to length of eligibility
- Unknown legislation and budget impacts
  - Removal of exemption for Medicaid Health Plans from premium tax
  - Potential optional service or eligibility group changes
- BBA Changes

*Future changes from current contractual requirements will result in adjustments to capitation rates and contract amendments when necessary*
Bid Submission

Nan Jeannero
Manager, Health Plan Operations
Response Specifications

- Original-plus seven copies
- Three copies of Network Development Disk/CD
- Sturdy 3 ring, 3 inch binders
- All pages numbered sequentially
Specifications (cont.)

- Page limits refer to 8½ by 11 inch paper
- 1 side of paper = 1 page
- Single spaced, typewritten in at least a 10 font
- Borders no less than ½ inch
Contracts and LOIs

- Receive equal weight
- Contract must include AHCCCS Acute Care line of business to be considered
- One LOI per provider with multiple service sites
- One LOI per group when proof of signatory authority available
Submission describes:

The same MCO/line of business throughout for bidders currently operating as MCO

AHCCCS Acute Care line of business for incumbents

New bidders w/o current experience will not respond to this submission requirement
Scoring

- Capitation and Network Development scored by Geographic Service Area
- Network Management, Program, Organization and Extra Credit will receive a statewide score
Questions & Written Answer Review

Kari Price
Assistant Deputy Director