AHCCCS Acute Care RFP

New Offerors Orientation

AHCCCS

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

Funding

- Federal
- State
- County
- Private
  - Premiums

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

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 Organizational Structure

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

Who Does AHCCCS Serve?

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

2003 Annual Income Standards

100% Federal Poverty Limit

Household Size	100% Federal Poverty Limit
1	$8,860
2	$11,940
3	$15,020
4	$18,100
5	$21,180
6	$24,260

Acute Eligibility Levels

	KidsCare	SOBRA Pregnant Women	Medicaid 0-5 years	Medicaid >6 years (exc. SOBRA and MED)	MED
Eligibility level	200%	133%	133%	100%	40%

Percentage of Arizonans on AHCCCS

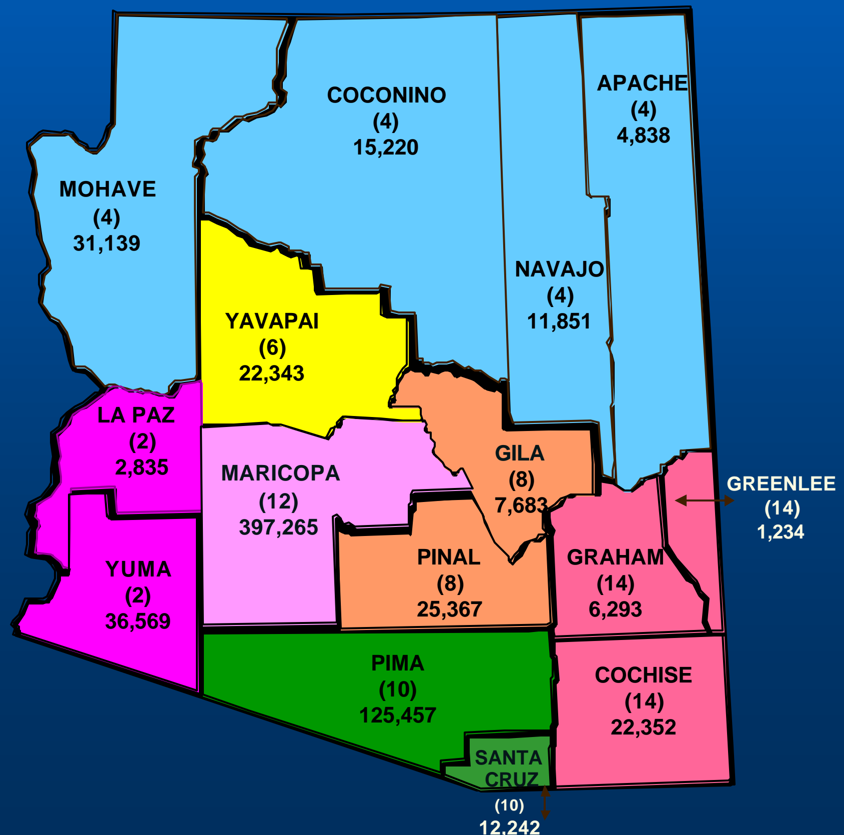
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
3.1%	5.0%	6.0%	4.5%	4.6%	5.6%	6.1%	7.7%	8.6%	10.0%	11.4	11.8%	11.4%	10.5	10.7%	10.0%	9.0%	9.2%	10.0%	11.8%	17.0%

Geographic Service Areas

Acute Enrollment As of February 1, 2003

GSA Number	Health Plan Enrollment
2	39,404
4	63,048
6	22,343
8	33,050
10	137,699
12	397,265
14	29,879

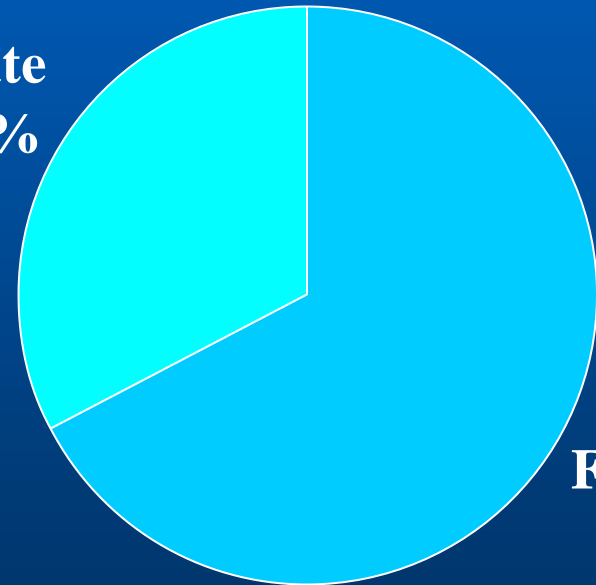


Total Health Plan Enrollment = 722,688

AHCCCS Appropriation SFY ’03

	FY 02-03
State	$1,496,850,000
Federal	$2,962,273,000
Total	$4,459,123,000

w/DES/ADHS



Federal Medical Assistance Percentage

Administration	50%
Program	67.25%

AHCCCS’ Partnership Strategy

The success of Arizona’s Medicaid Program is dependant 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:

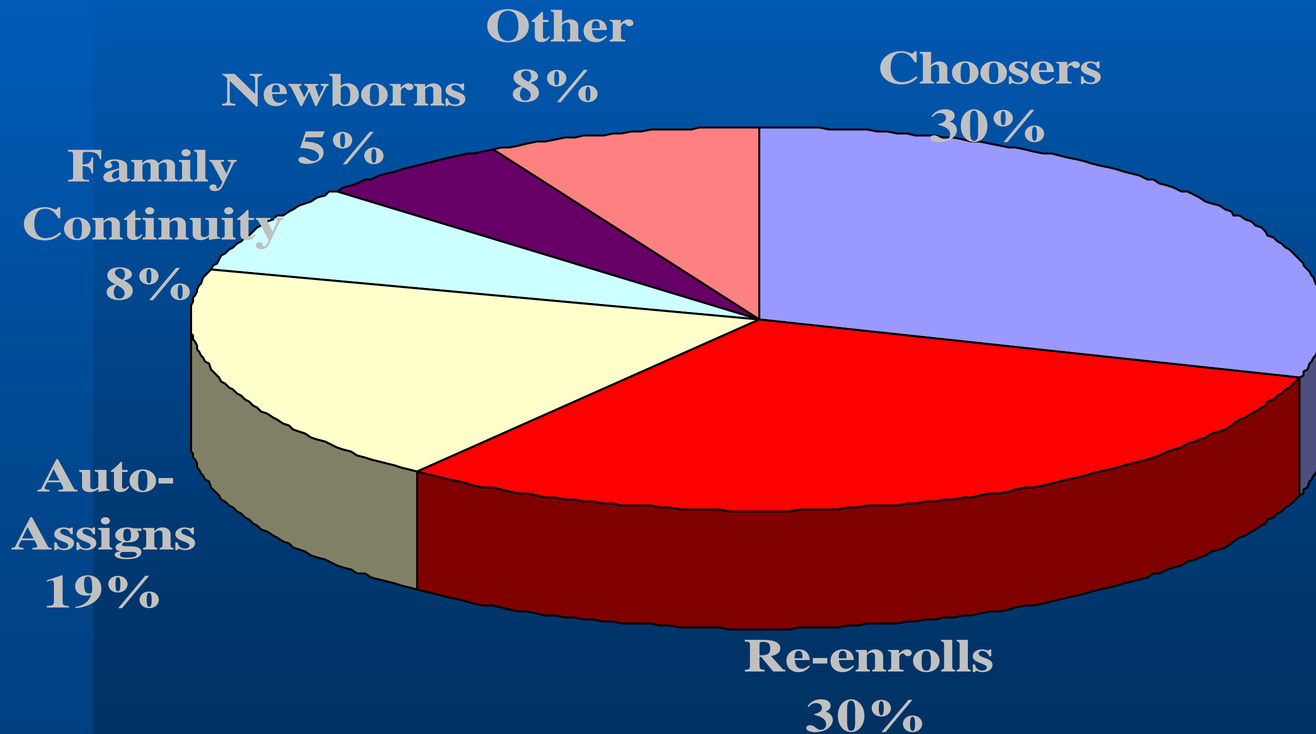
- Non-compliance with financial viability standards
- Changes in ownership
- Numerous changes in management
- Failure to meet minimum network standards
- New contractor
- Contractor serving new geographic service area
- Other contractual non-compliance

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

Source of Enrollment



Out of 723,000 members

Source of Enrollment

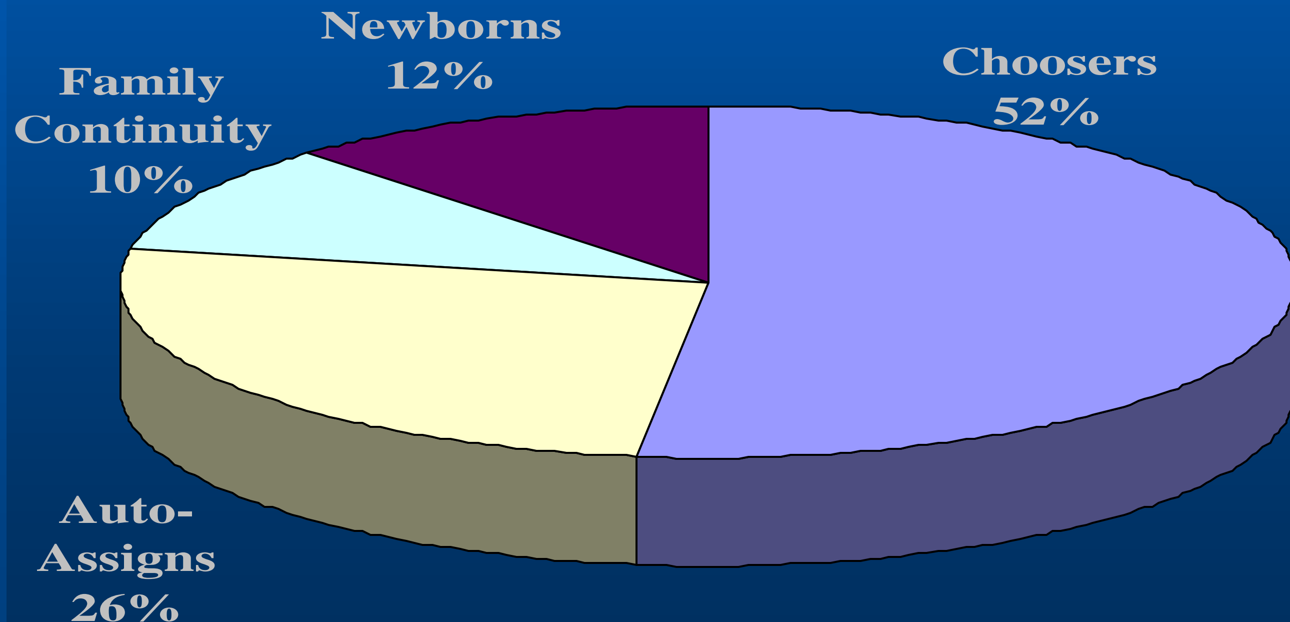
6 Months ending 1/31/03

Out of 332,500 members

Source of Enrollment

Members with Choice Only

6 months ending 1/31/03



Out of 229,000 members

Members Exercising Choice

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

Risk Group	Percent
TANF <1	6%
TANF 1-13	52%
TANF 14-44F	58%
TANF 14-44M	42%
TANF 45+	48%
SSI w/ Med	55%
SSI w/o Med	27%
KidsCare	100%
TWG MED	55%
TWG non-MED	55%
HIFA	100%

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

Enrollment	Deductible—all non-Title XIX Waiver Group Members	Title XIX Waiver Group Deductible	Coinsurance
0-34,999	$20,000	$15,000	75%
35,000-49,000	$35,000	$15,000	75%
50,000+	$50,000	$15,000	75%

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

Reinsurance - Other

- Contractor's will be reimbursed 100% for reinsurance cases after a case reaches $650,000 (except for transplants)

Financial Requirements

Anne Winter

Reimbursement and Projects Administrator

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%

Financial Standards

- Minimum Capitalization

GSA	Capitalization—New Contractors	Capitalization—Existing Contractors
Mohave/Coconino/Apache/Navajo	$4,400,000	$3,000,000
La Paz/Yuma	$3,000,000	$2,000,000
Maricopa	$5,000,000	$4,000,000
Pima/Santa Cruz	$4,500,000	$3,000,000
Cochise/Graham/Greenlee	$2,150,000	$2,000,000
Pinal/Gila	$2,400,00	$2,000,000
Yavapai	$1,600,000	$1,600,000

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**
  - 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

OMM

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

OMM

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

OMM

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

OMM

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

Encounter Data Uses (cont.)

- 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

Processing Results

- 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

Encounter Validation and Trends

- 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