AHCCCS Acute Care RFP

Prospective 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.

What's New in the RFP

Part I: Kari Price
Assistant Deputy Director

Part II: Anne Winter
Reimbursement and Projects Administrator

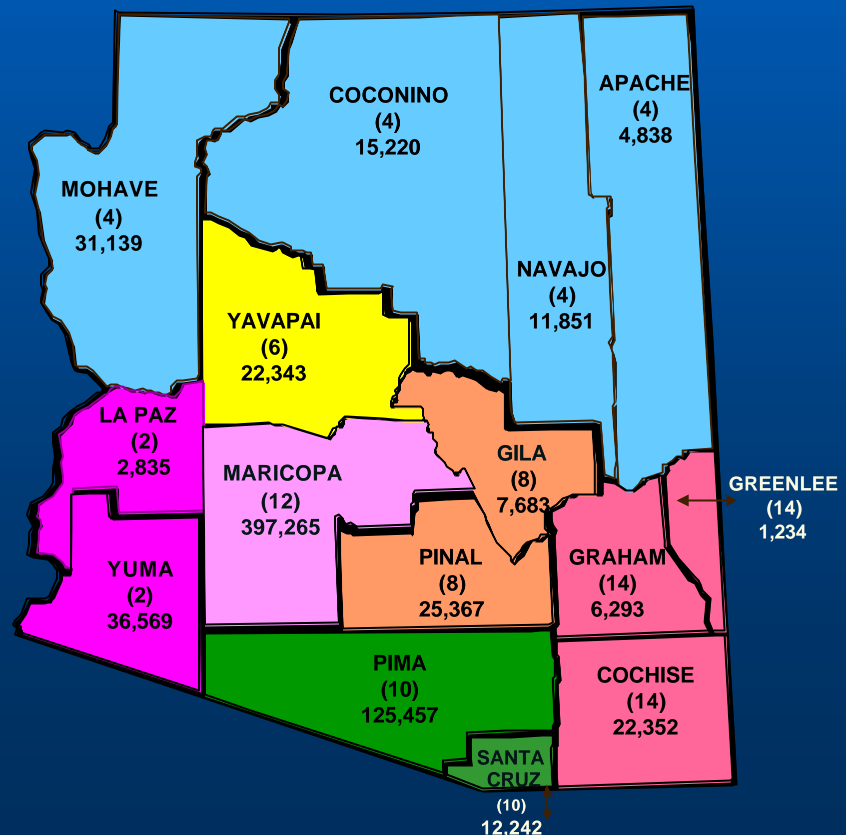
What’s New in the RFP - Part I

- 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

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

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

Provider Network Development & Mgmt Plan

- 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

BBA Changes (cont.)

- 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.

BBA Changes (cont.)

- 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.

BBA Changes (cont.)

- 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

BBA Changes (cont.)

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

BBA Changes (cont.)

- 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

Risk for Pharmacy

- 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%

Financial Standards (cont.)

- 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 (cont.)

- 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

Compensation - What's New

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

Compensation - What's New

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

Data Supplement (cont.)

- 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

Data Supplement (cont.)

- 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

Past Performance

- 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