PROGRAM CHANGES

When preparing the capitation rate bid submissions, the following program changes should be considered when reviewing the encounter and financial statement information provided in the data supplement. There are also program changes that are not included in this data supplement. These changes are either effective after the time period for which encounters have been gathered, or will be effective on or after October 1, 2008. This document should be used in conjunction with the RFP document to ensure all changes are considered. Anywhere below that states "TANF" means TANF/Kidscare/SOBRA/HIFA. Below is a brief description of the AHCCCS acute program changes and their effective dates:

Human Papillomavirus Vaccine (HPV)

Federal law requires that AHCCCS cover the Human Papillomavirus (HPV) vaccine as part of the EPSDT benefit package for all females age 20 and under. In addition, the recently enacted budget provided funding to cover women up to age 26. Coverage for women age 20 and under started on December 1, 2006 and coverage for women up to age 26 started on October 1, 2007. For women through age 18, the vaccine is covered under the Vaccines for Children Program described in Section D: Program Requirements of the RFP document. Contractors are only responsible for the administration costs for women through age 18, but are responsible for both vaccine and administration after age 18.

AHCCCS estimated the cost to be approximately $11.5 million for CYE08, which includes initial presentation for the new service and annual ongoing services and assumes a 30% presentation rate. TANF 1-13 initial costs were estimated to be approximately $560,000 and TANF 14-44 Female costs were estimated to be approximately $9,950,000. Ongoing annual costs for TANF 1-13 were estimated to be approximately $210,000 and the TANF 14-44 female ongoing annual costs were estimated to be approximately $740,000.

Est for CYE08	TANF 1-13	TANF 14-44 F	Total
Start Up	$ 560,000	$ 9,950,000	$ 10,510,000
Annual	$ 210,000	$ 740,000	$ 950,000
Total	$ 770,000	$ 10,690,000	$ 11,460,000

Hospice

Legislation passed by the State Legislature in 2007 allows the AHCCCS Acute program to cover Hospice services for adults effective October 1, 2007. The cost to AHCCCS to provide this service is estimated to be approximately $3 million for CYE08. Section Q in the Data Supplement shows historic hospice expenditures by GSA and risk group. Prior to the legislation, Acute contractors could cover adult Hospice at their option, but it was out of their administration budget and not included in the capitation rates. Hospice costs may increase as compared to historical data now that these costs are covered in the capitation rates.

Outlier

Laws 2007, Chapter 263, changed the methodology for the payment of claims with extraordinary operating costs per day. It stipulated that AHCCCS shall phase in the use of the most recent statewide urban and rural average Medicare or CMS approved cost-to-charge ratios to qualify and pay extraordinary operating costs starting October 1, 2007. Once fully-phased in, those cost-to-charge ratios will be updated annually. In addition, routine maternity charges will be excluded from outlier consideration. AHCCCS estimated program-wide (Acute, ALTCS, etc.) reductions of $22 million to inpatient costs in year one, $49 million in year two and $81 million in year three. It is estimated that the acute program accounts for approximately 93% of these costs with approximately 90% of the costs in Maricopa County, 7% in Pima and 3% in rural counties. These costs include both Prior Period Coverage (PPC) and prospective costs. AHCCCS estimated that approximately 81% of the costs were prospective. The tables below summarize the Acute program estimated yearly impact to hospital inpatient costs. Impacts in CYE09 and CYE10 are not presented as cumulative and do not include previous year impacts. Due to decreases in outlier trends, AHCCCS estimates that this will also impact reinsurance, thus decreasing the amount of reinsurance a plan would receive. AHCCCS has factored this impact into the reinsurance offsets.

CYE08 Annual Impact

Est Decrease in Hosp IP	CYE08 Outlier Impact			
	Maricopa	Pima	Rural	Total
Prospective	$ (14,973,069)	$ (1,167,061)	$ (579,879)	$ (16,720,009)
PPC	$ (3,473,043)	$ (270,703)	$ (134,505)	$ (3,878,250)
Total	$ (18,446,112)	$ (1,437,763)	$ (714,384)	$ (20,598,259)

CYE09 Annual Impact

Est Decrease in Hosp IP	CYE09 Outlier Impact			
	Maricopa	Pima	Rural	Total
Prospective	$ (18,385,352)	$ (1,433,027)	$ (712,031)	$ (20,530,410)
PPC	$ (4,264,531)	$ (332,394)	$ (165,157)	$ (4,762,082)
Total	$ (22,649,883)	$ (1,765,422)	$ (877,188)	$ (25,292,493)

CYE10 Annual Impact

Est Decrease in Hosp IP	CYE10 Outlier Impact			
	Maricopa	Pima	Rural	Total
Prospective	$ (21,668,670)	$ (1,688,942)	$ (839,188)	$ (24,196,800)
PPC	$ (5,026,105)	$ (391,755)	$ (194,652)	$ (5,612,511)
Total	$ (26,694,775)	$ (2,080,697)	$ (1,033,839)	$ (29,809,311)

Part D Reminder

The Medicare Modernization Act of 2003 created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B. Effective January 1, 2006, AHCCCS no longer covers prescription drugs that are covered under Part D for dual eligible members, even when the member is not enrolled in Medicare Part D. See definition of Medicare Part D Excluded Drugs in Section C of the RFP document.

Incontinence Briefs

Coverage of incontinence briefs was publicized and added to the capitation rates effective October 1, 2006. Coverage is specified in AHCCCS Rule A.A.C. R9-22-212 and the AMPM. The impact to the AHCCCS Acute Care program was estimated to be approximately $3 million for CY07.

Newborn Screen (PKU) Testing

The Arizona Newborn Program (Program) is administered by the Department of Health Services (DHS). The mission of the Program is to identify babies with hearing deficiencies as well as babies who have certain serious medical conditions. As required by Arizona law, the Program screens every baby born in Arizona for eight inherited disorders. A second newborn screen should be done at 1 to 2 weeks of age or at the time of the first doctor's visit. The first screen is included in the tier rates paid to the hospitals by the health plans. The second screen is paid to the physician. Senate Bill 1250 increased the fee for the second screen from $20 to $40, thus adding cost to the health plans. This increase was made to the TANF <1 risk group rates effective October 1, 2005.

In addition to the increase in fees for this newborn screen above, newborns are also required to receive an auditory screen at a cost of approximately $75 per screen. This screening was previously performed during the newborn hospital stay, thus covered by the tier rate paid to the hospitals. However, around this same time period, many hospitals began outsourcing this screen to the physicians and therefore, this entire cost was in addition to the newborn tier rate already paid to the hospitals.

The impact of these additional screens was estimated to be a 13.50% increase in PMPM for the primary care physician category of service to the TANF/KidsCare < 1 risk group for CYE 2006.

Reinsurance Deductible Level Changes

Refer to paragraph 57 of Section D: Program Requirements of the RFP document. Prior to this contract cycle, Title XIX Waiver Group (TWG) members had a separate annual deductible of $15,000, regardless of plan enrollment. Effective October 1, 2008, Title XIX Waiver members will no longer have a separate deductible. The deductibles below will apply to all prospective members except for SSDI-TMC, State Only Transplants and SOBRA Family Planning Extension members.

The following table represents deductible and coinsurance levels effective October 1, 2008-September 30, 2009:

Statewide Plan Enrollment	*Annual Deductible* *Prospective Reinsurance*	*Coinsurance*
0-34,999	$20,000	75%
35,000-49,999	$35,000	75%
50,000 and over	$50,000	75%

In addition, beginning October 1, 2009, each of the deductible levels above will increase $5,000 per year and capitation offsets will be adjusted accordingly.

Title XIX Waiver Group PPC Reinsurance

Effective October 1, 2006, AHCCCS eliminated the Prior Period Coverage (PPC) reinsurance for the Title XIX Waiver Group (TWG). Therefore, costs during PPC will no longer be applied towards the deductible level for TWGs.

Discontinuance of Same Day Admit and Discharge Reinsurance Coverage

Effective October 1, 2008, encounters in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, are not eligible for reinsurance coverage. Encounters in which the day of admission and the day of transfer are the same, termed same day admit and transfer, remain eligible for reinsurance coverage.

SOBRA Family Planning Extension Program

Effective July 1, 2007, the Department of Economic Security started performing a review of eligibility for SOBRA Family Planning Extension (SFP) members after 12 months. If the members are still determined eligible, they are continued for an additional 12 months, if not, they are disenrolled. Prior to July 2007, this review was not performed and members were left eligible for the full 24 months. See Section H of the Data Supplement for impact to SFP enrollment**.**

HIV/AIDS Drug Treatments

For all time periods for which financial and utilization data is presented in the data supplement, drugs used to treat HIV/AIDS have been carved out of capitation rates and paid to Contractors as a quarterly supplemental payment. Beginning in this contract cycle, effective October 1, 2008, all pharmaceutical expenditures for HIV/AIDS treatment will be included in the pharmacy component of the capitation rates and no supplemental payments will be made for HIV/AIDS. The drugs that were previously carved out may be found on the AHCCCS website at:
http://www.azahcccs.gov/Publications/Reference/AIDS-HIVDrugList/HIVinhibtors.pdf

State Only Transplants Option 1 and Option 2

Title XIX individuals, for whom medical necessity for a transplant has been established, who subsequently lose Title XIX eligibility may become eligible for one of two extended eligibility options as specified in A.R.S. 36-2907.10 and A.R.S. 36-2907.11. See Section D, Paragraph 2 of the RFP document for further details on eligibility.

Effective October 1, 2008, Contractors will be paid capitation for an administrative component only, for those Option 1 and Option 2 member months the member is enrolled with the Contractor. For Option 1 members the contractor will be paid the administrative component up to a 12-month continuous period of extended eligibility. For Option 2 members the administrative component will be paid for the period of time the transplant is scheduled or performed. See Section D, Paragraph 2, Eligibility Categories, for covered services for Option 1 and Option 2 members. All covered services will be reimbursed 100% with no deductible through Reinsurance payments based on adjudicated encounters. Delivery supplement payments will not apply to women who deliver during the 12 month continuous period of extended eligibility specified as Option 1.

Effective October 1, 2008, reinsurance coverage for State Only Option 1 and Option 2 members for transplants received at an AHCCCS contracted facility will be paid at the lesser of 100% of the AHCCCS contract amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment will be made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. The AHCCCS contracted transplantation rates may be found on the AHCCCS website.

See further details in Section D of the RFP document.

Hospital Supplemental Payment

Effective October 1, 2008 there will no longer be a hospital supplemental payment for the MED population. Approximately 95% of the hospital costs related to the supplemental payment occur during the PPC time frame, thus are reconciled as part of the PPC Reconciliation (see Paragraph 53, Compensation, of Section D of the RFP document for further information). The PPC and prospective rates will be adjusted accordingly. The data in the data supplement for the prospective MED population will include the prospective costs associated with these hospital stays.

HIFA Parents

Effective October 1, 2008, the HIFA parents' rate will be blended into the TANF rate. The cost and utilization experience in the encounter data has been restated to include the HIFA parents rate codes in the TANF/SOBRA/Kidscare risk groups.

Population Growth

See Section H for further information regarding enrollment and projected growth.

Outpatient and Emergency Room Payment Methodology Change

Based on chapter 279 laws 2004, effective July 1, 2005, AHCCCS changed the hospital outpatient and emergency room reimbursement methodology in order to help control costs and to allow for a better prediction of trends. AHCCCS developed a new prospective outpatient hospital payment methodology based on a procedure code level fee schedule that is derived from Medicare's Outpatient Hospital Prospective Payment System (OPPS). This new payment methodology applies to all in-state and out-of-state non-Indian Health Services hospitals. The methodology patterns itself after the OPPS by grouping together procedures that are similar in nature for the purpose of determining a fee. However, instead of assigning fees from the Medicare national database, fees are based on AHCCCS hospital specific data.

AHCCCS incorporated this increase into the CY06 rates as a program change. The statewide impact was a 6.4% increase in the outpatient and emergency room categories of service on a PMPM basis across all prospective risk groups.

Episodic/Diagnostic Risk Adjustment

AHCCCS anticipates utilizing an episodic/diagnostic risk adjustment methodology that will be applied to Contractor specific capitation rates for rates effective no sooner than

April 1, 2009, and annually thereafter effective October 1. AHCCCS will use a national model, based on a Contractor's membership at a specified date, and will share the methodology with the Contractor prior to implementation. For the episodic/diagnostic risk adjustment in CYE 09, AHCCCS will apply no more than 50% of the capitation rate adjustment to the remaining months of the contract year. Effective October 1, 2009, the full impact of the model will be applied. The methodology may apply to any or all risk groups and GSAs.