



Prospective Offerors' Conference Acute Care/CRS Programs

November 9, 2012



30 Years of Medicaid Innovation
Our first care is your health care
Arizona Health Care Cost Containment System

"Reaching across Arizona to provide comprehensive quality
health care for those in need"



Welcome



30 Years of Medicaid Innovation
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Agenda

- ❑ AHCCCS Overview
- ❑ Contracting Process
- ❑ Medicare Requirements
- ❑ AHCCCS Quality Strategy
- ❑ AHCCCS Finance and Rate Development
- ❑ Encounters, Reinsurance and Technology
- ❑ Other RFP Highlights





AHCCCS Overview

Tom Betlach
AHCCCS Director



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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



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 for Contractor performance
- ❑ Understand and respect each other's challenges
- ❑ Listen and provide feedback
- ❑ Ensure ongoing communication
- ❑ Promote mutual accountability
- ❑ Maintain flexibility
- ❑ Strive for a long-term relationship



Operational Expectations of Contractors

- Contractor performance accountability
 - Self-monitor operations and clinical performance, using available data
 - Develop and implement interventions designed to improve operational or clinical performance
 - Evaluate effectiveness of interventions and adjust as necessary to achieve excellence
 - Staff to meet AHCCCS performance expectations
- Contractor/AHCCCS partnership
 - Recognize that members and providers are valued partners in the AHCCCS program
 - Manage administrative subcontractors
 - Eliminate inefficient/burdensome Contractor policies/processes
- Contractor collaboration and best practices



Contractor Oversight

AHCCCS monitors Contractors' performance to ensure Contractor is able to perform under the contract via:

- ❑ Operational Reviews
- ❑ Deliverable review
- ❑ Clinical performance measures
- ❑ Quality improvement projects
- ❑ Medical Management/Utilization Management
- ❑ Provider network monitoring
- ❑ Claims payment timeliness and accuracy
- ❑ Grievance System (member grievances and appeals and claim dispute monitoring)



AHCCCS Today

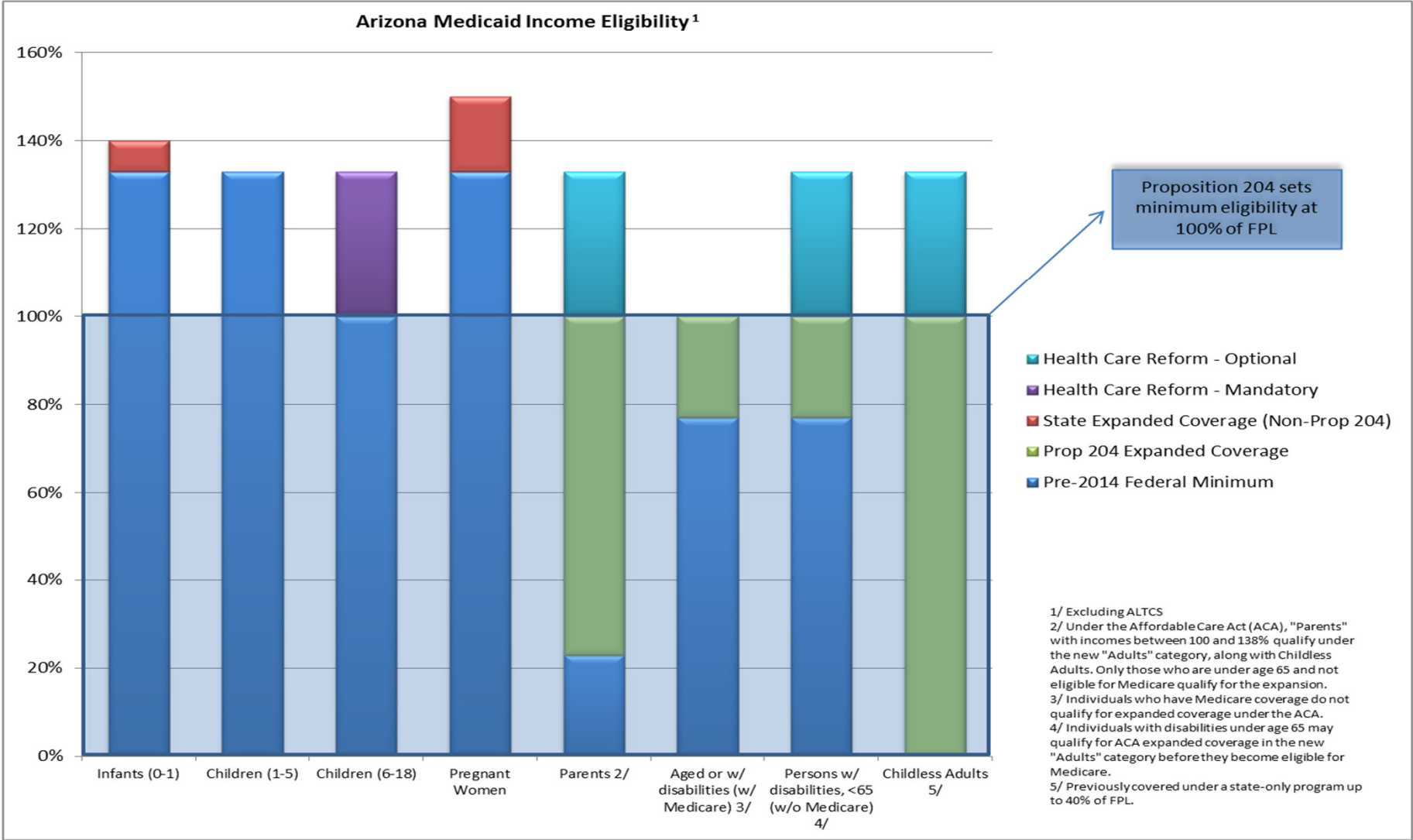
- ❑ Largest insurer in State
- ❑ \$9.0 billion Program and growing
- ❑ Covers over 50% of all births
- ❑ Covers two-thirds of nursing facility days
- ❑ Provides broader coverage than most States – childless adults – parents
- ❑ Relatively good payer compared with other State Medicaid programs



Arizona Managed Care Principles

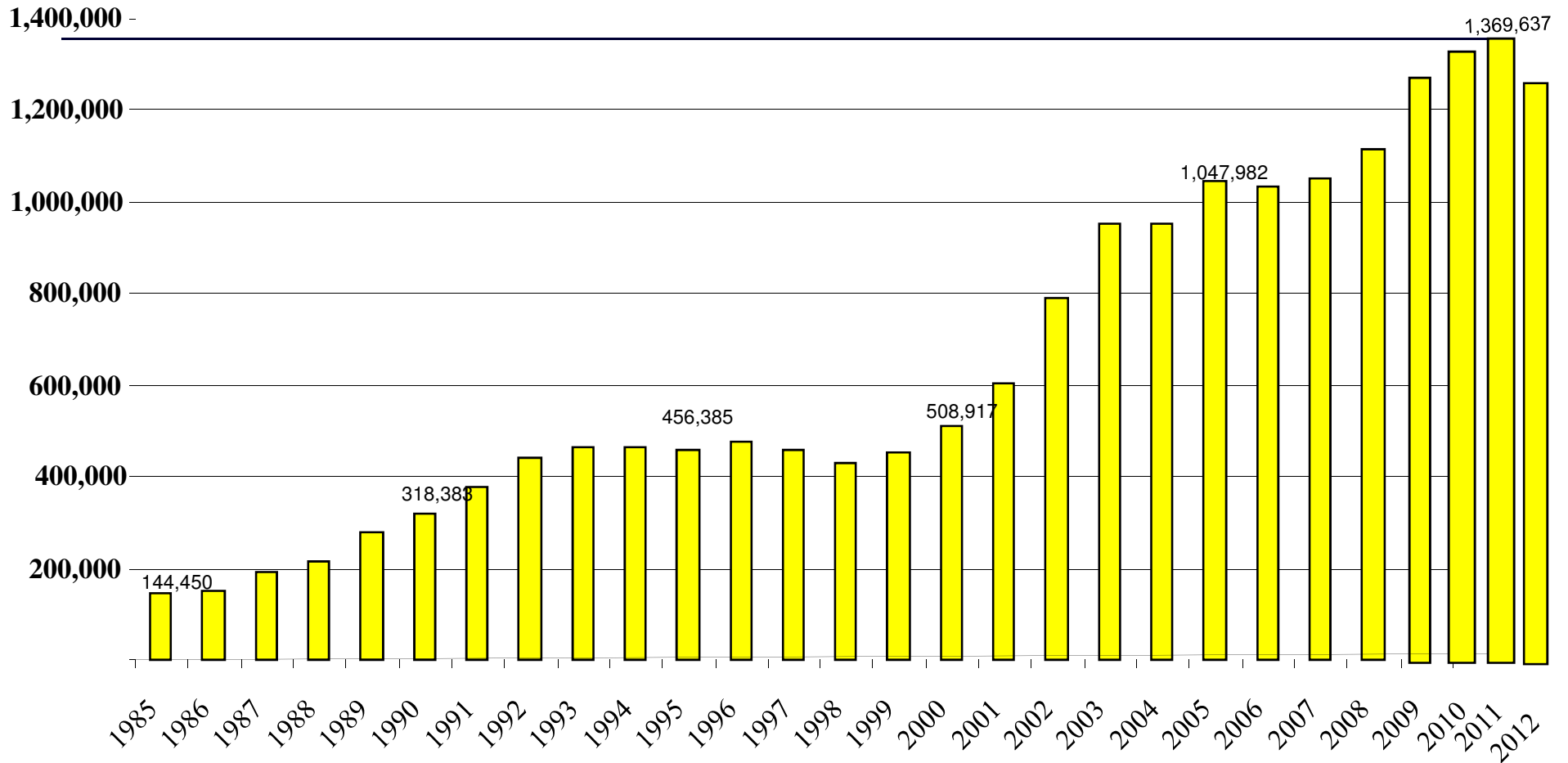
- Promote competition and choice in marketplace
 - RFPs strong Plan competition
- Establish proper infrastructure for oversight
 - Staff of 75 to oversee Plans
 - Very good encounter data used for rate setting and quality measures
- Demand improved member outcomes and Plan performance
 - Track quality measures – sanctions for poor results
- Establish broad networks that ensure member access
 - Regular monitoring
- Be a competitive payer that attracts providers
 - Professional/OP rates typically at Medicare





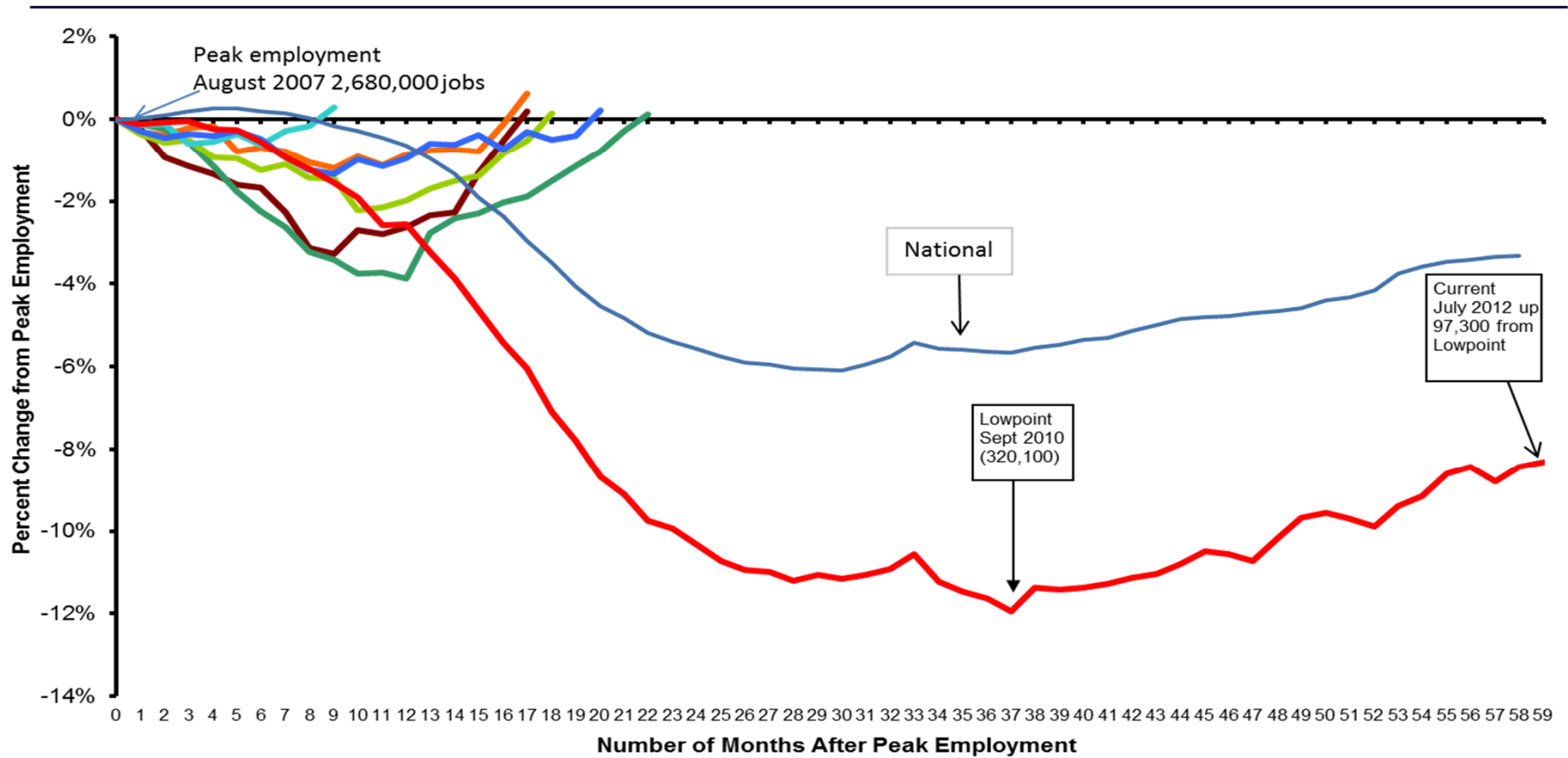
AHCCCS Population as of July 1, 2012

1985 – 2012

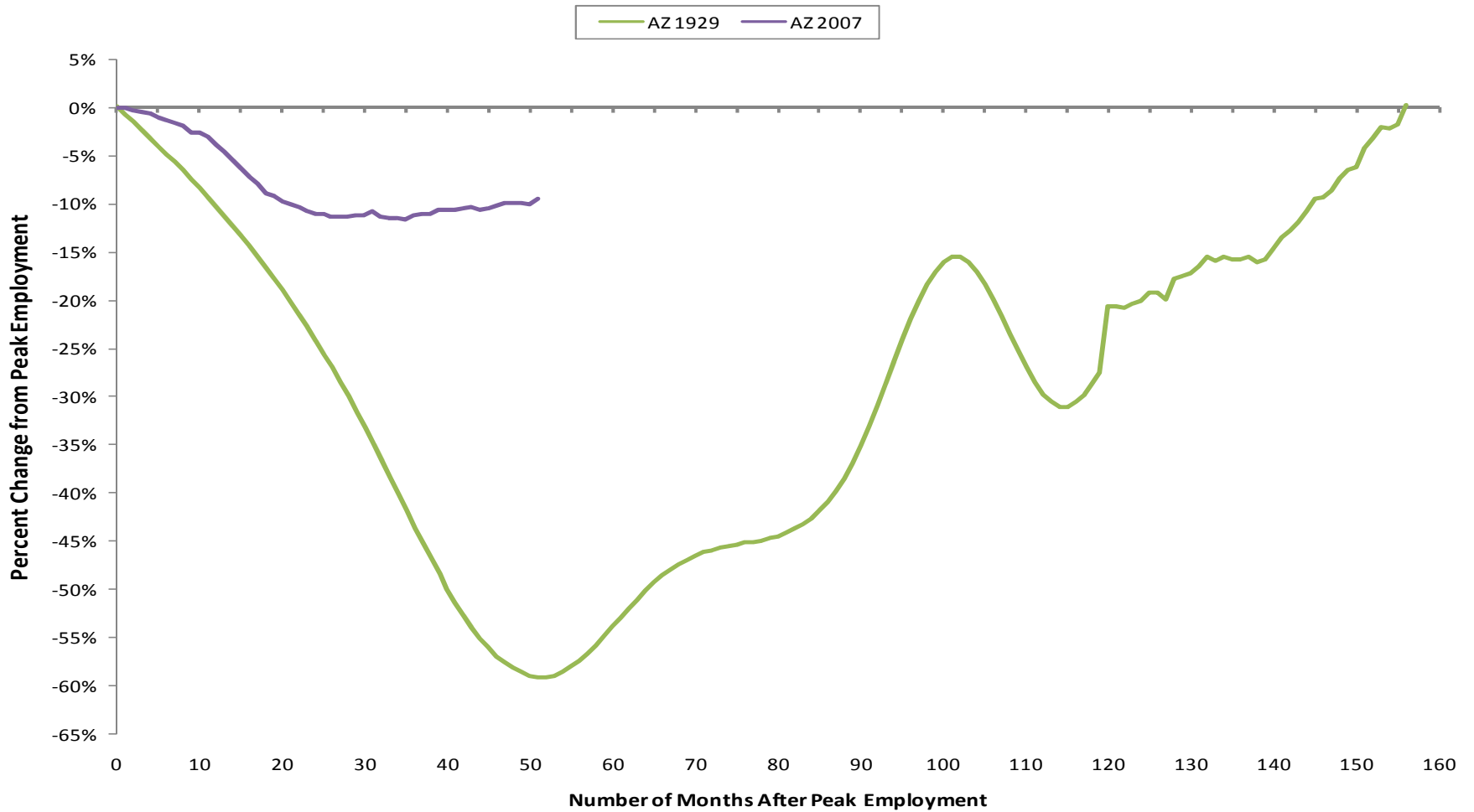


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Arizona Job Loss Non-Farm Seasonally Adjusted

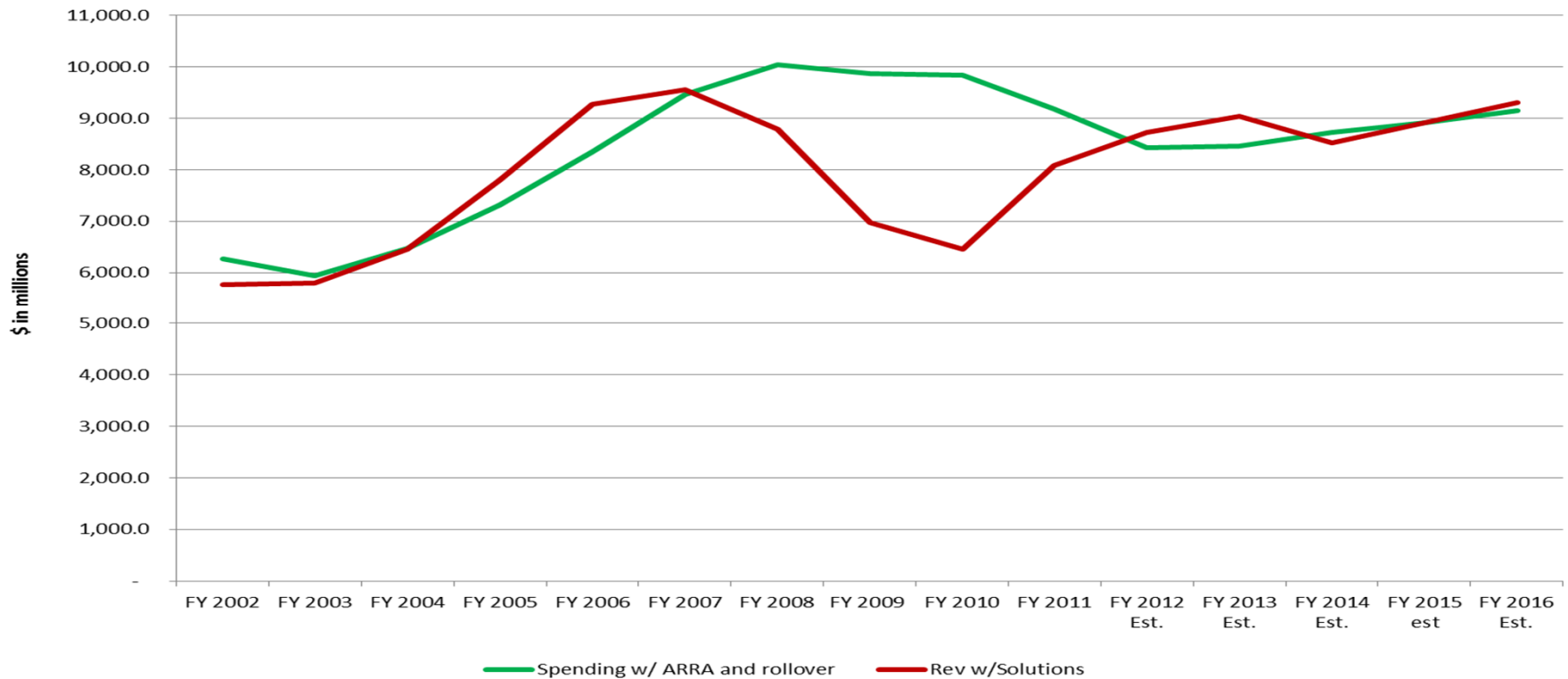


AZ Depression vs. Recession
Number of Months needed to surpass a peak in employment



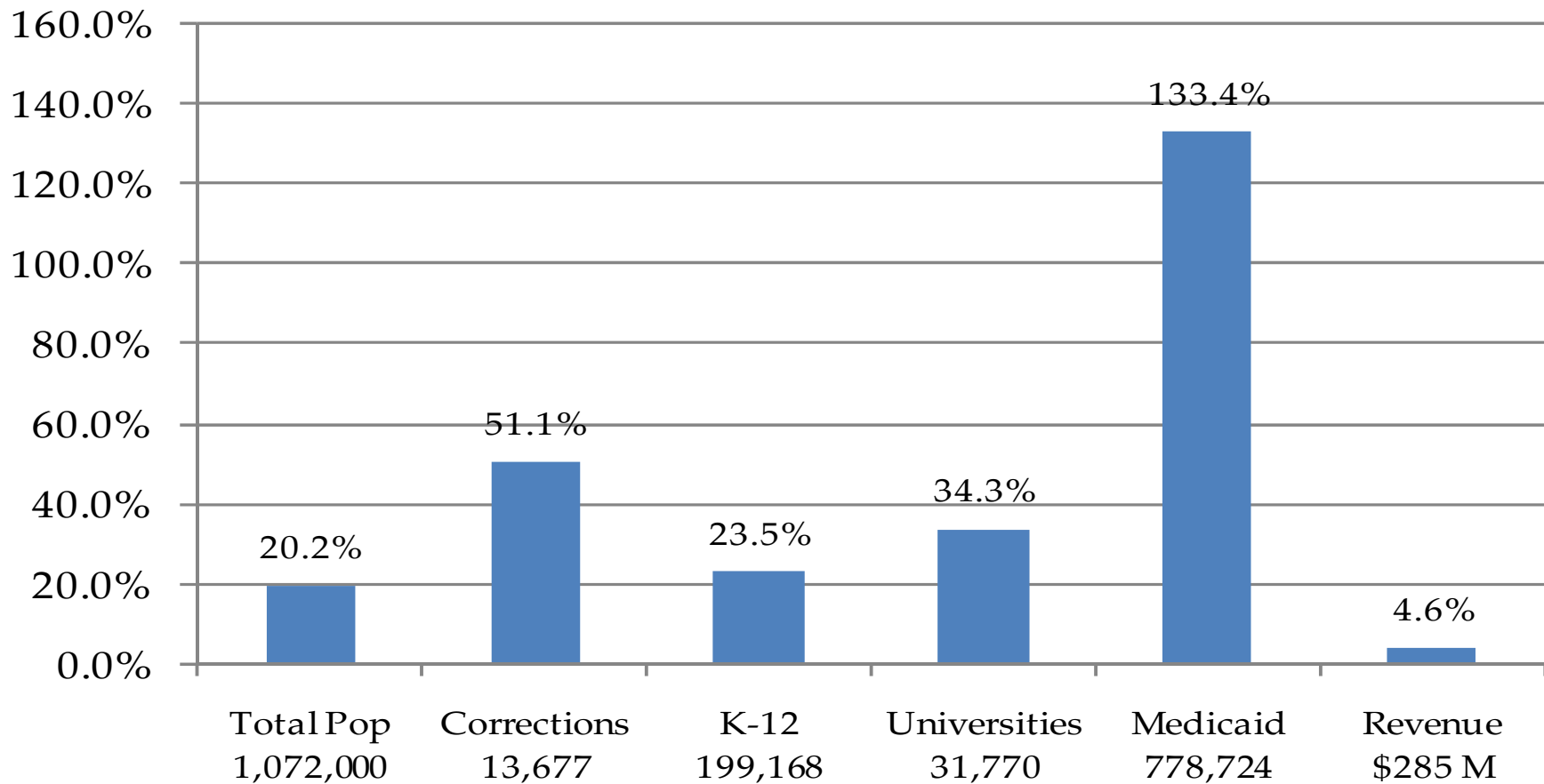
State Budget Outlook

Arizona General Fund Ongoing Expenditures and Revenues FY 2002-FY 2016

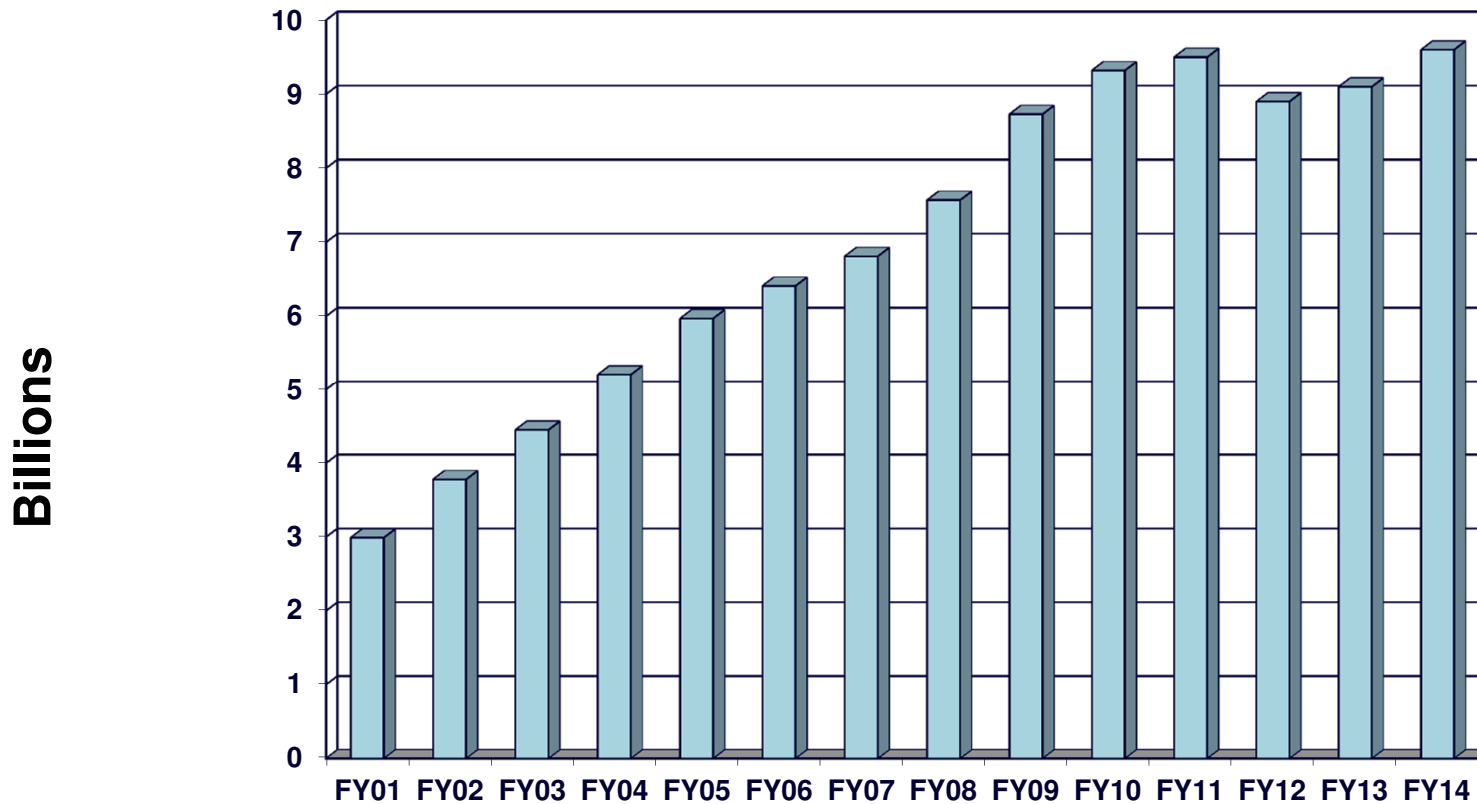


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Enrollment Growth FY 2001 to FY 2010

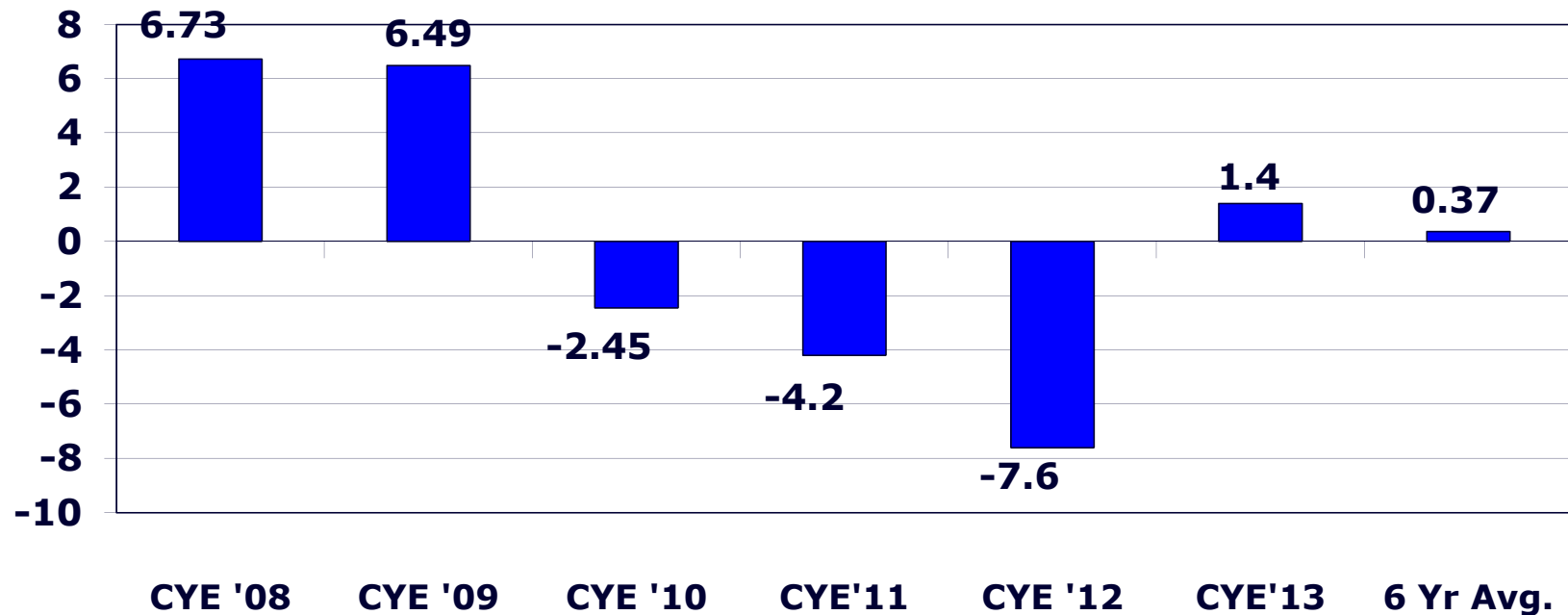


AHCCCS Spending



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AHCCCS Capitation Trends

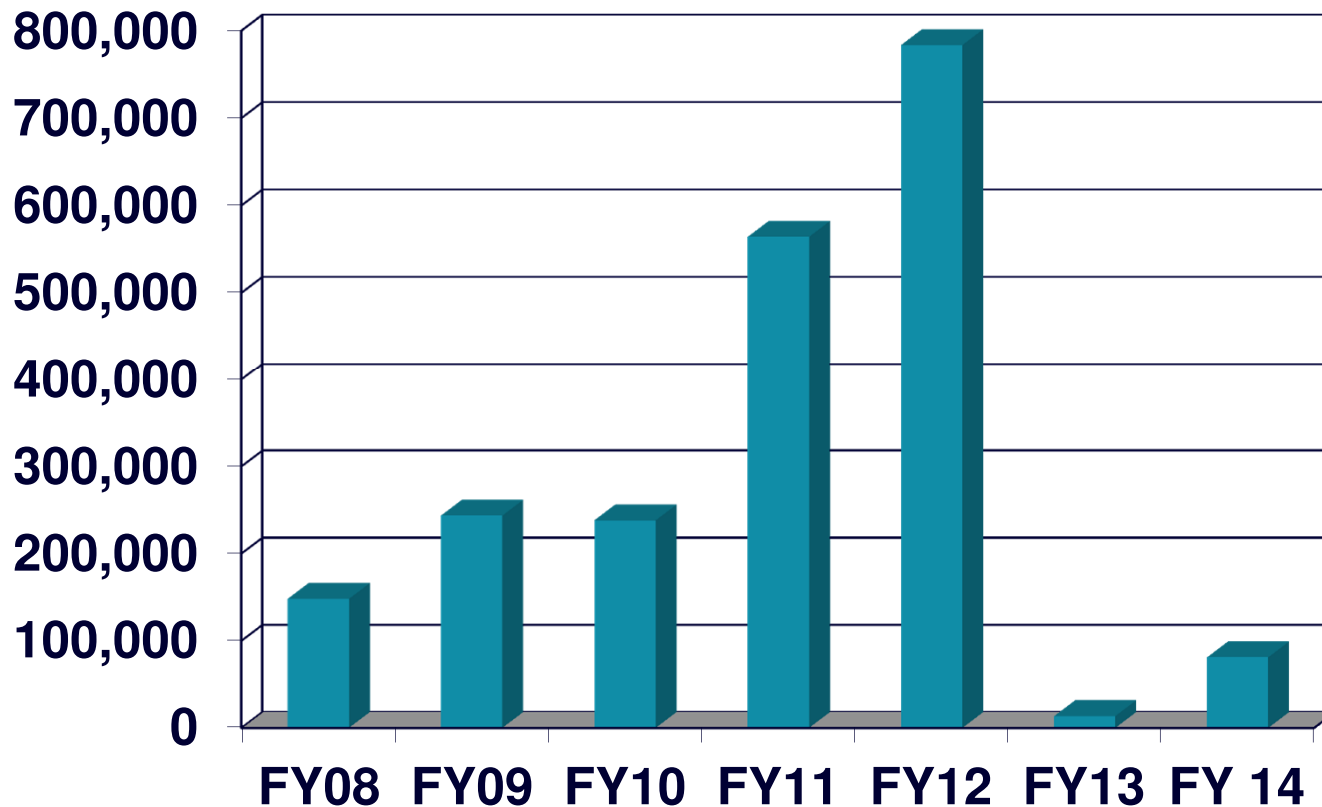


State Budget Process

- ◆ July - Sept – AHCCCS develops State budget submittal
- ◆ Sept - Dec – Governor’s Office and Legislature develop budget recommendations
- ◆ Jan – June – Legislature and Governor work on and develop budget
- ◆ July – June – AHCCCS works on implementation of budget Issues



AHCCCS Budget Request Increases



AHCCCS FY 2014 Request

- Total General Fund Increase - \$81 million
- Assumptions
 - Prop 204 freeze through 12-31-13
 - Enrollment resumes 1-1-14 at enhanced FMAP
 - Traditional Acute growth – 18%
 - KidsCare II – 50% to Medicaid
 - 3% cap rate current year and FY 2014
 - Require legislation – Outlier – IP – Transplant
 - No impact from sales tax initiative



FY 2014 ACA Summary

Issue (Effective Date)	Total Fund	Fiscal Year 2014	
		Federal Fund	State Match
Child Expansion (1/1/14)	28,634,800	20,263,100	8,371,700
Categorical Woodwork (7/1/13)	129,164,400	84,835,200	44,329,200
Streamlined Redeterminations (1/1/14)	67,338,300	44,227,900	23,110,400
Federal Emergency Services for Childless Adults (1/1/14)	12,307,800	10,195,900	2,111,900
Primary Care Physician Rates (1/1/13)	159,964,000	118,935,200	41,028,800
Health Insurer Fee (1/1/14)	35,018,600	23,767,900	11,250,700
Grand Total	432,427,900	302,225,200	130,202,700



Federal Spending - Sequester

- 7.8% decrease applied to all covered non-defense discretionary and mandatory programs (FY 13 AZ Impact \$132 million)
- 10% sequester decrease applied across the board for defense programs (AZ impact \$1.3 billion)
- Arizona is projected to lose 35,248 jobs to DOD cuts and 13,941 to Non-DOD cuts, according to a Aerospace Industries Association report





Impact of Expiration of Tax Cuts

- Expiration of Title I of the Tax Relief Act, Unemployment Insurance Reauthorization, 2010 Job Creation Act, and Title III (gift and estate tax) will lead to an increased tax burden of \$3.2 trillion between 2013-2022



Process and Timeline for Deliberations

- Ongoing: Await Federal guidance
- August 2012: Update fiscal estimates on State options
- July – November 2012: Engage stakeholders/public
- **September – Post 1115 waiver seeking enhanced funding for Prop 204 population**
- **November – Submit waiver to CMS**
- December 2012: Incorporate final decisions into normal policy-making process
- 2013 – Legislative process



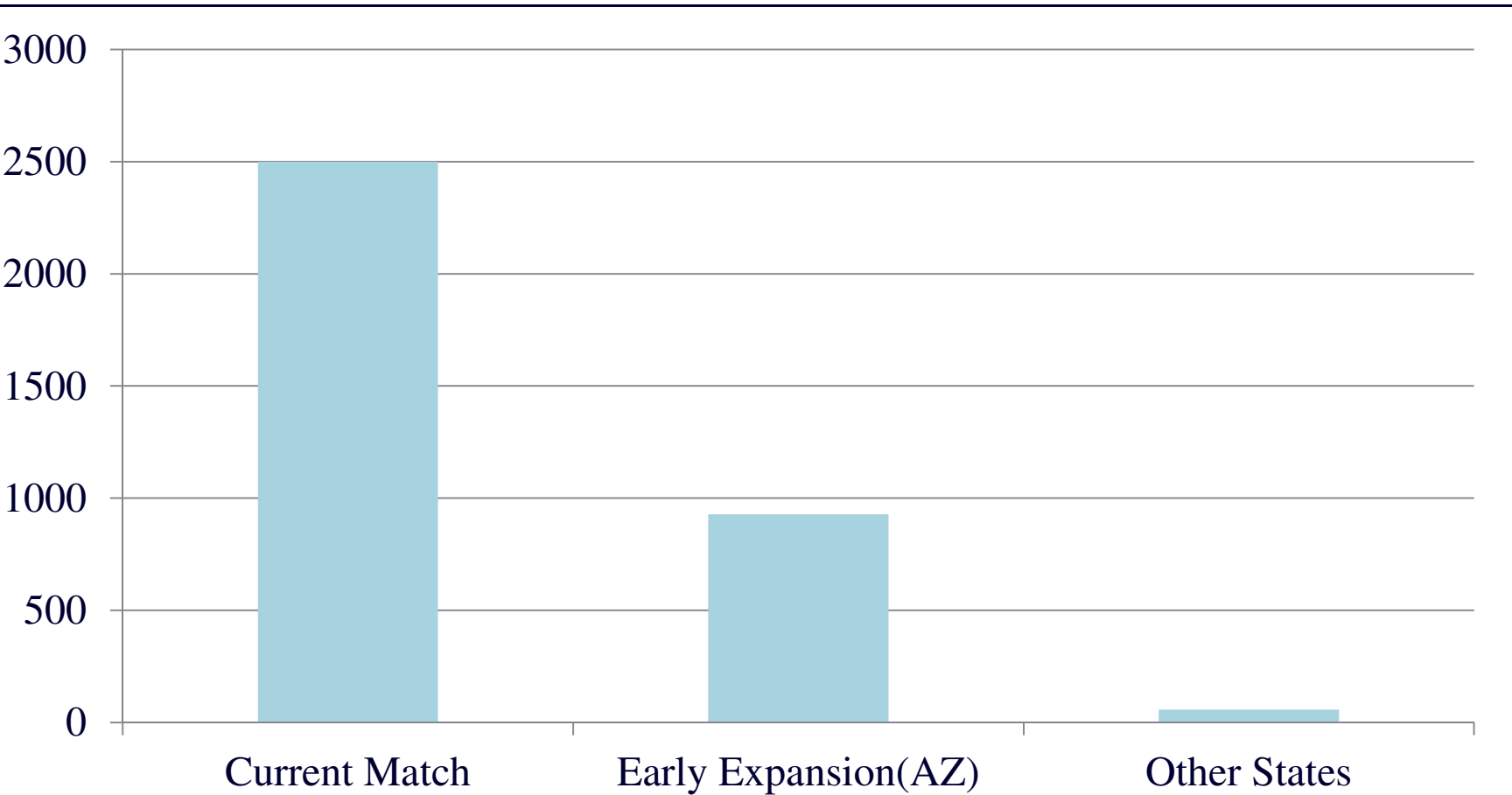
1115 Waiver Proposal

- ❑ Does not reflect any “decision” on AHCCCS coverage issues
- ❑ Agency has authority to seek waiver because of Prop 204 (2000) – Seeks Medicaid coverage beyond 1-1-14
- ❑ Waiver seeks enhanced funding levels and flexibility to manage within available resources



State Match Costs (FY 14-17)

Comparison In Millions



Population Fiscal Summary (FY 16)

Population	FPL	Est. #	State Cost	Total
Children 6-18	100-133	44,000	\$33 m	\$124 m
Eligible not enrolled	0-133	137,000	\$225 m	\$656 m
Childless Adult Restoration	0-100	154,000	\$170 m	\$1.4 B
Childless Adult not previously enrolled	0-100	33,600	\$37 m	\$306 m
Optional Parent Expansion	100-133	42,000	\$0	\$289 m
Optional Childless Adult Expansion	100-133	18,000	\$0	\$165 m



AHCCCS Summary

- Are there available resources to restore Proposition 204?
- What Federal match can the State get?
- Will the State pursue Medicaid coverage above 100% FPL?



Exchange Timeframes

- September 2012: Essential benefits decision
- **November 2012: Submit State's intent regarding Exchange to HHS Secretary**
- January 2013: HHS Secretary certifies Exchange
- July 2013: Systems readiness testing
- October 2013: Exchange enrollment begins
- January 2014: Exchange coverage begins
- January 2015: Exchange must be self-sustaining through user fees, assessments or other funding sources





Exchange Decisions

- State or Federal Exchange?
- If State Exchange – where does it live?



Long Term Strategies

- ❑ Improve care coordination as part Health Care Reform requirements
- ❑ Triple Crown of contracting – integration and modernization
- ❑ Dual Eligible members
- ❑ Program integrity efforts
- ❑ Payment reform
- ❑ Leverage Health Information Technology
- ❑ Improve American Indian health care delivery
- ❑ IT system requirements



AHCCCS Sunset

- Sunset Audit Process
 - TPL/COB – “AHCCCS processes help meet federal and state requirements...” - minimal findings
 - Eligibility – “Findings of a 1.1% error rate are commendable ...particularly when compared to the ...national eligibility error rate of 6.7%” (AHCCCS response)
 - Medicaid Fraud – “AHCCCS has processes in place to detect Medicaid fraud and abuse but should continue to enhance its training and data analysis”
- Sunset Factors – “Auditors’ analysis of the sunset factors found strong performance by AHCCCS with regard to many of these factors”
- Next Step - Legislation



Timeline

- November – Exchange Blueprint due
- December – Governor’s Medicaid recommendation
- January – ACA – PCP increase
- January – Legislative session
 - AHCCCS continuation
 - Inpatient legislation
 - Coverage and ACA decisions
- March – Duals Demonstration path decision
- October – New contracts in place – Acute – CRS – Maricopa RBHA
- October – Exchange application date
- January 1, 2014 – Exchange go live date/certain 1115 waivers expire
- October 2014 – ICD 10





Contracting Process

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Contracting Process

- Purpose
- Materials
- Timetable
 - Submission deadline January 28, 2013
3:00 p.m. Arizona time
- Website navigation/RSS Feed
- Questions/Answers
 - All questions must be submitted in writing using the template available in the Bidders' Library
 - Verbal responses today are not binding
- RFP prevails



RFP Milestone Dates

Activity	Date
RFP Issued	November 1, 2012
Prospective Offerors' Conference and Technical Interface Meeting	November 9, 2012
First Set of Technical Assistance and RFP Questions Due	November 14, 2012
RFP Amendment Including Responses to RFP Questions Issued On or Before	November 27, 2012
Second Set of Technical Assistance and RFP Questions Due	December 10, 2012
Second Amendment Including Responses to RFP Questions Issued On or Before	December 19, 2012
Proposals Due by 3:00 p.m. Arizona time	January 28, 2013
Contracts Awarded On or Before	March 22, 2013
Readiness Reviews Begin On or After	April 1, 2013
New Contracts Effective	October 1, 2013



Contracts to be Awarded

GSA #	County or Counties	Number of Awards
2	Yuma, La Paz	Maximum of 2
4	Apache, Coconino, Mohave, and Navajo	Maximum of 2
6	Yavapai	Maximum of 2
8	Gila, Pinal	Maximum of 2
10	Pima, Santa Cruz*	Maximum of 5
12	Maricopa	Maximum of 7
14	Graham, Greenlee, Cochise	Maximum of 2

*Two contracts will be awarded in Santa Cruz County from the five Pima contract awardees.



Response Specifications – NEW!

- ❑ Electronic version of proposal due with submission
- ❑ No proprietary information in submission with the exception of Section G: Representations and Certifications of Offeror
- ❑ In order to be considered for CRS – Offeror must bid and be awarded at least one GSA for Acute Program
- ❑ Proposals (including capitation rate bids) to be posted to website after contract awards



Response Specifications (cont')

- ❑ Hardcopy Submissions: Original plus six copies
- ❑ Sturdy 3-ring, 3-inch binders
- ❑ All pages numbered sequentially
- ❑ Single spaced, typewritten in at least 11 point Times New Roman font
- ❑ 8½ by 11 inch paper



Specifications (cont')

- ❑ 1 side of paper = 1 page
- ❑ Borders no less than 1/2 inch
- ❑ 5 pages maximum per submission requirement unless otherwise specified in the submission



Acute Scoring

- ❑ Capitation scored by Geographic Service Area
- ❑ Access to Care/Network Management, Program, and Organization will receive a Statewide score
- ❑ Only information within allotted page limits and permitted attachments will be considered
- ❑ AHCCCS will not consider information provided elsewhere in the proposal



CRS Scoring

- ❑ Acute scores for Access to Care/Network Management, Program, and Organization will be combined with CRS scores for same components
- ❑ CRS capitation scored independently; Acute capitation score not considered
- ❑ CRS weighting applied
- ❑ Only information within allotted page limits and permitted attachments will be considered
- ❑ AHCCCS will not consider information provided elsewhere in the proposal





CRS Term of Contract

- AHCCCS is seeking amendment to CRS statutes to change the term of the CRS contract from four years to five years
- Section E – Contract Terms and Conditions





Medicare Requirements

Katrina Cope

Medicare Administrator

Division of Health Care Management



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Exhibit D: Medicare Requirements



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Exhibit D: Medicare Requirements - Background

- All Acute Contractors are required to provide Medicare benefits
- In all awarded GSAs
- As a Medicare-Medicaid Demonstration Plan (MMP) or Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), as required by AHCCCS
- Starting on January 1, 2014



Exhibit D: Medicare Requirements – Background (cont’)

- ❑ A.R.S. 36-2901.01: Contractors must establish a separate corporation whose only authorized business is to provide services under the AHCCCS Acute Care contract
- ❑ Separate corporation must be established within 120 days of contract award
- ❑ Contractor must have legal and actual authority over both the Medicare product and the corporation under AHCCCS contract



Exhibit D: Medicare Requirements - Background

- Must ensure integration of Medicare and Medicaid within key areas
 - Network Management/Provider Relations
 - Member Services
 - Quality Management
 - Medical Management
 - Grievance System
- Must establish branding to ensure that Contractor's Medicare and AHCCCS Plans are easily identifiable as integrated to members and providers



Exhibit D: Medicare Requirements - Certification

- ❑ Medicare Advantage Plans are required to be licensed under State law
- ❑ AHCCCS has the authority to certify Contractors for Medicare purposes in lieu of licensing (A.R.S. 36-2903(B)(2))
- ❑ Contractors can apply for licensure with the Arizona Department of Insurance or certification through AHCCCS
- ❑ ACOM Policy 313 for details



Exhibit D: Medicare Requirements – Demonstration

- Pending Federal review
- AHCCCS intends to have an MOU with CMS in early 2013
- MOU may modify requirements of RFP
- Contractors must meet CMS Demonstration requirements in addition to requirements of RFP:
 - Demonstration specific application
 - Model of Care
 - Part D formulary



Exhibit D: Medicare Requirements – Demonstration (cont’)

- Rates for duals will be replaced with capitation rates computed by AHCCCS and CMS for the Medicaid and Medicare expenses
- AHCCCS intends to work with CMS:
 - To develop actuarially sound rates
 - To offer reconciliation for the Demonstration
- AHCCCS proposes to use its current rate-setting methods for the Medicaid component of the Demonstration



Exhibit D: Medicare Requirements – D-SNP

- AHCCCS will not contract with D-SNPs to serve the Acute Medicaid population outside of GSAs in which contracts are awarded
- If CMS and AHCCCS implement the Demonstration, Medicare-Medicaid Plans replace D-SNPs as the method for alignment
- ACOM Policy 107 for details



Exhibit D: Medicare Requirements – D-SNP (cont’)

- If AHCCCS does not move forward with the Demonstration, other methods will be explored for alignment/care coordination improvement such as:
 - Requiring D-SNPs to submit encounter data to AHCCCS
 - Transitioning members enrolled with Unsuccessful Incumbent Contractor to Contractor they are enrolled with for Medicare services
 - Ongoing alignment of Medicaid enrollment with Medicare
 - Plan/State outreach and education



Exhibit D: Medicare Requirements – NOIA

- All Offerors must submit to CMS a Notice of Intent to Apply as a Medicare-Medicaid Plan for the Demonstration by November 14th at 5:00 p.m. EST
- **In addition**, all Offerors must submit to CMS a Notice of Intent to Apply as a D-SNP by November 14th at 5:00 p.m. EST
- See Oct 19th CMS memo for instructions



Exhibit D: Medicare Requirements – CMS Application

- All Offerors must submit to CMS a Medicare-Medicaid Plan Application for the Demonstration by February 21, 2013
- **In addition**, all Offerors must submit to CMS a D-SNP Application by February 21, 2013
- CMS intends for applications to be released on January 10, 2013





AHCCCS Quality Strategy

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Clinical Quality Administrator
Division of Health Care Management



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Quality Management

- ❑ Developing and assessing the quality and appropriateness of care/services for members
- ❑ Quality of care combined with Contractor requirements
- ❑ Identifying priority areas for improvement
- ❑ Identifying, collecting and assessing relevant data





Quality Management

- ❑ Quality processes integrated throughout organization
- ❑ Quality Management processes locally driven
- ❑ Local CMO Chair of quality committees



Quality Management

- ❑ Local staff available 24/7 to ensure member health and safety
- ❑ Utilize AZ Health Plan Association Credential Verification Organization contract to reduce provider burden





Quality Improvement

- ❑ Performance Measures – the next generation
- ❑ Providing incentives for excellence and imposing sanctions for poor performance
- ❑ Significant transition in AHCCCS performance measures
 - ❑ Process measures
 - ❑ Outcomes measures



Quality Improvement

- Continue HEDIS-like measures and begin integration of CMS National Core Measure sets (CHIPRA, Well Child, Adult, Duals, SMI, LTC/HCBS and MU)
- Expanded use of data sources
 - Administrative
 - Hybrid
 - Advance to incorporate Health Information Technology (E.H.R. and H.I.E.)





Quality Improvement

- Public input
- Actionable
 - Improve health care outcomes
 - Improve access to care
 - Improve satisfaction
 - Maintain or reduce costs
- Sharing best practices
- Public reporting/transparency



Quality Improvement

- Performance Improvement Projects
 - Align with Federal or State goals/objectives
 - Data driven topics
 - Community partnering opportunities
 - PM and PIPs – compare to national benchmarks, Medicaid, commercial (age, gender, race/ethnicity and regional comparisons)





Maternal and Child Health (EPSDT)

- Adhere to Federal and State requirements
 - Almost everything is covered under EPSDT
- CMS minimum performance improvement requirements for certain CMS 416 reporting lines by 2015
- Focus on medical home and dental home



Maternal and Child Health (EPSDT)

- Strong community and Federal/State collaboration and partnering requirements
 - Early Intervention
 - Vaccine for Children
 - Breast and Cervical Cancer Treatment
 - Baby Arizona
 - HeadStart
- Family planning
- Sterilizations





Encounters, Reinsurance and Information Technology

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Data Analysis and Research Manager
Division of Health Care Management



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What Is An Encounter?

- A record (claim) of a medically related service rendered by a registered AHCCCS provider to an AHCCCS member enrolled with a Contractor (MCO), which has been adjudicated by the MCO.
 - Includes sub-capitated services and fee-for-service payments
 - Submitted electronically by MCO to AHCCCS
 - Includes both paid and certain denied/disallowed services



Encounter Data Uses

- ❑ MCO capitation/fee-for-service rate setting
- ❑ Reconciliations and risk adjustment
- ❑ Reinsurance calculation and payment
- ❑ Performance measure reporting
- ❑ Identification of centers of excellence
- ❑ Supplemental payments to hospitals
- ❑ Medical record audits
- ❑ CMS reports
- ❑ Fraud and abuse analysis & reporting
- ❑ General information management
- ❑ Decision support and “what-if” analysis
- ❑ Pharmacy Rebates



Encounter General Principles

- ❑ Guidelines for submitting individual encounters generally follow health insurance industry standards used by commercial insurance companies, Medicare and AHCCCS Fee for Service
- ❑ Some requirements are specific to the AHCCCS program; to avoid pending or denial of encounters, Contractors must ensure that encounters are consistent with both the general principles and those requirements specific to AHCCCS



Encounter Testing and Technical Assistance

- AHCCCS maintains a test environment that is available for use by all Contractors to submit test encounter files for AHCCCS processing
- AHCCCS makes available and encourages the use of a validation tool “Community Manager” for all Contractors
- AHCCCS Encounter Unit staff are available via phone or email Monday through Friday to assist Contractors in the submission of encounters as well as the resolution and research of encounter pends and denials



Encounter Testing and Technical Assistance (cont.)

- AHCCCS maintains several email addresses to assist Contractors with the submission of Encounter related questions:
 - For Encounter pend, denial or adjudication related questions
AHCCSEncounters@azahcccs.gov
 - For Encounter validation and/or translation related questions
AHCCSTIEncounters@azahcccs.gov
- Contractors may also request Encounter specific training, as needed, by contacting the Encounter Unit Staff
- Contractors are required to participate in regularly scheduled 1-1 meetings with Encounter Unit staff, as well as periodically scheduled AHCCCS Technical Consortiums



Encounter Related Files

- AHCCCS produces a number of files containing information pertaining to provider and reference data that are intended to assist Contractors with successful and accurate encounter submissions
- Contractors are encouraged to use this data as appropriate on a timely basis to facilitate timely and accurate encounter submissions





What is Reinsurance?

- A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain service costs incurred by a member or eligible person beyond a monetary threshold



Reinsurance General Principles

- ❑ Reinsurance calculation and payment based on encounter data
- ❑ To be considered for Reinsurance the encounter must have adjudicated in the AHCCCS encounter system
- ❑ Reinsurance system has edits to pass in addition to the encounter system edits
- ❑ There are three basic types of Reinsurance:
 - Regular, Catastrophic, and Transplant
- ❑ Specific timeliness standards apply to Reinsurance



Encounter and Reinsurance Processing

- Encounter cycles run twice monthly
- Reinsurance cycles run once monthly
- Processing includes claims-type edits
- Results are produced and communicated to Contractors after each cycle
- Detailed information is available in the Bidders' Library and on both the Encounter and Reinsurance pages on the AHCCCS website



Encounter Data Validation

- ❑ CMS requires that AHCCCS collect complete, accurate and timely encounter data from Contractors
- ❑ AHCCCS data validation studies evaluate these three standards on adjudicated encounter data on at least an annual basis
- ❑ AHCCCS also conducts ongoing review of encounter submission trends and data quality and may conduct focused reviews as needed
- ❑ Additional information is available in the AHCCCS Encounter Data Validation Technical Document on the Encounter page on the AHCCCS website



New Items Related to Technology

- ❑ Contractors must implement ICD10 code sets for Outpatient dates of service or Inpatient dates of discharge 10/1/2014 and after
- ❑ AHCCCS will move to an APR-DRG payment system for inpatient hospital claims effective 10/1/2014 – Contractors will be required to implement this system for payment of non-contracted hospital claims
- ❑ Contractors must comply with HIPAA requirements related to CORE Operating Rules for Eligibility Verifications and Claims Status Inquiries effective 1/1/2013
- ❑ AHCCCS will move to the use of a National Health Plan Identifier effective 10/1/2014 – Contractors will be required to comply with requirements related to the use of this element



Information Technology (IT) Systems Demonstration

- ❑ As noted in Section H, Instructions to Offerors, Paragraph 16.E. Narrative Submissions, No. 10, Information Technology (IT) Systems Demonstration, Offerors will be required to participate in mock Information Systems scenarios
- ❑ Demonstration begins January 29, 2013, the day after Proposals are due to AHCCCS
- ❑ Responses submitted over the 10 day demonstration will be scored along with Proposal submitted January 28, 2013
- ❑ See the Bidders' Library for more information





Finance and Capitation Rate Development

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Division of Health Care Management



DO NOT Submit Proposal Without...

- ❑ An ability to meet Minimum Capitalization requirements
- ❑ An ability to meet Performance Bond requirements
- ❑ Capitation rate bids:
 - Acute –within medical component range and administrative limit
 - CRS –within administrative limit
 - Or risk earning a score of ZERO points for each violation



Capitation – New

- CRS – will no longer be paid one month in arrears
- Payment Reform – Shared Savings
 - Acute – effective 10/1/13
 - Anticipate at least 1% capitation withhold
 - CRS – expect to implement at a later date
 - Acute & CRS – details provided 6 months prior to implementation



Acute Compensation - Overview

- Capitation
 - Prospective - Risk Adjusted
 - Prior Period Coverage
- Delivery Supplemental Payments
- Reinsurance (self-funded)
- Reconciliations
 - PPC
 - Acute Program Tiered Prospective Reconciliation
 - Watch Bidders' Library for draft policies coming soon
- Compensation policies detailed in ACOM Chapter 300



CRS Compensation - Overview

- Capitation
 - Prospective
 - Prior Period Coverage (\$0.00 PPC rate – rolled into Prospective rate)
- Reinsurance (self-funded)
- Reconciliation
 - CRS Program Tiered Prospective Reconciliation
 - Watch Bidders' Library for draft policy coming soon
- Compensation policies detailed in ACOM – Chapter 300



CRS Compensation – Overview (cont)

- Capitation for CRS members who receive Acute Care services through CRS Contractor will be paid like Acute Care Contractors:
 - Monthly and weekly capitation payments

- Capitation for CRS members who will not receive Acute Care services through CRS Contractor will be paid:
 - Monthly capitation payments only
 - Each subsequent month will reconcile prior month's capitation for partial member months



Reinsurance - New

- Regular
 - Acute – Single threshold - \$25,000
 - CRS – Single threshold - \$75,000
 - Coverage for inpatient stays, including inpatient psychiatric hospitals
- Catastrophic – Acute & CRS
 - Biotech drugs – when generic is available, AHCCCS will reimburse lesser of the biotech drug or its generic equivalent unless the generic is contra-indicated



Reinsurance – New (cont’)

- CRS Specific Issues
 - Catastrophic reinsurance for hemophilia and Von Willebrand’s Disease, and Transplant reinsurance, only apply to CRS members who receive Acute Care services through CRS Contractor
 - Costs incurred for a CRS member follow the member through a CRS coverage type change; restrictions apply



Reconciliations – New

- Eliminated TWG reconciliation
 - MED population eliminated
 - AHCCCS Care rolled into Acute Program Tiered Prospective Reconciliation
- Maximum profit: 4.5%
- Maximum loss: 3%
- Capitation withheld due to Payment Reform, if any, will be excluded from reconciliations



Financial Oversight - New

- Performance Bond increased to 100% of monthly capitation
- CRS - Minimum Capitalization requirement equals \$5.5 million
- Equity Per Member increased:
 - Acute - \$170/\$115 depending on enrollment
 - CRS - \$260 year 1 , \$320 year 2, \$370 year 3 and thereafter



Financial Oversight – New (cont.)

- Acute – quarterly financial reporting required for all Contractors’ Medicare Advantage Plans, regardless of certifying/licensing entity:
 - If certified by AHCCCS – viability ratios reviewed and monitored
 - If licensed by ADOI – viability ratios reviewed for informational purposes only
- Acute & CRS - unique AHCCCS Financial Reporting Guides



Auto-Assignment Algorithm - Acute

- Unique assignment process *will* be used *prior* to October 1, 2013 *if* any Unsuccessful Incumbent Contractors – Conversion Group Auto-Assignment
- Unique assignment process *will* be used for *part or all* of CYE 14 *if* any Contractors under stated thresholds – Enhanced Auto-Assignment Post Conversion
- CYE 14 Auto-Assignment Algorithm (AAA) factors:
 - Awarded capitation rate (50%)
 - Contractor’s score on Acute Care proposal, excluding Capitation component score (50%)



Auto-Assignment Algorithm – Acute (cont.)

- CYE 15+ Auto-Assignment Algorithm factors:
 - AHCCCS intends to recognize and reward Contractor performance across a variety of factors which may include a combination of capitation rates and one or more of the following types of performance measures:
 - Clinical performance measures
 - Encounter submission measures
 - Claims processing performance measures
 - Other administrative measures (e.g. measures related to grievances/hearings)
- Watch Bidders’ Library for new ACOM Chapter 300 policy – Auto-Assignment Algorithm
- Policy may be amended to address dual eligible alignment



Conversion Group Auto-Assignment

- Members enrolled with an Unsuccessful Incumbent Contractor (which is not awarded a capped contract) make up the “Conversion Group” (CG)
- CG members will be auto-assigned *only* to new & small Contractors:
 - New: New to the Acute Care Program or new to the GSA
 - Small: Based on enrollment as of May 1, 2013:

County/GSA	GSA-specific Enrollment Threshold
Maricopa – GSA 12	<65,000
Pima County Only	<35,000
Rural GSAs (including Santa Cruz County)	less than or equal to 45% of enrollment in the entire GSA



Conversion Auto-Assignment (cont.)

- Enough CG members to bring new & small Contractors to thresholds?
 - If yes, then once Contractors all at threshold, Conversion AAA ends and CYE 14 AAA model implemented for rest of CG
 - If no, bring all new & small Contractors as equal as possible
- Dual eligible members may be selectively assigned based on Medicare enrollment during the conversion process
- New Contractor in Maricopa and/or Pima GSAs might not have any members assigned
- If AHCCCS determines any Contractor unprepared to receive members, Contractor may not be included in Conversion AAA



Enhanced Auto-Assignment

- ❑ Contractors still below thresholds on September 1, 2013 will receive members under the Enhanced AAA beginning October 1, 2013
- ❑ Enhanced AAA for minimum three months, up to full year
- ❑ Contractors not qualifying for Enhanced AAA will *not* receive auto-assigned members during the Enhanced AAA period
- ❑ Enhanced AAA based on CYE 14 factors
- ❑ Upon completion of Enhanced AAA, all Contractors eligible for AA will be included in CYE 14 AAA methodology



Data Supplement

- ❑ Supplemental information/data to assist Offerors with bids
- ❑ Public data in Bidders' Library
- ❑ Data containing PHI, and large files, available only on EFT/SFTP server
- ❑ Assumptions regarding enrollment impact of Affordable Care Act, and State policy decisions, provided along with monthly Statewide enrollment expectations
- ❑ Risk Adjustment summaries and limited data available



Capitation Rate Submission

- Automated Excel Tools for both Acute & CRS
 - Must submit hard copies with Proposal(s)
 - In case of conflict between required hard copy and electronic tool submission, hard copy prevails
 - Must submit attestation(s) with Proposal(s)
 - Recommended that Offeror use same software version as AHCCCS to avoid any conversion errors
 - Microsoft Excel 2010
 - Will be able to save tools, return and amend until submitted to AHCCCS



Capitation Rate Submission (cont.)

- Automated Excel Tools for both Acute & CRS
 - Will be process for technical assistance
 - Questions not deemed technical in nature will not be answered; Offeror re-directed to formal Q&A process as outlined in Bidders' Library
 - Test early (once posted) so as to meet Q&A deadlines as noted in Bidders' Library
- No intent to solicit Best and Final Offers



Capitation Rate Submission - Acute

- Offerors will bid rates for all risk groups, for all GSAs desired, except the following that will be set by AHCCCS:
 - PPC
 - SOBRA Family Planning Extension
 - State Only Transplants
 - Reinsurance Offsets
- Medical Component
 - Gross PMPM
 - AHCCCS will provide range to bid within – anticipated by 12/14/12
- Administrative Component
 - 8% limit
- Each component scored separately
- Offerors must certify that bids are actuarially-sound



Capitation Rate Submission - CRS

- AHCCCS' actuaries will set three unique medical components:
 - Acute services
 - CRS services
 - Behavioral health services
- Actuaries will compute total medical component by CRS coverage types by combining up to three medical components, as appropriate
 - AHCCCS will provide total medical component rates – anticipated by 12/14/12
- Offerors will bid a single Statewide administrative component
 - Will not vary by CRS coverage type
 - \$60 PMPM limit
- Offerors must attest to both the published total medical component rates and bid administrative rate



Adjustments to Awarded Rates...

...May include, but are not limited to:

- ❑ Program changes
- ❑ Legislative requirements
- ❑ Changes in trend assumptions
- ❑ Updated encounter experience
- ❑ Updated actuarial assumptions
- ❑ Payment reform withhold (Acute)
- ❑ Moral and Religious Objections





Other RFP Highlights

Kari Price
Assistant Director
Division of Health Care Management



Integration Efforts

- ❑ Maricopa members diagnosed with Serious Mental Illness (SMI) will move to Maricopa RBHA for all behavioral health and acute services
- ❑ Members determined eligible for CRS will move from Acute Care Contractors to the CRS Contractor
- ❑ Contractors required to be a Medicare-Medicaid Demonstration Plan or MA D-SNP



Coverage Type	CRS Contractor Service Responsibility			Notes
	CRS	Acute	BH	
1. CRS Fully Integrated	X	X	X	Members receiving all services from the CRS Contractor including acute, behavioral health and CRS-related services.
2. CRS Partially-Integrated - Acute	X	X		AI members receiving all acute health and CRS-related services from the CRS Contractor and receiving behavioral health services from a Tribal RBHA.
3. CRS Partially-Integrated – Behavioral Health (BH)	X		X	CMDP or DDD members receiving all behavioral health and CRS-related services from the CRS Contractor and receiving acute health services from the primary program of enrollment.
3. CRS Only	X			Members receiving all CRS-related services from the CRS Contractor, receiving acute health services from the primary program of enrollment, and receiving behavioral health services as follows: <ul style="list-style-type: none"> • CMDP and DDD AI members from a Tribal RBHA • AIHP members from a T/RBHA CRS Only also includes ALTCS/EPD AI Fee For Service members.

CRS Changes

- CRS Contractor to provide:
 - Most members with CRS condition - CRS specialty, acute and behavioral health services
 - CMDP and DD members – CRS and behavioral health services
 - American Indian members may select – CRS specialty and acute **or** CRS specialty and behavioral health **or** CRS specialty only
 - No services to ALTCS/EPD members enrolled with MCO



CRS Changes

- ❑ AHCCCS will determine medical eligibility for CRS Program
- ❑ Contractor is required to offer more expansive network (outside of MSICs) for CRS specialty care
- ❑ Members may opt to remain in CRS upon turning 21 years of age
- ❑ Members can be made eligible for CRS while hospitalized



Access to Care/Network

- No Letters of Intent from providers
- AHCCCS adopting Medicare time and distance standards in Maricopa and Pima counties – (15 minutes or 10 miles)
 - PCPs
 - Dentists
 - Pharmacy





Contractor Enrollment

- AHCCCS to freeze auto-assignment of members if a Contractor reaches 45% of total enrollment in Maricopa or Pima county
 - Member choice and family continuity not limited



New Program Requirements

- Care Coordination/Medical Management
 - AHCCCS to provide encounter data:
 - One time to new Contractors in each GSA
 - Monthly for services not provided by the Contractor
 - Contractors and Qualified Health Plans to share information on members moving between the Exchange and the AHCCCS program
 - Contractors encouraged to exchange data with hospitals and providers



New Program Requirements (cont')

- Contractors are required to have PCPs who provide behavioral health services perform an annual assessment of members, using standardized screening tool
- Contractors required to accept electronic EPSDT Tracking Forms and to encourage electronic submission by providers



Policy Changes for 10/1/13

- See Bidders' Library for changes to policies and manuals:
 - AHCCCS Contractors Operations Manual (ACOM)
 - AHCCCS Medical Policy Manual (AMPM)
 - AHCCCS Financial Reporting Guides
 - Reinsurance Manual
- Note Draft Section of Bidders' Library



Attestation

- ❑ Acknowledgement of the importance of certain contractual provisions
- ❑ Offeror must attest to each and every element
- ❑ Failure to attest to any item is automatic disqualification
- ❑ Attestation Form in Section I, Exhibit C



Oral Presentations

- ❑ Offeror to present solutions and respond to questions regarding health care situations and operational challenges
- ❑ Limited to six presenters per Offeror – no consultants
- ❑ Presentations scheduled 2/18/13 to 3/6/13
- ❑ Notification of scheduled presentation by 5:00 p.m. on 1/31/13
- ❑ Previously prepared presentations will not be allowed
- ❑ See Section H, Instructions to Offerors for details





QUESTIONS



30 Years of Medicaid Innovation
Our first care is your health care
Arizona Health Care Cost Containment System

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“Reaching across Arizona to provide comprehensive quality health care for those in need”



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