PROGRAM CHANGES

When preparing the capitation rate bid submissions, the following program changes should be considered when reviewing the databook and financial statement information provided in the data supplement. These changes individually had an impact to rates of at least $150,000 statewide and were either effective sometime during the time period for which encounters have been presented, or will be effective on or after October 1, 2011. This document should be used in conjunction with the RFP document to ensure all changes are considered. Below is a brief description of the AHCCCS EPD program changes and their effective dates:

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. In addition, routine maternity charges are excluded from outlier consideration. The changes have been fully-phased in, therefore the total impact of the change was recognized in CYE10. The cost-to-charge ratios are updated annually with the Medicare published rates. AHCCCS estimated program-wide (Acute, ALTCS, etc.) reductions of $22 million to inpatient costs in year one, $49 million cumulative impact in year two and $81 million cumulative impact in year three. It is estimated that the ALTCS program accounts for only 1.5% of these costs with approximately 90% of the costs in Maricopa County, 7% in Pima and 3% in rural counties. AHCCCS estimated that approximately 99% of the costs were prospective. The table below summarizes the ALTCS program estimated yearly impact to prospective only 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.

Estimate Outlier Yearly Impact (non-cumulative)	Maricopa	Pima	Rural	Total
Prospective (CYE08 10/01/07 - 09/30/08)	$ (296,745)	$ (23,143)	$ (11,443)	$ (331,330)
Prospective (CYE09 10/01/08 - 09/30/09)	$ (361,959)	$ (28,285)	$ (14,002)	$ (404,246)
Prospective (CYE10 10/01/09 - 09/30/10)	$ (429,606)	$ (33,602)	$ (16,481)	$ (479,689)

Reinsurance Link to Inpatient Services

Currently the ALTCS reinsurance parameters do not require an inpatient stay to create a regular reinsurance case. Effective October 1, 2011, an inpatient stay will be required for regular reinsurance case creation. The inpatient stay encounter will trigger the case creation if the deductible level has been met using all reinsurable adjudicated encounters (not just the inpatient stay encounter) received to date for that contract year. It is estimated that this would have eliminated approximately $3.5 million from CYE09 reinsurance payments for the EPD program. AHCCCS has factored the impact of this change into the reinsurance offsets.

HIV/AIDS Drug Treatments

For CYE08 and prior, drugs used to treat HIV/AIDS were carved out of capitation rates and paid to Contractors as a quarterly supplemental payment. Beginning October 1, 2008 all pharmaceutical expenditures for HIV/AIDS treatment were included in the pharmacy component of the capitation rates and no supplemental payments are being made for HIV/AIDS.

Behavioral Health (BH)/Traumatic Brain Injury (TBI) Reinsurance Cases

Effective October 1, 2006 and forward, AHCCCS discontinued BH/TBI reinsurance coverage. Members already covered under BEH/TBI Reinsurance were grandfathered in effective October 1, 2006 and reinsurance has continued for these existing cases. All costs for these members are included in the databook and AHCCCS is incorporating changes to reinsurance payments in the reinsurance offsets each year as the population of BH/TBI cases declines.

See further reinsurance data in Section J of the Data Supplement for Offerors in the Bidder's Library.

Adult Dental Coverage

State legislation, signed into law in 2007, required AHCCCS to provide non-emergency (basic and preventive) dental services for ALTCS adults up to a limit of $1,000 annually per elderly and physically disabled (EPD) member starting October 1, 2007. In the 2008 legislative session, the State Legislature did not renew this program, therefore services were discontinued October 1, 2008. The statewide impact to the ALTCS EPD program based on encounter data was about $775,000 or $2.80 PMPM increase/decrease to expenditures during these two years. The table below summarizes the PMPM impact by GSA.

Dental Impact	GSA 40 (Pinal, Gila)	GSA 42 (Yuma, LaPaz)	(Apache, Coconino, Mohave,	(Cochise, Graham, Greenlee)	GSA 48 (Yavapai)	GSA 50 (Pima, Santa Cruz)	GSA 52 (Maricopa)
PMPM	$ (4.62)	$ (3.66)	$ (3.29)	$ (3.12)	$ (11.99)	$ (4.73)	$ (1.33)

Dual and Non-Dual Capitation Rates

Effective October 1, 2009, Dual and Non-Dual (with and without Medicare) rates were no longer set separately and were combined into one rate. For information purposes, the databook shows the data separated, but there will only be one blended capitation rate bid and awarded.

Provider Rate Changes

See General Trend and Rate Setting Assumptions in Section C of the Data Supplement for Offerors in the Bidder's Library.

Benefit Redesign Changes

Effective October 1, 2010 AHCCCS implemented the following benefit changes for adult members:

- Eliminated coverage of insulin pumps, percussive vests, bone-anchored hearing aids, cochlear implants and orthotics. Supplies, equipment maintenance and repair of component parts will remain a covered benefit.
- Eliminated coverage of well visits, microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs.
- Eliminated emergency dental except for medical and surgical oral services, that can be provided by a physician or dentist, when those services would be considered a physician service if furnished by a physician.
- Eliminated services provided by a podiatrist.
- Limiting outpatient physical therapy to 15 visits per contract year.
- Eliminated coverage of certain transplants (pancreas after kidney transplants, lung transplants, allogeneic unrelated hematopoietic cell (bone marrow) transplants, liver transplants for those with a diagnosis of Hepatitis C, and heart transplants for non-ischemic cardiomyopathies).

For adult members with Medicare, Contractors are required to pay cost-sharing for Qualified Medicare Beneficiaries (QMB) when the services noted above are covered by Medicare. Cost-sharing is not required for excluded services for non-QMB Medicare members.

The estimated annual savings for the EPD program for CYE11 is approximately $1.4 million statewide or $4.42 PMPM. The table below summarizes the impact by GSA.

Benefit Redesign Changes Impact	GSA 40 (Pinal, Gila)	GSA 42 (Yuma, LaPaz)	GSA 44 (Apache, Coconino, Mohave, Navajo)	GSA 46 (Cochise, Graham, Greenlee)	GSA 48 (Yavapai)	GSA 50 (Pima, Santa Cruz)	GSA 52 (Maricopa)
Estimate CYE11 PMPM	$ (3.91)	$ (4.44)	$ (4.17)	$ (3.03)	$ (8.67)	$ (3.10)	$ (4.67)