Non-Benefit Costs Bid Requirements

The Non-Benefit Costs Bid Submission workbook, found in the Bidders' Library, Data Supplement, Section F - Rate Development Information, will be utilized by each Offeror to submit their Non-Benefit Costs bid. The workbook contains seven tabs; six tabs are for the administrative cost component bid, each tab applicable to a defined member month range (i.e., membership tier) and the seventh tab is for the case management cost component bid. A single completed workbook must be submitted with each Offeror's proposal.

Non-Benefit Costs Bid - Input Descriptions:

- Pink cells are for numbers submitted by the Offeror,
- Blue cells are formulas, and
- Green cells are numbers provided/set by AHCCCS for the purposes of bidding/comparing bids.

Administrative Component Bid Information

The Offeror's administrative bid must meet the requirements of 42 CFR § 438.5(e), except that any potential start-up expenses should be excluded from the bid (AHCCCS does not reimburse start-up costs). If the administrative bid includes a management fee, the management fee must be broken out into the categories shown in the pink cells. Offerors should detail administrative costs by the line items listed in the Administrative Component Bid Tab Layout table below and utilize the Other Administrative Expenses line only when no other line applies (other administrative costs should be no more than 5 percent of the total administrative amount). Additionally, AHCCCS has a mechanism for ensuring capitation rates include the appropriate amount of premium tax for the Contractor, so premium tax should be excluded from the Offeror's administrative bid.

Each Offeror must bid amounts on each membership tier tab. The six membership tiers are: 0-34,999 member months, 35,000-69,999 member months, 70,000-104,999 member months, 105,000-139,999 member months, 140,000-174,999 member months, and 175,000+ member months. In the initial year of the contract, AHCCCS intends to determine the appropriate membership tier for each awarded Contractor based on projected membership after initial member assignment and member choice.

The administrative expenses will be allocated between the dual and non-dual risk groups by AHCCCS during the capitation rate development process. AHCCCS will evaluate administrative bids and AHCCCS will set administrative cost components of the capitation rates for each year of the contract in compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.

Administrative Component Bid Tab Layout (numbers are for demonstration purposes only)

ALTCS-EPD Administrative Component Bid		
	Year	
Detail Admin Break Out	**Variable Cost PMPM**	**Fixed Cost Total Dollars**
Compensation	$0.50	$2,000,000.00
Occupancy		$500,000.00
Depreciation		
Care Management/Care Coordination	$1.50	
Professional and Outside Services	$0.75	
Office Supplies and Equipment		
Travel		
Repair and Maintenance		
Bank Service Charge		
Insurance		
Marketing		
Interest Expense		
Pharmacy Benefit Manager Expenses		$100,000.00
Fraud Reduction Expenses		
Third Party Activities		
Sub Capitation Block Administrative		
Health Care Quality Improvement		
Program Integrity Fraud, Waste and Abuse Prevention Expenses		
Interpretation/Translation Services		
Other Administrative Expenses	$0.50	
Total Admin Costs	$3.25	$2,600,000.00

Member Months Assumed in Bid		80,000

Case Management Component Bid Information

The Offeror's case management bid must meet the requirements of 42 CFR § 438.5(e). AHCCCS intends to set case management cost components based on the information and calculated PMPMs in the "Case Management Bid" tab provided in the excel workbook. The member enrollment and mix percentages are provided by AHCCCS and are based on an average of the data from July through December 2022. These prescribed values cannot be changed when bidding on this RFP. AHCCCS will adjust the member enrollment

and mix percentages used in capitation rate development after awards have been set and final distribution of membership is known. The same case management PMPM will be applied to both Dual and Non-Dual rate cells; case management PMPMs can, and likely will, vary by GSA.

If the weights assigned to members or the maximum members per case manager changes from what is in the AHCCCS Medical Policy Manual (AMPM) 1630 AHCCCS will adjust the awarded bids as necessary to comply with any new requirements. Refer to AMPM 1630 Section D. Caseload Management for the current weights assigned to members and the maximum members allowable per ALTCS-EPD case managers. This information has been included in Appendix 1 for ease of reference, based on the AMPM 1630 policy as of April 20, 2023.

AHCCCS will evaluate case management bids and set case management cost components of the capitation rates for each year of the contract in compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.

Actuarial Certification

The actuarial certification must describe the development (data, assumptions, and methodologies) of the non-benefit costs (administrative component and case management component bids) in enough detail so an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit cost bid and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR § 438.7(b)(3). Further clarification on documentation can be found in the 2023-2024 Medicaid Managed Care Rate Development Guide.

Appendix 1

D. CASELOAD MANAGEMENT

Adequate numbers of qualified and trained case managers shall be provided to meet the needs of members, and shall meet the caseload ratios detailed below, except as otherwise specified in this policy.

Contractors and AHCCCS Tribal ALTCS Unit shall have written protocols to ensure newly enrolled ALTCS members are assigned to a case manager immediately upon enrollment.

1. Members Who Are Elderly and/or Have Physical Disabilities (E/PD):

   The following formula represents the maximum number of members allowable per E/PD case manager. Each case manager's caseload shall not exceed a weighted value of 96:

   a. For members in an institutional setting, a weighted value of **1.0** is assigned. Case managers may have up to 96 members (96 x 1.0 = 96),
   b. For members in a Home and Community Based Services (HCBS) (own home) setting, a weighted value of **2.2** is assigned. Case managers may have up to 43 members (43 x 2.2 = 96 or less),
   c. For members in an Alternative HCBS setting, a weighted value of **1.8** is assigned. Case managers may have up to 53 members (53 x 1.8 = 96 or less),
   d. For members in Acute Care Only (ACO) status, a weighted value of **1.0** is assigned. Case managers may have up to 96 members (96 x 1.0 = 96), and
   e. If a mixed caseload is assigned, there can be no more than a weighted value of 96. The following formula is to be used in determining a case manager's mixed caseload:

(# of members in an institutional setting x 1.0)
+
(# of members in an HCBS (own home) setting x 2.2)
+
(# of members in an Alternative HCBS setting x 1.8)
+
(# of members in Acute Care Only (ACO) status x 1.0)

= 96 or less

2. Members determined to have an SMI designation:

   The following formula represents the maximum number of members allowable per E/PD case manager serving members determined to have an SMI. Each case manager's caseload shall not exceed a weighted value of 96:

   a. For members in an institutional setting determined to have an SMI, a weighted value of **1.4** is assigned. Case managers may have up to **68** members with an SMI determination (68 x 1.4 = 96 or less),
   b. For members in an HCBS (own home) setting determined to have an SMI, a weighted value of **3.0** is assigned. Case managers may have up to **32** members with an SMI determination (32 x 3.0 = 96),
   c. For members in an Alternative HCBS setting determined to have an SMI, a weighted value of **1.9** is assigned. Case managers may have up to **50** members with an SMI determination (50 x 1.9 = 96 or less),
   d. For members in Acute Care Only (ACO) status determined to have an SMI, a weighted value of **1.0** is assigned. Case managers may have up to 96 ACO members with an SMI determination (96 x 1.0 = 96), and
   e. If a mixed caseload is assigned, there can be no more than a weighted value of 96. The following formula is to be used in determining a case manager's mixed caseload:

(# of members in an institutional setting x 1.0)
+
(# of members determined to have an SMI who are in an institutional setting x 1.4)
+
(# of members in an HCBS (own home) setting x 2.2)
+
(# of members determined to have an SMI who are in an HCBS (own home) setting x3.0)
+
(# of members in an Alternative HCBS setting x 1.8)
+
(# of members determined to have an SMI who are in an Alternative HCBS setting x 1.9)
+
(# of members in Acute Care Only (ACO) status x 1.0)
+
(# of members determined to have an SMI who are in Acute Care Only (ACO) status x 1.0)

_____

= 96 or less

3. A DES/DDD case manager's caseload shall not exceed a per District average ratio of 1:39 members, regardless of setting.

   Caseload Exceptions – The Contractor shall receive authorization from AHCCCS/Division of Health Care Services (DHCS) prior to implementing caseloads whose values exceed those specified above. Lower caseload sizes may be established at the discretion of the Contractor and do not require authorization.

   The Contractor's annual CM Plan shall describe how caseloads will be determined and monitored.