



Arizona Long Term Care System
(ALTCS)
RFP YH12-0001
Prospective Offerors' Conference



Welcome

Shelli Silver

Assistant Director

Division of Health Care Management

Agenda

- Contracting Process
- AHCCCS Overview
- Eligibility and Member Services
- The ALTCS Program
- AHCCCS Finance and Rate Development
- Encounters, Reinsurance and Technology
- RFP Highlights
- Questions?



Contracting Process

Michael Veit

Contracts Administrator

Division of Business and Finance

Contracting Process

- Purpose
- Materials
- Timetable
 - Submission deadline April 1, 2011
3:00 PM
- Website navigation
- Questions/Answers
 - All questions must be submitted in writing using the template available in the Bidder's Library
 - Verbal responses today are not binding
- RFP prevails

RFP Milestone Dates

ACTIVITY	DATE
RFP Issued	January 31, 2011
New Offerors, Prospective Offerors Conference and Technical Assistance Session	February 9, 2011 - AM
Information Technology (IT) PMMIS Technical Interface Meeting	February 9, 2011 - PM
Technical Assistance and RFP Questions Due	February 14, 2011
RFP Amendment and Formal Response to Questions	February 25, 2011
Second Set of Technical Assistance and RFP Questions Due	March 4, 2011
Second RFP Amendment Issued and Formal Response to Second Set of Questions	March 11, 2011
ALTCS Proposals Due by 3:00 P.M.	April 1, 2011
<i>Contracts Awarded on or about</i>	May 9, 2011
Readiness Reviews Begin	July 1, 2011
New Contracts Effective	October 1, 2011

Response Specifications

- Original plus six copies
- Sturdy 3-ring, 3-inch binders
- All pages numbered sequentially
- Single spaced, typewritten in at least 11 point font
- Scanned PDF version due to AHCCCS within seven (7) days via EFT/SFTP

Specifications (cont.)

- 8½ by 11 inch paper
- 1 side of paper = 1 page
- Borders no less than ½ inch
- 3 pages maximum per submission requirement unless otherwise specified in the submission

Scoring

- Capitation and Network Development scored by Geographic Service Area
- 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



AHCCCS OVERVIEW

Tom Betlach
Director

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 Managed Care Model

- Leverages competition and choice
- AHCCCS has the two largest RFPs in state government
- Data shows continued increased quality and cost containment
- Model integrates members into health care delivery system

Arizona Health Care Cost Containment System

Funding

• Federal

• State

• County

• Private

➤ Premiums

**AHCCCS
Administration**

• Medical Policy

• Eligibility (Special Populations)

• Contract for Medical and Long Term Care Services

• Monitor Quality of Care and Financial Viability

• Information Services

• Budget and Claims Processing

• Legal

• Intergovernmental Relations

- Medical Care

- Long Term Care

- Healthcare Group

• Health Plans

• Program Contractors for Long Term Care

• State Agencies

➤ DHS

· Behavioral Health

➤ DES

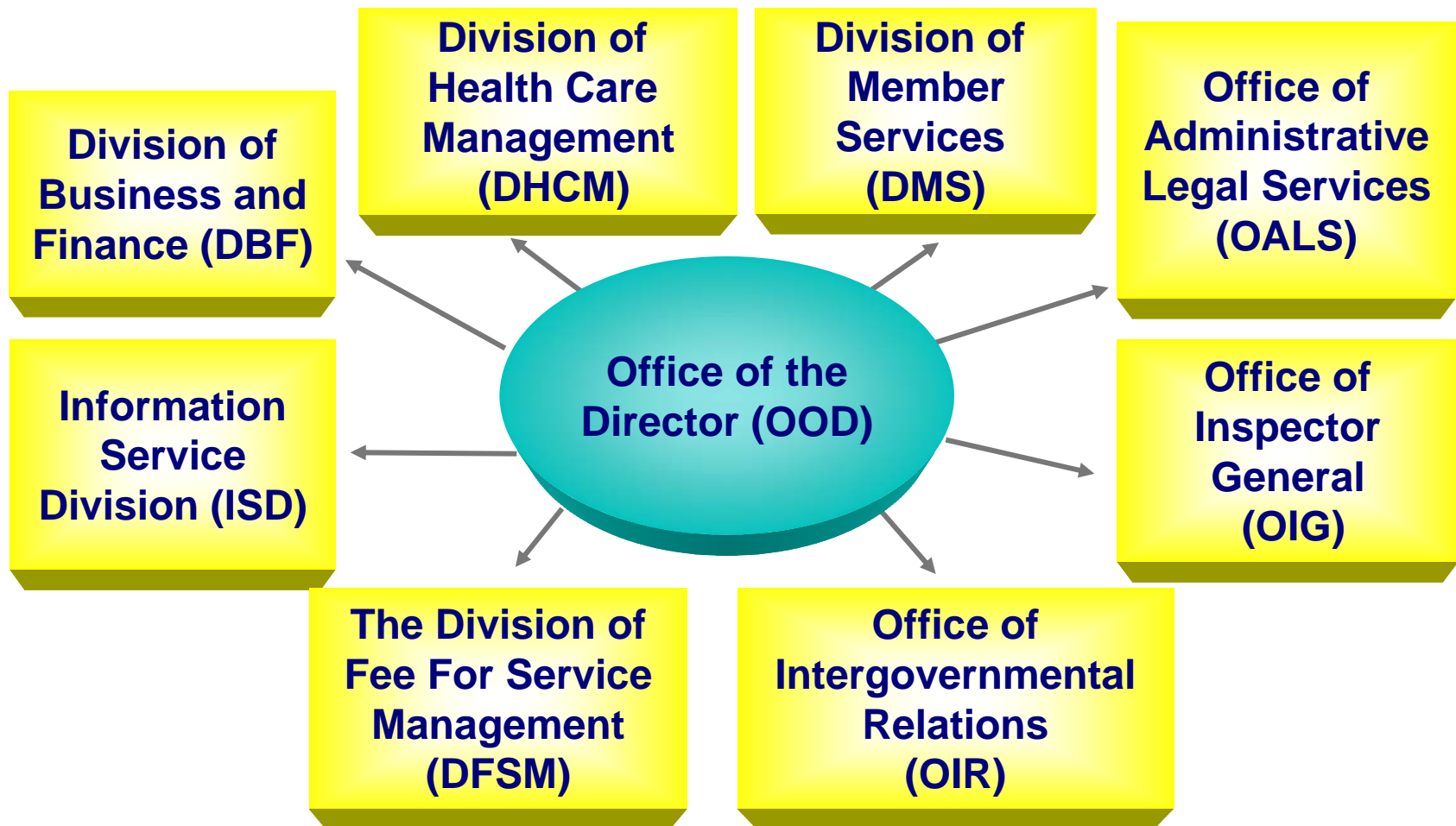
· Eligibility/DDD/CMDP

• Fee-For-Service

➤ Native Americans Referred Off Reservation

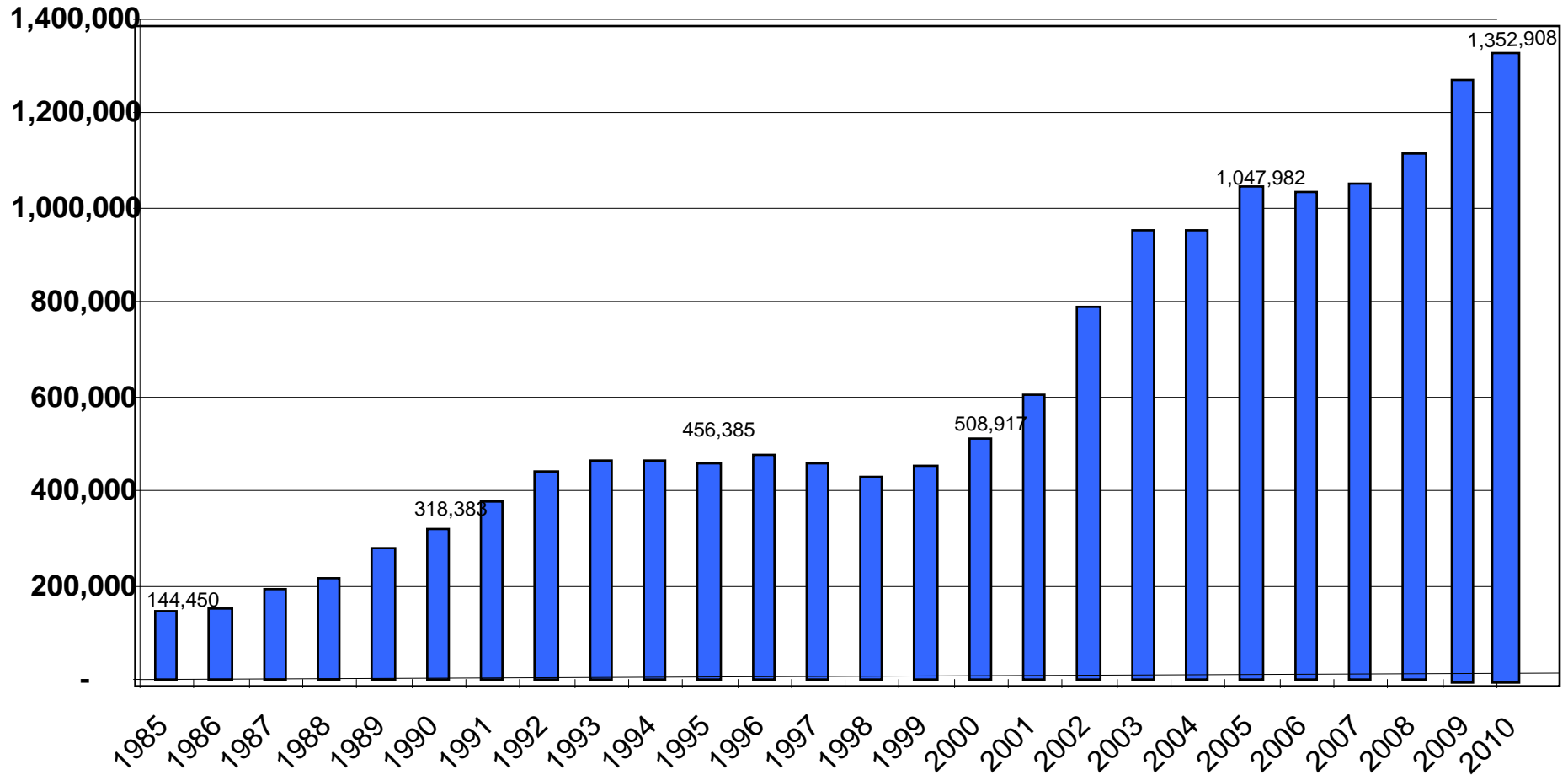
➤ Emergency Services

AHCCCS Organizational Structure

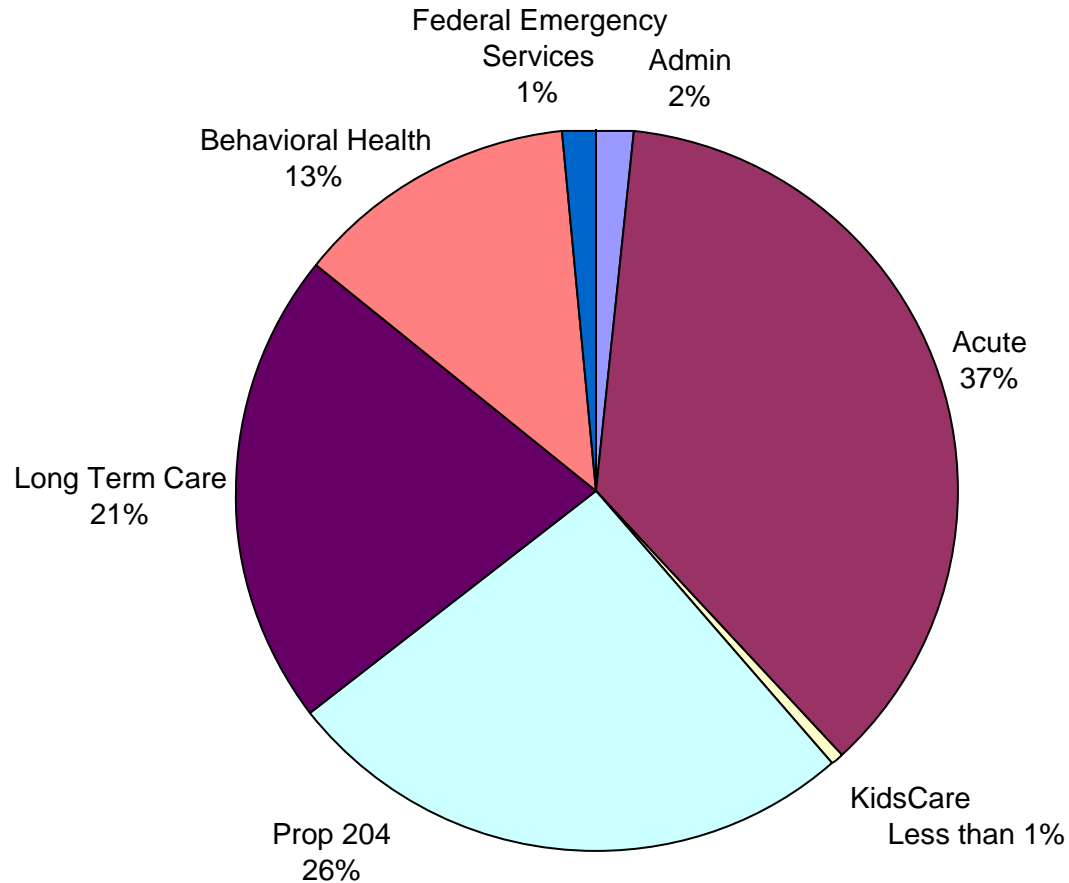


AHCCCS Population as of July 1, 2010

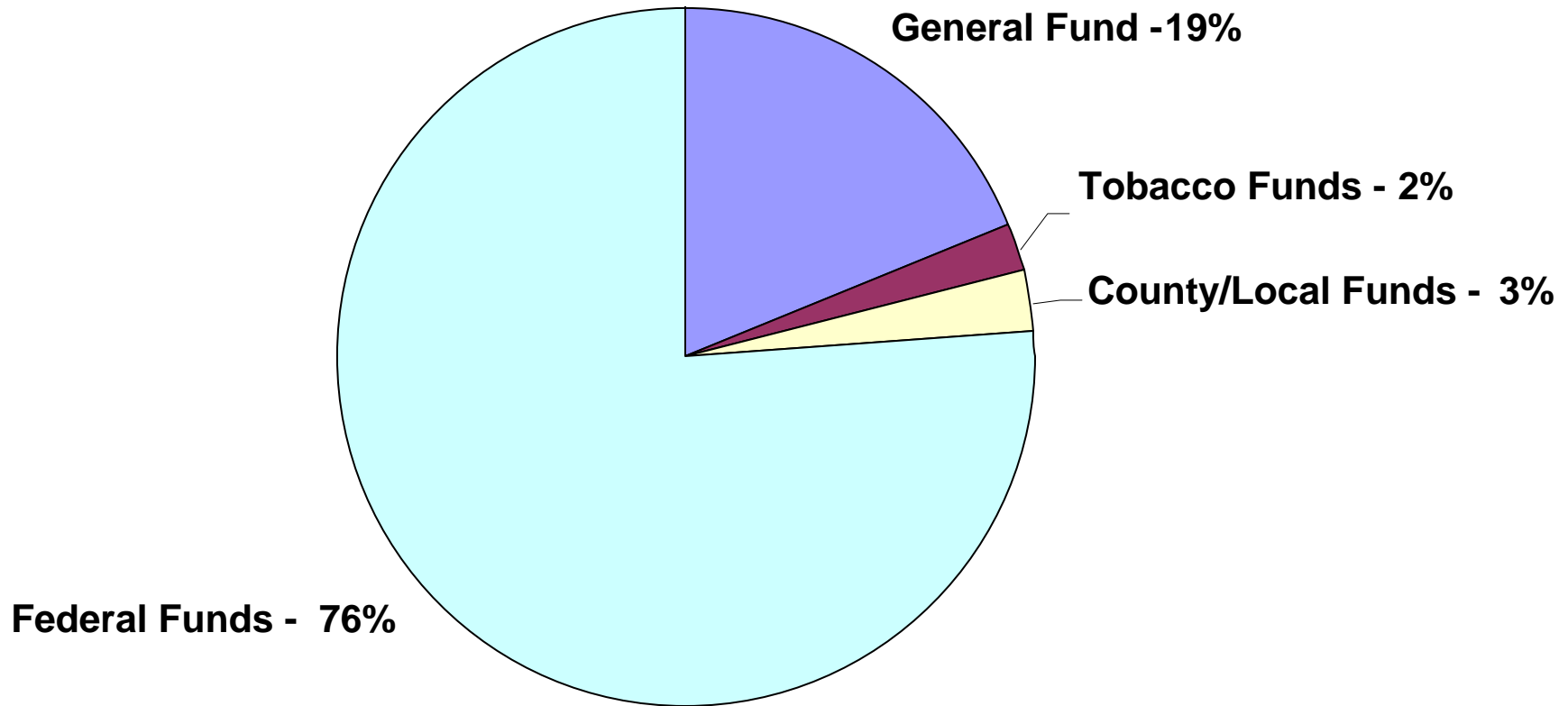
1985 – 2010



AHCCCS Expenditures by Program



AHCCCS Funding Sources



AHCCCS and CMS

- Arizona has been operating under an 1115 Demonstration Waiver
- Arizona is in the last year of the current 1115 Waiver which expires on September 30, 2011
- Waiver requires State to Operate a Budget Neutral Demonstration for the entire program
- 1115 Waiver from CMS provides flexibility
 - Authority to mandate managed care for all populations (exceptions are Native Americans and FES)
 - Waiver from Administrative requirements
 - Ability to have greater flexibility with Long Term Care

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 budget development
- ◆ July - June – AHCCCS works on implementation of budget Issues

FY 2011 Challenges

- Budget – Budget – Budget
- Health Care Reform
- Integration – payer and clinical
- Native American issues
- RFP – ALTCS, Behavioral Health Maricopa
- Sunset Audit 2011 & 2012
- Waiver renewal October 2011
- System issues – 5010; ICD 10

AHCCCS Budget Changes to Date

AHCCCS Program is \$874 million less as a result of policy changes

- \$413 million in provider reductions
- \$241 m in institutional rate freezes
- \$121 m in eligibility reductions
- \$39 m in benefit changes
- \$29.5 m in admin reductions
- \$28 m in increased member cost sharing
- On April 1, 2011 AHCCCS will be reducing almost all provider rates by 5% - Nursing Facilities will be exempt and In-Home service rate reductions will be 2.5%

45



Eligibility and Member Services

Melanie Norton
Deputy Assistant Director
Division of Member Services

ALTCS Eligibility

Determined by the AHCCCS Division of Member Services (DMS)

- Casa Grande
- Chinle
- Cottonwood
- Flagstaff
- Globe-Miami
- Kingman
- Lake Havasu City
- Phoenix
- Prescott
- Show Low
- Sierra Vista
- Tucson
- Yuma

Eligibility Requirements

- Aged, blind or disabled
- U.S. Citizen or qualified non-citizen
- Arizona residency
- Social Security Number
- ALTCS living arrangement
- Income limit
- Resource limit
- Medically eligible

Living Arrangements

Appropriate ALTCS living arrangements include:

- Home
- Alternative Residential Settings
- Certain Medical Institutions (e.g. Nursing Facilities)

ALTCS Financial Limits

- Resource limit = \$2,000

- Income limit = 300% FBR
 - (January 2011 = \$2,022)



What if Income Exceeds \$2,022?

- Special Treatment Income Only Trust
- Established when the customer is over the \$2,022 income limit but under the average private pay rate (\$5,777.74 for Maricopa County effective 10/1/10)
- Only income may be assigned/deposited to the trust

Share of Cost

Based on the customer's income only

- The customer may be asked to pay a share of cost if:
 - The customer lives in a nursing facility for an entire month; or
 - The customer lives in the community, but has income that exceeds Share of Cost deductions (Income Only Trusts)

Share of Cost Deductions

- Personal Needs Allowance (PNA)
 - HCBS - \$2,022
 - Nursing Facility - \$101.10
- Health insurance premiums
- Non-covered medical expenses like eyeglasses & dentures

More SOC Deductions

- Spousal Allowance
- Family Allowance (for dependent children)
- Home maintenance allowance (\$210) if there is a plan for discharge from the nursing facility within 6 months of the admission date

Medical Eligibility

Only applicants who are determined to be at risk of institutionalization and require care equal to that provided in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF-MR) are medically eligible for ALTCS services.

Medical Eligibility

- The Pre-Admission Screening (PAS) is used to determine medical eligibility
- The PAS is completed by a registered nurse or social worker from an ALTCS office



PAS Scoring

- The PAS is a statistically valid scoring tool
- Physician's review is required for customers whose medical eligibility is questionable

Enrollment Choice

- Enrollment choice is available to elderly or physically disabled (EPD) customers whose county of fiscal responsibility is a choice county

Who Can Make an Enrollment Choice?

- Customer's legal guardian
- Customer
- Customer's representative, family member, friend or anyone without a conflict of interest
 - A conflict of interest exists when an individual is employed by (or in some manner related to) a business or entity that may be financially impacted by the enrollment choice



Application Process Summary

- Initiate an application (phone, mail or walk-in)
- Financial interview (phone or in person)
- Verification and documentation
- Pre-Admission Screening (PAS)
- Program contractor choice (choice counties)
- Final determination

What Happens After Approval?

- Written Notice to Customer
(Includes SOC amount)
- AHCCCS sends roster to Contractor and ID card to customer
- Annual financial renewal and periodic medical reassessment completed by ALTCS office



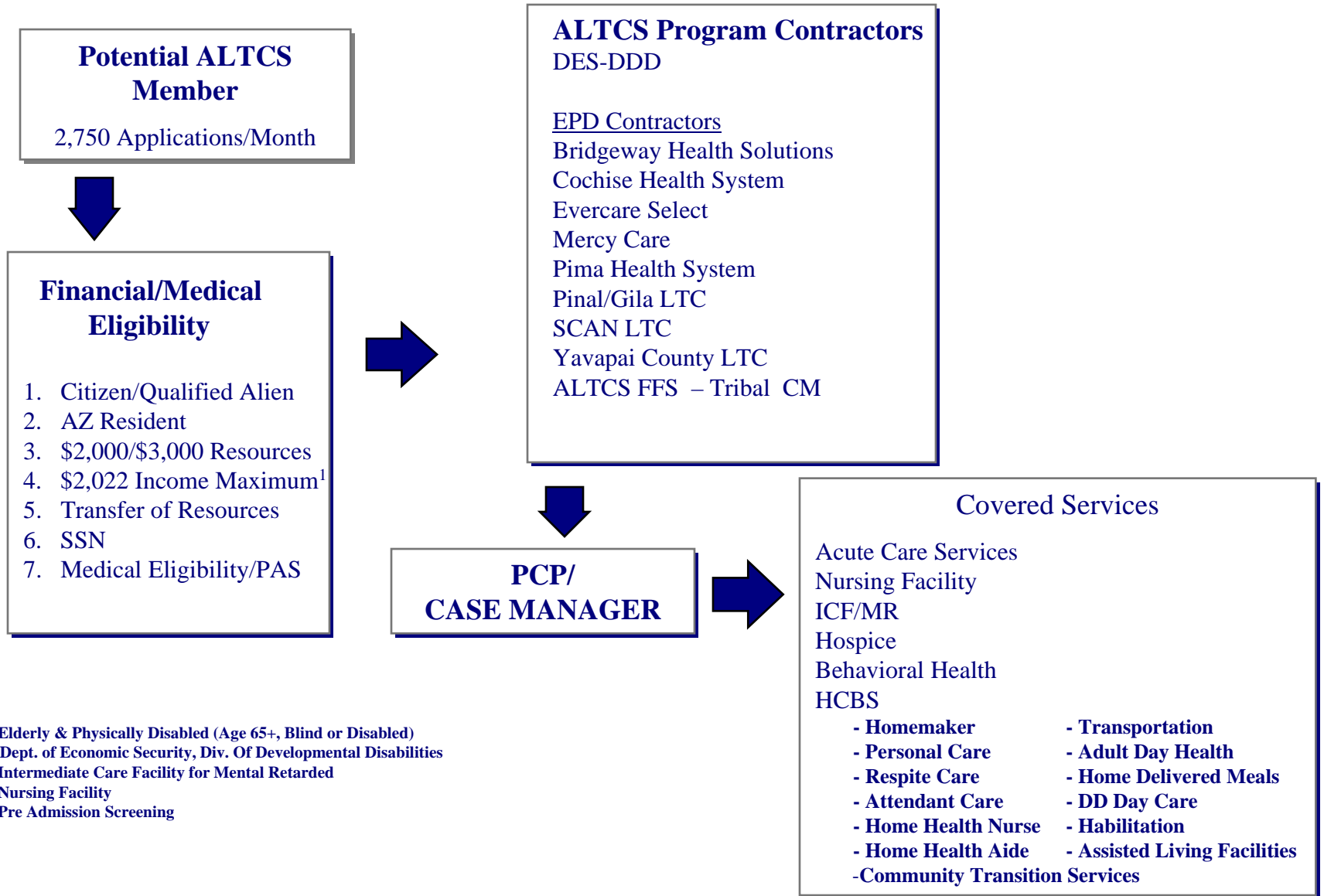
The ALTCS Program

Shelli Silver
Assistant Director
Division of Health Care Management

ALTCS Guiding Principles

- Member-centered case management
- Consistency of services
- Accessibility of network
- Most integrated setting
- Collaboration with stakeholders

Current System – ALTCS Model



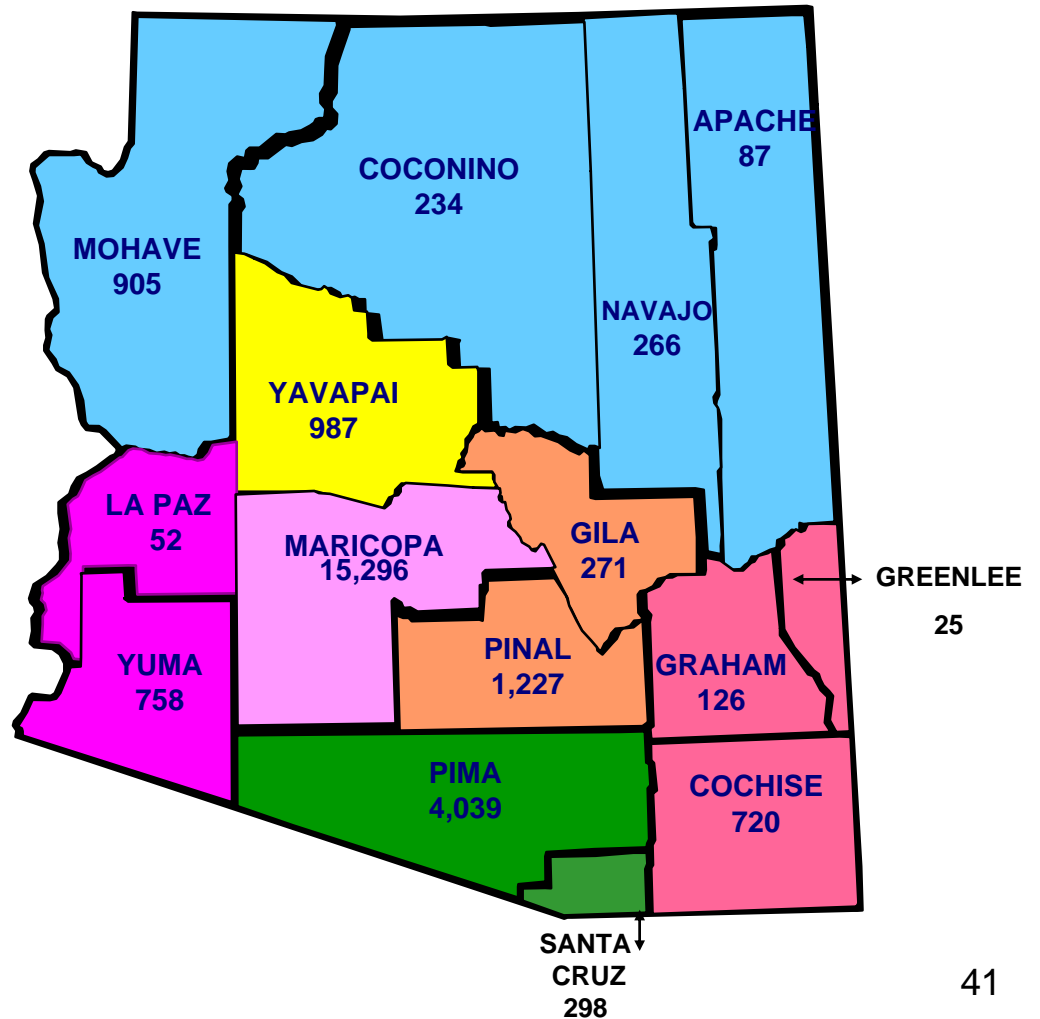
KEY

- EPD - Elderly & Physically Disabled (Age 65+, Blind or Disabled)
- DES/DDD Dept. of Economic Security, Div. Of Developmental Disabilities
- ICF/MR - Intermediate Care Facility for Mental Retarded
- NF - Nursing Facility
- PAS - Pre Admission Screening

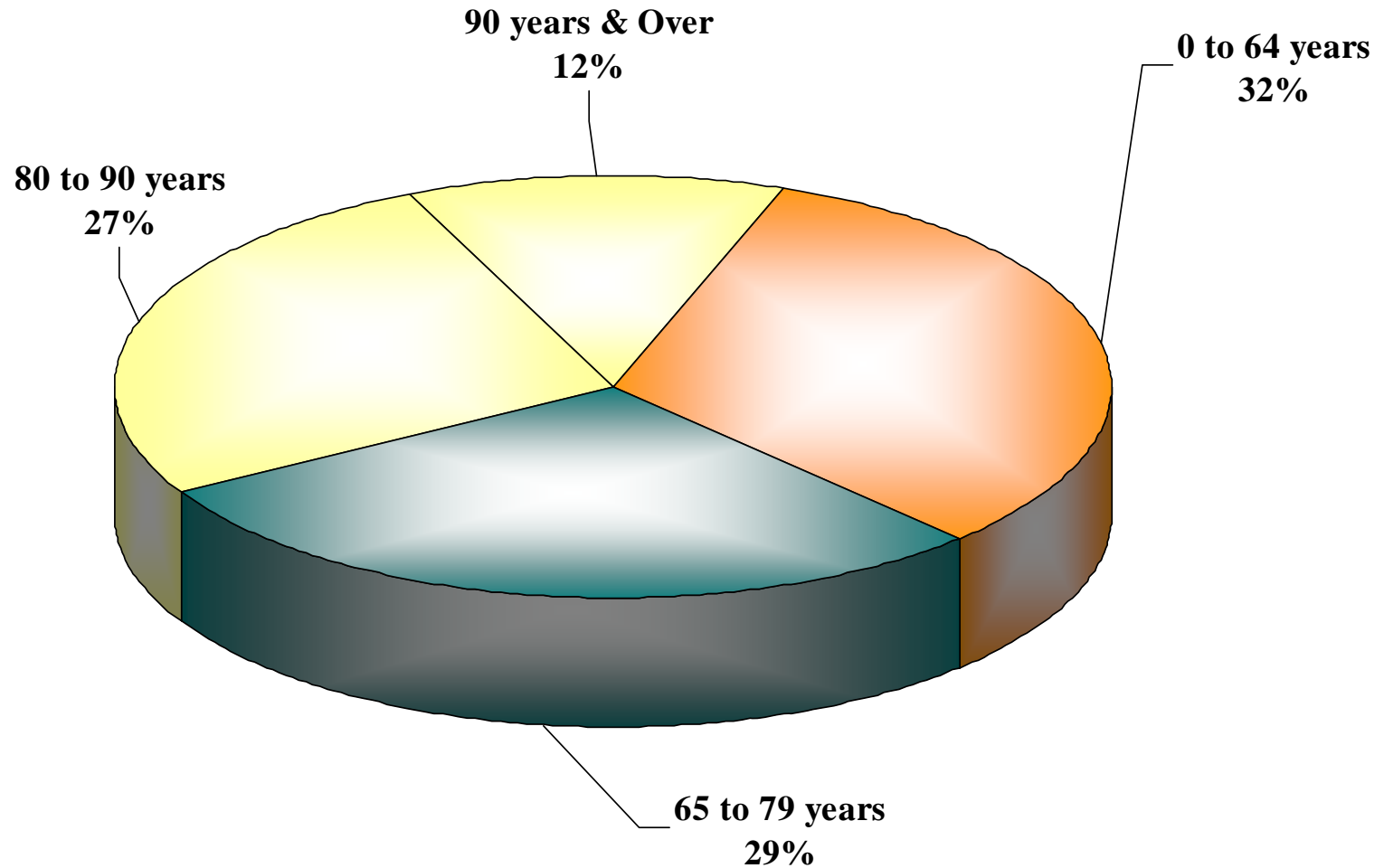
ALTCS Elderly and Physically Disabled Enrollment As of January 1, 2011

GSA Number	GSA Enrollment	GSA Counties
40	1,498	Pinal, Gila
42	810	La Paz, Yuma
44	1,492	Apache, Coconino, Mohave, Navajo
46	871	Cochise, Graham, Greenlee
48	987	Yavapai
50	4,337	Pima, Santa Cruz
52	15,296	Maricopa

Total Program Contractor Enrollment = 25,292

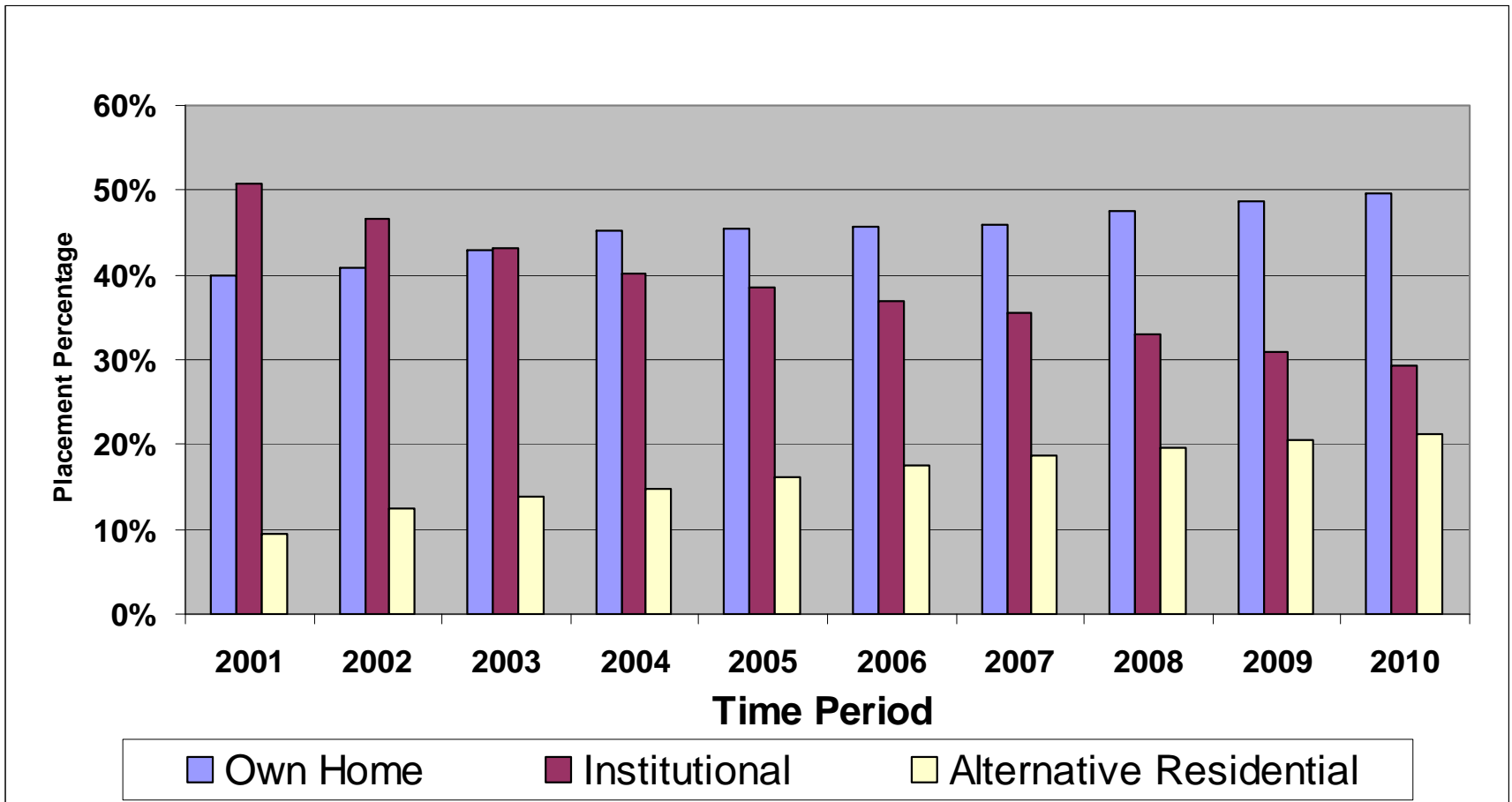


ALTCS Elderly and Physically Disabled Membership

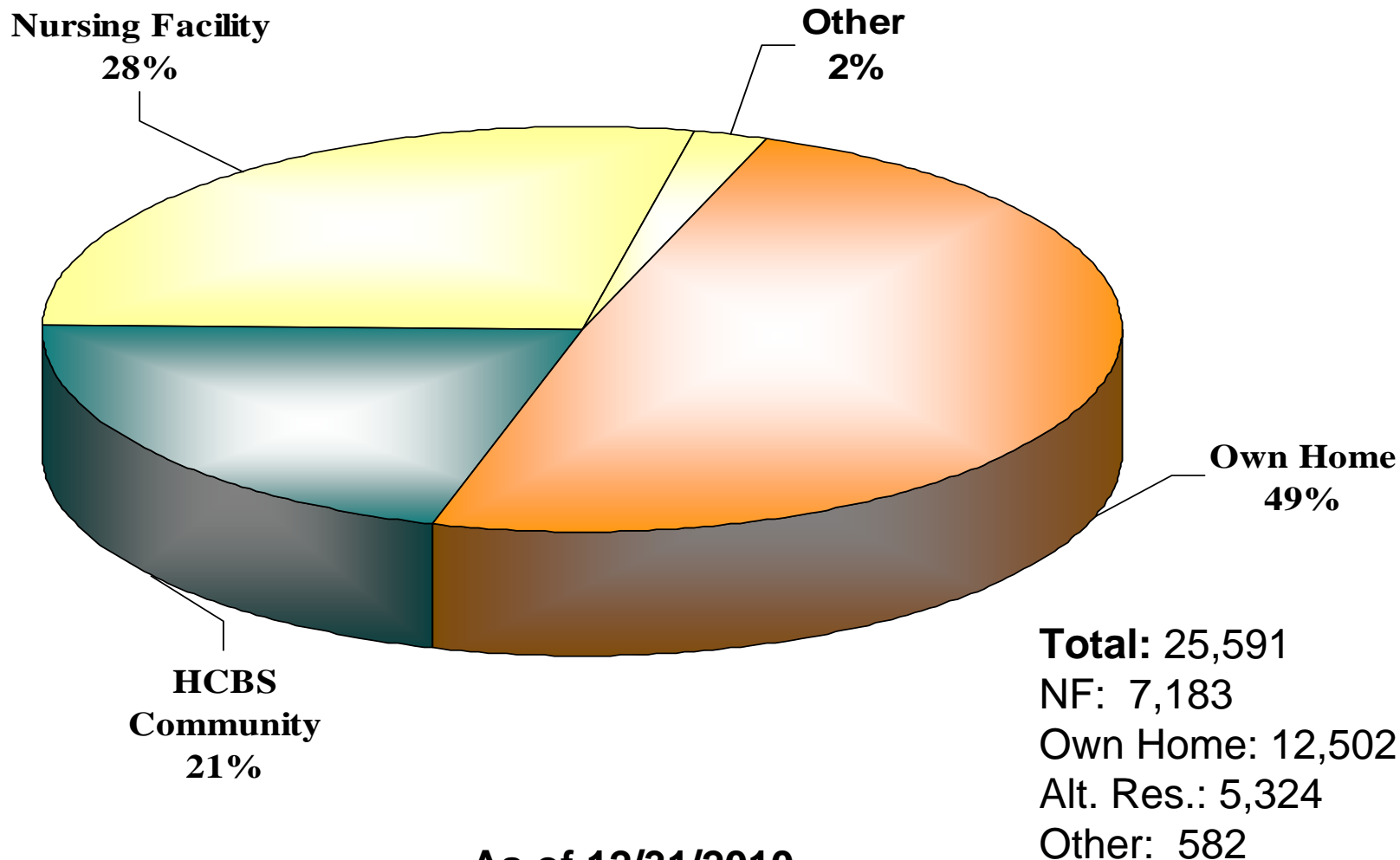


As of 12/31/2010

ALTCS Elderly and Physically Disabled Statewide Placement Percentage by Setting



ALTCS Elderly and Physically Disabled Placement



As of 12/31/2010

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 Responsibilities

- Develop and maintain adequate network
- Active monitoring and oversight
- Case management
- Member and family support
- Quality and medical management
- Integration of medical care
- Pay claims and process encounters
- Claims disputes and member appeals

Contractor Oversight

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

- Operational and Financial Review (OFR)
- Deliverable review
- Case management monitoring
- 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)



Finance and Capitation Rate Development

Shelli Silver

Assistant Director

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 within medical component range and administration limit

Capitation Rates

- Bid Full Long-Term Care rate only
 - One rate per GSA
 - Dual and Non-Dual combined

- Prior Period Coverage (PPC) rate set by AHCCCS (reconciled to 5%)

- Acute-Care Only rate set by AHCCCS

Three Components to Bid Submission

- **Medical Component**
 - Includes Nursing Facility, HCBS, and Acute costs
 - AHCCCS will provide range to bid within
 - Range in Data Supplement prior to 3/1/11

- **Case Management Component**
 - No range or limit

- **Administrative Component**
 - 8% Limit

All three components scored separately!

Bid Components/Tools Provided by AHCCCS

- Capitation Bid Template
- HCBS/NF mix percentages
- Share of Cost (SOC) amounts
- Reinsurance Offsets (in Data Supplement prior to 3/1/11)
- Case Management Model
- Risk Contingency/Premium Tax – auto calculation

Bid Submission Template

- Submit one Template per GSA bid via:
 - EFT/SFTP (see Section A of Data Supplement for Instructions to access)
 - Hard copy with proposal

- Actuarial Certification
 - Hard copy with proposal

Adjustments to Awarded Rates

May include, but are not limited to:

- HCBS/NF mix
- SOC
- Program changes
- Actuarial assumptions
- AHCCCS Waiver changes
- Changes to trend due to FFS rate updates
- Moral and Religious Objections
- Reinsurance Offset changes



Encounters, Reinsurance and Technology

Lori Petre

Data Analysis and Research Manager

Division of Health Care Management

What Is An Encounter?

- A record of a medically related service rendered by a registered AHCCCS provider to an AHCCCS member enrolled with a capitated contractor (MCO), which has been adjudicated by the MCO.
 - Includes capitated services and fee-for-service payments
 - Submitted electronically by MCO to AHCCCS

Encounter Data Uses

- MCO capitation/fee-for-service rate setting
- Reconciliations
- Reinsurance calculation and payment
- HEDIS reporting and clinical performance measurements
- 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 should ensure that encounters are consistent with the general principles

Encounter General Principles (cont.)

- Some encounter principles include, but are not limited to:
 - A service must be completed, and the provider's claim or encounter finalized by the contractor, before an encounter is submitted to AHCCCS
 - If a contractor makes a post payment revision to a provider's claim after it has been encountered to AHCCCS, the contractor must submit a replacement or void encounter (whichever is appropriate) to AHCCCS
 - Medicare and other third-party payment or indication of denial must be accounted for prior to submitting the encounter, and Medicare and third-party payment amounts must be entered in the appropriate fields on the submitted encounter



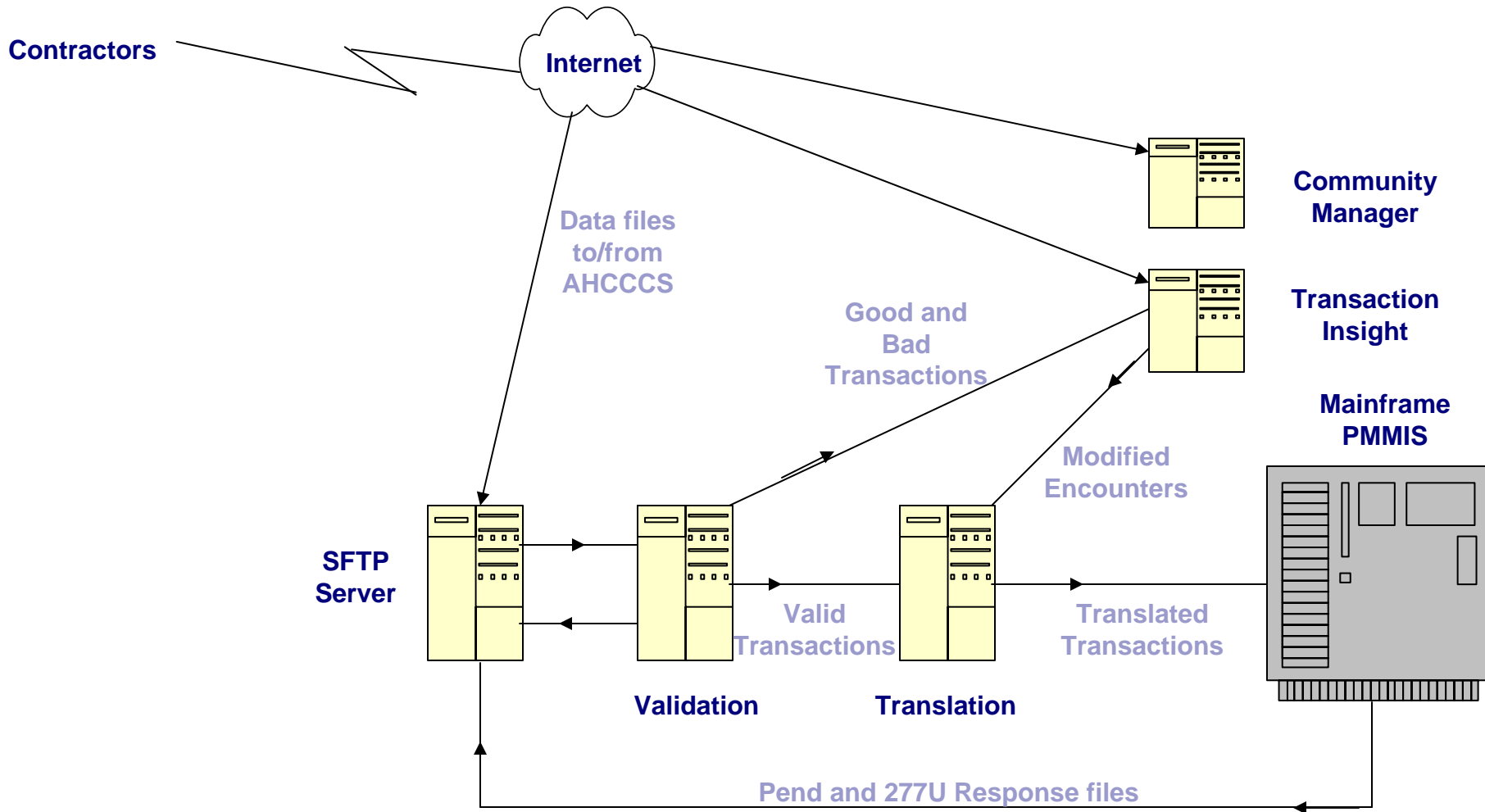
Encounter General Principles (cont.)

- Successful encounter submissions can be challenging especially for ALTCS related services such as HCBS. Contractors are encouraged to ensure that they understand these challenges as well as take advantage of available technical assistance options

Encounter Submission Standards

- Encounter files must be submitted to the AHCCCS EFT/SFTP server in appropriate HIPAA and NCPDP compliant formats (as defined in the AHCCCS Encounter Manual) and include HIPAA compliant data such as National Provider Identifiers (NPI)
- Each Encounter file must pass validation including assessment of appropriate file structures, validity of code sets, and financial balancing
- Each file must contain a required BBA related data attestation
- Each file undergoes translation and syntax checks

Encounters Processing Flow



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
- 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:
 - One full cycle – including the recycle of all pended encounters (*files are due by COB the first Thursday of the month*)
 - One limited cycle (*files are due by COB the third Thursday of the month*)
 - Contractors can and are encouraged to submit encounters throughout the month for processing in one or both cycles

- Reinsurance cycles run once monthly:
 - Reinsurance Case Creation and Association cycles run immediately following the completion of the first (full) encounter cycle
 - Reinsurance Payment cycle runs after the first Wednesday of each month

Encounter and Reinsurance Processing (cont.)

- Processing includes claims-type edits
- Results are produced and communicated to the Contractors after each cycle
- Detailed Information on encounter processing can be found in the AHCCCS Encounter Manual, in the *Encounter Keys* newsletter (published quarterly on the AHCCCS Website), in applicable EDI Companion Guides and on the AHCCCS Encounters Webpage <http://www.azahcccs.gov/commercial/ContractorResources/encounters/encounters.aspx>

Encounter and Reinsurance Processing (cont.)

- Detailed Information on reinsurance processing can be found in the AHCCCS Reinsurance Processing Manual, in the *Reinsurance Hot News* newsletter and on the AHCCCS reinsurance Webpage
<http://www.azahcccs.gov/commercial/ContractorResources/reinsurance/reinsurance.aspx>

Encounter Related Files

- AHCCCS produces a number of files containing information pertaining to provider and reference data that may assist Contractors with accurate encounter submissions (additional information for each file available in the AHCCCS Encounter Manual)
- Contractors are encouraged to use and load this data as appropriate on a timely basis to facilitate timely and accurate encounter submissions

Encounter Related Files (cont.)

- On a weekly basis AHCCCS produces two provider files: Provider Profile and Provider File. These files include AHCCCS PMMIS data related to: Provider Demographics; National Provider Identifiers; Provider Enrollment Status; Categories of Service, etc...
- At the beginning and middle of the month AHCCCS produces seven code set related reference files. These files include AHCCCS PMMIS data related to: HCPCS Status; Age, Gender and Frequency limitations; Modifiers; Coverage Indicators; AHCCCS Outpatient Fee Schedule (OPFS) processing rules; Fee for Service Fee Schedule Amounts, etc...

Encounter Related Files (cont.)

- Also at the beginning and middle of the month AHCCCS produces four additional reference files. These files include AHCCCS PMMIS information related to: Encounter internal field values for each form type; Encounter internal field relationship information for each error code; List of all current Encounter Error Codes and Descriptions

Encounter Testing and Technical Assistance

- AHCCCS maintains a test environment that is available for use by all Contactors to submit test encounter files for AHCCCS processing
- AHCCCS makes available a validation tool “Community Manager” for use by 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 Data Validation

- CMS requires that AHCCCS collect complete, accurate and timely encounter data from Contractors
- AHCCCS data validation studies evaluate the completeness, accuracy and timeliness of collected encounter data
- AHCCCS also conducts ongoing review of encounter submission trends and data quality
- Additional information is available in the AHCCCS Encounter Data Validation Technical Document
<http://www.azahcccs.gov/commercial/Downloads/Encounters/CompanionTechnical/EncounterValidationTechnicalDocument.pdf>

Technological Advancement

- Contractors must have the ability to conduct the following functions electronically:
 - Provide enrollment verification (HIPAA 5010 270/271)
 - Allow claims inquiry and response (HIPAA 5010 276/277)
 - Accept HIPAA compliant electronic claims (HIPAA 837)
 - Make claim payment via electronic funds transfer
 - Provide electronic remittance advice (HIPAA 5010 835)
 - Provide prior authorization (HIPAA 5010 278)
 - Accept Electronic Medical documentation

Technological Advancement (cont.)

- Contractors must participate in AHCCCS E-Health initiatives
- Contractors must have a website with links to the following:
 - Formulary
 - Provider Manual
 - Member Handbook
 - Provider listing
 - When available, Member and Provider Survey Results
 - Performance Measure Results
 - Prior Authorization criteria
 - Evidence Based Medicine Guidelines
 - Other links as identified in the ACOM Member Information and Provider Information Policies

New Items Related to Technology

- Contractor claims processing systems are expected to include Medicaid specific National Correct Coding Initiative (NCCI) editing and Medically Unlikely Editing (MUE) as defined by AHCCCS
- Contractor Pharmacy Encounter submission timeliness and data content changes must be complied with to support Managed Care Drug Rebates
- Contractors must implement ICD10 code sets for Outpatient dates of service or Inpatient dates of discharge 10/1/2013 and after



RFP Highlights

Shelli Silver

Assistant Director

Division of Health Care Management

Contracts To Be Awarded

Section I, #9

GSA #	County or Counties	Number of Awards
40	Pinal, Gila	Maximum of 1
42	Yuma, LaPaz	Maximum of 1
44	Apache, Coconino, Mohave, Navajo	Maximum of 1
46	Cochise, Graham, Greenlee	Maximum of 1
48	Yavapai	Maximum of 1
50	Pima, Santa Cruz	Maximum of 1
52	Maricopa	Maximum of 3

Oral Presentations

- Offeror to present solutions and respond to questions regarding two scenarios:
 - Scenario 1: Case Management
 - Scenario 2: Quality Management
- Limited to five presenters per Offeror
- Presentations schedule 4/11/11 to 4/22/11
- Notification of scheduled presentation by 4/1/11, 5:00 p.m.
- See Section I, Instructions to Offerors for details



Roster Billing

Section D, ¶44

- Standardized claims for services must be submitted per R9-22-710, therefore:
 - Roster billing is not permitted for nursing facilities for dates of service on or after October 1, 2011;
 - Contractors shall work with all other providers to eliminate roster billing and submit standardized claims with dates of service on or after October 1, 2012

Electronic Transmissions

Section D, ¶44

- Urban GSAs
 - Receive and pay 60% of all claims electronically based on volume of actual claims processed excluding claims processed by Pharmacy benefit Managers (PBMs). A Contractor who is in both urban and rural GSAs must meet the urban GSA benchmark.

Electronic Transmissions Cont.

Section D, ¶44

- Rural GSAs
 - Receive claims electronically based on volume of actual claims processed excluding claims processed by PBMs. Benchmarks as follows:

2011-2012	30%
2012-2013	40%
2013-2014	50%
2014-2016	60%
 - Pay 60% of all claims electronically based on volume of paid claims excluding claims processed by PBMs
- Annual report required for submission or payment volume below 60% including
 - measureable goals,
 - success of previous interventions,
 - barriers to goals,
 - action/tasks/timeframes to accomplish goals

Enrollment after Contract Award

Section I, #9

- For GSAs in which only one Contract is awarded:
 - AHCCCS will assign all members from the Unsuccessful Incumbent Contractor for the GSA to the Contractor to which an award is made under this RFP for that GSA

Enrollment after Contract Award

Section I, #9

- For GSAs in which multiple contracts are awarded, selective assignment will be based on the following order of priority:
 - Identify the Contractor whose network best aligns with the member's service provider(s)
 - If only one Contractor's network aligns with the member's service providers, the member will be assigned to that Contractor



Enrollment after Contract Award (cont.)

Section I, #9

- If more than one Contractors' network aligns with the member's service providers, the member will be assigned to the Contractor with lowest awarded capitation rate
- If more than one Contractors' network aligns with the member's service providers and more than one Contractor has the lowest awarded capitation rate, the member will be assigned to the Contractor with the lowest membership in the GSA until all contractors have membership as close to equal as possible

Member Identification Cards

Section D, ¶3

- Beginning October 1, 2011 the Contractor is responsible for paying the costs of producing AHCCCS member identification cards
- Contractors will have complete responsibility for the production, distribution and cost of member identification cards by no later than October 1, 2012

Change to HCBS Reconciliation

- The Contractor's capitation rate is based in part on the assumed ratio (“mix”) of HCBS and Nursing Facility placement
- Reconciliation compares capitation rate assumption to actual placement

Percent over/under assumed percentage:	Amount to be recouped/reimbursed:
0 - 1.0 percentage points	0% of capitation over/under payment
>1 percentage point	50% of capitation over/under payment

Reinsurance Inpatient Link

- Regular Reinsurance Link to Inpatient Service
 - Inpatient stay required for case creation
 - All encounters apply towards deductible
 - Incorporated Change into offset

Questions?

Technical Interface Meeting - 1pm