AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Prospective Offerors' Conference

November 8, 2016

Welcome

Virginia Rountree
Assistant Director
AHCCCS, Division of Health Care Management

AHCCCS OVERVIEW

Beth Kohler
AHCCCS, Deputy Director

AHCCCS Strategic Plan

Reaching Across Arizona to Provide Comprehensive, Quality Health Care for Those in Need

- Bend the cost curve while improving the member's health outcomes
- Pursue continuous quality improvement
- Reduce fragmentation in healthcare delivery driving towards an integrated system
- Maintain core organizational capacity, infrastructure and workforce.

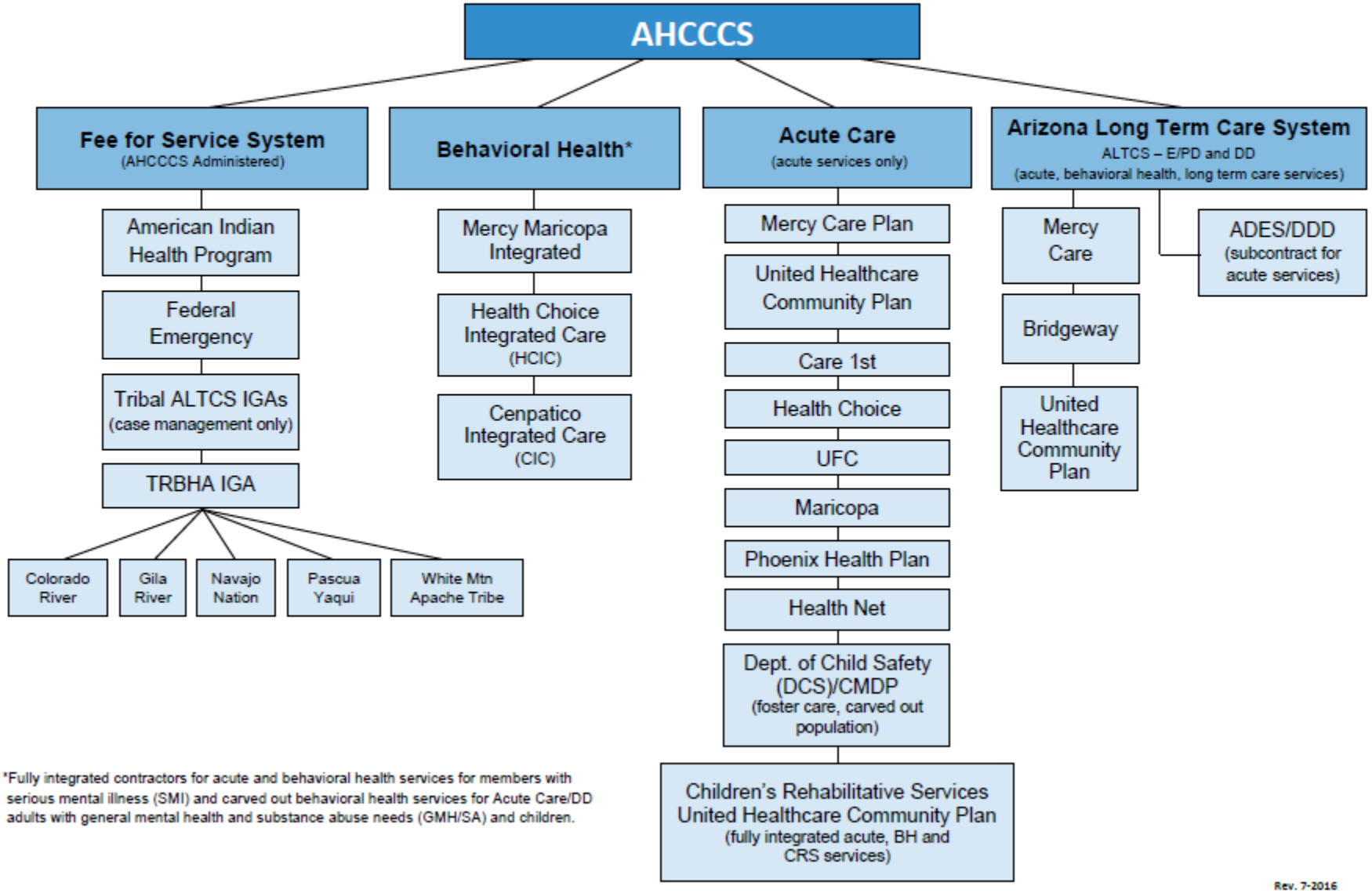
AHCCCS Partnership Strategy

Our success is dependent upon the success of our Contractors:

- 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
- Regulatory action as appropriate

AHCCCS
Arizona Health Care Cost Containment System

Care Delivery System



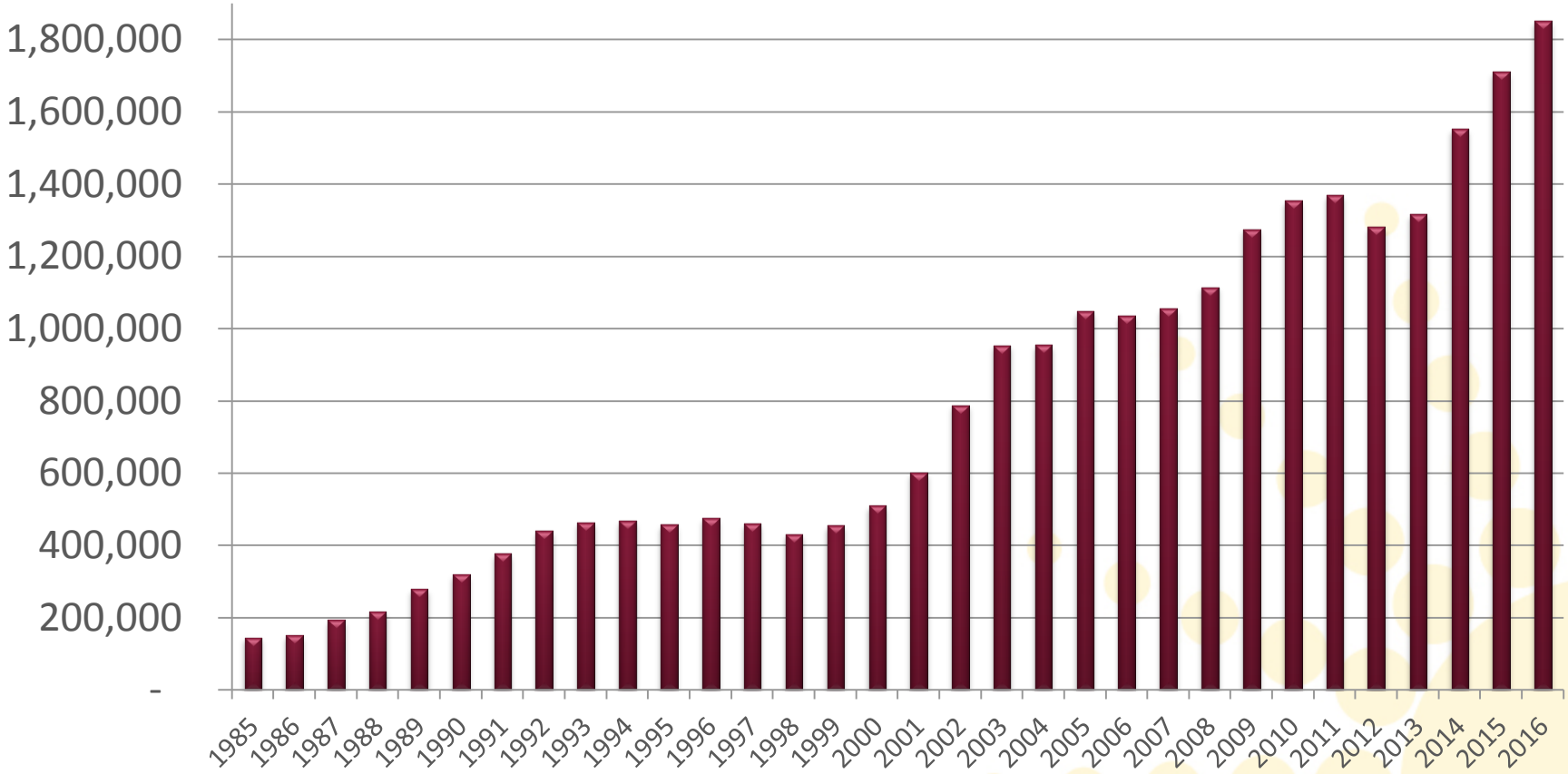
*Fully integrated contractors for acute and behavioral health services for members with serious mental illness (SMI) and carved out behavioral health services for Acute Care/DD adults with general mental health and substance abuse needs (GMH/SA) and children.

Rev. 7-2016

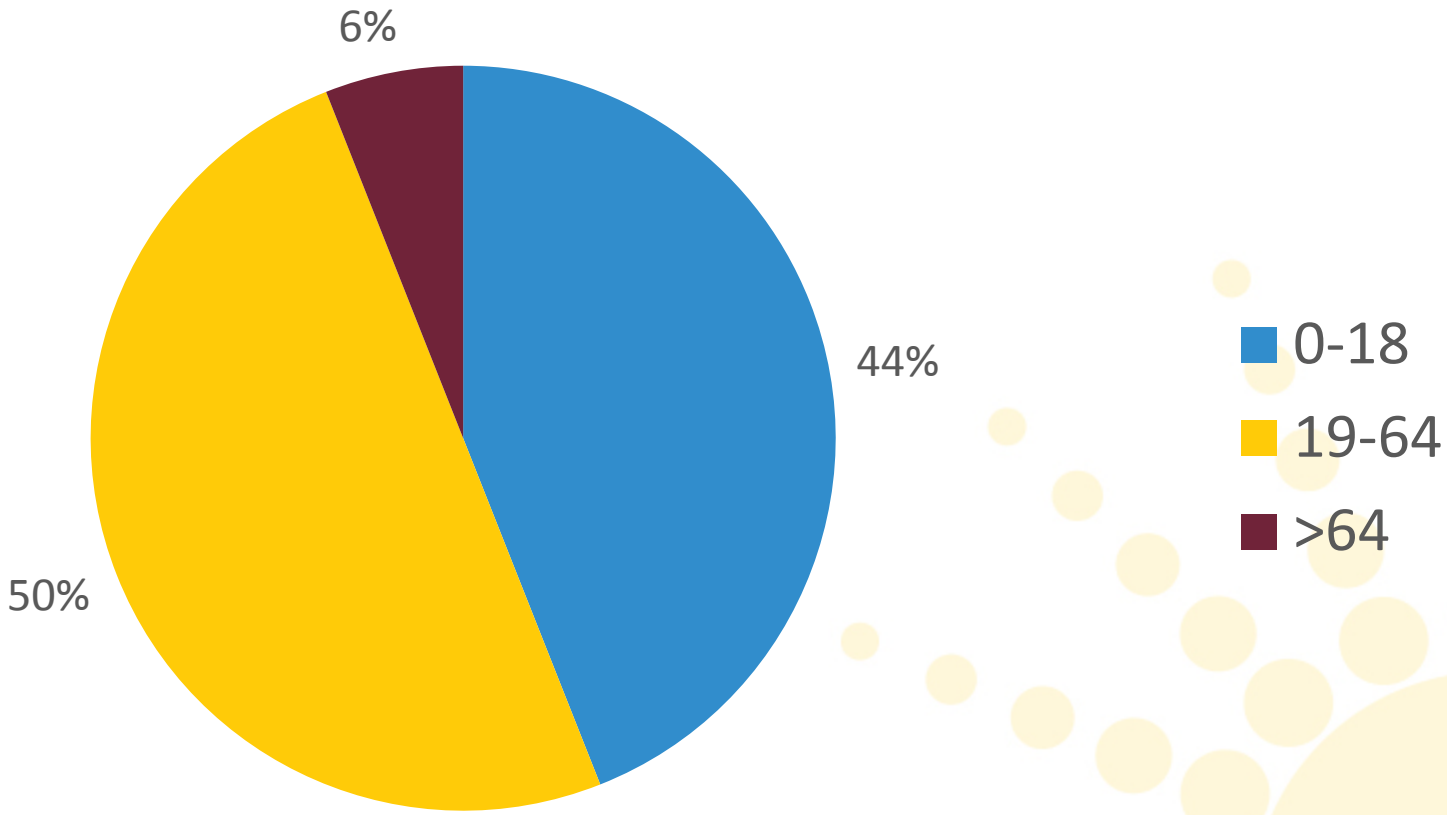
AHCCCS Facts and Figures

- Largest insurer in state
- $12.0 billion program and growing
- Covers over 50% of all births
- Covers two-thirds of nursing facility days
- 1.9 million enrollees
- 86% HCBS

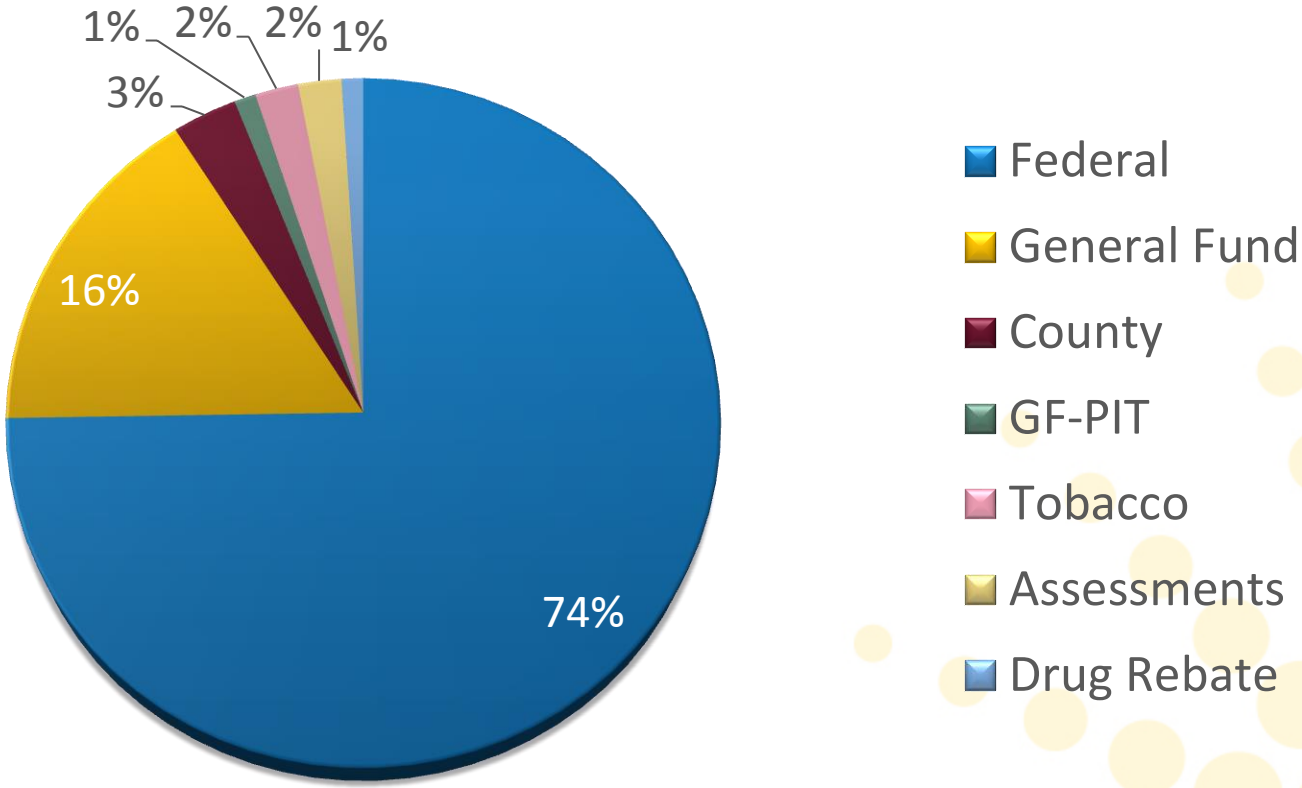
AHCCCS Population as of July 1, 1985 – 2016



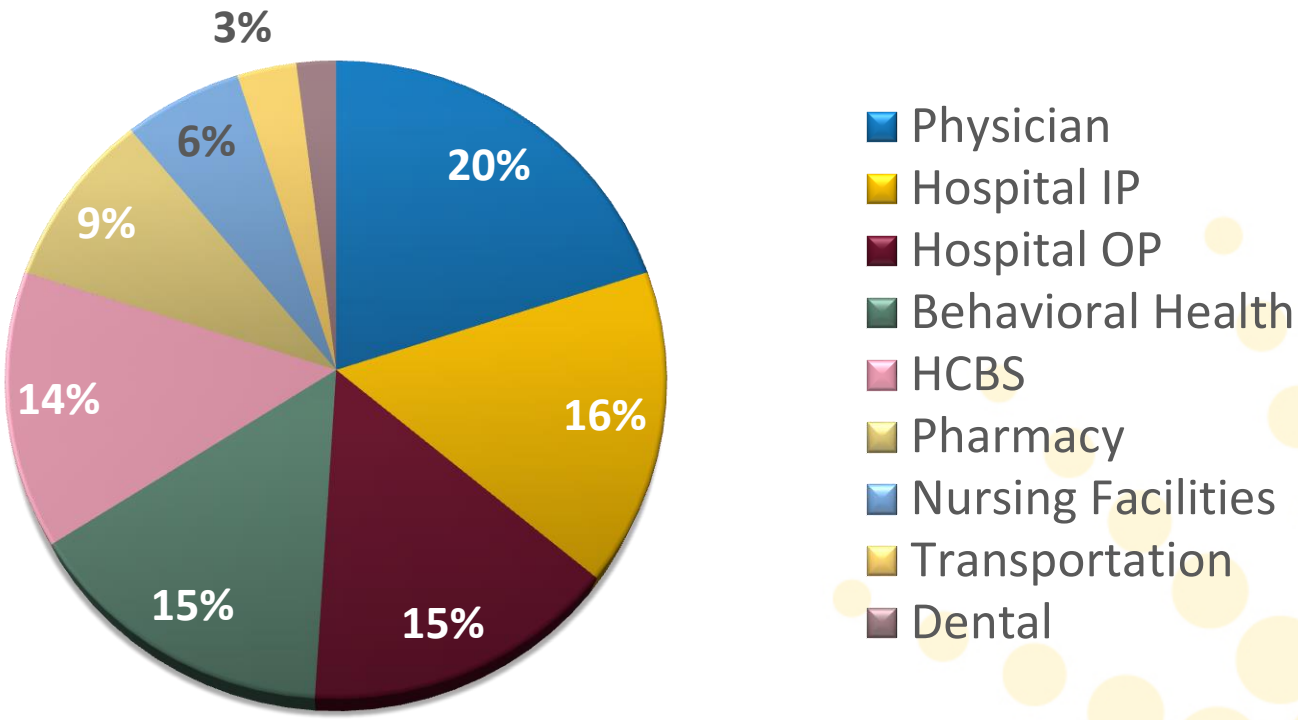
AHCCCS Population Age Breakout



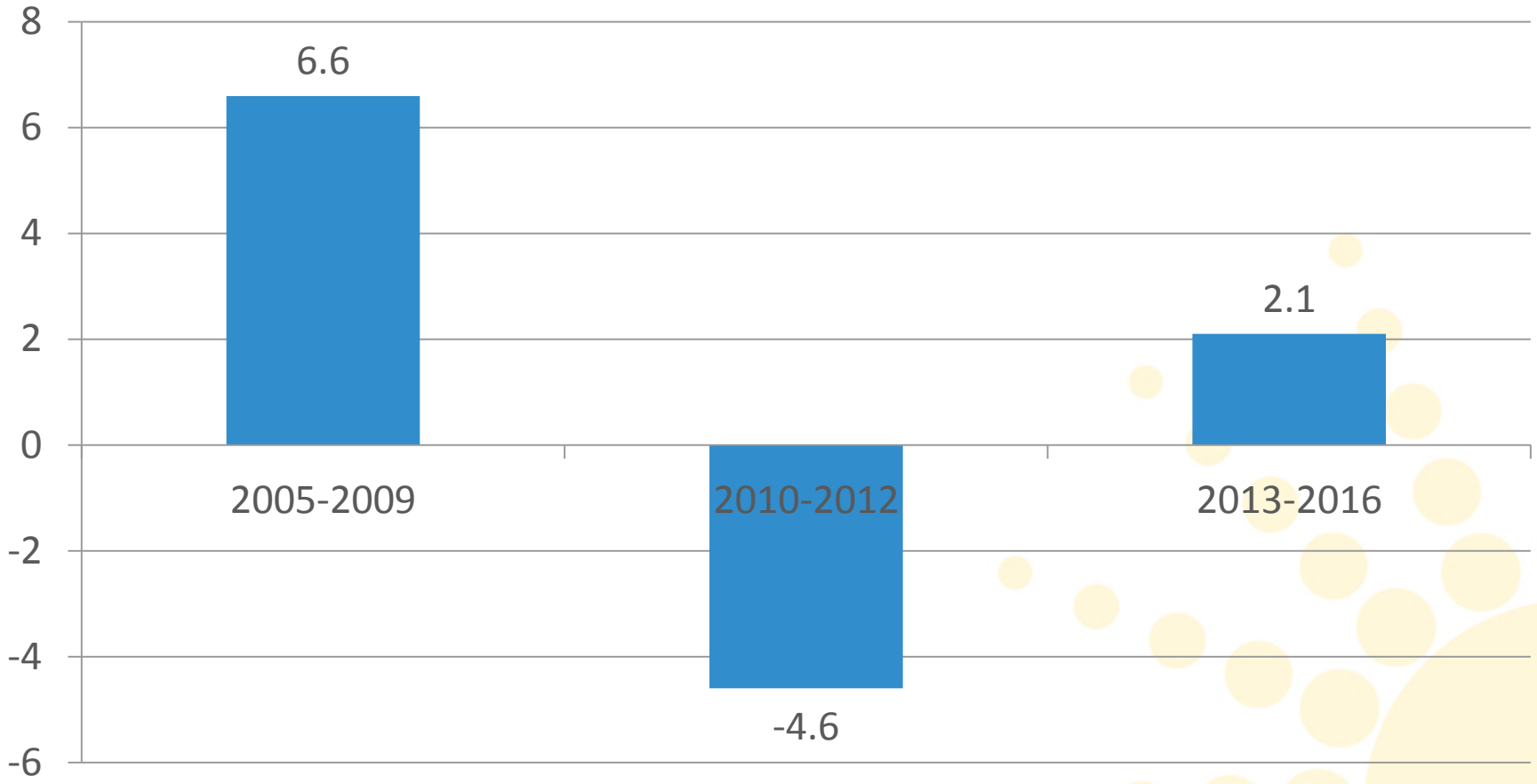
FY 2016 Funding Distribution



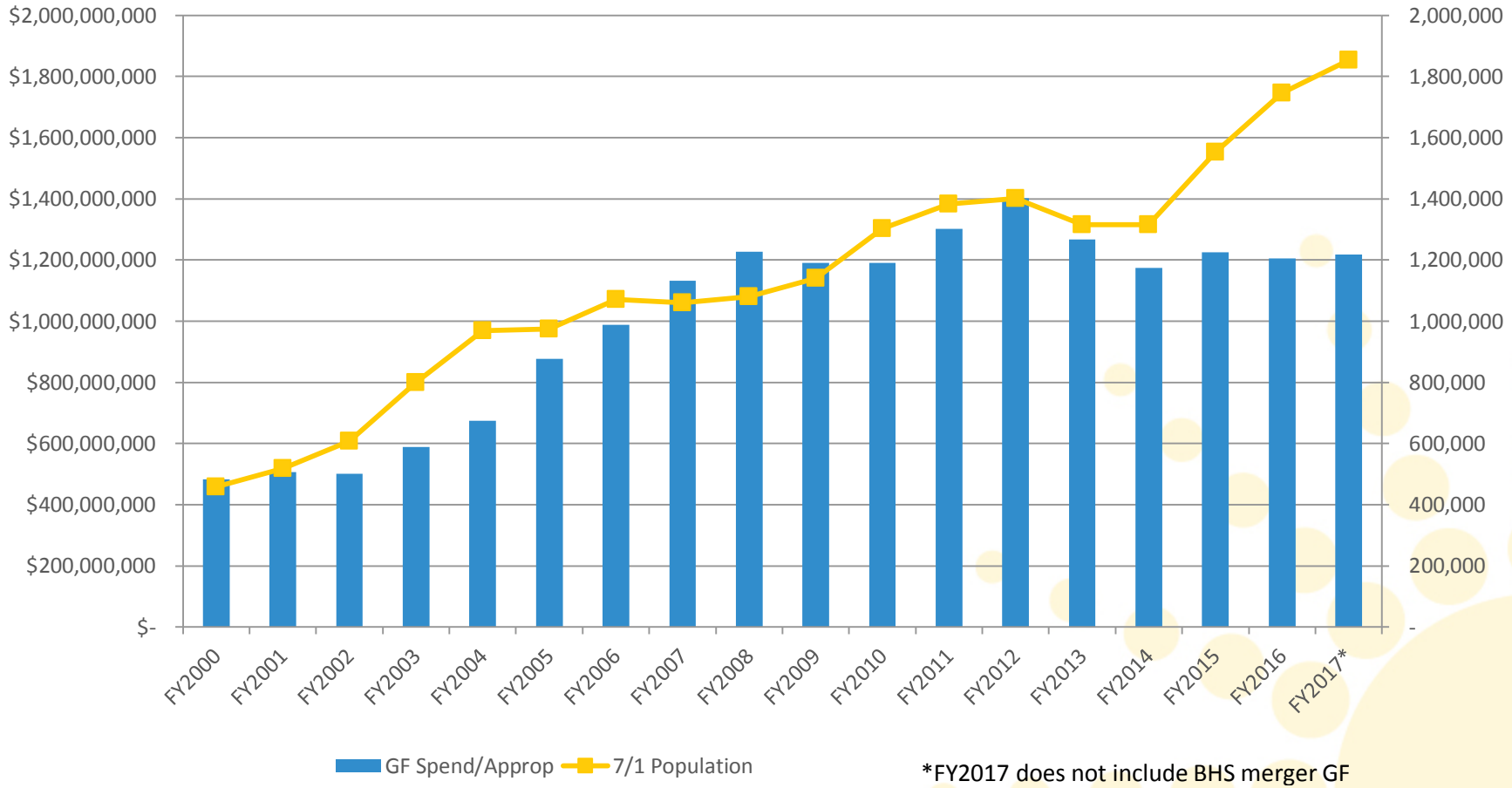
Spending by Provider Type



AHCCCS Cap Rate History

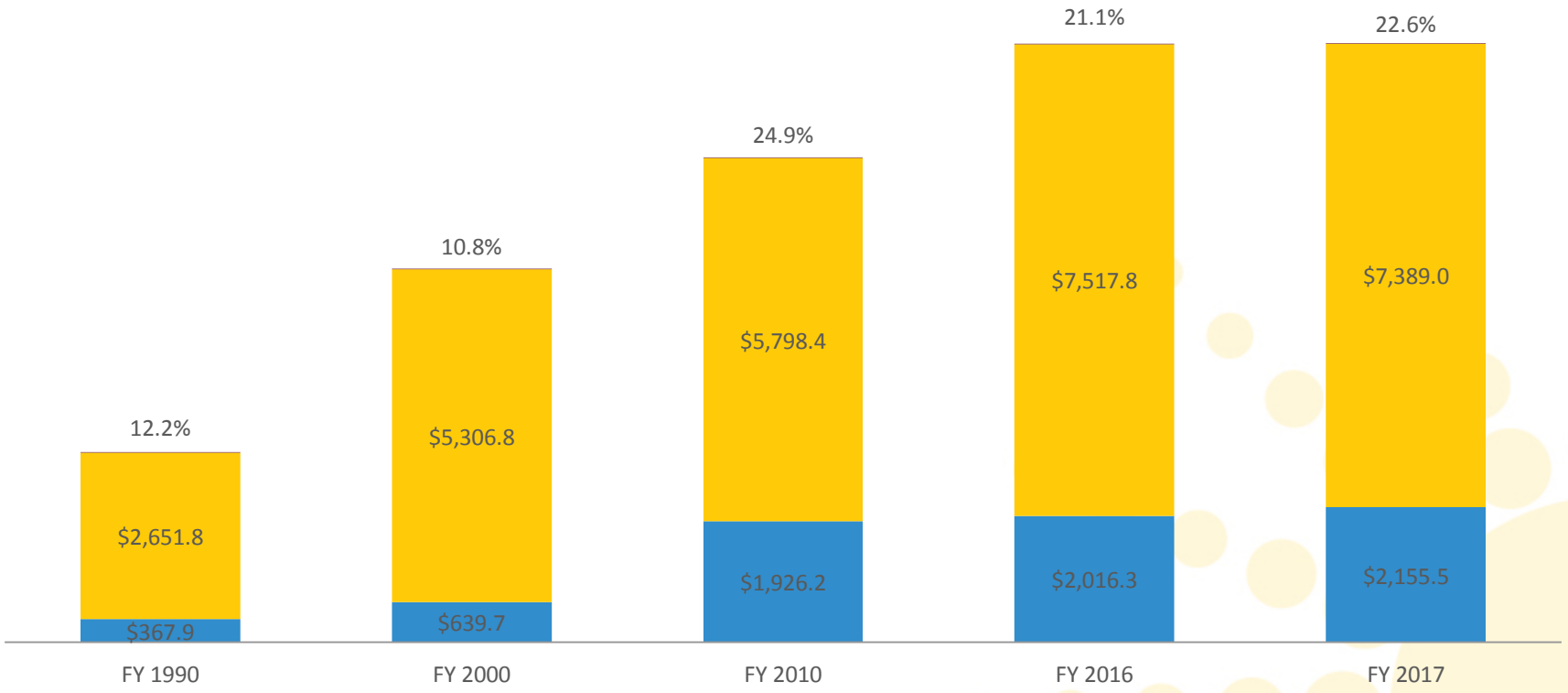


Historical GF Spend vs Population

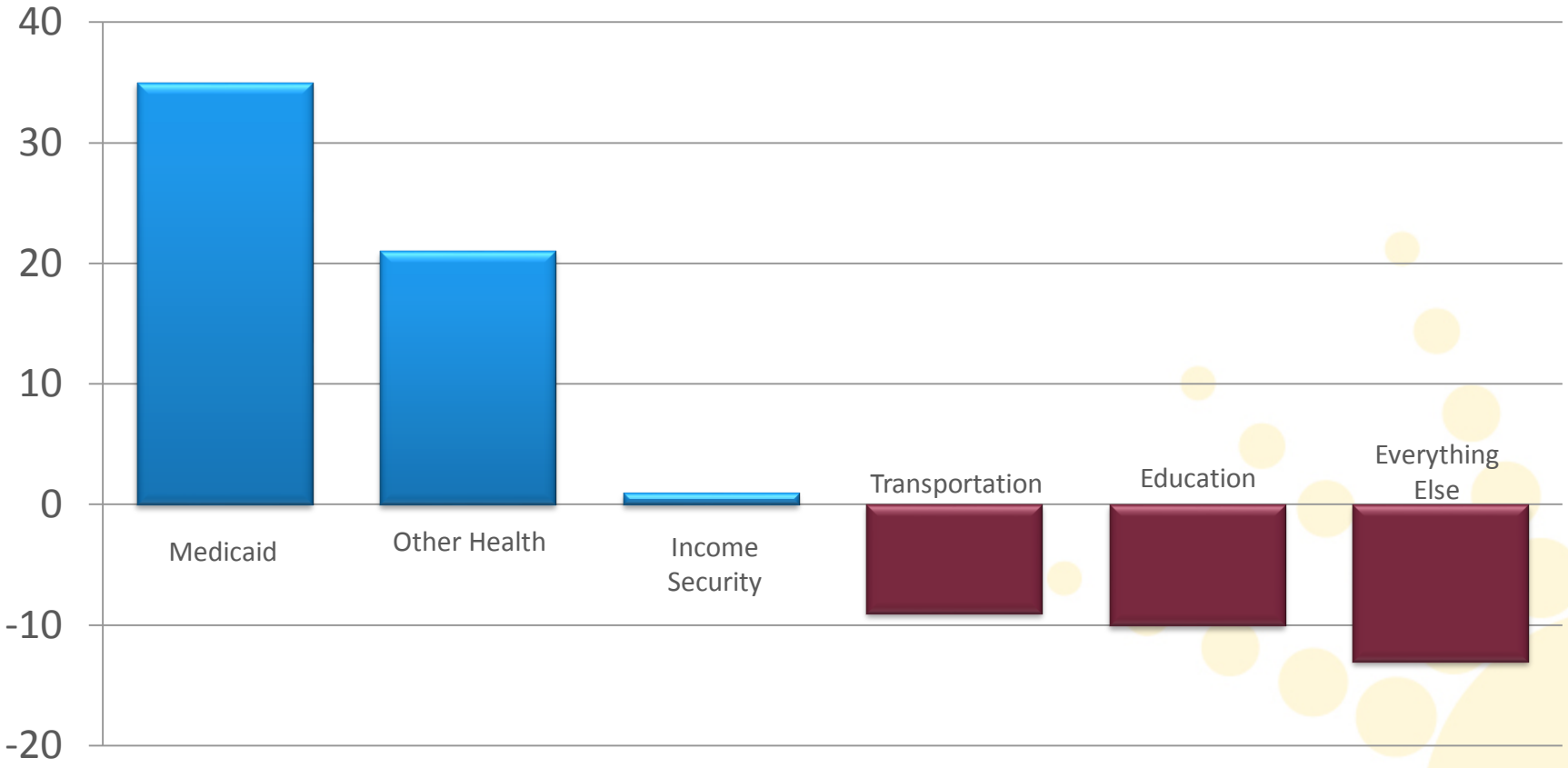


*FY2017 does not include BHS merger GF

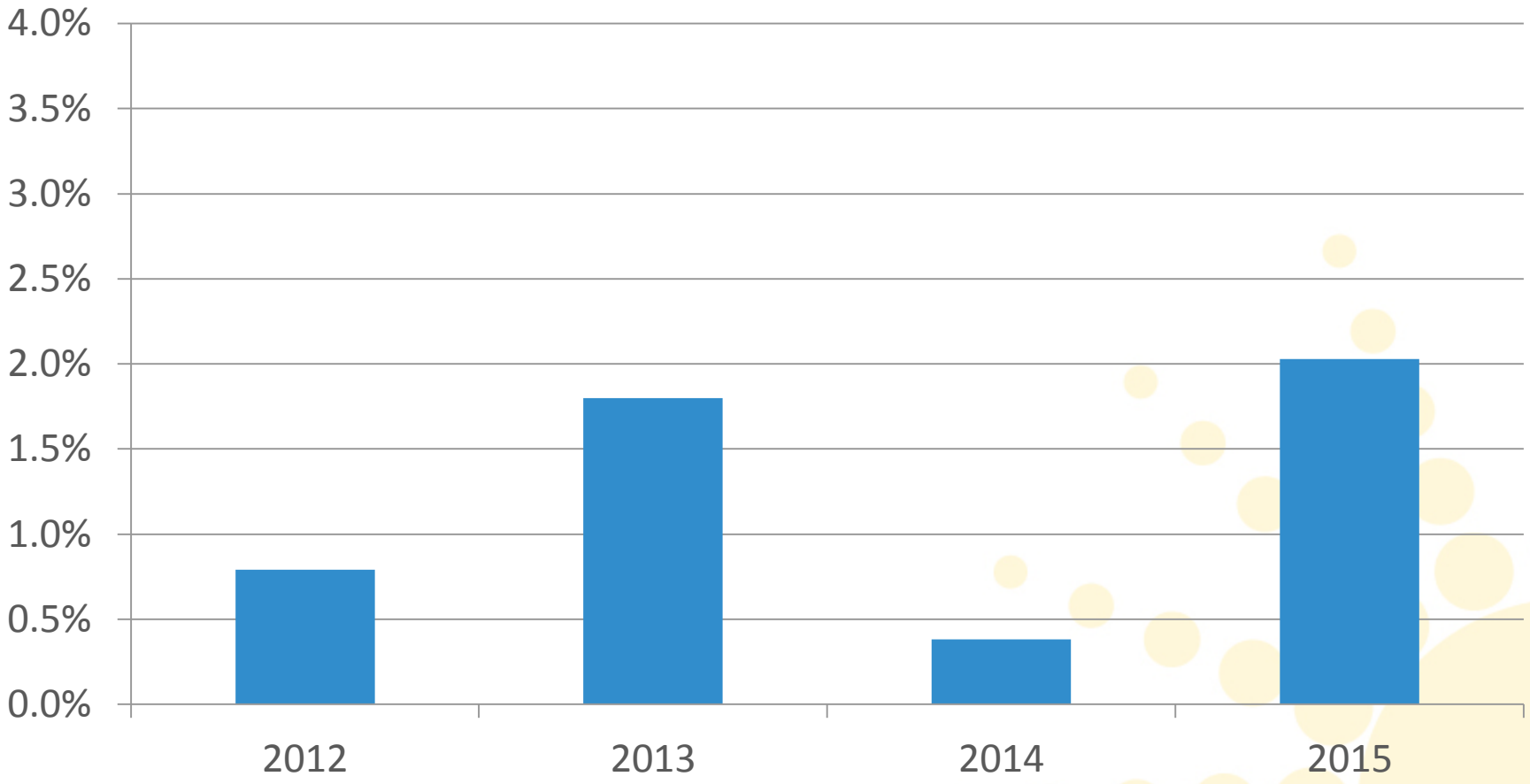
Medicaid Portion of General Fund



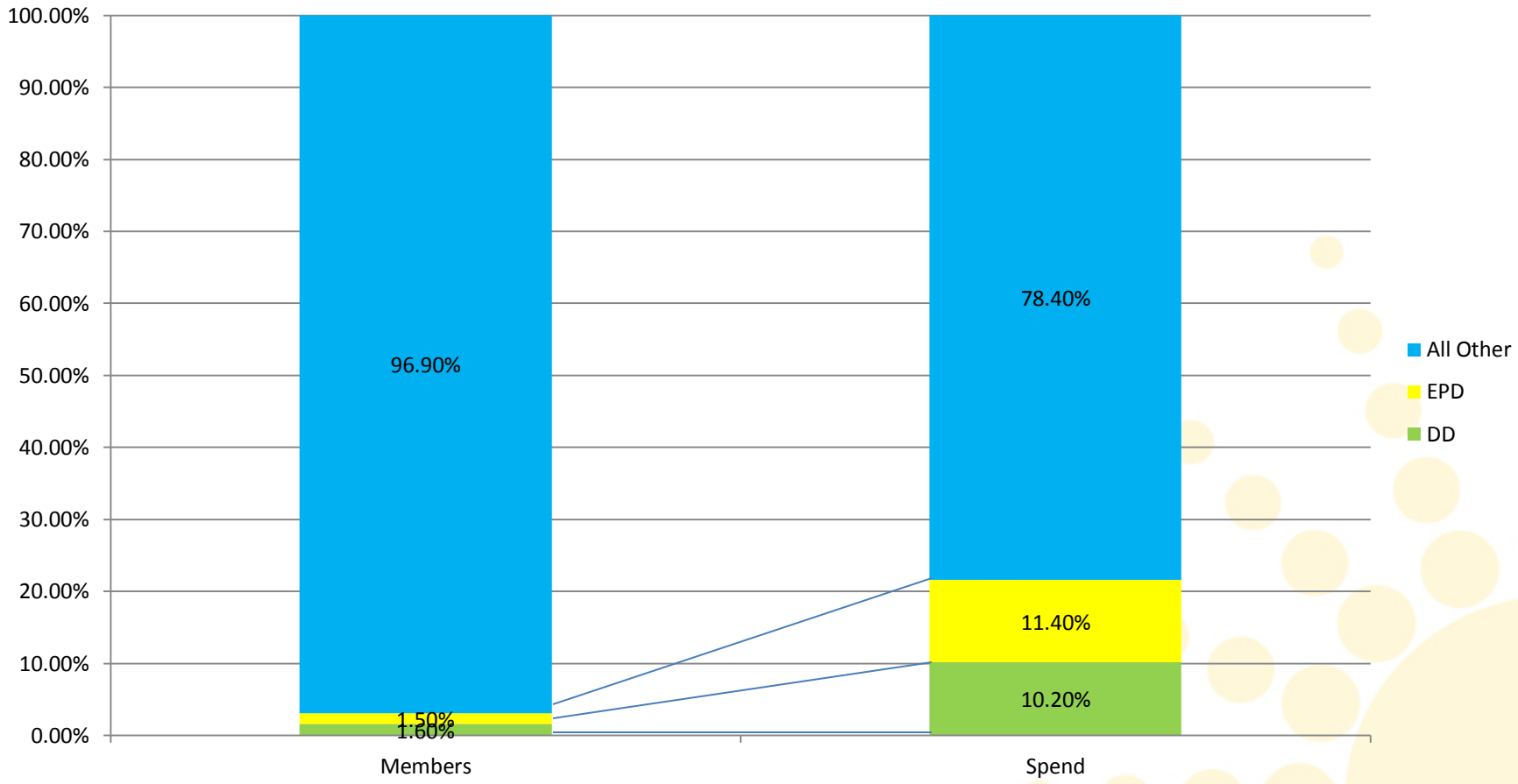
Percentage Change in Federal Funding (2008-2014)



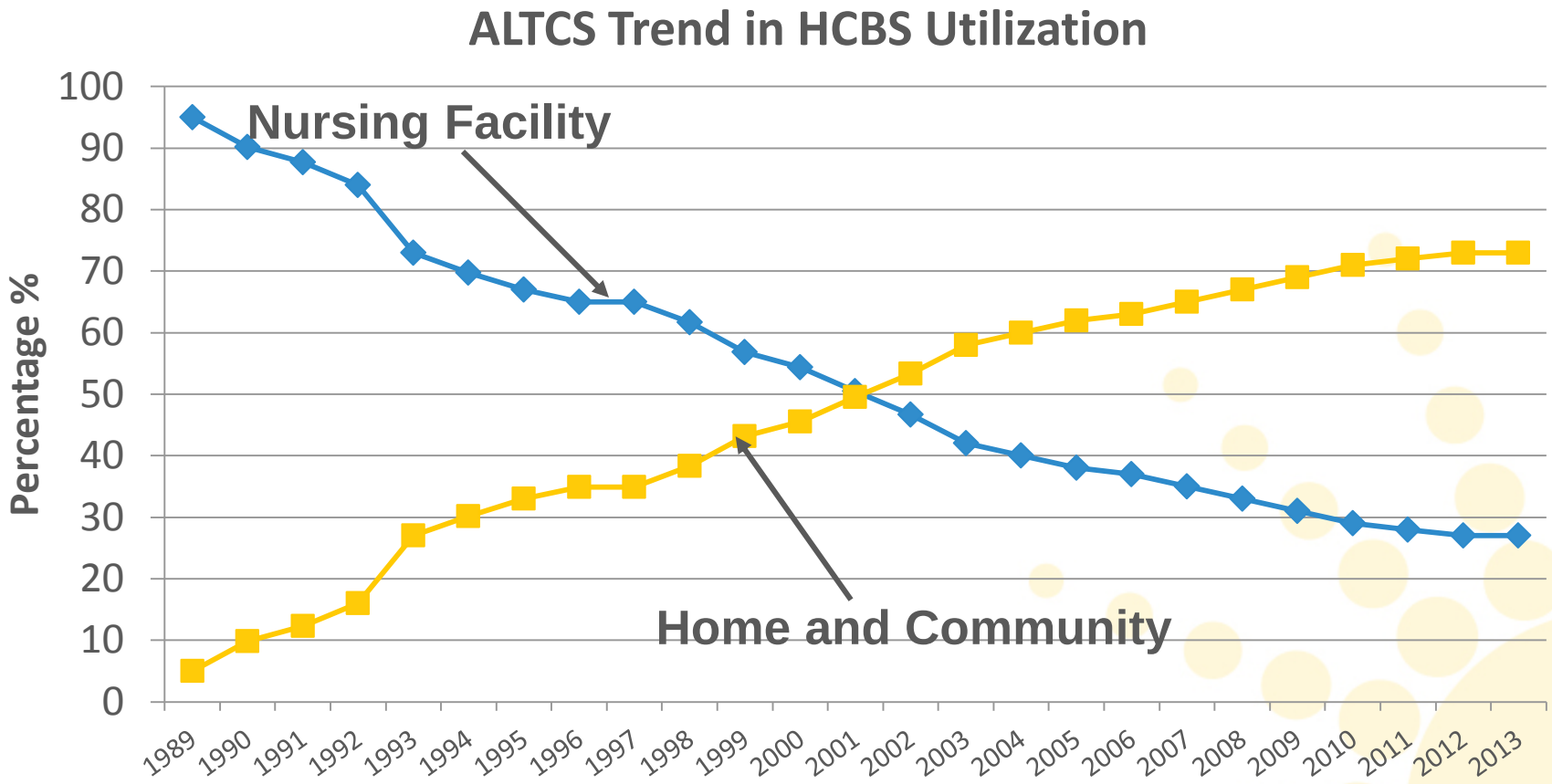
Total AHCCCS System Health Plan Profits



ALTCS Members are High Cost



Effective Use of Home and Community Based 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 and develop budget

July – June – AHCCCS works on implementation of budget Issues

AHCCCS Managed Care Principles

- Promote competition and choice in marketplace
  - RFPs structured to encourage strong plan competition
- Establish proper infrastructure for oversight
  - Staff of 140 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 to ensure member access
  - Regular monitoring

AHCCCS Expectations

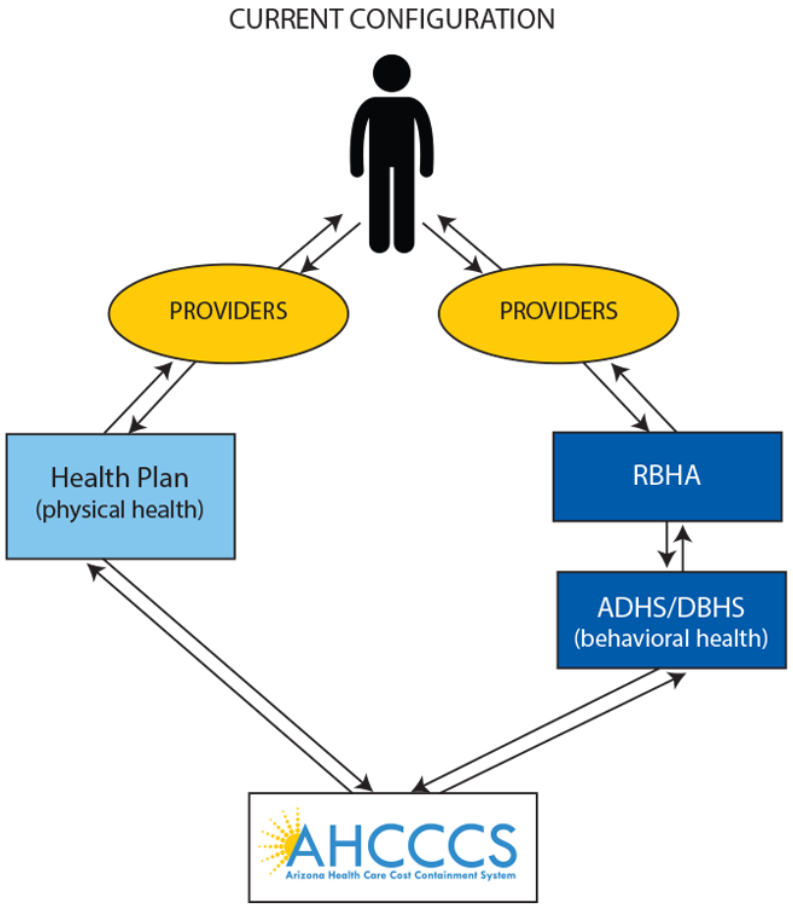
- Contractor performance accountability
  - Self-monitor operations and clinical performance, using available data
  - Develop and implement interventions designed to improve operational or clinical performance
  - Evaluate effectiveness of interventions and adjust as necessary to achieve excellence
  - 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

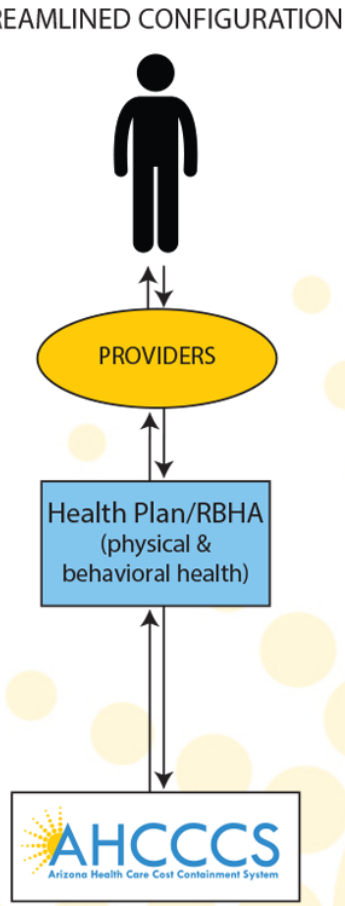
Examples of Contract Monitoring Tools

- 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 Focus and Initiatives

Vision - Integration at all 3 Levels





DBHS/AHCCCS Merger Update

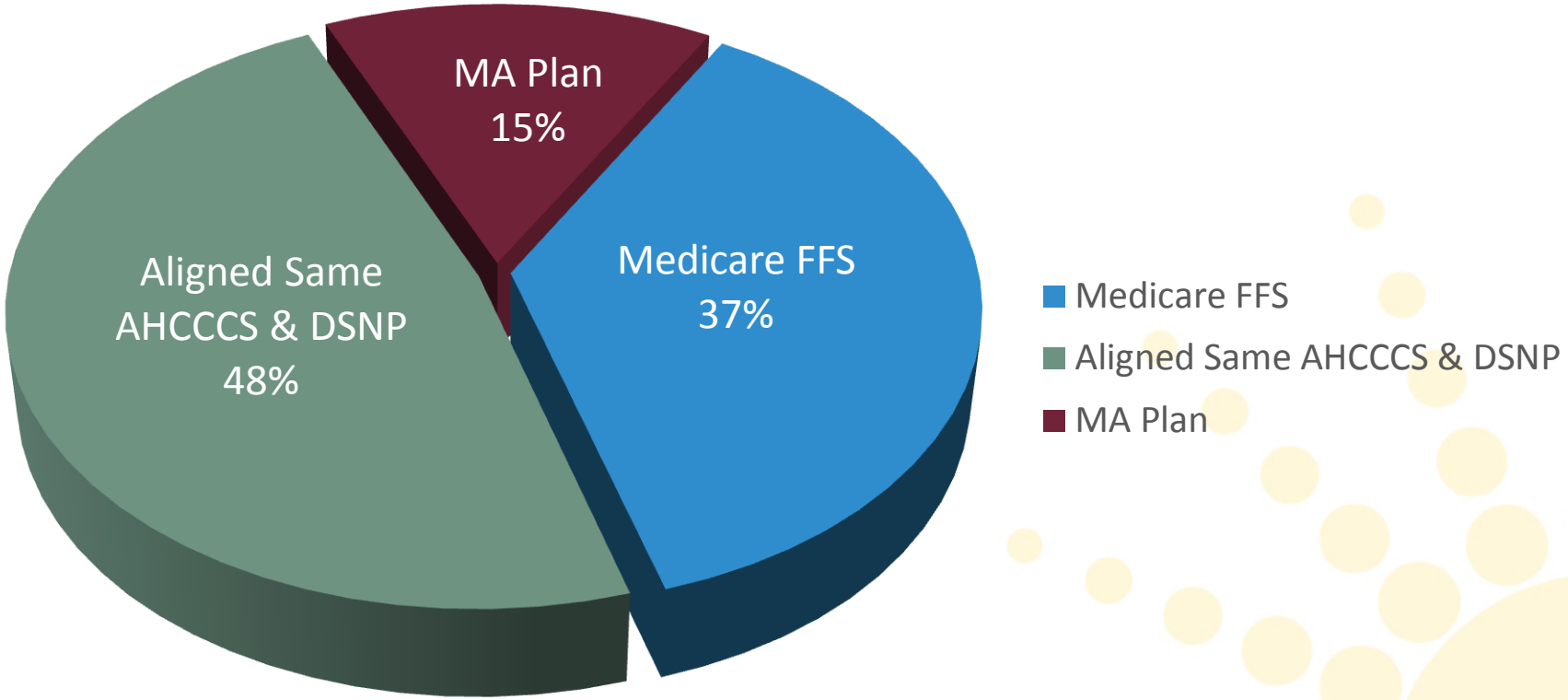
- 114 BHS staff or their established positions came to AHCCCS into 7 AHCCCS divisions

Division	New Staff
Division of Health Care Management	64
Division of Health Care Advocacy and Advancement	24
Office of Administrative Legal Services	9
Information Services Division	6
Division of Fee-For-Service Management	5
Division of Business and Finance	5
Office of Inspector General	1

Integration Efforts to Date

1. Ongoing – Duals – >40% alignment DSNP
2. 2013 – 17,000 Kids with special needs
3. 2014 – 20,000 Individuals with SMI – Maricopa
4. 2015 – 19,000 Individuals with SMI – Greater AZ
5. 2015 – 80,000 dual eligible members – Integrate BH
6. 2016 – Administrative Merger – 80,000 AIHP members
7. Future Possibilities
    1. 2017 – 29,000 members with DD – BH & PH
    2. 2018 – 34,000 Children with Autism or at risk
    3. 2018 or future date – Non-SMI adults – BH

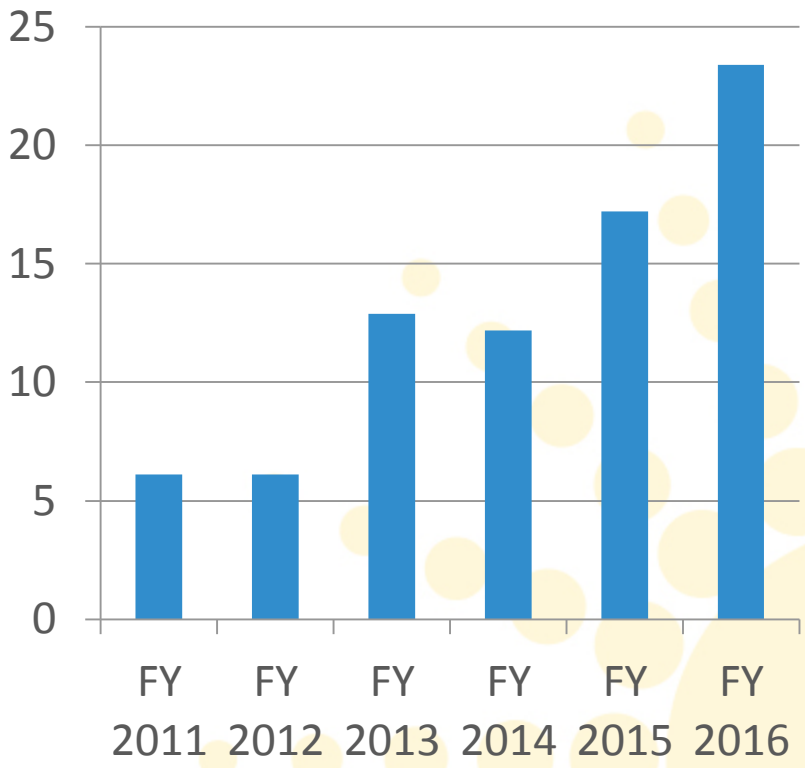
AHCCCS Dual Eligible Members Medicare Enrollment October 2016



Social/Economic Determinant Efforts

- Multiple Plans have partnered to create and support community social service centers
- MCO pilot to invest in low-income housing subsidy
- AHCCCS has dedicated staff resources focused on housing – employment – peer services
- State only investments made through RBHAs

State Housing Funding for Individuals with SMI



Justice System Transition Efforts

- Daily feeds with DOC/Jails +>90% pop.
- Member suspense – reinstatement
- Daily feed to plans - $30m cap savings
- Pre-release apps processed
- 1,100 care coordination efforts with MCOs
- Extensive work done by RBHAs in jails
- New reach-in requirements for MCOs
- Working on HIE connectivity

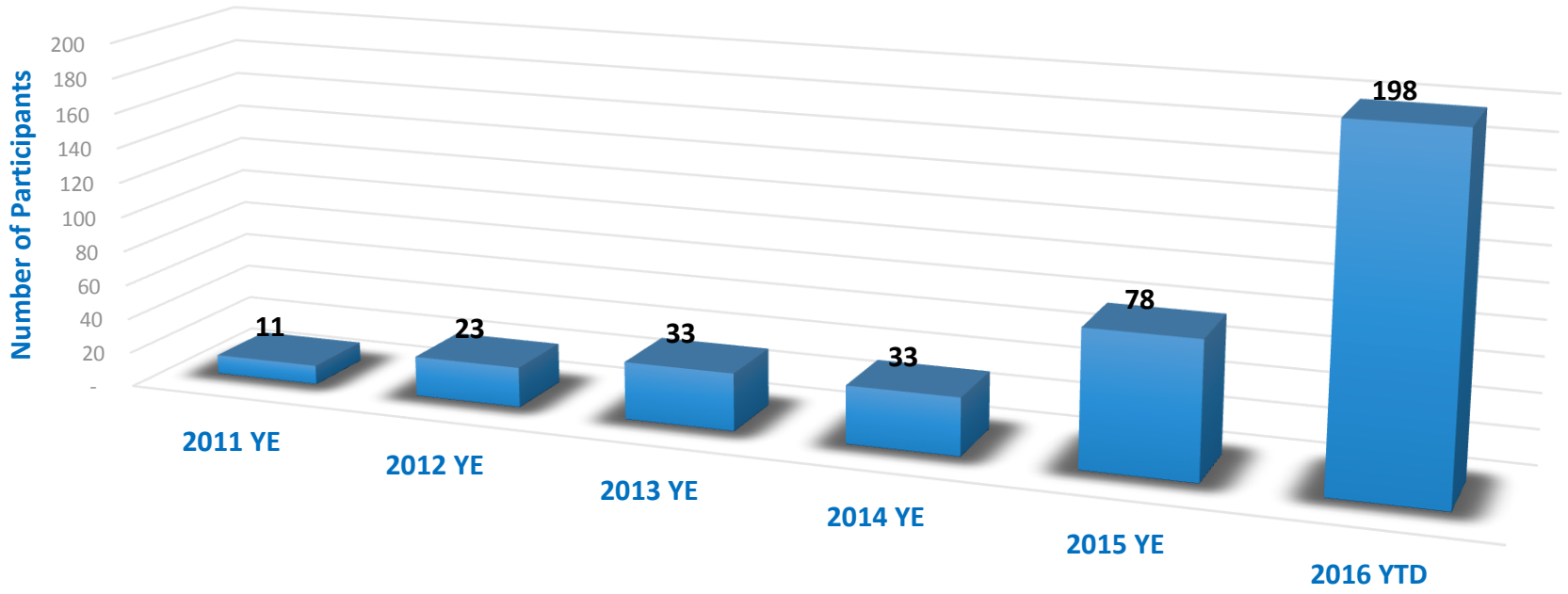
Health Information Technology

- All MCOs must contract with a non-profit organization that operates statewide health information exchange
- State looking to leverage state only dollars to connect BH providers to HIE through MCOs
- State supports having federal government revisit Part 2 requirements
- Blind Spot data – State shares, mandates MCOs leverage info
- Contractual requirements to increase use of e-prescribing

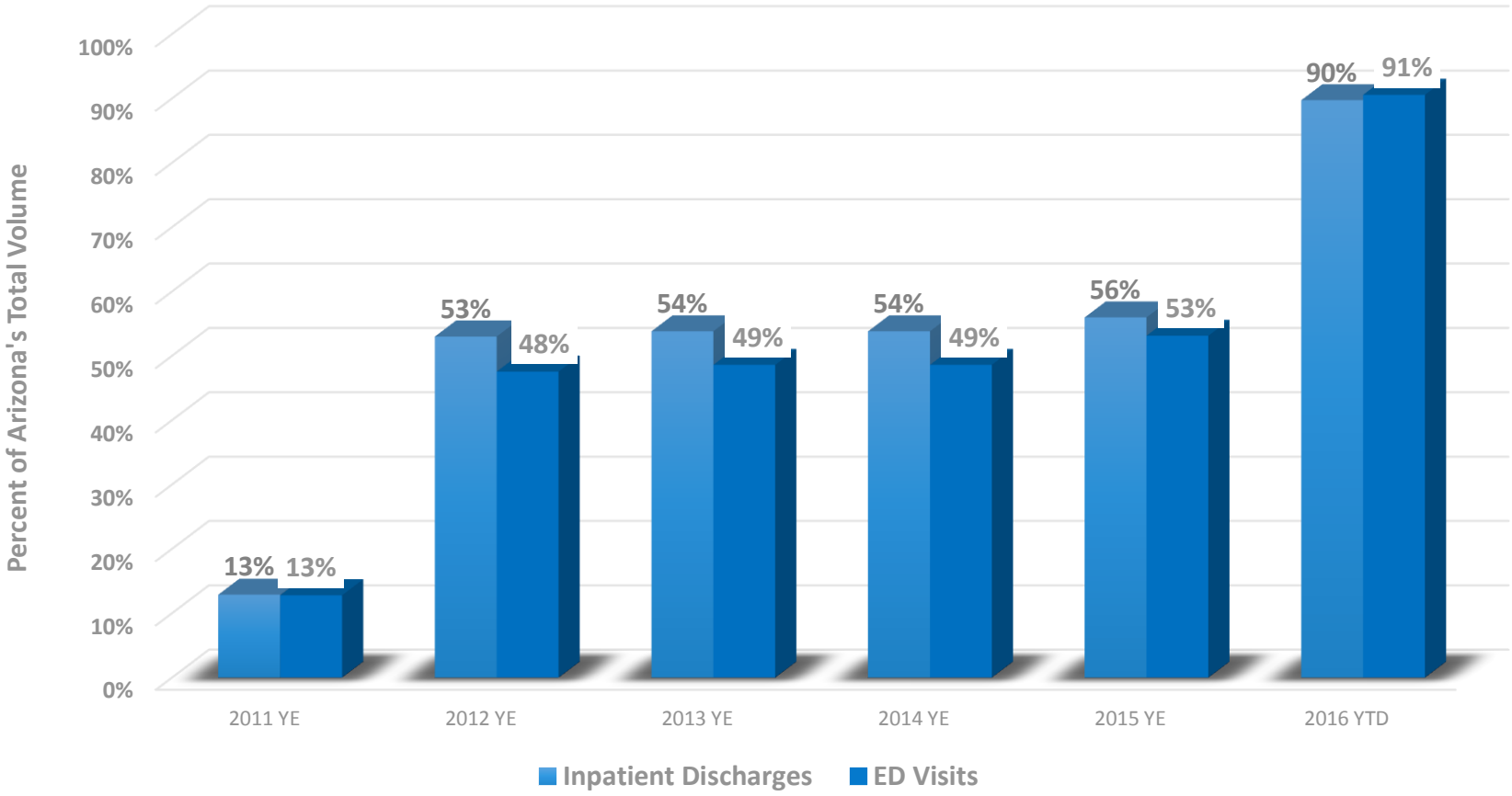
HIE Medicaid Collaboration

- Governance: Community organization with many wide representation – Medicaid Director is Treasurer
- Finance: Split 50/50 between Hospitals and Managed Care plans
  - Leveraged 90-10 funding for on-boarding hospitals and FQHCs
  - Mandated that Managed Care plans join HIE
  - Established VBP of .5% for hospitals to join
- Integration: Funded effort to bring on 90 BH providers – Crisis System
- Quality: Medicaid agency connectivity - receiving ADT alerts

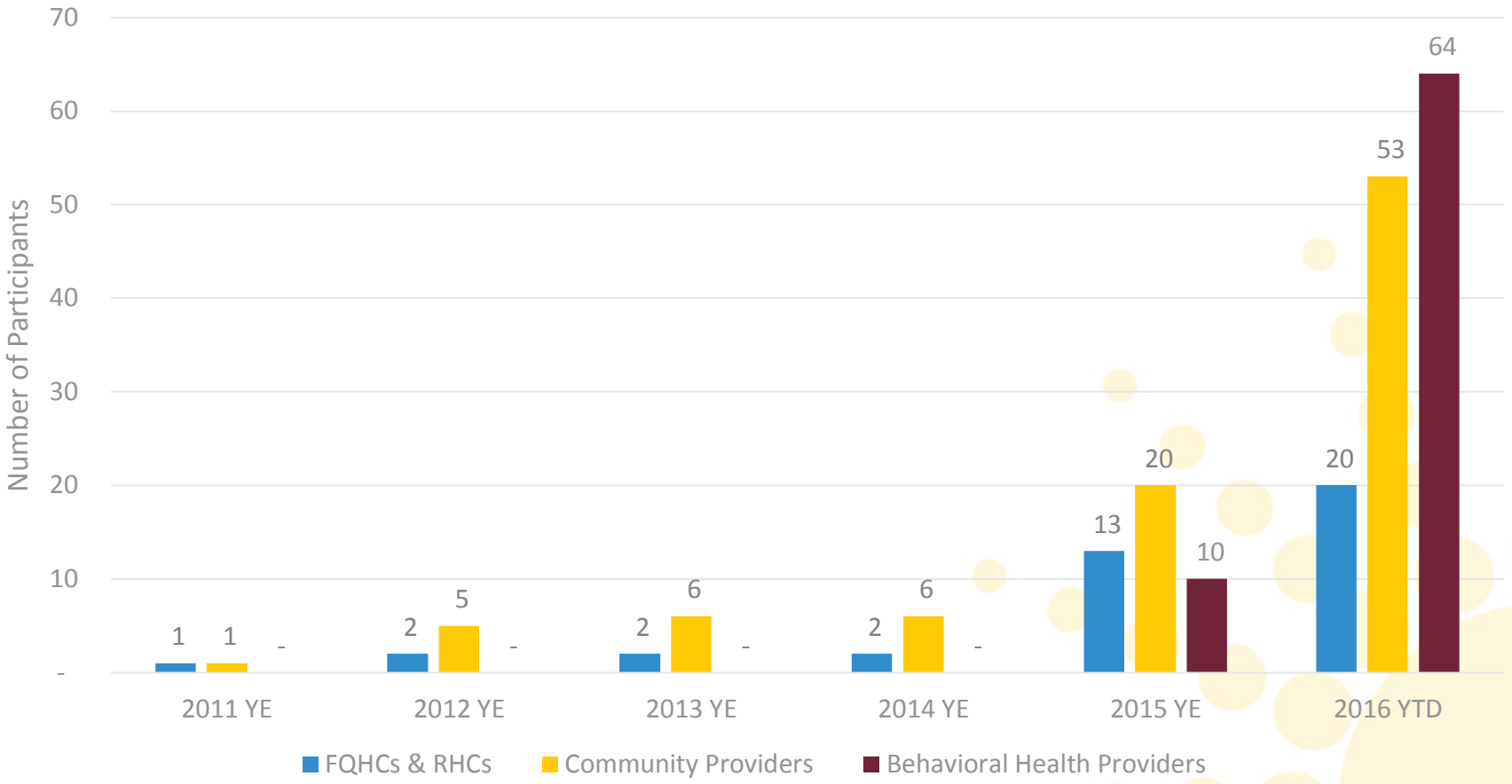
Network Growth



Network Hospital Participation



Network Provider Participation



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

Alternative Payment Models

Alternative Payment Models - Efforts to Date

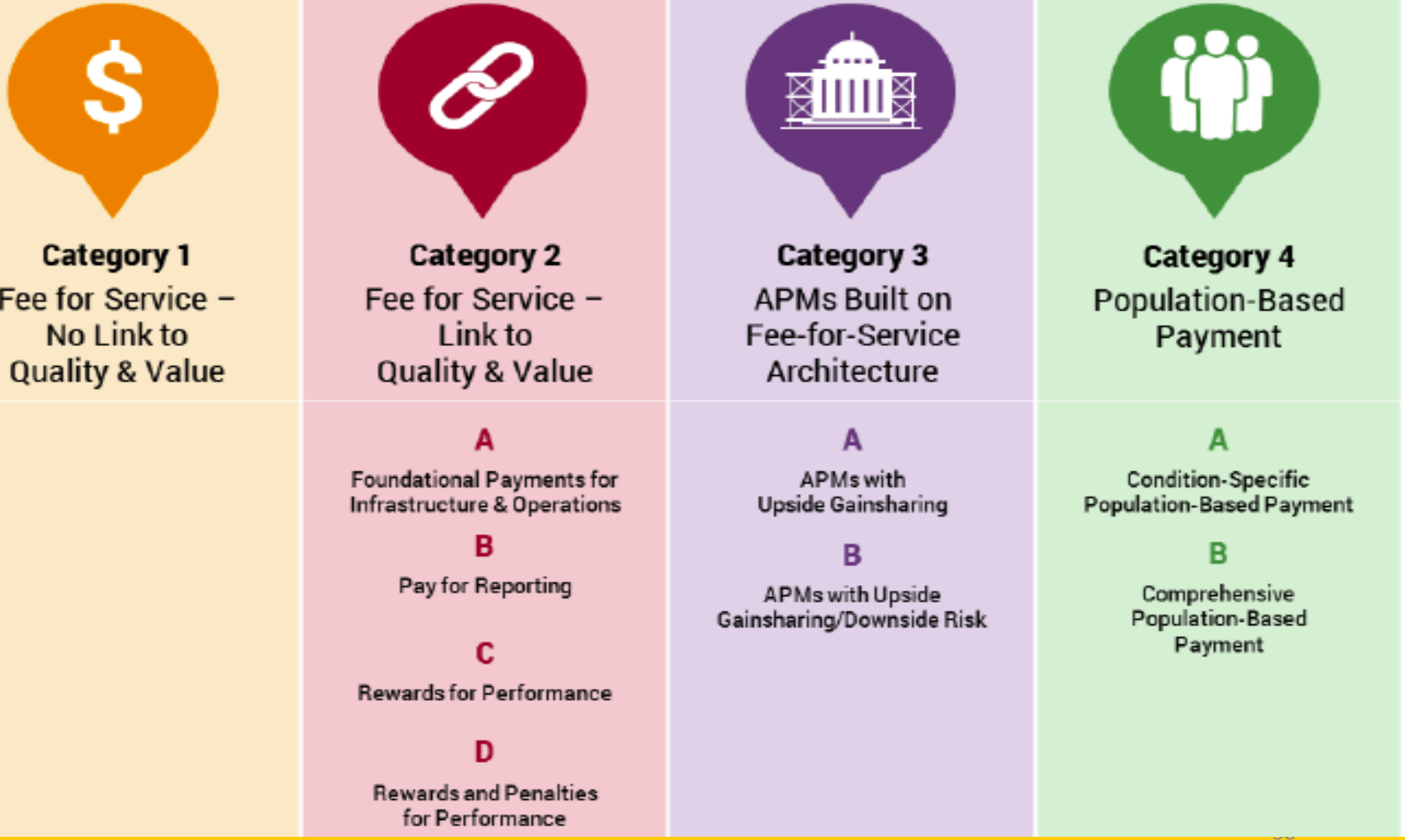
1. AHCCCS role – establish broad goals for system
2. Goals and progress is incremental
3. System Design Matters - True VBP requires Integration to align incentives
4. Pursuing VBP requires resources and leadership at Medicaid agency and MCOs
5. Culture of learning
6. Requires improved access to actionable data - HIE
7. Defining measures is challenging

AHCCCS VBP Fee Schedule Changes

- 2014 – Hospital IP – APR-DRG
- 2015 - MCOs pay FQHC full rate
- 2016 - Hospital bump for sharing data with HIE and meeting MU2
- 2016 - SNFs – increase for those above avg with pneumococcal vaccine
- 2016 - Integrated Clinics- physical health
- 2016 – Freestanding ED – new provider type
- 2016 – Treat and Refer

LAN Payment Reform Framework

Figure 1. APM Framework (At-A-Glance)



Value Based Purchasing Goals

Program	CYE 15	CYE 16	CYE 17	CYE 18	CYE 19
Acute	10%	20%	35%	50%	50%
ALTCS EPD	5%	15%	25%	35%	50%
RBHA		5%	15%	25%	35%

APM Proposed Targets

DSRIP Year	Percent Spend LAN 2-4	Percent Spend LAN 3 & 4
2017	30%	NA
2018	40%	5%
2019	50%	10%
2020	60%	20%
2021	70%	40%

Delivery System Reform Incentive Payments (DSRIP)

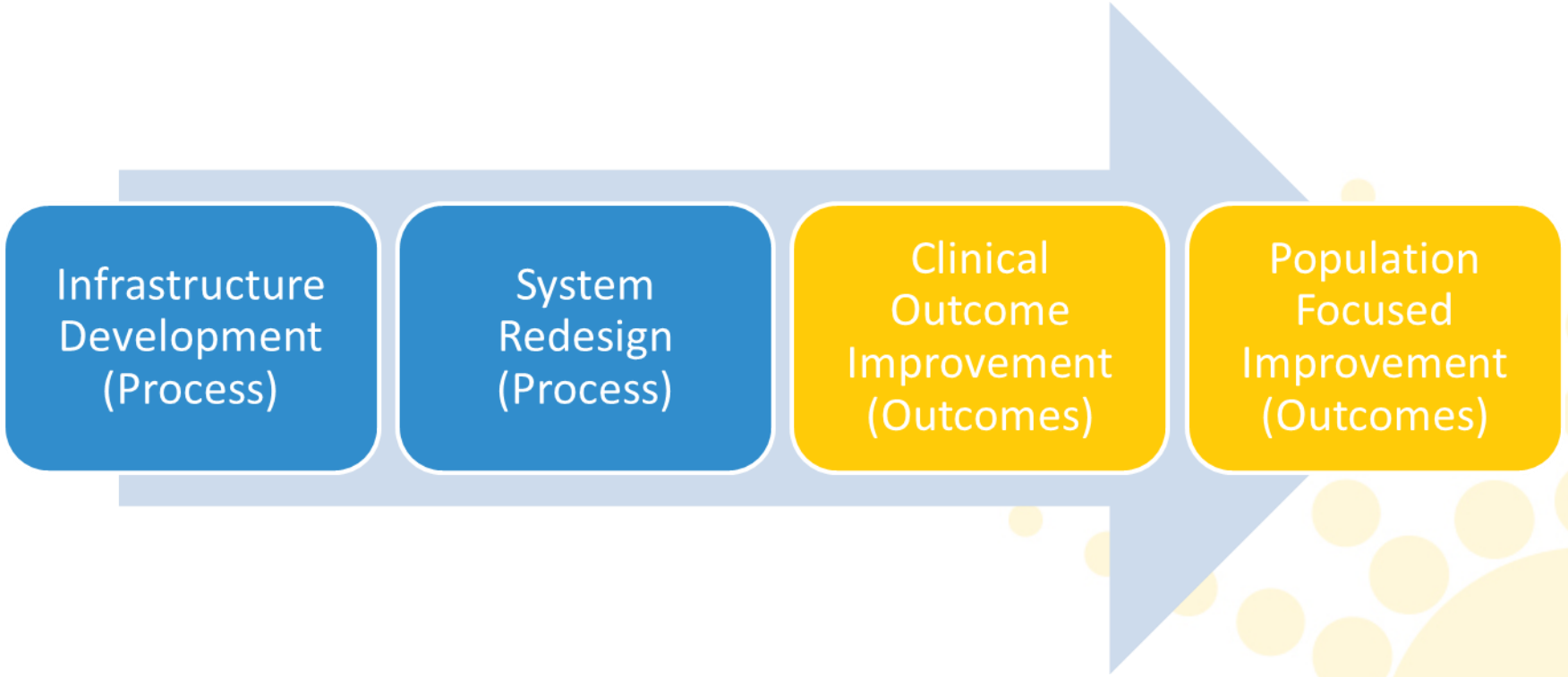
What is DSRIP?

- Federal funds administered by the Centers for Medicare & Medicaid Services (CMS)
- DSRIP initiatives provide states with funding to support providers in changing how they provide care to Medicaid beneficiaries
- DSRIP initiatives are part of broader Section 1115 Waiver programs

DSRIP Initiatives

- Five years
- No official federal criteria for DSRIP program qualification
- States have taken varying approaches
- Payment incentives distributed for meeting performance outcomes Providers can use funds to develop systems, infrastructure, and/or processes

DSRIP Emphasis over 5 Year Period



Arizona's DSRIP Focus Areas

- Adults with Behavioral Health Needs
- Children with Behavioral Health Needs
  - Children with and At-Risk for ASD
  - Children Engaged in the Child Welfare System
- Members Transitioning from the Justice System
- *Individuals enrolled in the American Indian Health Program (AIHP)

Role of Managed Care Organizations

- DSRIP accelerates Arizona's efforts to integrate at payer and provider level.
- DSRIP looks to build on Value Based Payment efforts by requiring MCOs and providers to continue increased Alternative Payment Models that drive to greater risk alignment
- DSRIP leverages important roles for MCOs in justice system initiative by having RBHAs serve as DSRIP lead while partnering providers and other managed care organizations
- DSRIP leverages MCO structure by allowing MCOs to be DSRIP lead for Integration strategic focus areas
- Provider organizations may form DSRIP entities but must collaborate with MCOs that have specific roles around data aggregation and sharing

CMS Regulations Tsunami

- Access Requirements
- New Outpatient Drug
- MCO requirements
- Parity Requirements
- Home and Community Based Requirements
- DOL – Overtime Requirements
- Capitation Rate Reviews

AHCCCS Mission and Vision

- **Mission:** Reaching across Arizona to provide comprehensive, quality health care to those in need
- **Vision:** Shaping tomorrow's managed care...from today's experience, quality and innovation
- **Values:** Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership
- **Credo:** Our first care is your health care

ALTCS E/PD Program Overview

Virginia Rountree
Assistant Director
AHCCCS, Division of Health Care Management

The ALTCS Program

1989 - Arizona expands Medicaid and establishes the Arizona Long Term Care Services (ALTCS) program including home and community based services

The Program serves:

- Individuals who are 65 years of age and older, OR
- Individuals with disabilities of any age AND
- Individuals that need ongoing services at a nursing facility level of care

AHCCCS ALTCS Program Values

- Choice
- Dignity
- Independence
- Individuality
- Privacy
- Self-Determination

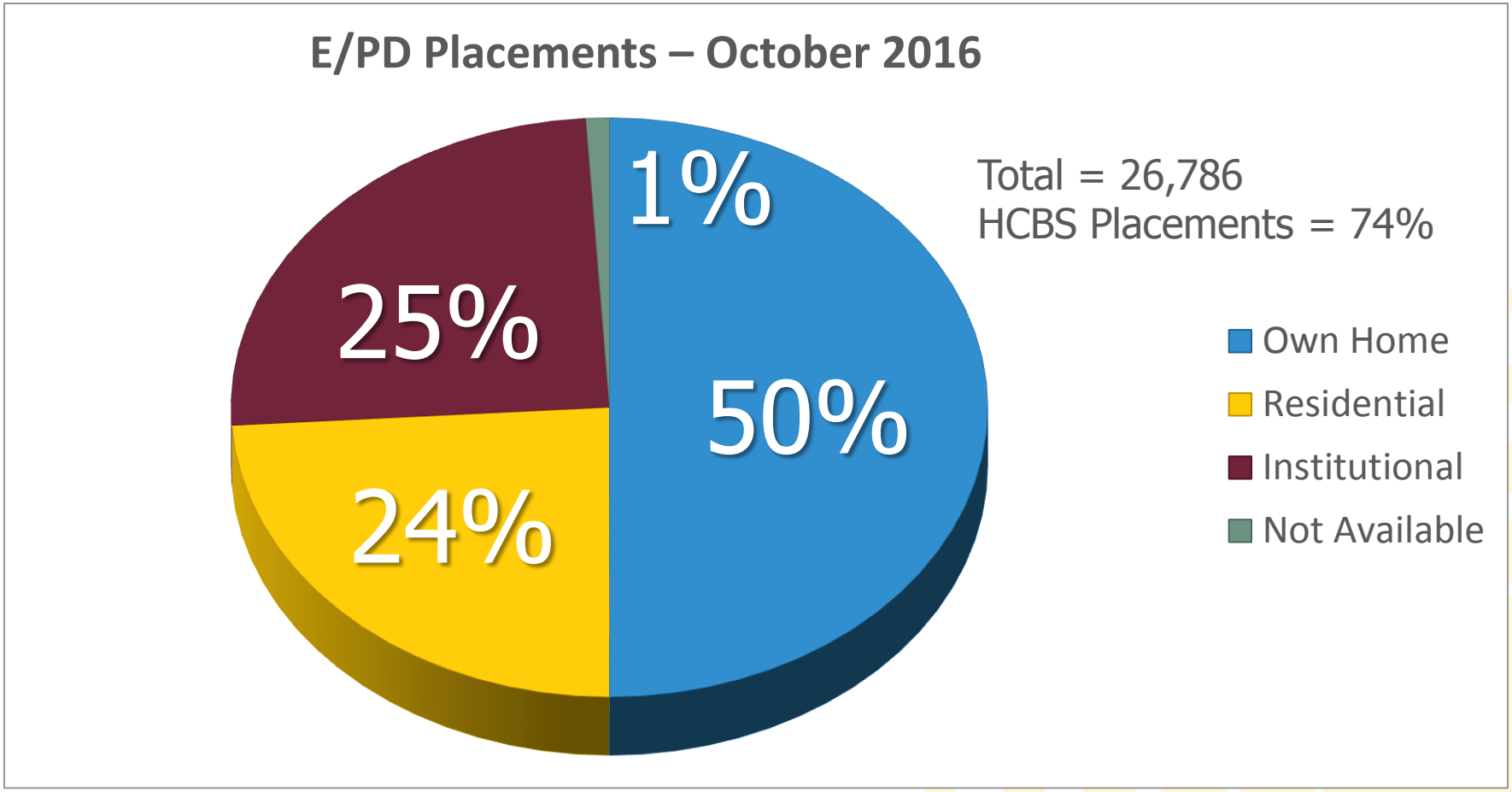
Guiding Principles and Practices

- Member-Centered Case Management
- Member-Directed Options
- Person-Centered Planning
- Consistency of Services
- Accessibility of Network
- Most Integrated Setting
- Collaboration with Stakeholders

ALTCS E/PD – Current Program

- Fully Integrated Program
  - Case Management
  - Long Term Services and Supports (LTSS)
    - Home and Community Based Services (HCBS)
  - Acute Care (inclusive of children with special health care needs)
  - Behavioral Health
- Three Incumbent Contractors

ALTCS E/PD – Current System



CONTRACTING PROCESS

Meggan Harley
Chief Procurement Officer
AHCCCS, Division of Business and Finance

PROCUREMENT TIMELINE

Activity	Date
Issue Request for Proposal	November 1, 2016
Pre-Proposal Prospective Offerors' Conference and Technical Interface Meeting	November 8, 2016
First Set of Technical Assistance and RFP Questions Due	November 10, 2016
First RFP Amendment Including Responses to RFP Questions Issued On or Before	November 30, 2016
Second Set of Technical Assistance and RFP Questions Due	December 07, 2016
Release Date for Capitation Rate Ranges/Rates	December 19, 2016
Second RFP Amendment Including Responses to RFP Questions Issued On or Before	December 21, 2016
Third Set of Technical Assistance and RFP Questions Due - *Limited to Published Capitation Rate Ranges/Rates*	December 27, 2016
Third RFP Amendment Including Responses to RFP Questions Issued On or Before	January 5, 2017

Procurement Timeline Continued

Activity	Date
Proposals Due by 3:00 p.m. Arizona Time	**January 23, 2017**
Contracts Awarded/Transition Services Begin On or Before	March 7, 2017
Transition Services Implementation: Post-Award Deliverables	March 27, 2017
Program and Medical Service Implementation On or After	October 1, 2017

Medicare Advantage (D-SNP) Application and Bid Review Process Timeline

- Medicare D-SNP Requirements
  - Contractors will be required to be a D-SNP on **January 1, 2018**
    - 11-14-16: Submit non-binding Notice of Intent to Apply (NOIA) for new entrants into Medicare market to CMS
    - 01/10/17: Final Applications posted by CMS
    - 01/27/17: Deadline for NOIA form submission
    - 02/15/17: Dual Eligible Special Needs Plan (D-SNP) applications due to CMS
  - Refer to Bidders' Library and RFP Exhibit E, Medicare Requirements
  - CMS Website

Process

- Timetable
  - Submission deadline January 23, 2017
    3:00 PM Arizona Time (No Exceptions)
- Website navigation (Bidders' Library)
- Questions/Answers
  - All questions must be submitted in writing using the template available in the Bidder's Library
  - Sent via email to EPDYH18_QuestionstoRFP@azahcccs.gov
  - Verbal responses today are not binding
  - RFP prevails

Term of Contract

- The initial term of this Contract, starting October 1, 2017, shall be for an initial period of three years with three renewal periods:
  - One renewal of two years, and
  - Two renewals of one year each
- The Contract Year is October 1 through September 30 with an annual October 1 renewal. The terms and conditions of any such contract extension shall remain the same as the original contract except, as otherwise amended.
- Any contract extension or renewal shall be through Contract amendment, and shall be at the sole option of AHCCCS.

Permissible Bids

PERMISSABLE BIDS BY GSA	
Central Only	No
Central and South Only	No
North Only	Yes
South Only	Yes
North and South Only	Yes
Central and North Only[1]	Yes
Central and North and South[2]	Yes

[1]In order to be considered for award in the Central GSA, the Offeror must submit a competitive bid in the North GSA as well. A submission for the Central GSA that does not include a proposal for the North GSA will not be considered. However, AHCCCS may choose not to award a contract for both GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.

[2]AHCCCS does not intend to award contracts for all GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.

Award of Contract

GSA Name/Counties	Number of Awards
North Mohave/Coconino/Apache/Navajo/ Yavapai	Maximum of 1
South Cochise/Graham/Greenlee/ La Paz/Pima/Santa Cruz/Yuma	Maximum of 1 (with an exception for Pima County which will have a maximum of 2)*
Central Maricopa/Gila/Pinal	Maximum of 3

*AHCCCS anticipates awarding the entire South GSA to the Successful Offeror with the highest score for the South GSA. In addition, AHCCCS anticipates awarding Pima County-only to the Successful Offeror with the second highest score for the South GSA when not in conflict with the provisions in RFP.

Post-Award Deliverables

- Refer to RFP Section H: Instructions to Offerors
  - Transition Services Implementation: Post-Award Deliverables
  - Due March 27, 2017

Response Specifications

- Refer to RFP Section H: Instructions to Offerors, Contents of Offeror's Proposal
- Hard Copy Submission (10 copies)
  - Excluding RFP Section G: Representations and Certifications of Offeror
- Electronic Submission (Via FTP Server)
- Adhere to Offeror's Checklist
- Calibri 11 point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement must be limited to five (5) 8½" x 11" one sided, single spaced, type written pages

Scoring

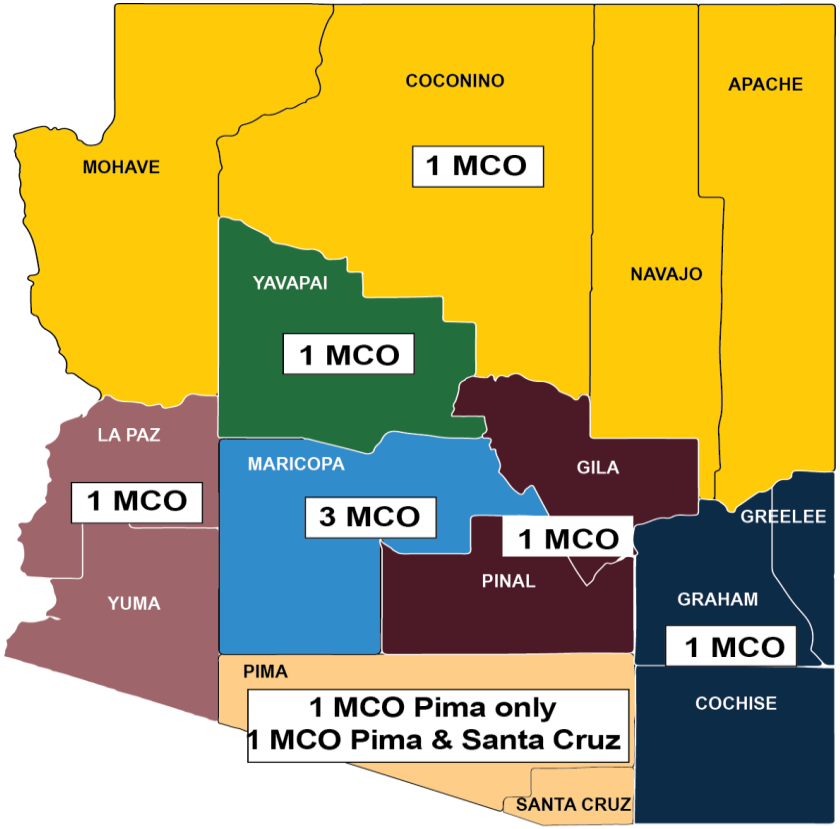
- Capitation scored by Geographic Service Area
- Access to Care/Network, Program, and Administration will receive a Statewide score
- Only information within allotted page limits and permitted attachments will be considered
- AHCCCS will not consider information provided elsewhere in the proposal

RFP HIGHLIGHTS

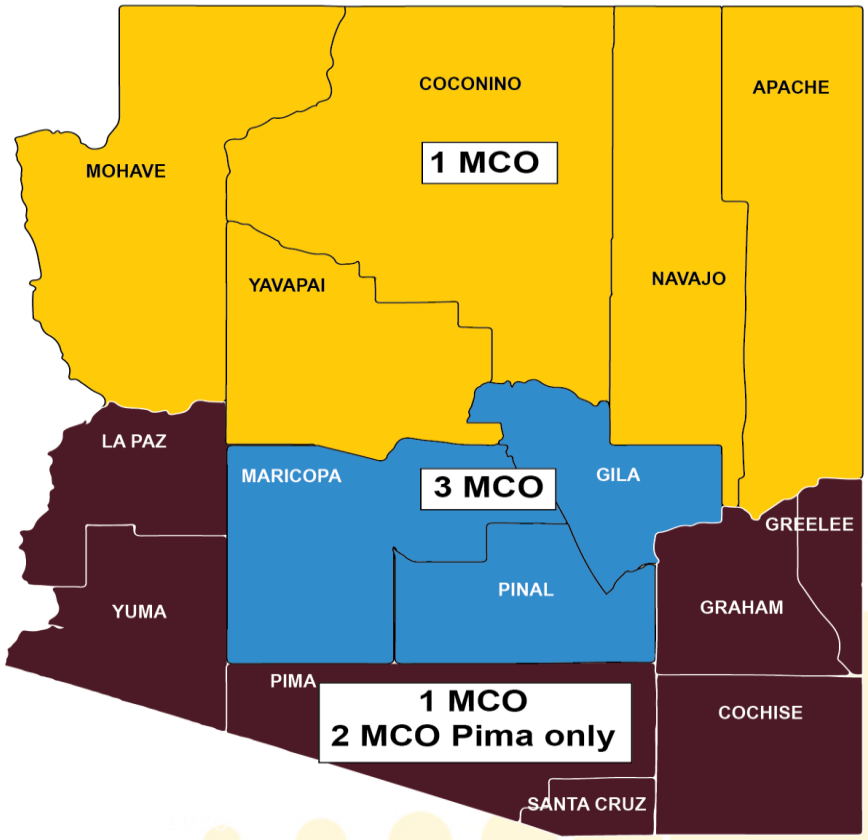
Shelli Silver
Assistant Director
AHCCCS, Division of Health Care Management

RFP Highlights – GSA Changes

CURRENT



RFP YH18



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RFP Highlights

- Members with SMI
  - Referral for SMI determinations
  - Covered Services (Title XIX and State-only)
  - Cost Reimbursement for State-only services
  - Unique case management ratios, effective October 1, 2019
- Enrollment of ALTCS members while hospitalized
- Advance Care Planning/End of Life care

RFP Highlights

- Key Staffing Requirements
- Delegated Agreements/Prohibitions
- Claims Processing
- Reinsurance Change - Phase-In
- Subcontractor Insurance Requirements

Pending Issues

- Managed Care Regulations
- Mental Health Parity and Addiction Equity Act
- Section 1115 Waiver Demonstration
- Home and Community Based Services Settings Rules
- Person-Centered Planning
- Electronic Visit Verification (EVV)
- Section 1557 of the Affordable Care Act
- Nursing Facility Workgroup
- Encounter Submission

Capitation & Finance-Related Issues

Shelli Silver
Assistant Director
AHCCCS, Division of Health Care Management

Important to Note

- RFP and Bidder's Library Content prevail in case of any inconsistencies between those documents and this presentation
- See the Data Supplement in the Bidders' Library for resources to assist with capitation bid development

Capitation Bid

- Dual and Non-Dual Capitation rates, each with 3 components, will be bid by GSA using the Capitation Bid Template/Tool:
  - Medical
  - Case Management
  - Administrative
- PPC and Acute-Care Only rates will not be bid

Capitation Bid, cont.

- Actuarially-sound rate ranges by GSA for medical component of cap rates published ~ December 19, 2016
- Offerors encouraged to bid rates utilizing *average* pmpm costs utilizing resources provided by AHCCCS
- Actuarial Attestation for all GSAs must be submitted

Bid Component Limits

- Medical component
  - Bids outside published range = zero points
- Case Management component
  - No limits
  - Case management ratios eff. October 2019 for members with SMI should NOT be in bid
- Administrative component
  - Bids > 8% administrative max = zero points

Case Management Model

- Case Management Model Template – optional for use and not a required submission
- Must use mix % provided by AHCCCS
- Each case manager's caseload must not exceed a weighted value of 96
- Weights must not exceed those found in AMPM Policy 1630

Cap Rate Adjustments

- Medical and CM components of rates will be adjusted after award/before October 1, 2017 and may include/not be limited to:
  - Pima County-Only adjustment for Successful Offeror
  - NF/HCBS mix unique to each Contractor
  - Program changes
  - Legislative requirements

Cap Rate Adjustments, cont.

- Reinsurance offset determined by AHCCCS
- Share of cost offset determined by AHCCCS
- Risk contingency and premium tax
- Changes in trend assumptions
- Updated encounter experience
- Population Risk
- Actuarial assumptions not previously included in published rate ranges or awarded rates
- CMS mandates

Value-Based Purchasing Assessment

- 1 percent of Prospective Gross Capitation, exclusive of Acute Care Only payments, will be assessed to fund quality distributions to Contractors (See ACOM Policy 318)
- 100% of assessed funds will be distributed to one or more Contractors according to performance on select Quality Management performance measures

Nursing Facility Rates – Short Term

- AHCCCS will reevaluate Level I – III nursing facility FFS rates for rates effective October 1, 2017
- Likely to include an expansion of FFS rates to include specialty and/or add on rates
  - Contractors will be mandated to adopt FFS rate methodology changes made by AHCCCS, if any

Nursing Facility Rates – Long Term

- AHCCCS to establish workgroup of E/PD Contractors and providers to consider alignment between Minimum Data Set (MDS) and AHCCCS Uniform Assessment Tool (UAT)
- The workgroup shall consider related payment methodologies for future implementation

Encounters, Reinsurance and Information Technology

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Encounter, Reinsurance and Information Technology

- High level overview of Encounters, Reinsurance and Information Technology
- In-depth review of technical and system considerations will be provided in the afternoon Technical Interfaces session

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 MCO, which has been adjudicated by the MCO
  - Includes sub-capitated services and fee-for-service payments
  - Submitted electronically by MCO to AHCCCS
  - Includes paid, zero payments and certain denied/disallowed services

Encounter Data Uses

- Including but not limited to:
  - MCO capitation/fee-for-service rate setting
  - Reconciliations and risk adjustment
  - Reinsurance calculation and payment
  - Pharmacy Rebates
  - 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

Encounter General Principles

- Guidelines and formats 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, MCOs 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 MCOs to submit test encounter (and other related) files for AHCCCS processing
- For certain types of changes to policy, payment methodologies, etc. testing may be prescribed and mandated for all MCOs
- AHCCCS makes available and encourages the use of a validation tool "Community Manager" for all MCOs as appropriate
- AHCCCS Encounter Unit staff are available via phone or email Monday through Friday during regular business hours to assist MCOs in the submission, resolution and research of encounters, as well as encounter pends and denials

Encounter Testing and Technical Assistance (cont.)

- AHCCCS maintains several email addresses to assist MCOs with the submission of Encounter related questions:
  - For Encounter general, pend, denial or adjudication related questions **AHCCCSEncounters@azahcccs.gov**
  - For Encounter validation and/or translation related questions **AHCCCSTIEncounters@azahcccs.gov**
- MCOs may also request Encounter specific training, as needed, by contacting their Encounter Unit assigned representative or the Encounter Unit Manager
- MCOs are required to participate in regularly scheduled 1-1 meetings with Encounter Unit staff, as well as periodically scheduled AHCCCS Technical Consortiums and Technical Workgroups

Encounter Related Files

- AHCCCS produces a number of files containing information pertaining to provider and reference data that are intended to assist MCOs with successful and accurate encounter submissions and makes these files available to all MCOs
- MCOs should 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 MCOs 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 distinct 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 MCOs after each cycle
- Detailed information is available in the Bidders' Library and on both the Encounter and Reinsurance pages on the AHCCCS website
- Current Processing schedules per the following link https://azahcccs.gov/PlansProviders/HealthPlans/encounters.html#Encounter_Processing_Schedules

Encounter Data Validation

- CMS requires that AHCCCS collect complete, accurate and timely encounter data from MCOs
- 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

Information Technology (IT) Systems Demonstration

- As noted in Section I, Exhibit C: Narrative Submission Requirements, No. 12, Information Technology (IT) Systems Demonstration, Offerors will be required to participate in the exchange of mock Information Systems scenarios
- Demonstration begins January 24, 2017, the Tuesday after Proposals are due to AHCCCS
- Responses submitted over the 10 day demonstration will be scored along with submitted Proposals

Information Technology (IT) Systems Demonstration (cont.)

- Additional information will be available in the Technical Interface session this afternoon or see the Bidders' Library for more information

Questions?

Closing Remarks

Thank You.