

**ARIZONA HEALTH CARE COST CONTAINMENT
SYSTEM (AHCCCS)**

**ADVANCE PLANNING DOCUMENT
CLAIMS PROCESSING SUB-SYSTEM
REPLACEMENT PROJECT**

[February 1, 2007]

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1.0 Statement of Needs and Objectives

1.1 Needs

In 1991, the Arizona Health Care Cost Containment System (AHCCCS) Administration implemented the Pre-Paid Medical Management Information System (PMMIS). At that time, it was the first Medicaid Management Information System (MMIS) specifically developed to support both fee-for-service and managed care models. PMMIS is a mainframe based system that uses CA/DATACOM database engine and CA/IDEAL programming language technologies operated on the ADOA IBM mainframe. PMMIS is a mainframe based system that uses CA/DATACOM database engine and CA/IDEAL programming language technologies operated on the ADOA IBM mainframe.

PMMIS provides for the capture and processing of data related to Health Care Providers, Recipient Eligibility, Enrollment of Recipients to contracted Health Plans, Utilization Review and Quality Assurance reporting, Fee-For-Service (claims) processing, capitated health care services (Encounters) processing, Reinsurance processing for capitated services and Financial tracking of both capitated and fee-for-service payments.

In 1996, the claims processing sub-system was re-written to support additional business requirements for AHCCCS, remaining tightly integrated with the rest of PMMIS. This new Claims Processing Sub-System was developed using the same technologies as the rest of PMMIS and continued to run on the IBM mainframe at ADOA.

In 2000, PMMIS was implemented as the MMIS for Medicaid program in the State of Hawaii (Med-QUEST). Since that time, enhancements to the system have been shared between the two states as well as the FFP matching funding.

Today, the Agency is experiencing significant changes to the business requirements in the fee-for-service area. Medical care for a number of new populations of recipients is being covered by the fee-for-service model and the needs of existing populations are increasing. Keeping up with these changes has proven troublesome for the existing claims processing sub-system. The complexity and extent of changes needed in the system have driven the lead time for enhancements to unacceptable levels. Given the age of this technology and the difficulty in recruiting technical staff capable of working in this environment, the Agency has opted not to re-write the claims processing sub-system.

Replacement of the entire PMMIS poses cost and organizational impacts that make such an undertaking inadvisable. In alignment with the Center for Medicare and Medicaid Services (CMS) Medicaid Information Technology Architecture (MITA), software vendors are preparing software that will allow this interaction of MIS components. The Agency sees the replacement of the Claims Processing Sub-System by purchasing a proven, state-of-the-art server based system as the first step in the replacement of the entire PMMIS. Obviously, moving from in-house development of custom software to management of packaged software environment is a significant undertaking for the Agency. As one part of the overall PMMIS functionality, replacing the Claims Processing Sub-System with a packaged system will allow the Agency to safely gain experience in this new environment.

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AHCCCS will employ a standard methodology for evaluating vendor responses in order to assure that the best and final offer represents the best value to the State. A detailed implementation plan will be finalized after a vendor and the necessary technologies are identified. The Agency adopt an implementation strategy that will minimize risks and provide the most reliable path to success. Because PMMIS will continue to operate, AHCCCS will continue to rely on PMMIS for production processing and implement new application modules on a phased basis to allow for adequate testing and training. The Agency and the selected vendor will define, program, test and implement interfaces between the new Claims Processing Sub-System and PMMIS.

During this development effort, AHCCCS will limit modifications to the existing claims processing sub-system in PMMIS. AHCCCS technical staff will work side-by-side with the vendor from the start of the project to facilitate knowledge and skill transfer to enable assumption of operation and maintenance tasks. The State of Hawaii, at its option, may adopt the new claims processing sub-system after AHCCCS has successfully implemented the system for Arizona claims.

1.2 Objectives In support of the Agencies objectives, this project has the following goals:

- Improve the system responsiveness to more easily support new populations or recipients
- Provide real time claims processing to improve responsiveness to the need of the medical providers
- Provide Web base access to the system to improve communications with the medical providers
- Improve the processing and communication of Prior Authorization activity to help streamline the delivery of medical services
- Provide Dashboard monitoring capabilities to allow real time management of claims activities
- Provide management reports to support quality, financial and throughput management activities
- Decrease the number of hard copy claims processed and stored by the Agency by allowing Web based submission of claims from Providers, Hospitals, Pharmacies, etc.
- Migrate to a newer technology with improved resource availability and providing a more flexible platform for the PMMIS environment.

2.0 Summary of Alternatives Analysis and Requirements Analysis

2.1 Alternatives Analysis

Options

Continue to use current system. This alternative is unacceptable for the following reasons:

- 1) Maintenance has become more and more challenging and costly as the requirements deviate further and further from the original design.
- 2) It has become more and more difficult to locate technical staff knowledgeable of the Computer Associates' database and programming tool forcing the agency to rely heavily on consultant staff.
- 3) The current system is not consistent with the long term HIPAA strategy to have an internally HIPAA compliant system.

Replace PMMIS in total. This alternative is unacceptable for the following reasons:

- 1) This alternative would require significant resources and time. Some estimates are in excess of \$100 million.
- 2) Trying to expand too quickly could put the agency at risk.

Replace the Claims Processing Sub-System with interfaces to the other existing PMMIS Sub-Systems.. This alternative was selected for the following reasons:

- 1) Minimize the risk to the Agency by concentrating on a single sub-system
- 2) Provides amigration strategy to new technologies and contracting arrangements. As opposed to replacing the entire MMIS

2.1 General Requirements Analysis

The Claims Processing Sub-System will be a proven, state-of-the-art server based packaged system. The system must be:

- Compliant with Federal and State requirements including the federal State Medicaid Manual, 42 and 45 CFR
- HIPAA compliant
- Meet all Arizona statues and rules, and agency policies and standards.
- Capable of operating in the AHCCCS environment
- provide thorough documentation and user-friendly user manuals and instructions
- provide for user-defined fields to accommodate AHCCCS specific data
- Support web-based inquiry to member information for providers and members
- meet the Agencies business requirements that will be outlined in the Request for Proposal document. These requirements include the

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following functional areas:

The software selected will have to provide the following functionality:

Members Management:

The system must provide a member management component that maintains accurate and timely information on all fee-for-service member. AHCCCS will provide a monthly member file at the end of each month of all members that are eligible as the first of the next month. AHCCCS will also provide daily member updates that includes adds, changes, and deletes/terminations.

Provider Management:

The system must provide a Provider management component that maintains accurate and timely information on all fee-for-service Providers. AHCCCS will provide a monthly Provider file at the end of each month of all Providers that are enrolled/active as the first of the next month. AHCCCS will also provide daily Provider updates that includes adds, changes, and deletes/terminations.

The system must provide the following capabilities:

PMMIS will be considered the system of record for provider data and all provider registration activity will occur in PMMIS.

Benefit Management:

The system must provide a Benefit management component that maintains accurate and timely information on all fee-for-service benefit packages.

Concurrent Review:

The system must provide a Concurrent Review component that maintains accurate and timely information on all fee-for-service Concurrent Reviews.

Finance:

Initially, AHCCCS requires that that the new claims processing sub-system interface with the agency's current ORACLE financial system. The requirements for this interface are described in the Claims subsection. In the future, AHCCCS plans to replace the ORACLE financial system. Consequently, AHCCCS would like the bidders to describe their capabilities for meeting the requirements presented below. Here the "Need Level" refers to future needs should the current ORACLE be replaced.

Premium Billing:

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The system must provide a Premium Billing component that maintains accurate and timely information on all Premium Billing.

- Provide necessary interfaces with member/eligibility files including AHCCCS recipient system, ACE, KidsCare, and potentially HCG to obtain/maintain member premium amounts
- Maintain detailed premium billing and payment history
- Lapse eligibility based on delinquent accounts – criteria to vary based on user-specified parameters such as benefit plan, line of business, etc.
- Flag members (families) with outstanding account receivables and generate reports/alerts if new eligibility updates are added to the member file
- Consolidate bills and notices by family unit/case
- Recognize returned payments for insufficient funds (NSF)
- Calculate billing amounts

Prior Authorization:

The system must provide a Prior Authorization component that maintains accurate and timely information on all fee-for-service Prior Authorizations.

- Maintain and track Prior Authorizations by automatically generated Prior Authorization numbers
- Provide capability to automatically match the appropriate Prior Authorization to claims during adjudication process
- Provide ability to adjust Prior Authorizations based for recoupments
- Allow for Prior Authorizations to be based on:
 - Procedure code ranges rather than specific codes
 - Date ranges rather than specific dates
 - Diagnosis code ranges rather than specific diagnosis codes
 - Different service settings at different, user-defined rates
- Calculate automatically and record the number of visits/services/units authorized, used, unused, and expired
- Maintain history of Prior Authorizations by Member, Provider, and service type
- Generate automatically user-defined Prior Authorization correspondence

Claims Processing:

The system must provide a Claims processing component that maintains accurate and timely information on all fee-for-service Claims

- System must support hardcopy and electronic entry of claims

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- Support current and future versions of standard HIPAA electronic formats for claims (837 transaction and NCPDP) and code sets including replacement claims with no restrictions on number of claims per submission
- Accept electronic claims directly from providers and from clearinghouses or AHCCCS' front end validation process
- Support electronic formats for standard attachments
- Provide for multiple versions of electronic formats (old & new) when new version released to allow for phase-in period for new version
- Provide means of data entry for all standard hardcopy claims forms; data entry screens should be designed to follow the form
- Provide providers, health plans, and other agencies with online data entry capability via Internet for all standard forms
- Provide ability to attach (cross reference) scanned documents such as original hardcopy claims, attachments, supplementary documentation, correspondence, and adjustment requests to the claim record
- Support real-time, background, and batch claims adjudication for both electronic and hardcopy claims
- Provide comprehensive and flexible set of system edits with configurable parameters and other criteria
- Allow user to set edit disposition (pay, pay and report, pend, deny, test, "turned off", etc.) by claim type (electronic vs. hardcopy) and source (AHCCCS data entry, provider direct entry, third party biller or clearinghouse, provider submitted electronic billing, etc)
- Allow user to configure edits via parameters such as provider type, service categories, line of business, health plan, Medicare/nonMedicare, member rate code, other member characteristics including user-defined fields, etc.
- Allow user to specify if edit is "overrideable" and if so by what level of staff (claims adjudicator, supervisor, medical review, Medical Director, etc.)
- Allow user to specify effective dates for edit parameters and specify as to whether edit is effective based on date of service or date of receipt or both
- Allow user to associate edit with "denial reason" code that will trigger the appropriate message to the provider on the remittance advice
- Provide report/screens of edits and edit parameters
- Maintain audit trails of changes to edits/edit criteria
- Basic system edits/audits must support AHCCCS benefit/coverage definitions and AHCCCS policies
- Provide user-configurable service limitations for number of services (units/days) and/or dollar amount
- Maintain member accumulators for deductibles, copayments, life time limitations, out-of-pocket expenses, share of cost, etc. and validate claims against accumulators

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- Support efficient data entry of hardcopy claims from paper and from images
- Support efficient claims correction process
- Support automatic generation of letters/emails for certain conditions such as a request for medical records
- Support all AHCCCS pricing methodologies based on line of business, type of provider, specific provider, type of service, specific service, etc.
- Allow users to define services/conditions that require manual pricing and then pend claims for manual pricing based on this criteria
- Maintain audits trails Process voids and adjustments and refunds
- Provide ability to generate mass adjustments
- Provide ability to re-price and/or re-edit claims
- Compute final claims payment and recoupment amounts
- Provide for generation of letters/correspondence
- Capture and maintain all data elements required to support Federal reporting requirements based on data from claim records
- Maintain a minimum of two years of claims history that is available for online, real time access and a minimum of five years of claims history total that is available for reporting.

3.0 Cost/Benefit Analysis

3.1 Cost Benefit

The State of Arizona anticipates that the implementation of a new Claims Processing Sub-System will provide the following benefits:

- Improvements in function like Prior Authorization and Case management functions will lead to an increased ability to monitor the delivery of care for Fee-For-Service populations
- More accurate and time payment of claims
- Improved responsiveness to changes in the business environment
- Improved claims data access to provider community leading to better data integrity and quicker payment of claims.
- Reduce the number of paper claims and in turn, reduce the amount of labor needed to enter claims.
- Modernization of the technology used provides a stepping stone to full replacement of the existing PMMIS.
- Alignment with MITA recommendations
- Internal HIPAA compliance

4.0 Personnel Resource Statement

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4.1 Project Organization and Personnel Resources

This project includes AHCCCS staff from the following areas:

	Assignment	Responsibilities
Executive Management Committee	Anthony Rodgers, Director Tom Betlach, Deputy Jim Cockerham, CFO Jim Wang, CIO Linda Martin, DFSM Shelli Silver, DHCM	Project oversight and review
Project Sponsor	Linda Martin, DFSM Jim Wang, ISD	Project oversight and review, funding auth
Project Manager	Linda Martin, DFSM	Overall project
AHCCCS Business Staff	Sue Carter, RFP Consultant Albert Escobedo, DFSM Denise Lipinski, HCG John Moorman, DBF Patsy Perry, DBF Lori Petre, DHCM Other staff TBD	Business requirements
AHCCCS Technical Staff	Rich Kocher, ISD Mike Upchurch, ISD Dan Lippert, ISD Other staff TBD based on vendor proposal	PMMIS Expertise Interface Development
Vendor Support Staff	Type and Number of staff TBD based on vendor proposal	Project Management and Project Reporting including Work Plan development and maintenance Gap Analysis and System Requirements System Modifications if needed Training System Configuration System and User Documentation Hardware configuration (optional)

5.0 Activities

5.1 Nature and Scope

Activities associated with this APD include those necessary to implement a Claims Process Sub-System as part of the Agencies overall MMIS. This includes:

- Project management and oversight
- Contract management
- System design and development
- Unit, system, integration, and regression testing
- User acceptance testing, with both internal and external customers
- Implementation
- Documentation
- System related business process re-engineering
- Post implementation support

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5.2 Methods to Accomplish

The project will be managed using established project management methodologies, and will have a detailed workplan with tasks, milestones and deliverables which will be developed and maintained by the vendor with oversight provide by AHCCCS staff. Some of the activities included in project management and oversight include:

:

- Workgroups attended by the respective state's business customers will meet regularly
- A project steering committee consisting of Arizona Executive Management representatives from various business units
- Lessons learned from prior projects will be incorporated into the project plan
- Actual progress will be closely monitored against planned progress
- Adjustments to scope, duration of activities, and/or staff allocation will be made as necessary to ensure success in meeting the project milestones and mandated implementation date.
- Project risks will be identified, continually reviewed for relevance, and addressed with appropriate corrective actions
- Formal test plans and scenarios with expected outcomes will be developed, executed, and tracked
- Post implementation support will be provided to address any identified technical or training issues following go-live

6.0 Activity Schedule

6.1 Major Milestones The following matrix identifies the major milestones and their associated planned completion dates for the Claims Processing Sub-System Replacement Project.

Milestone	
Public release of the Request for proposal	02/07
Receipt of Proposals	04/07
Contract Award	06/07
Project Initiation	07/07
Requirements Definition and Gap Analysis	07/07 - 10/07
Detail Design, Development and Modification	09/08 - 06/08
Testing	01/08 - 07/08
Training and Documentation	04/08
Conversion	10/08 - 07/08
Implementation	07/08
Post Implementation Support	07/08 - 01/09

7.0 Proposed Project Budget

7.1 Estimated Budget The following table provides an estimated budget for the development of the Claims Processing Sub-System Replacement Project

	Cost	
IT FTE	550,000	AHCCCS ISD FTE costs
User FTE	2,250,000	AHCCCS User department FTE costs
Hardware	600,000	Based on the proposal, this cost could be incurred by the Agency or it could be included in the contract price. Both options have been requested in the RFP
Communications	120,000	Based on the proposal, this cost could be incurred by the Agency or it could be included in the contract price. Both options have been requested in the RFP
Facilities	250,000	Based on the proposal, this cost could be incurred by the Agency or it could be included in the contract price. Both options have been requested in the RFP
Licensing and Maintenance Fees	3,500,000	This is the anticipated cost of the software licensing and first year maintenance fees
Training	50,000	Vendor cost to provide training to AHCCCS staff
TOTAL COST	7,320,000	

The amounts above reflect the budget requests submitted by AHCCCS to the State of Arizona. These numbers are preliminary and are based on commercial implementations of Claims Processing Systems. The vendor proposals will provide more detailed information on areas such as level of effort needed for FTEs, hardware requirements, etc. and will allow the Agency to refine these estimates.

8.0 Duration of Use

The RFP specifies a contract duration of 6 years, consisting of a 2 year development period and two (2) 2-year contract extensions for operation of the system. Additional contracts beyond the six years will be possible as long as the system meets the Agencies requirements.

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9.0 Cost Allocation

	Cost	FFP Match	FFP Share	State Share
IT FTE	550,000	90%	495,000	55,000
IT Services	2,250,000	90%	2,025,000	225,000
Hardware	600,000	75%	450,000	150,000
Communications	120,000	75%	90,000	30,000
Facilities	250,000	50%	125,000	125,000
Licensing and Maintenance Fees	3,500,000	90%	3,150,000	350,000
Training	50,000	90%	45,000	5,000
TOTAL	7,320,000		6,380,000	940,000

10 Security, Interfaces, System Failure and Disaster Recovery

Compliance with the current HIPAA security standards and Disaster Recovery capabilities have been included in the RFP as required items. Specifications for the Interfaces between the existing PMMIS and the new claims processing sub-system will be detailed in the early phases of the implementation plan. The development and maintenance of these interfaces will be the responsibility of AHCCCS ISD staff.

11.0 Assurances

11.1 Access to Records The following are assurances that the State of Arizona will adhere to all requirements for CMS Access to Records relevant to the Claims Processing Sub-System project.

45 CFR Part 95.615
SMM Section 11267

Yes
 Yes

No
 No

11.2 Software Ownership, Federal Licenses, Information Safeguarding The following is an assurance that the State of Arizona will adhere to all requirements for Software Ownership, Federal Licenses, and Information Safeguarding relevant to the Claims Processing Sub-System project.

42 CFR Part 433.112 (b) (5) - (9)

Yes

No

11.3 Progress Reports The following is an assurance that the States of Arizona will adhere to all requirements for progress reports relevant to the Claims processing Sub-System project. to be delivered to CMS as requested.

SMM Section 11267

Yes

No