

RESPONSE TO REQUEST FOR PROPOSAL
AHCCCS Acute Care Services

January 28, 2013

Solicitation Number: YH14-0001



Compassionately Caring1st for our Community.



Compassionately Caring1st for our Community...



Challenging ourselves every day to exceed the expectations of our members, providers and regulators.



“ The sponsorship of Care1st Health Plan Arizona which led to the establishment of the Care1st Avondale Resource & Housing Center has enabled **the City of Avondale to expand health and human services offerings to the entire southwest region of Maricopa County** by making it easy for existing organizations to expand services to the area, ” said Avondale Mayor Marie Lopez Rogers, adding that non-profit organizations, both small and large, have benefitted through the availability of free space, reception services, copying, phones, Wi-Fi, and a large community room for programming.

SECTION I: EXHIBITS
EXHIBIT A OFFEROR'S CHECKLIST

Contract/RFP No. YH14-0001

EXHIBIT A: OFFEROR'S CHECKLIST

The Offeror's Checklist must be submitted with the proposal and shall be the first pages in the binder. Offerors must submit all items below, unless otherwise noted.

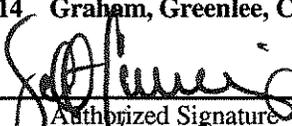
The Offeror must complete the Offeror's Bid Choice Form, Section A1 identifying the program(s) for which the Offeror is submitting a proposal. In addition, when bidding on the Acute Care Program, the Offeror must indicate the Geographical Service Area(s) (GSAs) for which the Offeror is submitting a proposal.

In the column titled "Offeror's Page No.," the Offeror must enter the appropriate page number(s) from its proposal where the AHCCCS Evaluation Team may find the Offeror's response to the specified requirement.

A. GENERAL MATTERS

<i>Subject:</i>	<i>Page Number Reference</i>	<i>Offeror's Page No.</i>
Offeror's Checklist (<i>This Exhibit</i>)	Exhibit A	1 - 3
Offeror's Bid Choice Form (<i>Form provided below in this Exhibit and submitted with the checklist</i>)	See A1 below	N/A
Offeror's Signature Page	1 and 2	4 - 5
Signed Cover Sheets of Solicitation Amendments, if any	289	6-10
Completion of all items in Section G: Representations and Certifications of Offeror	Section G	4-39

A1: OFFEROR'S BID CHOICE FORM

ACUTE CARE PROGRAM	
<input checked="" type="checkbox"/> Checking this box indicates the Offeror is bidding on the <i>Acute Care Program</i> .	
<u>Care1st Health Plan Arizona, Inc.</u> Offeror's Name	is bidding on the ACUTE Care Program in the GSAs checked below:
<input checked="" type="checkbox"/> GSA 2 Yuma, La Paz <input type="checkbox"/> GSA 4 Apache, Coconino, Mohave, and Navajo <input checked="" type="checkbox"/> GSA 6 Yavapai <input checked="" type="checkbox"/> GSA 8 Gila, Pinal <input checked="" type="checkbox"/> GSA 10 Pima, Santa Cruz <input checked="" type="checkbox"/> GSA 12 Maricopa <input checked="" type="checkbox"/> GSA 14 Graham, Greenlee, Cochise	
<u></u> Authorized Signature	<u>1-25-2013</u> Date
<u>Scott Cordoba</u> Print Name	<u>Chief Administrative Officer</u> Title

CHILDREN'S REHABILITATIVE PROGRAM	
<input type="checkbox"/> Checking this box indicates the Offeror is bidding on the <i>Children's Rehabilitative Program</i> .	
_____	_____
Authorized Signature	Date
_____	_____
Print Name	Title

NOTE: The "Requirement No." shown in Parts B, C, D, E, and F below refers to the **Submission Requirements** outlined in *Section H: Instructions to Offerors* of this RFP.

B. ATTESTATION

Attestation	Requirement No.	Offeror's Page No.
	1-34	40 - 45

C. CAPITATION SUBMISSION

Capitation	Requirement No.	Offeror's Page No.
Acute Care Program Capitation Bid Submission Including Actuarial Certification	1	46 - 104
CRS Program Capitation Bid Submission Including Actuarial Attestation	2	NA

D. EXECUTIVE SUMMARY AND DISCLOSURE

Executive Summary and Disclosure	Requirement No.	Offeror's Page No.
	1	106 - 108
	2	109

E. ACUTE CARE NARRATIVE SUBMISSIONS

Access to Care/Network	Requirement No.	Offeror's Page No.
	1	111 - 115
	2	116 - 120

**SECTION I: EXHIBITS
EXHIBIT A OFFEROR'S CHECKLIST**

Contract/RFP No. YH14-0001

Program	Requirement No.	Offeror's Page No.
	3	121 - 125
	4	126 - 130
	5	131 - 135
	6	136 - 140

Organization	Requirement No.	Offeror's Page No.
	7	141 - 145
	8	146 - 150
	9	151 - 155
	10	156

F. CRS NARRATIVE SUBMISSIONS

Access to Care/Network - CRS	Requirement No.	Offeror's Page No.
	11	NA

Program - CRS	Requirement No.	Offeror's Page No.
	12	NA
	13	NA
	14	NA

Organization - CRS	Requirement No.	Offeror's Page No.
	15	NA



“ The innovative public-private **partnership of Care1st and the Town of Gila Bend** has been a true blessing to our region, one that has **surpassed even our most optimistic expectations**. Without this innovative partnership and the **operational synergies** it creates, probably 70% of our social services would not exist today, ” said Frederick Buss, Gila Bend Town Manager.



Notice of Request for Proposal		AHCCCS Arizona Health Care Cost Containment System
SOLICITATION NO.: YH14-0001	PAGE 1	701 East Jefferson, MD 5700
	OF 337	Phoenix, Arizona 85034

Solicitation Contact Person

Meggan Harley
Contracts and Purchasing Section
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

Telephone: (602) 417-4538
Telefax: (602) 417-5957
E-Mail: Meggan.Harley@azahcccs.gov
Issue Date: November 1, 2012

LOCATION: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Contracts and Purchasing Section (First Floor)
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

DESCRIPTION: ACUTE CARE / CHILDREN'S REHABILITATIVE SERVICES (CRS)

PROPOSAL

DUE DATE: January 28, 2013 AT 3:00 P.M. Arizona Time

Pre-Proposal Conference: A Pre-Proposal Offer's Conference has been scheduled for **Friday, November 9, 2012** starting at **9:00 A.M. Arizona time**. The Conference will be held in the following location:

**AHCCCS
Gold Room, Third Floor
701 E. Jefferson
Phoenix, AZ 85034**

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE SOLICITATION CONTACT PERSON NAMED ABOVE, IN WRITING VIA E-MAIL AS SPECIFIED IN SECTION H, INSTRUCTIONS TO OFFERORS. QUESTIONS MUST BE SUBMITTED ON THE ACUTE CARE AND CRS PROGRAM RFP YH14-0001 QUESTIONS AND RESPONSES TEMPLATE LOCATED IN THE BIDDERS' LIBRARY.

The Solicitation Process shall be in accordance with the "RFP and Contract Process" Rules set forth in Title 9 Chapter 22 Article 6 and effective November 11, 2012. These rules are posted on the AHCCCS website at:

http://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOFR22_6.pdf

The RFP and Contract Process Rules were also published on October 5, 2012 in the Arizona Administrative Register at:

http://www.azsos.gov/public_services/Register/contents.htm

Competitive sealed proposals will be received at the above specified location, until the time and date cited. Proposals received by the correct time and date will be opened and the name of each Offeror will be publicly read. Proposals must be in the actual possession of AHCCCS on or prior to the time and date and at the location indicated above.

Late proposals shall not be considered.

Proposals must be submitted in a sealed package with the Solicitation Number and the Offeror's name and address clearly indicated on the package. All proposals must be typewritten. Additional instructions for preparing a proposal are included in this solicitation document.

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the appropriate Procurement Agency. Requests should be made as early as possible to allow time to arrange the accommodation. A person requiring special accommodations may contact the solicitation contact person responsible for this procurement as identified above.

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.



Notice of Request for Proposal

AHCCCS

Arizona Health Care Cost Containment System

SOLICITATION NO.: YH14-0001

PAGE 2

701 East Jefferson, MD 5700

OF 337

Phoenix, Arizona 85034

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, and amendments.

Arizona Transaction (Sales) Privilege Tax License No.:

AZ57-1165217

For Clarification of this offer, contact:

Name: Scott Cummings

Federal Employer Identification No.:

57-1165217

Phone: 602-778-1860

Fax: 602-778-1871

E-Mail Address: scummings@care1st.com

Signature of Person Authorized to Sign Offer

Handwritten signature of Scott Cummings

Printed Name

Chief Administrative Officer

Care1st Health Plan Arizona, Inc.

Company Name

2355 E. Camelback Road, Suite 300

Address

Phoenix AZ 85016

City

State

Zip

CERTIFICATION

By signature in the Offer section above, the bidder certifies:

The submission of the offer did not involve collusion or other anti-competitive practices.

The bidder shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 99-4 or A.R.S. §41-1461 through 1465.

The bidder has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.

In accordance with A.R.S. §35-393, the Offeror hereby certifies that the Offeror does not have scrutinized business operations in Iran.

In accordance with A.R.S. §35-391, the Offeror hereby certifies that the Offeror does not have scrutinized business operations in Sudan.

The bidder certifies that the above referenced organization is / X is not a small business with less than 100 employees or has gross revenues of \$4 million or less.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits and amendments contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS.

This contract shall henceforth be referred to as Contract No. YH14-0001 Awarded this ___ day of ___, 2013

Michael Veit, as AHCCCS Contracting Officer and not personally



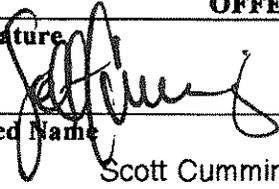
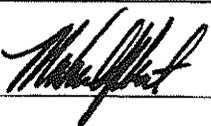
“ Having established this regional resource center also enabled the City of Avondale to **leverage First Things First funding for early childhood funding to further support families with young children.** The Care1st Avondale Resource and Housing Center has become an indispensable human service hub to the Southwest Valley. It is a “win-win” for our residents, non-profit organizations and the City of Avondale, ” said Mayor Rogers.

	SOLICITATION AMENDMENT	AHCCCS
	Solicitation No.: RFP YH14-0001 Amendment No. 1 (One) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 27 th day of November, 2012, in Phoenix, Arizona.	
OFFEROR		AHCCCS	
Signature 	Date 1-17-13	Signature 	
Typed Name Scott Cummings		Typed Name Michael Veit	
Title Chief Administrative Officer		Title Contracts and Purchasing Administrator	
Name of Company Care1st Health Plan Arizona, Inc.		Name of Company AHCCCS	

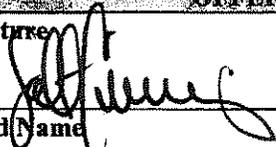
	SOLICITATION AMENDMENT	AHCCCS
	Solicitation No.: RFP YH14-0001 Amendment No. 3 (Three) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Any questions submitted that were unrelated to capitation rates/rate ranges were not addressed.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 4 th day of January, 2013, in Phoenix, Arizona.	
OFFEROR		AHCCCS	
Signature 	Date 1.17.13	Signature 	
Typed Name Scott Cummings		Typed Name Michael Veit	
Title Chief Administrative Officer		Title Contracts and Purchasing Administrator	
Name of Company Care1st Health Plan Arizona, Inc.		Name of Company AHCCCS	

	<p style="text-align: center;">SOLICITATION AMENDMENT</p> <p>Solicitation No.: RFP YH14-0001 Amendment No. 4 (Four)</p> <p>Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)</p>	<p>AHCCCS Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034</p> <p>Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov</p>
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Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows:

1. Section H: Instructions to Offerors, Paragraph 16, Capitation, *Acute Care Program Capitation Bid Submission (Submission Requirement No. 1)*, page 302 is amended as follows:

Acute Care Program Capitation Bid Submission (Submission Requirement No. 1)

All GSAs for which an Offeror bids will require a capitation rate bid submission for each risk group. Each bid will encompass two components; a gross medical component and an administrative component. Each component will be scored separately. In addition, the combined components (i.e. the gross medical and administrative components) may be scored for each risk group and GSA. The lowest bid within each GSA and risk group will receive the maximum allowable points. However, AHCCCS may award the maximum allowable points to any bid for the administrative component equal to or below a minimum threshold considered by AHCCCS to be reasonable, either for the scoring of the administrative component and/or the combined components. ~~Conversely, the highest bid will receive the least number of points.~~

Bid component requirements:

1. Offerors will submit a gross medical component PMPM bid for each risk group by GSA. Neither reinsurance offsets nor capitation withheld for payment reform initiatives should be considered in the medical component bid. Prior to October 1, 2013 AHCCCS will develop projections for reinsurance offsets and will adjust awarded capitation rates accordingly.
 - o Capitation bids submitted with a medical component outside of the published ranges (described below) will earn a medical component score of zero points.
2. Offerors will submit an administrative component PMPM bid for each risk group by GSA. The administrative component is limited to a maximum of 8%. The administrative component percentage shall be calculated as: Administration / Gross Medical Component.
 - o Capitation bids submitted with an administrative component exceeding 8% will earn an administrative component score of zero points.
3. In the event that AHCCCS elects to score the combined components, in any instance where zero points are awarded for either the medical or administrative component, the combined component score will be zero.
4. In any instance where zero points are awarded for either the medical or administrative component and the Offeror is awarded a contract, the awarded capitation rate for the impacted GSA/risk group will be as follows:
 - o For a medical component score of zero points: the bottom of the actuarial rate range for the medical component for that GSA/risk group (as adjusted by Section D, Paragraph 53, Compensation and Section D, Paragraph 55, Capitation Adjustments); and
 - o For an administrative component score of zero points: the lowest awarded administration rate for that GSA/risk group.

	SOLICITATION AMENDMENT	AHCCCS
	Solicitation No.: RFP YH14-0001 Amendment No. 4 (Four) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

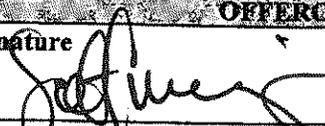
2. Section H: Instructions to Offerors, Paragraph 16, Capitation, *CRS Program Capitation Bid Submission (Submission Requirement No. 2)*, page 304 is amended as follows:

CRS Program Capitation Bid Submission (Submission Requirement No. 2)

The Offeror will submit a capitation rate bid submission for the administrative component. The lowest bid will receive the maximum allowable points. However, AHCCCS may award the maximum allowable points to any bid for the administrative component equal to or below a minimum threshold considered by AHCCCS to be reasonable. Conversely, the highest bid will receive the least number of points.

Bid component requirements:

1. Offerors will submit a single administrative component bid that will be added to the total medical component by coverage type. The administrative component will not vary by coverage type.
2. The administrative component bid will be stated as a per member per month (PMPM) figure.
 - o Capitation bids submitted with an administrative component PMPM value exceeding \$60 PMPM will earn an administrative component score of zero points.
3. In any instance where zero points are awarded for the administrative component and the Offeror is awarded a contract, the awarded administrative component will be \$52.00 PMPM.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 10 th day of January, 2013, in Phoenix, Arizona.	
OFFEROR		AHCCCS	
Signature	Date	Signature	
	1.17.13		
Typed Name		Typed Name	
Scott Cummings		Michael Veit	
Title		Title	
Chief Administrative Officer		Contracts and Purchasing Administrator	
Name of Company		Name of Company	
Care1st Health Plan Arizona, Inc.		AHCCCS	



“ The Care1st Gila Bend Resource Center is a social sustainability model that **improves operational efficiencies and outcomes**, not just with AHCCCS, but by attacking the cycle of poverty itself. This ultimately reduces societal health care costs – locally, regionally and statewide.

With over 24 social services programs being provided out of the Care1st Gila Bend Resource Center, it is **a model of social sustainability and governmental efficiency**. Care1st’s investment and commitment to our region is unsurpassed and we are humbled and blessed to have Care1st in our community. ”

– Frederick Buss, Gila Bend Town Manager

In accordance with Questions and Responses Amendment 2, Section G, pages 11 to 39, are removed due to their proprietary nature. A separate document containing these pages is provided separately.



Compassionately Caring1st for our Community...



Challenging ourselves every day to exceed the expectations of our members, providers and regulators.

B. Attestation

SECTION B
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B. Attestation

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EXHIBIT C: ATTESTATION FORM

In order to be considered a responsive offer, the Offeror must attest to each element below by indicating with a check mark in the box next to each requirement. Failure to check any box will result in automatic disqualification of the offer.

If the Offeror is submitting a proposal for both the Acute Care and CRS Programs, the attestation of each element shall apply to both Programs. If the Offeror is submitting a proposal for the Acute Care Program only, the attestation of each element shall apply to that Program only.

In addition to complying with all contractual requirements, the Offeror specifically acknowledges the importance of the following provisions and their critical value to the Arizona Health Care Cost Containment System program. The statements in the attestations are not intended to alter or amend the contractual obligations set forth elsewhere in the Request for Proposal. In the event of any inconsistency or ambiguity regarding the meaning of an attestation, the provisions of the Request for Proposal are controlling.

AHCCCS has identified the general references for each element as a convenience for the Offeror; however, all references may not have been identified. It is the responsibility of the Offeror to identify all relevant sources for each element.

<i>Corporate Compliance</i>	
AHCCCS is committed to protecting the public from fraud, waste and abuse. As part of this commitment, AHCCCS Contractors must comply with all applicable Federal and State program integrity requirements. The Offeror attests that it will:	
1. <input checked="" type="checkbox"/>	Have a corporate compliance program and plan consistent with 42 CFR 438.608, and practices which comply with program integrity requirements specified in 42 CFR 455, and the AHCCCS requirements described in ACOM Policy 103 and the contract, by the contract start date <i>RFP Section D, Paragraph 62, Corporate Compliance</i>
<i>Staffing</i>	
The Offeror will demonstrate by the start date of the contract that all staff shall be fully qualified to perform the requirements of the contract. The Offeror attests that it will:	
2. <input checked="" type="checkbox"/>	Maintain a local presence within the State of Arizona as outlined in Section D, Paragraph 16, Staffing Requirements and Support Services, of the contract <i>RFP, Section D, Paragraph 16, Staff Requirements and Support Services</i>
3. <input checked="" type="checkbox"/>	Limit Key Staff to occupying a maximum of two of the Key Staff positions <i>RFP, Section D, Paragraph 16, Staff Requirements and Support Services</i>
4. <input checked="" type="checkbox"/>	Have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies on urgent issue resolutions <i>RFP, Section D, Paragraph 16, Staff Requirements and Support Services</i>
5. <input checked="" type="checkbox"/>	Not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities <i>RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance</i>

SECTION I: EXHIBITS
EXHIBIT C: ATTESTATION FORM

Contract/RFP No. YH14-0001

<i>Staffing - continued</i>	
6. <input checked="" type="checkbox"/>	Screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal health care programs <i>RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance</i>
7. <input checked="" type="checkbox"/>	Require all staff members to have appropriate training, education, experience and orientation to fulfill the requirements of the position <i>RFP, Section D, Paragraph 16, Staff Requirements and Support Services</i>
8. <input checked="" type="checkbox"/>	Have sufficient staffing levels to operate in compliance with the terms of the contract <i>RFP, Section D, Paragraph 16, Staff Requirements and Support Services</i>
9. <input checked="" type="checkbox"/>	Have an Administrator/Chief Executive Officer (CEO) who shall have the authority and ability to direct Arizona priorities. <i>RFP, Section D, Paragraph 16, Staff Requirements and Support Services</i>
<i>Information Systems</i>	
The Offeror will demonstrate by the start date of the contract that its information system has clearly defined change control processes. The Offeror attests that it will:	
10. <input checked="" type="checkbox"/>	Maintain a change control process which includes the Offeror's ability to participate in setting and modifying the priorities for all information systems including those of the Parent Company, subcontractors and vendors <i>RFP, Section D, Paragraph 16, Staff Requirements and Support Services</i>
11. <input checked="" type="checkbox"/>	Maintain system upgrade and conversion processes which include appropriate planning and implementation standards <i>RFP, Section D, Paragraph 16, Staff Requirements and Support Services</i>
12. <input checked="" type="checkbox"/>	Have structures in place to ensure and support current and future IT Federal mandates <i>RFP, Section D, Paragraph 64, Systems and Data Exchange Requirements</i>
<i>Claims/Encounters Processing</i>	
The Offeror will demonstrate by September 1, 2013 that its systems and related processes can support the following key components of the AHCCCS Medicaid claims processing lifecycle. The Offeror attests that the entity and its IT system will:	
13. <input checked="" type="checkbox"/>	Accept and process both paper and electronic submissions <i>RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting</i>
14. <input checked="" type="checkbox"/>	Allow for the proper load of provider contract terms, support processing of claims within timeliness standards, incorporate coordination of benefit activities, and generate claims payments and HIPAA compliant remittance advices <i>RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting</i>

<i>Claims/Encounters Processing- continued</i>	
15. <input checked="" type="checkbox"/>	Have the ability to generate encounter submissions and have the appropriate remediation processes in place when standards are not met <i>RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting</i>
<i>Quality Management</i>	
The Offeror attests that, by the start date of the contract, it will have:	
16. <input checked="" type="checkbox"/>	A process to include the health risks assessment tool in the new member welcome packet. The Offeror has/will have a process for coordination of care across the continuum based on early identification of health risk factors or special care needs, including those members identified who would benefit from disease management and care coordination. [42 C.F.R. 438.208] <i>AMPM Chapter 900</i>
17. <input checked="" type="checkbox"/>	A process that requires the reporting of all incidents of abuse, neglect, exploitation, unexpected deaths, healthcare acquired and provider preventable conditions to the AHCCCS Clinical Quality Management Unit <i>AMPM Chapters 900 and 1000</i>
18. <input checked="" type="checkbox"/>	Processes in place to receive data and forms from a provider's certified electronic medical records including Early, Periodic, Screening, Diagnostic and Treatment forms, performance measure and audit information, and information to facilitate assistance with care coordination activities <i>AMPM Chapter 400</i>
19. <input checked="" type="checkbox"/>	A process that meets AHCCCS requirements for identifying, reviewing, evaluating and resolving quality of care or service issues raised by any source <i>RFP, Section D, Paragraph 23, Quality Management and Performance Improvement (QM/PI)</i>
20. <input checked="" type="checkbox"/>	A process to provide recurring scheduled transportation for members with on-going medical needs, including, but not limited to dialysis, chemotherapy, and radiation <i>RFP, Section D, Paragraph 11, Special Health Care Needs</i>
<i>MCH/EPST</i>	
The Offeror attests that it will have:	
21. <input checked="" type="checkbox"/>	A process and a plan that includes outreach and care coordination processes for children with special health care needs and other hard to reach populations, and coordination with community and government programs <i>AMPM Chapter 400</i>
<i>Medical Management</i>	
The Offeror attests that it will have:	
22. <input checked="" type="checkbox"/>	A process in place for proactive discharge planning when members have been admitted to an inpatient facility <i>RFP, Section D, Paragraph 24, Medical Management (MM)</i>

SECTION I: EXHIBITS
EXHIBIT C: ATTESTATION FORM

Contract/RFP No. YH14-0001

<i>Medical Management - continued</i>	
23. <input checked="" type="checkbox"/>	A process that ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in that field and disseminated to providers <i>RFP, Section D, Paragraph 24, Medical Management (MM)</i>
24. <input checked="" type="checkbox"/>	A process in place to provide emergency services without prior authorization regardless of contract status of the provider <i>AMPM Chapter 310F</i>
25. <input checked="" type="checkbox"/>	A process to analyze utilization data and use the results to implement medical management changes to improve outcomes and experience <i>RFP, Section D, Paragraph 24, Medical Management (MM)</i>
26. <input checked="" type="checkbox"/>	Disease and chronic care management programs that are designed to coordinate evidence based care focused on improving outcomes for members with one or more chronic illnesses which may include behavioral health conditions <i>RFP, Section D, Paragraph 24, Medical Management (MM)</i>
<i>Behavioral Health</i>	
The Offeror attests that it will have:	
27. <input checked="" type="checkbox"/>	A process for identifying members with behavioral health care needs and assisting members in accessing services in the Regional Behavioral Health Authority system <i>RFP, Section D, Paragraph 12, Behavioral Health Services; AMPM Chapters 400 and 1000</i>
<i>Access to Care</i>	
<i>(Only Offerors submitting a proposal for the CRS Program must attest to #29)</i>	
The Offeror attests that it will have:	
28. <input checked="" type="checkbox"/>	A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013 <i>RFP, Section D, Paragraph 27, Network Development</i>
29. <input type="checkbox"/> CRS Only	A comprehensive network that complies with all CRS network sufficiency standards as outlined in RFP YH14-0001 (see Section D, Paragraphs 10, Scope of Services and 27, Network Development), no later than August 1, 2013 <i>RFP, Section D, Paragraph 27, Network Development</i>
30. <input checked="" type="checkbox"/>	A process for researching, resolving, tracking and trending provider inquiries/complaints and requests for information that includes contacting providers within three days and resolving issues within 30 days <i>RFP, Section D, Paragraphs 27, Network Development and 29, Network Management</i>
31. <input checked="" type="checkbox"/>	A process for monitoring and addressing provider performance issues up to and including contract termination <i>RFP, Section D, Paragraphs 27, Network Development and 29, Network Management</i>

<i>Finance</i>	
The Offeror attests that it will:	
32. <input checked="" type="checkbox"/>	Have a separate entity established for purposes of this contract within 120 days of the contract award if the Offeror is a non-governmental <i>New Contractor</i> . <i>RFP, Section D, Paragraph 51, Separate Incorporation</i>
33. <input checked="" type="checkbox"/>	Meet the minimum capitalization requirements within 30 days of the contract award if the Offeror is a <i>New Contractor</i> ; or, fund through a capital contribution the necessary amount to meet the equity per member requirement within 30 days of the contract award if the Offeror is a <i>Successful Incumbent Contractor</i> . <i>RFP, Section D, Paragraph 45, Minimum Capitalization; Section H, Instructions to Offerors-Paragraph 14, Minimum Capitalization</i>
34. <input checked="" type="checkbox"/>	Secure a performance bond as defined in amount and type in Section D, Paragraphs 46, Performance Bond or Bond Substitute and 47, Amount of Performance Bond, and ACOM policies 305 and 306 no later than 30 days after notification by AHCCCS of the amount required. <i>RFP, Section D, Paragraphs 46, Performance Bond or Bond Substitute; 47, Amount of Performance Bond</i>

ATTESTATION SIGNATURE

In order for the proposal to be considered for AHCCCS review purposes, all boxes must be checked. The attestation must be signed and dated by the Offeror. A proposal containing check boxes left blank or lacking a signature and date below will not be considered further.

Offeror's Name: Care1st Health Plan Arizona, Inc. certifies the elements attested to in this document are true and it is understood that AHCCCS will rely on this attestation in determination of the award.


 Authorized Signature 1.25.2013
 Date

SCOTT CUNDINGS
 Individual's Printed Name CHIEF ADMINISTRATIVE OFFICER
 Title



Compassionately Caring 1st for our Community...



Challenging ourselves every day to exceed the expectations of our members, providers and regulators.

SECTION C
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January 23, 2013

**Actuarial Certification
Care1st Health Plan Arizona
AHCCCS Acute Care Capitation Bids: GSAs 2, 6, 8, 10, 12, and 14
October 1, 2013 – September 30, 2014**

I, Michael Cook, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its qualification standards for rendering this opinion. I have been retained by Care1st Health Plan Arizona, Inc. (Care1st) to provide a certification of the actuarial soundness of its proposed capitation rates for Acute Care Services in GSAs 2, 6, 8, 10, 12, and 14 under the Arizona Health Care Cost Containment System (AHCCCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Acute Care Services Request for Proposal (including amendments through the date of this certification) issued by AHCCCS. This certification may not be appropriate for other purposes.

The capitation rates to which this certification applies are attached in AHCCCS's required Bid Template sheets and shown in tables 1 and 2 below. The rates apply to the period October 1, 2013 through September 30, 2014

**Table 1
Gross Medical Component by Risk Group and GSA**

Risk Group	GSA 2	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	\$393.97	\$451.41	\$467.51	\$439.77	\$463.43	\$413.32
TANF 1-13	\$85.30	\$103.53	\$90.68	\$79.10	\$92.76	\$86.58
TANF 14-44 F	\$182.71	\$275.49	\$236.99	\$193.32	\$210.74	\$216.95
TANF 14-44 M	\$103.81	\$176.54	\$148.24	\$119.97	\$137.66	\$146.69
TANF 45+	\$294.35	\$402.05	\$413.86	\$326.71	\$375.78	\$355.14
SSI W/ Medicare	\$155.26	\$100.00	\$119.59	\$114.76	\$147.57	\$130.89
SSI W/O Medicare	\$803.66	\$887.46	\$695.85	\$736.22	\$746.20	\$825.79
AHCCCS Care	\$327.43	\$446.75	\$398.16	\$317.51	\$387.44	\$363.62
Delivery Supplemental	\$4,654.37	\$5,373.06	\$5,276.31	\$5,278.00	\$5,450.00	\$5,018.84



Table 2
Administrative Component by Risk Group and GSA

Risk Group	GSA 2	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	\$27.58	\$35.66	\$36.47	\$32.10	\$36.61	\$28.93
TANF 1-13	\$5.97	\$8.18	\$7.07	\$5.77	\$7.33	\$6.06
TANF 14-44 F	\$12.79	\$21.76	\$18.49	\$14.11	\$16.65	\$15.19
TANF 14-44 M	\$7.27	\$13.95	\$11.56	\$8.76	\$10.88	\$10.27
TANF 45+	\$20.60	\$31.76	\$32.28	\$23.85	\$29.69	\$24.86
SSI W/ Medicare	\$10.87	\$7.90	\$9.33	\$8.38	\$11.66	\$9.16
SSI W/O Medicare	\$56.26	\$70.11	\$54.28	\$53.74	\$58.95	\$57.81
AHCCCS Care	\$22.92	\$35.29	\$31.06	\$23.18	\$30.61	\$25.45
Delivery Supplemental	\$325.81	\$424.47	\$411.55	\$385.29	\$430.55	\$351.32

It is my opinion that the above rates are adequate, in the aggregate, to fund claims and administrative expenses for an average Medicaid population for GSAs 2, 6, 8, 10, 12, and 14 during the time period for which they are intended. AHCCCS has recommended that bidders submit rates reflecting the average gross monthly cost of a member utilizing the Data Book provided in the Bidders' Library; my opinion reflects this recommendation.

My determination is based on a review of the claim experience and other information provided by AHCCCS, experience data and descriptions of provider contracts provided by Care1st, and my judgment. In performing my analysis, I relied on data and other information provided by AHCCCS and Care1st. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my analysis.

I also relied on Care1st provider reimbursement descriptions without audit. My opinion that the rates are actuarially sound is based on the assumption that Care1st's capitated providers are financially stable and have the financial resources to absorb capitation risk. I did not review the financial resources or medical management abilities of any provider to confirm their ability to assume financial risk.



The utilization rates and average costs in the attached Bid Template sheets are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of Care1st and / or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience deviates from expected experience.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

A handwritten signature in black ink that reads "Michael Cook". The signature is written in a cursive style with a large, looping initial "M".

Michael Cook, FSA, MAAA
January 23, 2013

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Gross Medical Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	\$393.97	\$0.00	\$451.41	\$467.51	\$439.77	\$463.43	\$413.32
TANF 1-13	\$85.30	\$0.00	\$103.53	\$90.68	\$79.10	\$92.76	\$86.58
TANF 14-44 F	\$182.71	\$0.00	\$275.49	\$236.99	\$193.32	\$210.74	\$216.95
TANF 14-44 M	\$103.81	\$0.00	\$176.54	\$148.24	\$119.97	\$137.66	\$146.69
TANF 45+	\$294.35	\$0.00	\$402.05	\$413.86	\$326.71	\$375.78	\$355.14
SSIW	\$155.26	\$0.00	\$100.00	\$119.59	\$114.76	\$147.57	\$130.89
SSIW/O	\$803.66	\$0.00	\$887.46	\$695.85	\$736.22	\$746.20	\$825.79
AHCCCS Care	\$327.43	\$0.00	\$446.75	\$398.16	\$317.51	\$387.44	\$363.62
Delivery Supp	\$4,654.38	\$0.00	\$5,373.06	\$5,276.31	\$5,278.00	\$5,450.00	\$5,018.84

Administrative Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	\$27.58	\$0.00	\$35.66	\$36.47	\$32.10	\$36.61	\$28.93
TANF 1-13	\$5.97	\$0.00	\$8.18	\$7.07	\$5.77	\$7.33	\$6.06
TANF 14-44 F	\$12.79	\$0.00	\$21.76	\$18.49	\$14.11	\$16.65	\$15.19
TANF 14-44 M	\$7.27	\$0.00	\$13.95	\$11.56	\$8.76	\$10.88	\$10.27
TANF 45+	\$20.60	\$0.00	\$31.76	\$32.28	\$23.85	\$29.69	\$24.86
SSIW	\$10.87	\$0.00	\$7.90	\$9.33	\$8.38	\$11.66	\$9.16
SSIW/O	\$56.26	\$0.00	\$70.11	\$54.28	\$53.74	\$58.95	\$57.81
AHCCCS Care	\$22.92	\$0.00	\$35.29	\$31.06	\$23.18	\$30.61	\$25.45
Delivery Supp	\$325.81	\$0.00	\$424.47	\$411.55	\$385.29	\$430.55	\$351.32

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Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF < 1

Selected GSA: GSA 2

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	2,742	\$879.36	\$200.93
Outpatient Facility	293	\$285.47	\$6.97
Emergency Room	845	\$233.94	\$16.48
Primary Care	10,623	\$42.99	\$38.06
Referral Physician	16,110	\$62.94	\$84.50
Other Professional	2,087	\$61.04	\$10.62
Pharmacy	4,015	\$21.68	\$7.25
Emergency and Non-Emergency Transportation	400	\$608.29	\$20.27
Dental	116	\$29.46	\$0.29
Laboratory, X-Ray, Med Image	4,254	\$16.96	\$6.01
Physical Therapy	3	\$14.33	\$0.00
DME and Oxygen	579	\$49.73	\$2.40
NF and Home Health Care	42	\$54.34	\$0.19
Miscellaneous	-	\$0.00	\$0.00
Gross Medical Component			\$393.97
Administrative Component			\$27.58

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 1-13** Selected GSA: **GSA 2**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	34	\$1,461.54	\$4.16	
Outpatient Facility	119	\$592.79	\$5.90	
Emergency Room	363	\$288.85	\$8.74	
Primary Care	1,809	\$53.91	\$8.13	
Referral Physician	3,305	\$47.04	\$12.96	
Other Professional	1,806	\$58.84	\$8.86	
Pharmacy	3,797	\$28.21	\$8.93	
Emergency and Non-Emergency Transportation	201	\$200.60	\$3.36	
Dental	7,189	\$31.88	\$19.10	
Laboratory, X-Ray, Med Image	3,302	\$11.73	\$3.23	
Physical Therapy	20	\$14.05	\$0.02	
DME and Oxygen	494	\$46.52	\$1.91	
NF and Home Health Care	0	\$358.20	\$0.01	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$85.30	
	Administrative Component		\$5.97	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 F** Selected GSA: **GSA 2**

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	102	\$1,883.39	\$16.08
Outpatient Facility	430	\$630.34	\$22.58
Emergency Room	784	\$398.61	\$26.03
Primary Care	348	\$321.97	\$9.33
Referral Physician	5,824	\$64.87	\$31.48
Other Professional	3,418	\$59.17	\$16.85
Pharmacy	10,483	\$22.73	\$19.86
Emergency and Non-Emergency Transportation	474	\$222.88	\$8.81
Dental	1,675	\$41.01	\$5.72
Laboratory, X-Ray, Med Image	11,143	\$25.42	\$23.60
Physical Therapy	195	\$13.38	\$0.22
DME and Oxygen	387	\$47.35	\$1.53
NF and Home Health Care	53	\$138.88	\$0.61
Miscellaneous			\$0.00
	Gross Medical Component		\$182.70
	Administrative Component		\$12.79

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF 14-44 M Selected GSA: GSA 2

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	70	\$1,936.62	\$11.35	
Outpatient Facility	174	\$628.48	\$9.09	
Emergency Room	353	\$441.81	\$13.01	
Primary Care	725	\$107.57	\$6.50	
Referral Physician	2,819	\$65.36	\$15.36	
Other Professional	2,146	\$59.47	\$10.64	
Pharmacy	5,377	\$32.75	\$14.67	
Emergency and Non-Emergency Transportation	199	\$286.58	\$4.75	
Dental	2,439	\$41.10	\$8.35	
Laboratory, X-Ray, Med Image	3,999	\$22.78	\$7.59	
Physical Therapy	147	\$14.12	\$0.17	
DME and Oxygen	444	\$51.91	\$1.92	
NF and Home Health Care	41	\$118.36	\$0.40	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$103.81	
	Administrative Component		\$7.27	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 45+** Selected GSA: **GSA 2**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	220	\$1,673.42	\$30.71	
Outpatient Facility	1,015	\$551.43	\$46.64	
Emergency Room	370	\$554.68	\$17.11	
Primary Care	1,685	\$134.59	\$18.90	
Referral Physician	8,135	\$83.86	\$56.85	
Other Professional	4,631	\$53.12	\$20.50	
Pharmacy	22,924	\$28.11	\$53.70	
Emergency and Non-Emergency Transportation	1,122	\$99.80	\$9.33	
Dental	152	\$26.97	\$0.34	
Laboratory, X-Ray, Med Image	13,484	\$30.15	\$33.88	
Physical Therapy	585	\$13.09	\$0.64	
DME and Oxygen	695	\$65.49	\$3.79	
NF and Home Health Care	203	\$115.41	\$1.96	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$294.35	
	Administrative Component		\$20.60	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: SSIW Selected GSA: GSA 2

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	812	\$298.28	\$20.20	
Outpatient Facility	1,344	\$221.87	\$24.84	
Emergency Room	405	\$97.42	\$3.29	
Primary Care	2,271	\$63.24	\$11.97	
Referral Physician	15,209	\$24.54	\$31.10	
Other Professional	4,437	\$18.05	\$6.67	
Pharmacy	3,257	\$8.62	\$2.34	
Emergency and Non-Emergency Transportation	7,830	\$39.46	\$25.75	
Dental	116	\$26.62	\$0.26	
Laboratory, X-Ray, Med Image	16,079	\$13.91	\$18.64	
Physical Therapy	713	\$3.37	\$0.20	
DME and Oxygen	878	\$28.63	\$2.09	
NF and Home Health Care	1,645	\$57.65	\$7.90	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$155.26	
	Administrative Component		\$10.87	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: SSIW/O Selected GSA: GSA 2

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	1,078	\$1,692.94	\$152.14	
Outpatient Facility	1,449	\$763.25	\$92.17	
Emergency Room	1,156	\$518.73	\$49.98	
Primary Care	2,322	\$148.72	\$28.77	
Referral Physician	14,537	\$83.74	\$101.44	
Other Professional	4,622	\$76.48	\$29.46	
Pharmacy	41,893	\$57.20	\$199.69	
Emergency and Non-Emergency Transportation	5,963	\$125.14	\$62.18	
Dental	1,083	\$34.60	\$3.12	
Laboratory, X-Ray, Med Image	18,858	\$30.64	\$48.15	
Physical Therapy	298	\$14.04	\$0.35	
DME and Oxygen	2,054	\$87.20	\$14.92	
NF and Home Health Care	1,529	\$166.96	\$21.27	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$803.65	
	Administrative Component		\$56.26	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **AHCCCS Care** Selected GSA: **GSA 2**

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	389	\$1,793.50	\$58.20
Outpatient Facility	857	\$591.79	\$42.27
Emergency Room	671	\$512.54	\$28.67
Primary Care	810	\$155.98	\$10.53
Referral Physician	8,017	\$88.16	\$58.90
Other Professional	3,687	\$68.01	\$20.89
Pharmacy	16,231	\$36.94	\$49.96
Emergency and Non-Emergency Transportation	1,456	\$152.68	\$18.52
Dental	632	\$40.32	\$2.12
Laboratory, X-Ray, Med Image	11,326	\$30.44	\$28.73
Physical Therapy	311	\$14.00	\$0.36
DME and Oxygen	651	\$68.31	\$3.71
NF and Home Health Care	328	\$166.59	\$4.56
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$327.44
	Administrative Component		\$22.92

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Units per Delivery and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **Delivery Supp** Selected GSA: **GSA 2**

Service Categories:	Units per		Cost per	
	Delivery	Delivery	Unit	Delivery
Hospital Inpatient	2		\$1,339.12	\$2,537.84
Primary Care	2		\$774.63	\$1,504.22
Emergency and Non-Emergency Transportation	0		\$1,134.97	\$63.46
Laboratory, X-Ray, Med Image	1		\$60.31	\$40.83
Miscellaneous	3		\$202.99	\$508.02
	Gross Medical Component			\$4,654.38
	Administrative Component			\$325.81

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF < 1

Selected GSA: GSA 6

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	2,782	\$952.33	\$220.77	
Outpatient Facility	459	\$301.19	\$11.53	
Emergency Room	1,293	\$263.33	\$28.37	
Primary Care	11,458	\$39.62	\$37.83	
Referral Physician	17,377	\$58.00	\$83.99	
Other Professional	5,005	\$45.91	\$19.15	
Pharmacy	4,667	\$43.71	\$17.00	
Emergency and Non-Emergency Transportation	386	\$637.59	\$20.53	
Dental	133	\$44.46	\$0.49	
Laboratory, X-Ray, Med Image	4,488	\$15.21	\$5.69	
Physical Therapy	0	\$26.17	\$0.00	
DME and Oxygen	808	\$89.13	\$6.00	
NF and Home Health Care	33	\$20.32	\$0.06	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$451.41	
	Administrative Component		\$35.66	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF 1-13

Selected GSA: GSA 6

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	52	\$1,364.59	\$5.86	
Outpatient Facility	159	\$522.03	\$6.92	
Emergency Room	615	\$271.24	\$13.90	
Primary Care	2,110	\$57.88	\$10.18	
Referral Physician	3,856	\$50.51	\$16.23	
Other Professional	1,567	\$50.92	\$6.65	
Pharmacy	3,350	\$43.53	\$12.15	
Emergency and Non-Emergency Transportation	160	\$288.26	\$3.84	
Dental	6,253	\$43.85	\$22.85	
Laboratory, X-Ray, Med Image	2,263	\$14.22	\$2.68	
Physical Therapy	13	\$22.70	\$0.02	
DME and Oxygen	544	\$49.34	\$2.23	
NF and Home Health Care	3	\$23.90	\$0.01	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$103.53	
	Administrative Component		\$8.18	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 F** Selected GSA: **GSA 6**

Service Categories:	Annualized		Cost per		PMPM
	Units per 1000	Unit	Unit	Unit	
Hospital Inpatient	180		\$1,876.41		\$28.10
Outpatient Facility	538		\$694.21		\$31.15
Emergency Room	1,446		\$367.11		\$44.24
Primary Care	470		\$339.48		\$13.31
Referral Physician	7,876		\$68.40		\$44.89
Other Professional	2,906		\$58.64		\$14.20
Pharmacy	15,217		\$38.74		\$49.13
Emergency and Non-Emergency Transportation	659		\$218.63		\$12.00
Dental	1,610		\$54.01		\$7.24
Laboratory, X-Ray, Med Image	11,772		\$28.48		\$27.94
Physical Therapy	196		\$16.43		\$0.27
DME and Oxygen	609		\$54.87		\$2.78
NF and Home Health Care	105		\$27.88		\$0.24
Miscellaneous	-		\$0.00		\$0.00
			Gross Medical Component		\$275.50
			Administrative Component		\$21.76

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 M**

Selected GSA: **GSA 6**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	150	\$1,771.93		\$22.19
Outpatient Facility	280	\$845.04		\$19.74
Emergency Room	816	\$363.61		\$24.72
Primary Care	1,090	\$125.78		\$11.43
Referral Physician	4,241	\$76.42		\$27.01
Other Professional	2,002	\$56.23		\$9.38
Pharmacy	8,233	\$45.05		\$30.91
Emergency and Non-Emergency Transportation	497	\$183.21		\$7.59
Dental	2,281	\$53.88		\$10.24
Laboratory, X-Ray, Med Image	4,186	\$28.42		\$9.91
Physical Therapy	113	\$17.55		\$0.17
DME and Oxygen	633	\$58.25		\$3.07
NF and Home Health Care	1,823	\$1.20		\$0.18
Miscellaneous	-	\$0.00		\$0.00
	Gross Medical Component			\$176.54
	Administrative Component			\$13.95

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF 45+ Selected GSA: GSA 6

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	385	\$2,030.72	\$65.21	
Outpatient Facility	808	\$714.86	\$48.16	
Emergency Room	767	\$448.77	\$28.69	
Primary Care	1,922	\$138.63	\$22.20	
Referral Physician	9,279	\$86.37	\$66.79	
Other Professional	4,000	\$56.98	\$18.99	
Pharmacy	25,703	\$41.36	\$88.59	
Emergency and Non-Emergency Transportation	1,614	\$125.48	\$16.87	
Dental	301	\$45.19	\$1.14	
Laboratory, X-Ray, Med Image	11,695	\$34.69	\$33.81	
Physical Therapy	528	\$16.22	\$0.71	
DME and Oxygen	1,343	\$84.86	\$9.50	
NF and Home Health Care	430	\$38.88	\$1.39	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$402.05	
	Administrative Component		\$31.76	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: SSIW

Selected GSA: GSA 6

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	688	\$235.99	\$13.52	
Outpatient Facility	781	\$183.89	\$11.96	
Emergency Room	651	\$100.76	\$5.47	
Primary Care	1,699	\$50.20	\$7.11	
Referral Physician	11,374	\$19.48	\$18.46	
Other Professional	2,965	\$19.10	\$4.72	
Pharmacy	2,541	\$14.88	\$3.15	
Emergency and Non-Emergency Transportation	6,024	\$41.35	\$20.76	
Dental	266	\$49.55	\$1.10	
Laboratory, X-Ray, Med Image	4,684	\$13.27	\$5.18	
Physical Therapy	535	\$4.70	\$0.21	
DME and Oxygen	1,399	\$23.30	\$2.72	
NF and Home Health Care	647	\$104.65	\$5.64	
Miscellaneous	-	\$0.00	\$0.00	
Gross Medical Component			\$100.00	
Administrative Component			\$7.90	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: SSIW/O Selected GSA: GSA 6

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	1,081	\$1,889.94	\$170.32	
Outpatient Facility	1,191	\$909.04	\$90.21	
Emergency Room	1,615	\$469.57	\$63.18	
Primary Care	2,419	\$158.28	\$31.91	
Referral Physician	15,148	\$89.13	\$112.51	
Other Professional	4,894	\$70.71	\$28.84	
Pharmacy	48,055	\$57.71	\$231.11	
Emergency and Non-Emergency Transportation	7,236	\$106.92	\$64.47	
Dental	1,059	\$50.63	\$4.47	
Laboratory, X-Ray, Med Image	17,576	\$31.75	\$46.50	
Physical Therapy	475	\$21.22	\$0.84	
DME and Oxygen	3,437	\$92.22	\$26.42	
NF and Home Health Care	2,129	\$94.16	\$16.71	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$887.48	
	Administrative Component		\$70.11	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **AHCCCS Care** Selected GSA: **GSA 6**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	480	\$2,236.15	\$89.43	
Outpatient Facility	716	\$830.89	\$49.57	
Emergency Room	1,155	\$432.46	\$41.64	
Primary Care	990	\$158.65	\$13.09	
Referral Physician	9,797	\$89.67	\$73.21	
Other Professional	3,719	\$61.21	\$18.97	
Pharmacy	22,004	\$47.84	\$87.72	
Emergency and Non-Emergency Transportation	2,283	\$130.22	\$24.77	
Dental	606	\$53.97	\$2.72	
Laboratory, X-Ray, Med Image	11,786	\$33.56	\$32.96	
Physical Therapy	376	\$20.09	\$0.63	
DME and Oxygen	1,114	\$76.27	\$7.08	
NF and Home Health Care	591	\$100.60	\$4.95	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$446.75	
	Administrative Component		\$35.29	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Units per Delivery and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **Delivery Supp** Selected GSA: **GSA 6**

Service Categories:	Units per	Cost per	Cost per
	Delivery	Unit	Delivery
Hospital Inpatient	2	\$1,332.79	\$2,985.16
Primary Care	3	\$824.43	\$2,154.26
Emergency and Non-Emergency Transportation	0	\$2,019.77	\$134.69
Laboratory, X-Ray, Med Image	0	\$45.54	\$17.62
Miscellaneous	2	\$53.13	\$81.34
	Gross Medical Component		\$5,373.06
	Administrative Component		\$424.47

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF < 1

Selected GSA: GSA 8

Service Categories:	Annualized		Cost per		PMPM
	Units per 1000	Unit	Unit	Unit	
Hospital Inpatient	3,186		\$917.81		\$243.66
Outpatient Facility	418		\$289.25		\$10.08
Emergency Room	1,531		\$213.32		\$27.21
Primary Care	11,357		\$41.92		\$39.67
Referral Physician	17,223		\$61.38		\$88.10
Other Professional	4,008		\$42.47		\$14.18
Pharmacy	5,736		\$35.54		\$16.99
Emergency and Non-Emergency Transportation	687		\$287.38		\$16.45
Dental	111		\$33.76		\$0.31
Laboratory, X-Ray, Med Image	4,515		\$16.09		\$6.05
Physical Therapy	-		\$0.00		\$0.00
DME and Oxygen	632		\$89.43		\$4.71
NF and Home Health Care	54		\$19.42		\$0.09
Miscellaneous	-		\$0.00		\$0.00
		Gross Medical Component			\$467.50
		Administrative Component			\$36.47

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF 1-13

Selected GSA: GSA 8

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	59	\$1,411.49	\$6.92	
Outpatient Facility	148	\$503.28	\$6.19	
Emergency Room	649	\$208.75	\$11.29	
Primary Care	1,942	\$59.03	\$9.55	
Referral Physician	3,549	\$51.51	\$15.23	
Other Professional	1,277	\$50.00	\$5.32	
Pharmacy	3,771	\$33.60	\$10.56	
Emergency and Non-Emergency Transportation	228	\$189.78	\$3.61	
Dental	5,932	\$35.65	\$17.62	
Laboratory, X-Ray, Med Image	1,917	\$14.64	\$2.34	
Physical Therapy	1	\$12.97	\$0.00	
DME and Oxygen	524	\$46.59	\$2.03	
NF and Home Health Care	2	\$20.82	\$0.00	
Miscellaneous			\$0.00	
		Gross Medical Component	\$90.68	
		Administrative Component	\$7.07	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF 14-44 F

Selected GSA: GSA 8

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	220	\$1,725.60	\$31.57	
Outpatient Facility	794	\$473.35	\$31.32	
Emergency Room	1,137	\$332.15	\$31.46	
Primary Care	430	\$335.76	\$12.04	
Referral Physician	7,205	\$67.65	\$40.62	
Other Professional	2,089	\$68.48	\$11.92	
Pharmacy	12,078	\$30.96	\$31.16	
Emergency and Non-Emergency Transportation	793	\$190.95	\$12.62	
Dental	1,487	\$43.58	\$5.40	
Laboratory, X-Ray, Med Image	11,073	\$28.83	\$26.60	
Physical Therapy	26	\$12.71	\$0.03	
DME and Oxygen	437	\$46.95	\$1.71	
NF and Home Health Care	79	\$79.32	\$0.52	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$236.99	
	Administrative Component		\$18.49	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 M** Selected GSA: **GSA 8**

Service Categories:	Annualized		Cost per		PMPM
	Units per 1000	Unit	Unit	Unit	
Hospital Inpatient	183		\$1,711.74		\$26.10
Outpatient Facility	291		\$679.16		\$16.46
Emergency Room	690		\$330.30		\$18.99
Primary Care	937		\$115.70		\$9.04
Referral Physician	3,647		\$70.30		\$21.37
Other Professional	1,343		\$64.17		\$7.18
Pharmacy	6,937		\$38.42		\$22.21
Emergency and Non-Emergency Transportation	425		\$254.53		\$9.01
Dental	2,053		\$43.83		\$7.50
Laboratory, X-Ray, Med Image	3,462		\$26.67		\$7.69
Physical Therapy	11		\$11.42		\$0.01
DME and Oxygen	525		\$56.02		\$2.45
NF and Home Health Care	32		\$87.76		\$0.23
Miscellaneous	-		\$0.00		\$0.00
			Gross Medical Component		\$148.24
			Administrative Component		\$11.56

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 45+** Selected GSA: **GSA 8**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	556	\$1,552.29	\$71.97	
Outpatient Facility	1,229	\$604.91	\$61.98	
Emergency Room	713	\$402.82	\$23.92	
Primary Care	2,225	\$128.71	\$23.87	
Referral Physician	10,745	\$80.19	\$71.80	
Other Professional	2,882	\$73.16	\$17.57	
Pharmacy	27,628	\$34.40	\$79.20	
Emergency and Non-Emergency Transportation	1,968	\$97.54	\$15.99	
Dental	331	\$37.82	\$1.04	
Laboratory, X-Ray, Med Image	13,175	\$35.54	\$39.02	
Physical Therapy	54	\$9.58	\$0.04	
DME and Oxygen	879	\$67.53	\$4.95	
NF and Home Health Care	298	\$100.46	\$2.50	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$413.85	
	Administrative Component		\$32.28	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **SSIW**

Selected GSA: **GSA 8**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	901	\$271.10	\$20.35	
Outpatient Facility	1,161	\$216.73	\$20.96	
Emergency Room	712	\$100.46	\$5.96	
Primary Care	2,028	\$49.71	\$8.40	
Referral Physician	13,578	\$19.29	\$21.83	
Other Professional	2,066	\$19.29	\$3.32	
Pharmacy	3,214	\$14.15	\$3.79	
Emergency and Non-Emergency Transportation	7,111	\$36.74	\$21.77	
Dental	288	\$40.85	\$0.98	
Laboratory, X-Ray, Med Image	7,400	\$12.53	\$7.73	
Physical Therapy	63	\$4.34	\$0.02	
DME and Oxygen	904	\$25.66	\$1.93	
NF and Home Health Care	415	\$73.52	\$2.54	
Miscellaneous	-	\$0.00	\$0.00	
		Gross Medical Component	\$119.59	
		Administrative Component	\$9.33	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: SSIW/O Selected GSA: GSA 8

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	1,146	\$1,791.82	\$171.10	
Outpatient Facility	1,273	\$643.17	\$68.23	
Emergency Room	1,292	\$422.92	\$45.53	
Primary Care	2,176	\$149.91	\$27.18	
Referral Physician	13,625	\$84.41	\$95.84	
Other Professional	3,026	\$72.38	\$18.25	
Pharmacy	36,792	\$47.83	\$146.65	
Emergency and Non-Emergency Transportation	5,840	\$114.09	\$55.53	
Dental	1,480	\$38.88	\$4.80	
Laboratory, X-Ray, Med Image	13,294	\$35.37	\$39.18	
Physical Therapy	60	\$18.57	\$0.09	
DME and Oxygen	2,007	\$78.06	\$13.06	
NF and Home Health Care	1,049	\$118.94	\$10.39	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$695.84	
	Administrative Component		\$54.28	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **AHCCCS Care** Selected GSA: **GSA 8**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	587	\$2,049.66	\$100.32	
Outpatient Facility	899	\$684.77	\$51.30	
Emergency Room	950	\$409.30	\$32.41	
Primary Care	922	\$155.47	\$11.94	
Referral Physician	9,122	\$87.87	\$66.79	
Other Professional	2,251	\$73.80	\$13.85	
Pharmacy	16,778	\$40.79	\$57.03	
Emergency and Non-Emergency Transportation	1,934	\$146.58	\$23.62	
Dental	615	\$46.15	\$2.37	
Laboratory, X-Ray, Med Image	10,015	\$35.03	\$29.24	
Physical Therapy	45	\$13.90	\$0.05	
DME and Oxygen	677	\$76.48	\$4.32	
NF and Home Health Care	553	\$106.38	\$4.90	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$398.15	
	Administrative Component		\$31.06	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Units per Delivery and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **Delivery Supp** Selected GSA: **GSA 8**

Service Categories:	Units per		Cost per	
	Delivery	Unit	Unit	Delivery
Hospital Inpatient	3		\$1,306.35	\$3,317.65
Primary Care	2		\$742.68	\$1,698.80
Emergency and Non-Emergency Transportation	0		\$1,293.23	\$91.31
Laboratory, X-Ray, Med Image	1		\$48.97	\$25.41
Miscellaneous	2		\$89.38	\$143.14
	Gross Medical Component			\$5,276.31
	Administrative Component			\$411.55

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF < 1

Selected GSA: GSA 10

Service Categories:	Annualized		Cost per		PMPM
	Units per 1000	Unit	Unit	Unit	
Hospital Inpatient	3,127		\$932.13		\$242.92
Outpatient Facility	850		\$134.02		\$9.49
Emergency Room	1,267		\$163.38		\$17.25
Primary Care	11,510		\$41.60		\$39.90
Referral Physician	17,455		\$60.90		\$88.58
Other Professional	3,250		\$42.70		\$11.56
Pharmacy	5,031		\$30.54		\$12.81
Emergency and Non-Emergency Transportation	643		\$134.41		\$7.20
Dental	176		\$36.06		\$0.53
Laboratory, X-Ray, Med Image	3,857		\$16.92		\$5.44
Physical Therapy	2		\$27.86		\$0.00
DME and Oxygen	649		\$72.28		\$3.91
NF and Home Health Care	69		\$30.17		\$0.17
Miscellaneous	-		\$0.00		\$0.00
		Gross Medical Component			\$439.77
		Administrative Component			\$32.10

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF 1-13

Selected GSA: GSA 10

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	55	\$1,404.58	\$6.40	
Outpatient Facility	297	\$225.13	\$5.56	
Emergency Room	518	\$168.53	\$7.28	
Primary Care	1,901	\$55.82	\$8.84	
Referral Physician	3,473	\$48.71	\$14.10	
Other Professional	974	\$51.83	\$4.21	
Pharmacy	3,412	\$36.46	\$10.37	
Emergency and Non-Emergency Transportation	202	\$106.74	\$1.80	
Dental	6,111	\$33.35	\$16.98	
Laboratory, X-Ray, Med Image	1,718	\$13.91	\$1.99	
Physical Therapy	1	\$17.46	\$0.00	
DME and Oxygen	433	\$42.69	\$1.54	
NF and Home Health Care	38	\$13.93	\$0.04	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$79.10	
	Administrative Component		\$5.77	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 F** Selected GSA: **GSA 10**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	156	\$1,514.72	\$19.64	
Outpatient Facility	1,028	\$314.80	\$26.97	
Emergency Room	962	\$313.54	\$25.15	
Primary Care	372	\$339.12	\$10.51	
Referral Physician	6,229	\$68.33	\$35.47	
Other Professional	2,178	\$60.25	\$10.93	
Pharmacy	11,976	\$28.28	\$28.22	
Emergency and Non-Emergency Transportation	731	\$115.58	\$7.04	
Dental	1,362	\$39.27	\$4.46	
Laboratory, X-Ray, Med Image	9,634	\$28.74	\$23.07	
Physical Therapy	57	\$11.14	\$0.05	
DME and Oxygen	325	\$53.82	\$1.46	
NF and Home Health Care	152	\$26.71	\$0.34	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$193.32	
	Administrative Component		\$14.11	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 M** Selected GSA: **GSA 10**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	120	\$1,664.95	\$16.67	
Outpatient Facility	419	\$381.26	\$13.30	
Emergency Room	587	\$284.87	\$13.94	
Primary Care	820	\$117.20	\$8.01	
Referral Physician	3,189	\$71.21	\$18.92	
Other Professional	1,228	\$57.99	\$5.93	
Pharmacy	6,106	\$45.69	\$23.25	
Emergency and Non-Emergency Transportation	318	\$171.03	\$4.53	
Dental	2,047	\$38.87	\$6.63	
Laboratory, X-Ray, Med Image	3,076	\$25.49	\$6.53	
Physical Therapy	35	\$11.66	\$0.03	
DME and Oxygen	407	\$56.90	\$1.93	
NF and Home Health Care	337	\$10.64	\$0.30	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$119.97	
	Administrative Component		\$8.76	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 45+**

Selected GSA: **GSA 10**

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	395	\$1,523.76	\$50.10
Outpatient Facility	1,395	\$408.80	\$47.53
Emergency Room	594	\$379.29	\$18.77
Primary Care	1,706	\$142.94	\$20.32
Referral Physician	8,237	\$89.06	\$61.13
Other Professional	2,945	\$52.75	\$12.95
Pharmacy	23,446	\$34.80	\$67.99
Emergency and Non-Emergency Transportation	1,211	\$88.15	\$8.90
Dental	258	\$31.08	\$0.67
Laboratory, X-Ray, Med Image	11,507	\$32.93	\$31.58
Physical Therapy	101	\$10.83	\$0.09
DME and Oxygen	683	\$71.44	\$4.06
NF and Home Health Care	405	\$77.41	\$2.61
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$326.71
	Administrative Component		\$23.85

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **SSIW** Selected GSA: **GSA 10**

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	833	\$307.71	\$21.36
Outpatient Facility	1,270	\$155.27	\$16.43
Emergency Room	530	\$99.64	\$4.40
Primary Care	1,971	\$59.68	\$9.80
Referral Physician	13,196	\$23.16	\$25.47
Other Professional	2,433	\$20.89	\$4.24
Pharmacy	3,107	\$13.74	\$3.56
Emergency and Non-Emergency Transportation	6,020	\$22.48	\$11.28
Dental	192	\$22.62	\$0.36
Laboratory, X-Ray, Med Image	8,654	\$13.80	\$9.95
Physical Therapy	147	\$2.96	\$0.04
DME and Oxygen	1,029	\$36.01	\$3.09
NF and Home Health Care	2,986	\$19.26	\$4.79
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$114.76
	Administrative Component		\$8.38

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **SSIW/O** Selected GSA: **GSA 10**

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	1,215	\$1,505.43	\$152.46
Outpatient Facility	1,906	\$474.37	\$75.36
Emergency Room	1,385	\$418.44	\$48.29
Primary Care	2,091	\$162.63	\$28.34
Referral Physician	13,094	\$91.58	\$99.93
Other Professional	2,877	\$83.53	\$20.02
Pharmacy	39,515	\$62.00	\$204.16
Emergency and Non-Emergency Transportation	5,892	\$79.82	\$39.19
Dental	974	\$33.99	\$2.76
Laboratory, X-Ray, Med Image	13,204	\$32.75	\$36.04
Physical Therapy	101	\$12.23	\$0.10
DME and Oxygen	2,058	\$78.31	\$13.43
NF and Home Health Care	2,951	\$65.58	\$16.13
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$736.21
	Administrative Component		\$53.74

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **AHCCCS Care** Selected GSA: **GSA 10**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	493	\$1,540.85	\$63.28	
Outpatient Facility	1,077	\$411.58	\$36.94	
Emergency Room	978	\$360.24	\$29.36	
Primary Care	781	\$159.20	\$10.37	
Referral Physician	7,730	\$89.98	\$57.96	
Other Professional	2,391	\$58.22	\$11.60	
Pharmacy	16,506	\$42.15	\$57.98	
Emergency and Non-Emergency Transportation	1,481	\$118.17	\$14.58	
Dental	585	\$42.20	\$2.06	
Laboratory, X-Ray, Med Image	9,402	\$31.67	\$24.81	
Physical Therapy	99	\$11.83	\$0.10	
DME and Oxygen	594	\$72.48	\$3.59	
NF and Home Health Care	513	\$114.07	\$4.88	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$317.51	
	Administrative Component		\$23.18	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Units per Delivery and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **Delivery Supp** Selected GSA: **GSA 10**

Service Categories:	Units per		Cost per	
	Delivery	Delivery	Unit	Delivery
Hospital Inpatient	2		\$1,260.33	\$3,108.16
Primary Care	3		\$725.06	\$1,941.30
Emergency and Non-Emergency Transportation	0		\$389.54	\$31.02
Laboratory, X-Ray, Med Image	1		\$54.78	\$28.75
Miscellaneous	3		\$60.88	\$168.76
	Gross Medical Component			\$5,278.00
	Administrative Component			\$385.29

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF < 1

Selected GSA: GSA 12

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	2,924	\$992.37	\$241.82
Outpatient Facility	725	\$237.55	\$14.35
Emergency Room	1,223	\$277.96	\$28.33
Primary Care	12,710	\$39.93	\$42.29
Referral Physician	19,275	\$58.47	\$93.92
Other Professional	1,752	\$54.84	\$8.01
Pharmacy	4,918	\$40.16	\$16.46
Emergency and Non-Emergency Transportation	1,127	\$69.38	\$6.52
Dental	139	\$34.38	\$0.40
Laboratory, X-Ray, Med Image	4,244	\$16.70	\$5.91
Physical Therapy	0	\$20.73	\$0.00
DME and Oxygen	732	\$82.06	\$5.00
NF and Home Health Care	166	\$30.86	\$0.43
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$463.43
	Administrative Component		\$36.61

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 1-13**

Selected GSA: **GSA 12**

Service Categories:	Annualized		Cost per		PMPM
	Units per 1000	Unit	Unit	Unit	
Hospital Inpatient	64		\$1,413.55		\$7.51
Outpatient Facility	249		\$338.44		\$7.03
Emergency Room	460		\$282.49		\$10.82
Primary Care	2,235		\$56.11		\$10.45
Referral Physician	4,084		\$48.96		\$16.66
Other Professional	760		\$60.39		\$3.82
Pharmacy	3,469		\$39.16		\$11.32
Emergency and Non-Emergency Transportation	340		\$56.69		\$1.61
Dental	7,186		\$32.40		\$19.40
Laboratory, X-Ray, Med Image	2,087		\$13.00		\$2.26
Physical Therapy	2		\$14.60		\$0.00
DME and Oxygen	451		\$48.84		\$1.83
NF and Home Health Care	10		\$38.83		\$0.03
Miscellaneous					\$0.00
			Gross Medical Component		\$92.76
			Administrative Component		\$7.33

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 F**

Selected GSA: **GSA 12**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	194	\$1,588.96		\$25.68
Outpatient Facility	726	\$350.13		\$21.19
Emergency Room	901	\$362.84		\$27.23
Primary Care	471	\$332.11		\$13.03
Referral Physician	7,884	\$66.91		\$43.96
Other Professional	1,833	\$67.26		\$10.27
Pharmacy	11,630	\$30.71		\$29.76
Emergency and Non-Emergency Transportation	1,218	\$55.31		\$5.61
Dental	1,865	\$38.61		\$6.00
Laboratory, X-Ray, Med Image	9,640	\$31.73		\$25.49
Physical Therapy	56	\$13.41		\$0.06
DME and Oxygen	401	\$54.40		\$1.82
NF and Home Health Care	135	\$54.85		\$0.62
Miscellaneous	-	\$0.00		\$0.00
		Gross Medical Component		\$210.73
		Administrative Component		\$16.65

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 M** Selected GSA: **GSA 12**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	158	\$1,728.08		\$22.76
Outpatient Facility	278	\$526.79		\$12.20
Emergency Room	507	\$348.61		\$14.74
Primary Care	1,029	\$111.20		\$9.54
Referral Physician	4,005	\$67.57		\$22.55
Other Professional	1,315	\$61.14		\$6.70
Pharmacy	6,219	\$50.04		\$25.93
Emergency and Non-Emergency Transportation	499	\$85.12		\$3.54
Dental	2,796	\$37.26		\$8.68
Laboratory, X-Ray, Med Image	3,309	\$28.57		\$7.88
Physical Therapy	39	\$11.95		\$0.04
DME and Oxygen	471	\$61.96		\$2.43
NF and Home Health Care	104	\$78.08		\$0.67
Miscellaneous	-	\$0.00		\$0.00
			Gross Medical Component	\$137.66
			Administrative Component	\$10.88

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF 45+

Selected GSA: GSA 12

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	511	\$1,669.58	\$71.10	
Outpatient Facility	977	\$525.97	\$42.82	
Emergency Room	580	\$410.57	\$19.85	
Primary Care	2,307	\$127.20	\$24.46	
Referral Physician	11,141	\$79.25	\$73.57	
Other Professional	3,010	\$56.52	\$14.18	
Pharmacy	23,655	\$40.28	\$79.40	
Emergency and Non-Emergency Transportation	2,089	\$41.71	\$7.26	
Dental	248	\$21.86	\$0.45	
Laboratory, X-Ray, Med Image	11,685	\$35.97	\$35.03	
Physical Therapy	142	\$11.30	\$0.13	
DME and Oxygen	815	\$63.60	\$4.32	
NF and Home Health Care	512	\$75.16	\$3.21	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$375.78	
	Administrative Component		\$29.69	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: SSIW Selected GSA: GSA 12

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	1,249	\$346.72	\$36.10	
Outpatient Facility	1,271	\$182.64	\$19.35	
Emergency Room	564	\$105.77	\$4.97	
Primary Care	2,500	\$55.57	\$11.58	
Referral Physician	16,742	\$21.57	\$30.09	
Other Professional	3,036	\$19.13	\$4.84	
Pharmacy	2,733	\$19.26	\$4.39	
Emergency and Non-Emergency Transportation	7,237	\$19.66	\$11.86	
Dental	223	\$20.66	\$0.38	
Laboratory, X-Ray, Med Image	10,879	\$15.19	\$13.77	
Physical Therapy	207	\$3.42	\$0.06	
DME and Oxygen	1,334	\$27.32	\$3.04	
NF and Home Health Care	1,706	\$50.26	\$7.15	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$147.58	
	Administrative Component		\$11.66	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: SSIW/O Selected GSA: GSA 12

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	1,376	\$1,658.48	\$190.12	
Outpatient Facility	1,500	\$597.74	\$74.70	
Emergency Room	1,108	\$416.13	\$38.44	
Primary Care	2,495	\$154.76	\$32.18	
Referral Physician	15,625	\$87.15	\$113.48	
Other Professional	2,952	\$87.30	\$21.48	
Pharmacy	34,588	\$61.11	\$176.14	
Emergency and Non-Emergency Transportation	6,513	\$43.82	\$23.78	
Dental	1,841	\$33.10	\$5.08	
Laboratory, X-Ray, Med Image	12,756	\$36.37	\$38.66	
Physical Therapy	98	\$16.54	\$0.14	
DME and Oxygen	1,991	\$83.38	\$13.84	
NF and Home Health Care	1,853	\$117.75	\$18.18	
Miscellaneous			\$0.00	
	Gross Medical Component		\$746.22	
	Administrative Component		\$58.95	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **AHCCCS Care** Selected GSA: **GSA 12**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	626	\$1,749.05	\$91.25	
Outpatient Facility	842	\$533.75	\$37.43	
Emergency Room	923	\$396.15	\$30.46	
Primary Care	1,051	\$152.90	\$13.39	
Referral Physician	10,394	\$86.42	\$74.86	
Other Professional	2,594	\$64.57	\$13.96	
Pharmacy	17,037	\$49.08	\$69.68	
Emergency and Non-Emergency Transportation	2,490	\$57.68	\$11.97	
Dental	723	\$45.51	\$2.74	
Laboratory, X-Ray, Med Image	9,676	\$36.29	\$29.26	
Physical Therapy	102	\$13.61	\$0.12	
DME and Oxygen	701	\$77.03	\$4.50	
NF and Home Health Care	779	\$120.44	\$7.82	
Miscellaneous			\$0.00	
		Gross Medical Component	\$387.44	
		Administrative Component	\$30.61	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Units per Delivery and Cost per Unit by service matrix category and PMPM admin expenses in the green cells
 Selected Risk Group: **Delivery Supp** Selected GSA: **GSA 12**

Service Categories:	Units per		Cost per	
	Delivery	Delivery	Unit	Delivery
Hospital Inpatient	3		\$1,255.10	\$3,408.41
Primary Care	2		\$752.24	\$1,865.60
Emergency and Non-Emergency Transportation	0		\$283.91	\$23.80
Laboratory, X-Ray, Med Image	1		\$45.33	\$23.13
Miscellaneous	2		\$71.18	\$129.06
Gross Medical Component				\$5,450.00
Administrative Component				\$430.55

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF < 1

Selected GSA: GSA 14

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	2,439	\$1,066.97	\$216.90	
Outpatient Facility	407	\$236.53	\$8.02	
Emergency Room	1,138	\$291.58	\$27.66	
Primary Care	9,699	\$42.20	\$34.11	
Referral Physician	14,709	\$61.79	\$75.74	
Other Professional	1,412	\$44.03	\$5.18	
Pharmacy	3,407	\$47.58	\$13.51	
Emergency and Non-Emergency Transportation	474	\$589.26	\$23.29	
Dental	136	\$37.76	\$0.43	
Laboratory, X-Ray, Med Image	2,941	\$19.39	\$4.75	
Physical Therapy	-	\$0.00	\$0.00	
DME and Oxygen	522	\$81.80	\$3.56	
NF and Home Health Care	61	\$30.28	\$0.15	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$413.31	
	Administrative Component		\$28.93	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANSF 1-13

Selected GSA: GSA 14

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	64	\$1,306.91	\$6.99	
Outpatient Facility	253	\$321.30	\$6.77	
Emergency Room	499	\$312.00	\$12.97	
Primary Care	1,686	\$58.24	\$8.18	
Referral Physician	3,081	\$50.82	\$13.05	
Other Professional	628	\$55.30	\$2.90	
Pharmacy	2,982	\$41.44	\$10.30	
Emergency and Non-Emergency Transportation	233	\$271.91	\$5.28	
Dental	4,792	\$41.78	\$16.68	
Laboratory, X-Ray, Med Image	1,330	\$15.28	\$1.69	
Physical Therapy	-	\$0.00	\$0.00	
DME and Oxygen	384	\$54.58	\$1.75	
NF and Home Health Care	3	\$44.82	\$0.01	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$86.58	
	Administrative Component		\$6.06	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: TANF 14-44 F

Selected GSA: GSA 14

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	157	\$1,556.81	\$20.42
Outpatient Facility	1,154	\$401.62	\$38.62
Emergency Room	864	\$457.29	\$32.92
Primary Care	387	\$323.10	\$10.41
Referral Physician	6,473	\$65.10	\$35.12
Other Professional	1,255	\$68.64	\$7.18
Pharmacy	11,327	\$33.92	\$32.02
Emergency and Non-Emergency Transportation	685	\$230.17	\$13.14
Dental	1,410	\$52.75	\$6.20
Laboratory, X-Ray, Med Image	6,788	\$32.88	\$18.60
Physical Therapy	1	\$9.72	\$0.00
DME and Oxygen	303	\$71.26	\$1.80
NF and Home Health Care	65	\$95.56	\$0.52
Miscellaneous	-	\$0.00	\$0.00
Gross Medical Component			\$216.95
Administrative Component			\$15.19

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 14-44 M** Selected GSA: **GSA 14**

Service Categories:	Annualized		Cost per Unit	PMPM
	Units per 1000	Unit		
Hospital Inpatient	136	\$1,826.81	\$20.73	
Outpatient Facility	545	\$468.80	\$21.28	
Emergency Room	570	\$451.69	\$21.47	
Primary Care	855	\$115.41	\$8.22	
Referral Physician	3,325	\$70.12	\$19.43	
Other Professional	681	\$70.25	\$3.98	
Pharmacy	6,160	\$47.82	\$24.55	
Emergency and Non-Emergency Transportation	368	\$323.82	\$9.94	
Dental	1,958	\$53.43	\$8.72	
Laboratory, X-Ray, Med Image	2,225	\$30.91	\$5.73	
Physical Therapy	1	\$3.15	\$0.00	
DME and Oxygen	399	\$67.05	\$2.23	
NF and Home Health Care	48	\$103.16	\$0.41	
Miscellaneous	-	\$0.00	\$0.00	
	Gross Medical Component		\$146.69	
	Administrative Component		\$10.27	

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **TANF 45+**

Selected GSA: **GSA 14**

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	383	\$1,520.46	\$48.56
Outpatient Facility	1,865	\$422.08	\$65.60
Emergency Room	621	\$555.98	\$28.76
Primary Care	1,734	\$129.99	\$18.79
Referral Physician	8,373	\$80.99	\$56.51
Other Professional	1,307	\$69.81	\$7.60
Pharmacy	24,464	\$39.57	\$80.67
Emergency and Non-Emergency Transportation	1,108	\$212.31	\$19.61
Dental	269	\$36.77	\$0.82
Laboratory, X-Ray, Med Image	6,803	\$39.29	\$22.27
Physical Therapy	3	\$11.39	\$0.00
DME and Oxygen	688	\$74.35	\$4.26
NF and Home Health Care	156	\$128.21	\$1.67
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$355.14
	Administrative Component		\$24.86

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **SSIW**

Selected GSA: **GSA 14**

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	710	\$305.46	\$18.06
Outpatient Facility	1,390	\$190.68	\$22.09
Emergency Room	699	\$159.79	\$9.31
Primary Care	1,844	\$56.95	\$8.75
Referral Physician	12,350	\$22.10	\$22.75
Other Professional	1,202	\$25.80	\$2.58
Pharmacy	2,848	\$14.57	\$3.46
Emergency and Non-Emergency Transportation	5,116	\$70.99	\$30.26
Dental	230	\$48.05	\$0.92
Laboratory, X-Ray, Med Image	3,300	\$16.38	\$4.50
Physical Therapy	7	\$2.65	\$0.00
DME and Oxygen	734	\$29.31	\$1.79
NF and Home Health Care	717	\$107.22	\$6.41
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$130.89
	Administrative Component		\$9.16

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **SSIW/O** Selected GSA: **GSA 14**

Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	1,175	\$1,522.34	\$149.02
Outpatient Facility	2,362	\$518.28	\$102.04
Emergency Room	1,246	\$587.14	\$60.98
Primary Care	2,201	\$153.81	\$28.22
Referral Physician	13,785	\$86.61	\$99.50
Other Professional	1,742	\$78.68	\$11.42
Pharmacy	44,181	\$63.24	\$232.83
Emergency and Non-Emergency Transportation	4,926	\$170.17	\$69.86
Dental	826	\$47.19	\$3.25
Laboratory, X-Ray, Med Image	9,393	\$45.57	\$35.67
Physical Therapy	7	\$11.26	\$0.01
DME and Oxygen	2,586	\$85.42	\$18.41
NF and Home Health Care	1,333	\$131.42	\$14.60
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$825.79
	Administrative Component		\$57.81

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Utilization and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **AHCCCS Care** Selected GSA: **GSA 14**

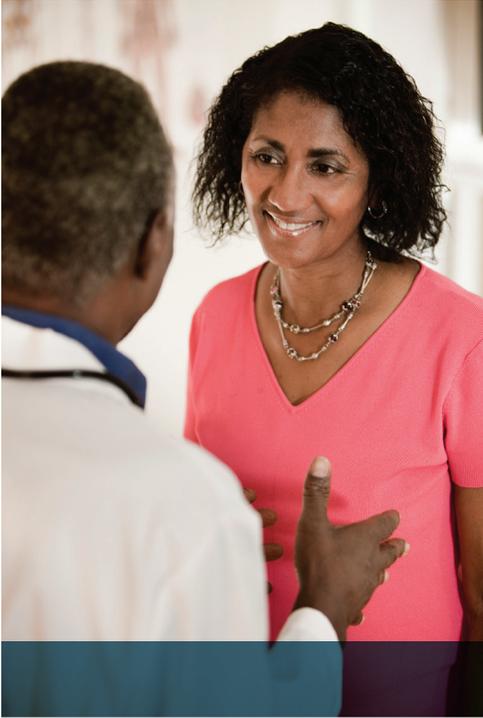
Service Categories:	Annualized		PMPM
	Units per 1000	Cost per Unit	
Hospital Inpatient	479	\$1,755.06	\$69.99
Outpatient Facility	1,448	\$480.07	\$57.94
Emergency Room	823	\$522.37	\$35.82
Primary Care	802	\$150.27	\$10.04
Referral Physician	7,932	\$84.93	\$56.14
Other Professional	1,186	\$75.80	\$7.49
Pharmacy	18,231	\$46.82	\$71.13
Emergency and Non-Emergency Transportation	1,483	\$204.19	\$25.24
Dental	642	\$60.88	\$3.26
Laboratory, X-Ray, Med Image	6,283	\$36.78	\$19.26
Physical Therapy	6	\$11.71	\$0.01
DME and Oxygen	584	\$82.18	\$4.00
NF and Home Health Care	346	\$114.75	\$3.31
Miscellaneous	-	\$0.00	\$0.00
	Gross Medical Component		\$363.62
	Administrative Component		\$25.45

Acute Care RFP Bid Template - Care1st Health Plan Arizona, Inc.

Enter Units per Delivery and Cost per Unit by service matrix category and PMPM admin expenses in the green cells

Selected Risk Group: **Delivery Supp** Selected GSA: **GSA 14**

Service Categories:	Units per		Cost per	
	Delivery	Delivery	Unit	Delivery
Hospital Inpatient	2		\$1,312.59	\$2,820.61
Primary Care	2		\$771.76	\$1,864.62
Emergency and Non-Emergency Transportation	0		\$1,134.96	\$126.34
Laboratory, X-Ray, Med Image	0		\$75.67	\$34.02
Miscellaneous	2		\$79.98	\$173.26
			Gross Medical Component	\$5,018.84
			Administrative Component	\$351.32



Compassionately Caring1st for our Community...



Challenging ourselves every day to exceed the expectations of our members, providers and regulators.

SECTION D
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Overview of organization and relevant experience

Care1st Health Plan Arizona, Inc. (Care1st) was a new participant in the AHCCCS Acute Care Program in 2003 – starting with 11,500 members. We now serve approximately 50,000 Acute members, 1,600 Dual Eligible Special Needs Plan members through a contract with CMS, and 800 ALTCS members through a subcontract with the Division of Developmental Disabilities (DDD). Over our 10 years in Arizona, Care1st has successfully expanded our AHCCCS-related business in order to better serve Arizona residents.

In addition, we have recently been selected by Compass Cooperative Health Network (CCHN) to provide support functions for their new health plan. CCHN is a new non-profit health insurance company based on the principles of a business cooperative (CoOp). CCHN will offer products on and off the health care Exchange for both individual and small employer groups. CCHN is committed to the lower income and historically uninsured populations – which is a great fit for Care1st. CCHN and Care1st will offer members a well-coordinated alternative when switching between an exchange insurance product and AHCCCS (and vice-versa). We are excited to partner with CCHN.

We are a wholly-owned subsidiary of Care1st Health Plan, a California Corporation. Care1st CA was created in 1994 by a group of physicians and health professionals from medical groups and hospitals with long histories of serving the under-served market. Our founding physicians still practice medicine today and are actively involved in the daily operations of Care1st. We believe “patients come first” and that healthcare is best administered from the physician’s perspective. Care1st CA has served Medi-Cal members in southern California since its inception and now serves over 350,000 Medi-Cal and Medicare members in the Los Angeles, San Bernardino and San Diego areas.

Our Senior Management team (CAO/CMO/CFO/COO) has a combined 53 years of AHCCCS program experience and the entire leadership team has over 135 years. Not only do we have this valuable historical perspective and program experience, we understand that this environment is ever-changing and we are poised to effectively respond to these changes.

When this new contract begins in October 2013, Care1st will have 10 years under our belt as an AHCCCS contractor. As you will see throughout our RFP response, we have used the past 10 years to build a solid foundation on which to grow—both within Maricopa County and through service area expansion. We are ready! We believe we have clearly demonstrated this with our performance over this current contract cycle and with this RFP response.

High-level description of proposed approach to meeting contract requirements

As an existing AHCCCS contractor, we have proven our abilities to meet and exceed contract requirements through our Operational & Financial Review (OFR) results. In the two OFRs conducted during our current contract cycle, Care1st ranked #1 in the number of standards with full compliance. In one of the two, Care1st was the only plan without a single non-compliant finding. Consistent high performance is our goal and will remain so in the future.

Outside of OFR performance, Care1st excels in encounter data submission. AHCCCS Administration commonly refers to encounter data as “the lifeblood of the program” and Care1st understands its importance to the program and to Care1st’s success. Our commitment is evidenced by our results in the most recent CYE10 Acute “A” and “B” Encounter Data Validation study. Below is an excerpt from the final results letter dated February 22, 2012:

Care 1st Health Plan, lower limit error rate of 0.03% for Acute “A” and lower limit error rate of 0.0% for Acute “B” are below the allowable error rate of 5%. Applying the formula shown in the CYE10 contract this results in a sanction of \$0 for Acute “A” and sanction of \$0 for Acute “B”. The overall weighted omission rates for all Program Contractors are 1.8% and 1.2% for Acute “A” and “B” respectively.

Care1st has outperformed all Acute Care plans since 2007 with our childhood immunization rates and we perform well above average on the AHCCCS Performance Measures when compared to the statewide average and other Acute Care plans. Care1st was one of three plans not issued sanctions in August 2012 related to the CYE10 performance measure results. Our performance resulted in AHCCCS adjusting the auto-assignment algorithm to assign more members to Care1st.

These are just a few of the many examples of Care1st’s positive track record in meeting AHCCCS contract requirements, and are key components of our strong foundation.

Discussion on how we will bring added value to the program

Care 1st adds value to the program through the high level of service provided to our members and their communities, our providers, and our regulators. Our theme statement, developed for this RFP, sums up our commitment:

Compassionately Caring 1st for our Community...Challenging ourselves every day to exceed the expectations of our members, providers and regulators.

You will see evidence of this commitment throughout our RFP response.

Members / Communities: our philosophy is to care for ‘the whole’ person. We understand that our members are faced with many life issues that affect the need for healthcare services, or the way they either utilize or fail to utilize their healthcare services. One way we attempt to address these issues is through our sponsorship of community resource centers in Avondale and Gila Bend. These centers are multifaceted hubs for human services made possible by innovative public and private partnerships between Care 1st and the cities. Non-profit health and human service agencies are provided free space at the centers in exchange for providing their much needed services in the Southwest Valley. Services provided include literacy, GED, and ESL classes, behavioral counseling, Women, Infant and Children nutritional assistance, Teen Outreach and Pregnancy support and Teen parenting classes, and many more. Feedback from Avondale Mayor Marie Lopez Rogers and Gila Bend Town Manager Fredrick Buss are included on the next page.

We also have a innovative relationship with the Area Agency on Aging (AAA). AAA social workers extend our case/disease management (CM/DM) programs into the member’s home. When telephonic CM/DM is not enough, we send a AAA social worker to members, who performs an in person assessment and provides critical information which is used to complete the member specific care plan. In addition to gathering this information, AAA identifies any additional services needed, which may be provided by AAA, including home-delivered meals, attendant services/support, homecare and adaptive equipment for bathrooms. This support allows members and their case/disease managers to focus on member medical issues; decrease high-cost utilization of hospital services including ED, admissions, and readmissions; improve member quality of life, and lower costs.

Providers: We understand that most of our providers operate a small business and rely on quick, accurate claim processing with few administrative barriers. Large providers value this as well. As evidenced by our claims dashboards submitted monthly under our existing AHCCCS contract, Care 1st consistently processes 100% of our claims within 30 days with 98% accuracy. On average, we process our claims in 14 days. Over the past 5 years (2008-2012), we have a provider claim dispute ratio of 4.13 disputes per 1,000 claims processed. Credentialing is recognized as a heavy administrative burden on provider offices, and Care 1st led the effort to establish the AzAHP Credentialing Alliance in order to reduce the burden of credentialing on provider offices. This commitment to operational improvement results in efficiencies and costs savings for all parties.

Our high-touch customer service approach extends through all levels of our organization. If a provider has an issue with service received from anyone on our team, we invite them to speak directly to Care 1st Senior Management—**this sets us a part from our competitors!** As part of our expansion efforts, AHCCCS and Medicare contracting efforts are underway in several other counties. We have committed in writing to each and every provider that upon contracting with Care 1st, they will receive a letter listing the names and direct phone numbers of each Senior Manager: Chief Medical Officer Alvena Baharieva, MD; Chief Administrative Officer Scott Cummings; Chief Operating Officer Susan Cordier; and Chief Financial Officer Deena Sigel. The results of this level of commitment in our customer service efforts are reflected in extremely low provider turnover. Since we began reporting provider terminations to AHCCCS in 2010, only 1 contracted provider left our network after stating dissatisfaction with Care 1st.

Regulators: Care 1st is recognized as a leader in many of the areas that AHCCCS provides comparison data across plans. Namely, results of AHCCCS Operational and Financial Reviews (OFR), submission of accurate encounter data, childhood immunization rates, and Quality Performance Measures. We consider it our job to pay strict attention to these guiding principals:

- » Member focused
- » Knowledgeable and effective
- » Care Management expertise
- » Accountable
- » Flexible
- » Innovative
- » Share the vision on improved health outcomes while bending the cost curve

Care 1st focuses every day on the seven key expectations that AHCCCS has of its contracted plans.

Describe how we will meet the requirements specified in Section I, Exhibit D, Medicare requirements, Section 2

As an existing AHCCCS contractor under Care1st Health Plan Arizona, Inc. and CMS contractor under ONECare by Care1st Health Plan, Inc., the required corporate structure is already in place. We will submit both a Medicare-Medicaid Plan (MMP) application and a D-SNP application to CMS by February 21, 2013 to cover the counties bid under this AHCCCS RFP.

We are local and we control all operations that are currently and will be performed by Care1st and ONECare right here in Phoenix. The necessary functional areas of Network Management / Provider Relations, Member Services, Quality Management, Medical Management, Corporate Compliance, and Grievance system have been integrated. 66% of our Care1st members that are eligible for Medicare, are enrolled in ONECare. We look forward to further alignment and integration opportunities with the implementation of the MMP / Dual Demonstration.



The innovative public-private partnership of Care1st and the Town of Gila Bend has been a true blessing to our region, one that has surpassed even our most optimistic expectations. Without this innovative partnership and the operational synergies it creates, probably 70% of our social services would not exist today.

The Care1st Gila Bend Resource Center is a social sustainability model that improves operational efficiencies and outcomes not just with AHCCCS, but by attacking the cycle of poverty itself. This ultimately reduces societal health care costs – locally, regionally, and statewide.

With over 24 social services programs being provided out of the Care1st Gila Bend Resource Center, it is a model of social sustainability and governmental efficiency. Care1st's investment and commitment to our region is unsurpassed and we are humbled and blessed to have Care1st in our community.

Fredrick Buss, Town Manager
Town of Gila Bend

December 2, 2012



The sponsorship of Care1st Health Plan Arizona which led to the establishment of the Care1st Avondale Resource & Housing Center has enabled the City of Avondale to expand health and human services offerings to the entire southwest region of Maricopa County by making it easy for existing organization to expand services to the area," said Avondale Mayor Marie Lopez Rogers, adding that non-profit organizations, both small and large, have benefited through the availability of free space, reception services, copying, phones, Wi-Fi and a large community room for programming.

Having established this regional resource center also enabled the City of Avondale to leverage First Things First funding for early childhood funding to further support families with young children. The Care1st Avondale Resource and Housing Center has become an indispensable human services hub to the Southwest Valley. It is a "win-win" for our residents, non-profit organization and the City of Avondale.

Marie Lopez Rogers, Mayor
City of Avondale

November 30, 2012

Care 1st Health Plan Arizona, Inc. does not have any moral or religious objections to providing or reimbursing for services covered under this contract.



Compassionately Caring 1st for our Community...



Challenging ourselves every day to exceed the expectations of our members, providers and regulators.

**SECTION E
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Access to Care / Network



Prepared for growth with:

- strong network and non-traditional provider partnerships to ensure access to care
 - high performing, flexible management/operational structure
 - robust, scalable IT systems
-

1. AHCCCS anticipates that its membership will grow as a result of implementation...

Care1st has been preparing for growth since 2008 when we successfully retained our existing contract with AHCCCS in Maricopa County. Every day for nearly five years, we've made it a priority to achieve excellence in operations, compliance, quality, and utilization management. Our goal is simple: Excel in all areas, outperform our competitors. We are happy to say we've performed very well towards our goal. You'll find evidence of our success throughout our RFP response. What is important to this response is recognizing that, in order to successfully handle growth, building a solid foundation is critical.

Our response discusses:

- How we will ensure access to care
- How our operational and administrative structure will support membership growth expected from ACA implementation and service area expansion
- How we will continue to exceed expectations for our members, providers and regulators

Our current provider network has the capacity to serve 100,000 members and exceed the AHCCCS accessibility and availability standards.

Network Design, Management & Strategy

Care1st meets all requirements of our contract with AHCCCS for Maricopa County including credentialing, contracting and provider relations staffing requirements to provide medically necessary care to all eligible members. We provide excellent care while recognizing the distinct medical and cultural characteristics that define each community.

Our provider network meets the needs of all of our members today (general and special needs), and we have proactively identified opportunities to enhance and improve our network so we may meet the needs of tomorrow. We'll meet future needs by leveraging meaningful provider and community partnerships, and continuing our diligence in network design.

Current Service Area Capacity: Network accessibility is continually evaluated using the methods listed below. Continually monitoring network capacity during and following membership growth is critical to ensuring access to care.

1. Quarterly open/closed PCP panel analysis and documented outreach efforts to PCPs with closed panels.
2. Ratio and radius analysis and overall market assessment (GeoAccess availability analysis).
3. Feedback gathered from functional areas including quality management, prior authorization, case management and concurrent review, and from providers and through appointment availability analysis.

Our current Maricopa network consists of more than 4,000 physicians, 715 midlevels, and a strong hospital and ancillary network. An October 2012 mileage analysis (Table 1) confirms the network **meets the AHCCCS accessibility and availability standards in all specialties, and exceeds standards in most.** Our PCP network includes physician extenders, and allows panel assignments at numbers that ensure members are seen according to AHCCCS appointment availability and wait-time standards. Our goal is to ensure that more than 80% of PCP panels remain open at any time. PCP recruitment remains an ongoing priority. Currently, more than 93% of Care1st contracted PCPs maintain open panels, and we review panel status quarterly.

	FP/GP	IM	Ped	OB/GYN	Dentist	Pharmacy	Hosp.	Specialist
Average miles to Contracted Provider	2.98	4.15	3.57	4.97	3.70	1.67	7.77	4.27 – 7.94

Despite Arizona's budget challenges and their impact on AHCCCS, our network growth remains steady. Our network grew by nearly 67% between 2008 and 2012, with average annual growth of more than 16%. Table 2 outlines our 2012 ratio analysis. We analyze ratios annually to verify adequate geographic distribution of our network and contracted provider availability. Our current PCP-to-member ratio is 1 PCP per 61 members versus a standard of 1 PCP per 500.

PCP Standard	1:500	PCP Actual	1:61
OB/GYN Standard	1:2,000	OB/GYN Actual	1:55
Dentist Standard	1:675	Dentist Actual	1:60

While excess capacity exists today, the healthcare system will be stretched with the influx of members through Medicaid expansion and implementation of the Exchange, projected at more than 1.3 million in Arizona. Continual network evaluation and monitoring will be critical. Also needed: Further development of provider partnerships that include alternative strategies to financially incentivize and motivate providers through pay for performance and reimbursement for services beyond the patient visit. Our strategies include reimbursing care coordination provided by non physicians and looking beyond the traditional delivery system, as with our relationships with Cigna Medical Group, Banner Health, the Area Agency on Aging and Care Level Management.

Care 1st is *one of two* AHCCCS plans **Cigna Medical Group** chose to work with on a patient-centered medical home (PCMH) model. We believe this model will result in additional capacity and more effective, efficient and timely care delivery. The model incentivizes and motivates through pay for performance to achieve improved outcomes and appropriate utilization. Our arrangement includes additional fee for service reimbursement, a per member per month care management fee, and shared savings by achieving AHCCCS performance and utilization measures. We have also partnered with Maricopa Integrated Health System and Banner Good Samaritan Family Medicine Center on PCMH initiatives.

Another alternative strategy that leverages current capacity is our **pilot with Cigna Care Today**. Adult members in a specific geographic area with no chronic health or behavioral conditions (and who no longer have a well exam benefit) are assigned to the Cigna Care Today nurse practitioner. Members can be seen without an appointment Monday through Friday from 9 a.m. to 7 p.m. and on weekends and most holidays from 10:30 a.m. to 5:30 p.m., with a short wait time—usually less than 15 minutes.

As described in AHCCCS’ *Access to Care May 2012* Report, “FQHCs are a critically important part of our health care system and represent a valuable source of primary care for AHCCCS members.” FQHCs are an integral part of our provider network. *Access to Care May 2012* discusses excess capacity in the current FQHC system and the Arizona Association of Community Health Centers reports plans exist for additional FQHC expansion: “It is expected that the existing and proposed centers will serve a large portion of AHCCCS membership and actually increase access to care for Medicaid.” We contract and are focused on all FQHCs and FQHC look-alikes in our service area. Our partnerships have led to unique opportunities such as the relocation of Adelante Healthcare’s WIC program to our Avondale Resource Center, which allows easier access to these and other community services in the west valley. We’ll continue to expand our FQHC and FQHC look-alike relationships to leverage their capacity and expertise in managing Medicaid members.

Recruiting Tools, Monitoring, Outreach and Partnership: Although AHCCCS program enrollment has been declining, Care 1st continues recruiting as part of our strategy for growth. We use GeoAccess reporting (Table 1) to confirm the adequacy of the geographic distribution of PCP, OB/GYN, high volume specialists, dental, hospital and pharmacy providers. Other tools include our Network Needs List, which we continually update from GeoAccess reporting, feedback from internal resources (quality management/MCH, prior authorization, case management, concurrent review, etc.) and external resources (provider feedback, appointment availability analysis, etc.). These tools help prioritize efforts, and assure recruitment based on geographic need as well as our population’s cultural, demographic and medical needs.

Expansion Efforts: We intend to expand our Medicaid and Medicare service area. In 2012, we began building our provider network in additional counties. Our efforts focus on new members achieved through service area expansion as well as ACA implementation. Senior Leadership (Chief Administrative Officer Scott Cummings, Chief Medical Officer Albena Baharieva, MD, and Chief Operating Officer Susan Cordier) have met face-to-face with FQHC and hospital leaders to solicit feedback on strategies to ensure access to care. These conversations have positively impacted our expansion strategy and understanding of new markets.

Our expanded network will provide the full complement of covered services and meet AHCCCS network availability standards. We contract with several large providers that serve AHCCCS and Medicare members in counties outside our current service area such as Sonora Quest, Preferred Homecare, Option 1 Nutritional Solutions, Hanger Orthotics & Prosthetics, Southwest Kidney-Davita, PTPN (Physical, Occupational and Speech Therapy), Nationwide Vision, MTBA, and NextCare. We are contracting at levels to ensure a growth capacity of 190,000 members. We’ve completed contracts and Letters of Intent (LOI) with a number of providers (see Table 3).

Table 3 - Network Expansion

<i>As of 1/1/13:</i>	Contract	LOI
PCP and OB/GYN	173	117
Specialist and Dentist	413	753

Contracting & Education Plan for Expansion Areas: If awarded additional service areas, we will execute a fully developed project plan to ensure network adequacy and readiness. Highlights of the plan, scheduled from March to September 2013, include:

1. Sending a mailing to newly contracted providers, obtaining additional information needed to complete the credentialing and provider load process, to be completed within 60 days of contract award
2. Completing all outstanding contracts and Letters of Intent between March 22 through June 30, 2013
3. Completing credentialing and mailing welcome packets between March 22 and August 30, 2013
4. Evaluating staffing needs and hiring and training additional staff to support additional counties by July 1, 2013
5. Performing in-services and distributing education materials to new providers including claims submission, prior

authorization, grievance and appeals, and quality performance measure expectations between May 1 and September 30, 2013

6. Discussing, creating, testing and implementing new fee schedule arrangements by September 1, 2013
7. Loading and auditing providers and fee schedules by September 1, 2013 (We've built a robust database to track providers, organizations, facilities and other information needed to create additional records in our core system through an automated process that requires minimal staff intervention.)
8. Conducting provider forums in new service areas by September 30, 2013

Partnerships and Strategies Impacting Access to Care

Over the past two years, Care1st has developed important nontraditional partnerships to expand access to care and meet the needs of the whole person.

Banner Rapid Care Clinic (BRCC): Appropriate use of resources enhances access to care. We are one of a few AHCCCS plans that collaborated with Banner Health on ways to reduce non emergent use of the emergency department (ED). Months of collaboration culminated on May 1, 2012, with the opening of the Banner Rapid Care Clinic (BRCC) on the Banner Estrella Medical Center (BEMC) campus. BRCC markets its services as an ED alternative and receives patients triaged from the BEMC ED who present with non emergent symptoms. Average wait time for members seen at BRCC is 15 minutes or less versus a 2-hour wait at BEMC ED. In addition to ED diversion, BRCC serves as a place for members to receive timely follow-up care after an inpatient stay. For discharged members who cannot arrange timely follow-up with their PCP, an appointment is made at BRCC, and BRCC communicates with their PCP after the visit. This assures the discharging physician of timely follow-up care and will reduce preventable readmissions. We're seeing the impact through reduced low acuity ED visits at BEMC: 53% of BEMC ED visits were Level 1-3 (low acuity) in Q3 2011, decreasing to 48% in Q3 2012. During this same period, Banner Good Samaritan Medical Center (BGS MC), saw a significant increase in lower acuity ED visits, from 40% to 52% of their volume. Results are encouraging, and we expect the shift to be more pronounced as we gather more data. We're discussing a second BRCC on BGS MC's campus.

Area Agency on Aging (AAA): When members participate in their care, they're more likely to use healthcare resources appropriately. Our philosophy: *In order for members to participate in their care and achieve improved health, their most basic needs must first be met.* To that end, we developed an innovative relationship with the Area Agency on Aging (AAA) that extends our case/disease management. AAA is a private nonprofit organization that advocates, plans, coordinates, develops and delivers social support services for adults, and persons of any age with HIV/AIDS. This relationship utilizes existing AAA staff members already serving our population to feed critical information back to Care1st, allowing us to address members' quality of life and link them to social and/or Home or Community Based Services (HCBS).

Care Level Management (CLM): Care1st partners with CLM to provide in-home PCP visits to frail members and members coping with disabilities, compromised daily living activities, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues. *By bringing care to the member,* we make certain they receive needed care and care coordination, resulting in greater compliance and improved health, and decreasing the use of more acute resources.

Our Operational and Administrative Structure

Our robust and efficient operational and administrative structure allows us to accommodate membership growth.

Proven Ability to Successfully Increase/Maintain Staffing Using a Thoughtful, Analytical Approach: Our membership grew by 20% in 2008 and our approach to staffing resulted in *service levels that exceeded both AHCCCS requirements and our (higher) internal requirements in all areas, with no loss in productivity.* Senior management (Chief Administrative Officer Scott Cummings, Chief Financial Officer Deena Sigel and Chief Operating Officer Susan Cordier) completed a detailed staffing analysis that included monthly staffing requirements to maintain services levels. The analysis projected membership growth and associated work. For example, we estimated claims receipts, claims disputes, medical and pharmacy prior authorization requests, call volume, quality performance measure resources, and clinical staffing. This analysis generated data necessary to project staffing increases. By late spring 2008, we posted positions and began recruitment, allowing sufficient time to hire and train new staff well in advance of the enhanced auto assignment effective October 1.

Early Preparation for Additional Staffing Needs: After the TWG enrollment freeze, we maintained current staffing levels in critical areas to prepare for growth from service area expansion and ACA implementation. We value investments in recruitment, training and education with our existing team, and wanted to be ready to provide excellent service to new members. Although maintaining staffing levels helps us prepare for new members, additional staff is required. As a result, we analyzed potential membership growth under 3 scenarios:

1. Service area expansion (SAE)
2. ACA Medicaid expansion at 180,000 level (ACA 180k)
3. ACA Medicaid expansion at 430,000 level (ACA 430k)

Growth projections under these scenarios include current membership, service area expansion as detailed in the RFP and ACA implementation. ACA growth considers members who will “choose” Care 1st based on current percent of elected choice plus a factor combining auto assignment, family continuity and newborns. We used these projections to estimate additional staffing in key departments such as claims, member services, medical and quality management, pharmacy, and claim disputes and appeals. Table 4 provides a sample claims staffing projection.

We recently secured rights for additional office space needed for employee growth, and are positioned to complete build-out within the readiness period.

Flexible Core System (MHC):

We process claims accurately and timely according to AHCCCS guidelines and exceeding AHCCCS requirements. MHC collects, analyzes, integrates and reports data, and provides information on areas including, but not limited to, service utilization and claim disputes and appeals per 42 CFR 438.242(a). MHC integrates member demographic data, provider information, service provision, claims submission and reimbursement; and produces information for financial, medical and operational management. MHC is scalable and can easily

accommodate up to 1 million members. **MHC allows flexibility for design and business expansion required for long-term growth and ongoing compliance with federal and state rules, regulations and AHCCCS program requirements.** MHC handles multiple benefit structures and reimbursement arrangements, including DRG inpatient hospital payments based on ICD-9 or ICD-10 and is ICD-10 compliant.

AWD – A Powerful Customer Service and Claim Work Flow Tool: In November 2012, we implemented a fully integrated customer service and workflow distribution application, Automated Workflow Distributor (AWD). AWD is integrated with our core business application system, MHC. AWD automates workflow distribution and includes robust tracking. Our customer service center call teams use the AWD customer service module to access everything they need to know about a member or provider and **effectively complete calls using a single screen.** As a result, we answer calls faster and more effectively. AWD provides management with superior routing oversight and reporting tools for Customer Service and Claims Processing. Beyond improving efficiency and effectiveness, AWD is key to our strategy for growth and readiness preparedness related to service area expansion and ACA implementation. We expect to see a 17% improvement in claim productivity, and to complete 4 more calls per hour per Customer Service Representative- a 35% improvement within the first 6 months. AWD is scalable and enables us to add increased call and claim volume faster and more efficiently than previous processes. It allows for real-time claims routing and queue changes. Assignments can be made on the fly with no system down time and no negative impact to claims in process.

Auto Adjudication, EDI and EFT: We have worked hard to maximize electronic transactions and minimize manual claims adjudication. As a result we are ready to accommodate the additional claims volume that comes with membership growth. Table 5 illustrates the results of our efforts.

Table 4 - CYE14 Claim Staffing Projection				
Actual:	8/12	9/12	10/12	Total
Claim receipts	65,262	54,351	61,588	181,201
Membership	47,162	47,315	46,787	141,264
Claims received pmpm				1.28
			ACA	ACA
Projection:	SAE	180k	430k	
Projected membership		126,666	25,744	61,501
Projected claims volume		162,476	33,022	78,888
HCFA claims (80%)		129,981	26,418	63,110
Auto adjudication @ 65%		84,488	17,172	41,022
Analyst adjudication @ 35%		45,493	9,246	22,089
UB claims (20%)		32,495	6,604	15,778
HCFA productivity per analyst per month		4,368	4,368	4,368
Additional HCFA Analysts		10	2	5
UB productivity per analyst per month		2,016	2,016	2,016
Additional UB Analysts		16	3	8

Table 5	2007	2008	2009	2010	2011	2012
EDI	35%	64%	75%	78%	82%	82%
EFT	6%	26%	42%	43%	61%	65%
Auto Adjudication	18%	35%	49%	58%	61%	62%

Streamlined Prior Authorization: A Care1st cross functional workgroup analyzes code sets and utilization to define prior authorization (PA) requirements and continually improve the authorization process. The Prior Authorization Cross Department Workgroup manages all changes to PA Guidelines. Arizona-based experts from Medical Management, Administration, Claims, Provider Network Operations, and Information Systems actively participate and ensure effective guidelines. The team continually reviews opportunities to reduce requirements. Other improvements currently under way include the Milliman web-based AutoAuth Module, with an automated, evidence- and rules-based system that further streamlines prior authorization. Reducing administrative burdens positions Care1st as a top choice in the provider community and positions us to accommodate growth.

Credentialing Alliance is Reducing Administrative Burden and Speeding Up Credentialing/Recredentialing: Care1st led the effort on behalf of the Arizona Association of Health Plans (AzAHP) to establish and implement the AzAHP Credentialing Alliance. The Alliance decreases credentialing burdens by minimizing duplication and standardizing forms and requirements across participating health plans. It's backed by the nation's largest Credentials Verification Organization, which supports increased credentialing volume during our initial expansion and ongoing maintenance of a larger, more geographically dispersed, provider network.

Quality and Performance Measures will remain a priority: A hallmark of our operations has been a “high-touch” approach to engaging members in care that promotes health and wellness, which resulted in Care1st driving several AHCCCS benchmarks. Care1st employs a bilingual, qualified and knowledgeable staff that provides personal outreach to our members, with a focus on women and children. We will continue to use this successful approach as our membership expands.

Care1st will continue to implement strategies across all member populations that improve engagement and access to services. Our strategies include using technology—text messaging, social media and web based applications—while investing in staff, community education and outreach.

AHCCCS has made it clear it wants to see more members enrolled with those plans that have the highest quality ratings, manage costs more effectively and provide the highest level of service to members and providers. Care1st has established a track record of doing just that and will continue to do so at any level of membership. Through the efforts outlined above, we are confident we will ensure access to care to support the influx of members anticipated through service area expansion and ACA implementation. Our structure allows us to successfully implement all program operations while accommodating membership growth. **We care compassionately for our community and challenge ourselves every day to exceed the expectations of our members, providers and regulators.**



Accessible leadership, strong community and provider partnerships focused on network improvement and access to care

Care1st uses monitoring and analysis tools to identify deficiencies and needs, and develops strategies to meet those needs and ensure a sustainable network. Care1st sustains and supports an adequate network through accessible leadership, customer service, and a focus on network retention. We use managed care strategies to drive volume to key providers with whom we have developed arrangements centered on accountability for quality and access to service, and reimbursement that incentivizes outcomes.

The Economic and Social Research Institute includes low-income individuals, immigrants, racial and ethnic minorities, and the elderly in their definition of the underserved population ¹. Based on this description, all AHCCCS members are at risk for being underserved. Care1st has identified additional individuals with special health care needs that put them at *even greater risk* than the general AHCCCS population, and has developed strategies focused on access to care for these vulnerable populations.

Our response discusses:

- Methods used to thoroughly evaluate, measure (identify deficiencies) and manage the network
- Network quality indicators
- The role of customer service, accessible leadership and staff in network retention
- Provider partnerships that enhance primary care services
- Strategies for network improvement that focus on members with special healthcare needs:
 - Members with chronic medical conditions
 - Members with serious and chronic mental health issues
 - Members with social service needs
 - Homebound members
 - Homeless members
- Strategies used to sustain and support an adequate network

Network Evaluation and Measurement (Identification of Deficiencies)

We maintain effective processes to analyze, evaluate and measure our network to ensure timely access to care, and to manage, identify and resolve identified network deficiencies. Our Network Management and Development Plan guides our work and measures outcomes. Our Maricopa County results are highlighted below.

Network Growth (Table 1): We measure network growth quarterly. Our network consists of more than 4,000 physicians. Despite challenges weathered by the AHCCCS program, our network (Table 1) grew nearly 67% between 2008 and 2012, with average growth per year of more than 16%.

Table 1 - Quantitative Analysis of Care1st Network - Number of Network Providers

	2008	2009	2010	2011	2012
PCP	509	675	782	784	805
OB/GYN	228	219	246	257	259
Dentist	367	408	436	446	489
Other Specialists	1,524	1,954	2,321	2,563	2,830
Total	2,628	3,256	3,785	4,050	4,383

Mileage and Ratio Analysis (Table 2 and 3): Our robust network exceeds current standards. We perform GeoAccess and ratio analysis annually to verify adequate geographic distribution and the availability of contracted providers. For hospitals and high volume specialists where AHCCCS mileage standards do not exist, Care1st uses national Medicaid and commercial payor standards: 1 specialist within 15 miles and 1 hospital within 20 miles of the member's primary residence. PCP and OB/GYN ratio targets are based on national data and the dental ratio reflects the AHCCCS target. Results feed into our Network Needs List, which our Provider Network Operations (PNO) team uses to correct gaps. As part of our expansion efforts, we have identified additional targets in rural service areas and will measure against these targets following a service area award.

Table 2 - GeoAccess Results – Distance from Providers

	Standard	2008	2009	2010	2011	2012
FP/GP	5	2.80	1.53	2.53	1.31	2.98
Internal Medicine	5	4.73	3.84	3.71	2.79	4.15

1. Economic and Social Research Institute, Patient-Centered Care for Underserved Populations: Definition and Best Practices, January 2006

Table 2 - GeoAccess Results – Distance from Providers continued

	<i>Standard</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>
Pediatrics	5	4.51	3.87	3.45	3.67	3.57
OB/GYN	5	3.87	4.30	4.00	3.70	4.97
Dentist	5	3.40	1.54	2.89	2.77	3.70
Pharmacy	5	1.82	1.68	1.93	1.64	1.67
Hospital	20	8.23	7.58	7.46	6.59	7.77
High Volume Specialists	15	4.43-6.48	3.88-6.65	3.57-6.35	3.26-5.78	4.27-7.94

Table 3 - Ratio Analysis Providers to Members

	<i>PCP</i>	<i>OB/GYN</i>	<i>Dental</i>
Standard	1:500	1:2,000	1:675
Actual	1:61	1:55	1:60

Appointment Availability and Wait Time Surveys (Table 4): PNO informs and educates our network on appointment accessibility and wait time standards using the provider contract, provider in-services/visits, regular network mailings, our Provider Quick Reference Guide and Provider Manual. PNO Representatives maintain goals to visit PCP and OB/GYN offices at least twice (2x) per year, and specialist and dentist offices at least once (1x) each year. The visits build relationships with and educate providers, and promote accessibility. PNO Representatives conduct surveys during every office visit to monitor and track provider appointment availability and wait time for new and established patients. More frequent visits occur when we identify trends and educational opportunities through surveys, provider inquiries and complaints, member feedback, and feedback received through our internal workgroups and committees. We document each visit and all survey results in a dedicated Visit Database that generates monitoring reports, and we report results to AHCCCS each quarter. CYE12 Provider appointment availability continued to be strong (Table 4). When a provider fails to meet appointment availability and/or wait time standards, their PNO Representative works with them on requirements, potential solutions and best practices. We reassess the provider within 90 days of a failed survey, and if we see no improvement, the PNO Representative helps the provider and office staff implement best practices to impact delays. If we don't observe improvement, within 60 days, we consider panel closure and member reassignment and/or referral limitation. Every effort is made to avoid contract termination but this is an option should accessibility not improve.

PCP Capacity and Open/Closed Panels (Table 4): PNO reviews PCP panel size and status each quarter. PNO Representatives reach out to closed-panel PCPs to discuss reopening to new members. Our goal: More than 80% of our PCP panels should be open. Our percentage of open primary care panels reflects our outreach efforts. We recognize that panel capacity differs in other service areas where we are expanding, and we'll focus on key provider partnerships to mitigate this challenge. We are responsive to quarterly notices received from AHCCCS documenting PCPs with panels exceeding 1,800 members. Our Internal PNO Representative mails a detailed letter to each of these PCPs, reminding them of appointment and wait time standards, and their Representative visits in person to assess. If the PCP is unable to meet the requirements, we initiate the steps described above.

Table 4 - Qualitative Analysis of Care1st Network

	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>
Appointment Availability % Met Standard	NA	99.97%	99.96%	99.94%	99.94%
% Open PCP panels	99.00%	97.40%	93.60%	92.90%	93.90%

Network Quality Indicators

Quality of Care (QOC) Grievances: QOC grievances signal potential problems within the network, and we monitor all QOC grievances to ensure quality of care and safety. In CYE12, only 1 substantiated grievance was categorized as access/availability/adequacy. We monitor rates quarterly and report them to AHCCCS, Senior Management, our Board of Directors and operational committees for review and feedback.

HEDIS Results: We understand that the Access and Availability domain of the Healthcare Effectiveness Data and Information Set (HEDIS) doesn't accurately measure network access on its own. However, poor rates can indicate lack of access when viewed with other adequacy measures. Care1st rates exceed AHCCCS minimum performance standards for access to care in all age groups, and the AHCCCS goal for one age group.

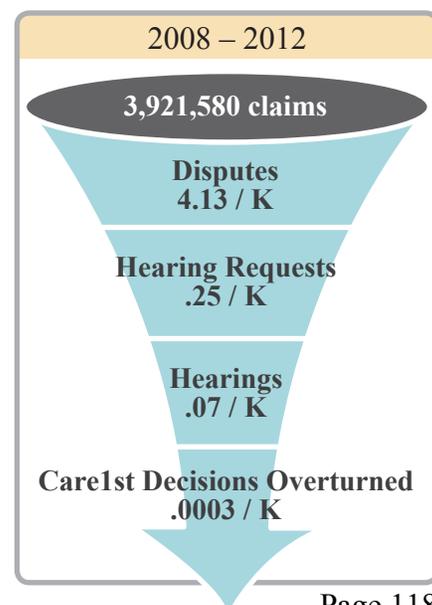
EPSDT Dental Results: Given the ratio of practicing dentists to the state’s population, the Kaiser Foundation considers Arizona underserved (AHCCCS, May 2012; available at http://www.azahcccs.gov/commercial/Downloads/rates/AccessToCare2012_Web.pdf). The AHCCCS ratio is 1 network dentist for every 675 members, which reflects better service than the general population. Our ratio of 1 dentist for every 60 members exceeds the AHCCCS ratio target. In addition to this ratio, we evaluate dental network adequacy through access to services, as measured by both HEDIS Annual Dental Visits and EPSDT Dental Participation rates. Internal monitoring for CYE12 shows our HEDIS Medicaid dental visit rate is 63.8%, exceeding our CYE11 rate and the AHCCCS minimum performance standard of 57%. The most recent national Medicaid mean for this measure is 45.7%. The Care1st EPSDT Dental Participation rate is 46.4% which exceeds the AHCCCS Minimum Performance standard.

Member, Provider and Staff Feedback: We use member, provider and staff feedback to identify deficiencies and improve the network. We value feedback received during calls/inquiries, satisfaction and accessibility surveys, and grievances. Even feedback from just one member provides important information on service quality. We train our staff to raise issues and make suggestions to management. Feedback is documented, evaluated, reported and monitored through the Contracting, PNO/Credentialing and Performance Measures Workgroups, the Clinical and Service Quality Improvement Committee, and the Grievance Committee. We report results to our Care1st Board of Directors. Feedback drives network improvements. For example, our Grievance Committee meets weekly and reviews and resolves all member grievances, paying special attention to access to care grievances. Representatives from Member Services, Medical Management, Quality Management, PNO, Compliance, and Claims Disputes and Appeals participate. The committee identifies trends in member and provider dissatisfaction and opportunities for improvement through interventions. One such intervention occurred in January 2012 when the committee identified a trend concerning member complaints about abandoned pickups by our taxi provider (MTBA), when the member was not curbside when the taxi arrived. Care1st and MTBA partnered to implement changes in the pickup process: 1) taxi driver calls prior to arrival, 2) knocks on door if unable to reach by phone, 3) if no response to either attempt, taxi waits five minutes prior to departing. During the 4 months following the changes, abandoned pickup grievances diminished by 18%. We continue to monitor transportation grievances each month during Joint Operating Committee meetings held with MTBA to address new trends. Another example: We formed our Prior Authorization Cross Department Workgroup in response to provider feedback. This workgroup further streamlines our authorization process and looks for opportunities to reduce authorization requirements. Since 2011, we have removed authorization requirements for many ASC and in-office procedures.

Role of Customer Service, and Accessible Leadership and Staff in Network Retention

Service and accessibility drive provider satisfaction. We continually enhance service, and are accessible at every level of the organization. Every day, we challenge ourselves to **exceed the expectations of our providers**. Here are a few examples of how we succeed:

- **We are locally run and operated – our entire team is in Arizona**...and we are dedicated to our AHCCCS and Medicare Special Needs Plan lines of business.
- **We pay claims accurately and timely.** On average, we process claims within 14 days, with a payment accuracy rate of more than 98%. For example, our Banner rework average during the last reported 12-month period was 15%, compared to an average of 27% for all other AHCCCS plans.
- **We minimize claim disputes** through accurate claim payment, a successful alternative dispute resolution process with hospital partners, and monthly or quarterly Joint Operating Committee (JOC) meetings with other large provider groups. Our dispute volume per 1,000 claims received decreased from 4.73 in 2008 to 3.98 in 2012, and only 5% of our claim disputes result in a hearing request, 70% of which are resolved prior to hearing.
- **Our focus is high-touch, excellent provider customer service.** We assign a PNO Representative to each provider. The Representative makes personal visits and is available by phone and e-mail. Our dedicated Internal Provider Network Operations Representative provides additional live support while Representatives are in the field.
- **We communicate effectively and regularly with our providers.** PNO Representatives meet personally with their assigned providers to provide training on processes including prior authorizations, claims submission, claim dispute submission, availability and location of clinical guidelines. Regular



communications and comprehensive provider reference materials are distributed by blast-fax, e-mail, mail and website postings.

- Our **No-Show Workgroup** is dedicated to **intervention development** to impact “no-show” rates, a significant source of provider dissatisfaction.
- **We decrease providers’ administrative burdens.** Most recently, our Chief Administrative Officer Scott Cummings, on behalf of the Arizona Association of Health Plans (AZAHP), led creation of the newly implemented Credentialing Alliance, which focuses on reducing work required to complete the credentialing and recredentialing process. ONE vendor is now used to complete primary source verification, file creation and file maintenance for ALL credentialing and re-credentialing files across ALL participating health plans (1 application and 1 data form).

Our high-touch customer service approach extends through all levels of the organization. If a provider has an issue with service received from anyone on our team, we want them to go directly to Senior Management – *this sets us apart from our competitors!* As part of our expansion efforts, AHCCCS and Medicare contracting efforts are underway in several other counties. We have committed in writing to each and every provider that upon contracting with Care1st, they will receive a letter listing the names and direct phone numbers of each Senior Manager: Chief Medical Officer Albena Baharieva, MD; Chief Administrative Officer Scott Cummings; Chief Operating Officer Susan Cordier; and Chief Financial Officer Deena Sigel. The results of our efforts are reflected in low provider turnover. Between July 2010 and September 2012, only 1 contracted provider left our network after stating dissatisfaction with Care1st.

Provider Partnerships to Enhance Primary Care Services

We use managed care strategies to drive volume to key providers with whom we have arrangements that focus on accountability for quality and access to services. We have carefully chosen partners like Cigna Medical Group, Maricopa Integrated Health System (MIHS) and Banner Good Samaritan Family Medicine Center to implement patient centered medical homes. Their locations allow almost 80% of our members access to PCPs within AHCCCS standards. Today, 13% of our members are assigned to their PCPs. Following recent changes to assignment criteria, we estimate the percentage will grow to 25% to 30% by September 30, 2013. Our strategy will drive complex members to these practices. We use an accountability model that financially incentivizes and motivates these providers through pay for performance and shared savings for providing care, utilizing evidence based decision making, and achieving improved outcomes. We rely on evidence-based decision-making to improve outcomes.

Strategies for Network Improvement that Focus on Members with Special Health Care Needs

Members in Underserved Areas: Care1st Community Resource Centers (CRCs) bring innovation and address basic needs such as food, housing and safety so healthcare does not become a lower priority. Our goal is to strengthen the human service delivery system in high-density underserved areas. Our efforts resulted in the creation of 2 comprehensive CRCs—one in the City of Avondale and the other in the Town of Gila Bend. Both serve all community residents. Community Based Organizations (CBOs) that traditionally serve central Maricopa County or urban cores can’t afford to serve such remote locations. Our CRC model provides an incubator at no cost to CBOs, allowing them to expand their service areas and bring needed services to underserved regions. Our CRCs cohesively deliver much-needed information and assistance to a population that greatly needs reliable information, trustworthy referrals, and human service navigation assistance. Our CRCs provide assistance with nutrition, parenting/child care, housing, education, the AHCCCS application process, domestic and sexual violence, and behavioral health counseling. More than 3,500 residents receive services each month at our Avondale CRC, more than 850 receive services each month at Gila Bend, and the numbers continue to rise. We plan to duplicate this award-winning model (WESTMARC’s 2010 Best of the West Public Private Partnership) in Buckeye in 2013 and in the most rural areas of southern Arizona and Yavapai County if chosen to serve them.

As described in AHCCCS’ Access to Care May 2012 Report, “FQHC clinics are located in medically underserved areas – both rural and urban. FQHCs are a critically important part of our healthcare system and represent a valuable source of primary care for AHCCCS members.” We work closely with FQHCs and FQHC look-alikes in our contracted service area, which led to unique solutions such as the relocation of Adelante Healthcare’s WIC program into our Avondale CRC, allowing easier access to WIC and other west valley community services, as well as delivering significant cost savings to Adelante.

Members with Chronic Medical Conditions: Our patient centered medical home strategy with Cigna Medical Group, Maricopa Integrated Health System (MIHS) and Banner Good Samaritan Family Medicine Center follows the Patient Centered Primary Care Collaborative² model. High-risk members with chronic conditions receive high-touch care

2. Patient Centered Primary Care Collaborative <http://www.pcpec.net/evaluation-evidence> Evidence of the Effectiveness of the PCMH on Quality of Care and Cost Published on Patient Centered Primary Care Collaborative

coordination, intensive management of their chronic condition(s), and active monitoring to increase use of preventative services. Our model financially incentivizes and motivates providers through shared savings and pay for performance for achieving quality measures, providing timely care, and improving outcomes.

Members with Serious and Chronic Behavioral Health Conditions: The medical community often underserves this vulnerable population. Effective July 2012, Care1st partnered with MIHS and Quality Care Network of Arizona (QCN) to embed nurse practitioner PCPs within 6 RBHA SMI clinics and general mental health/substance abuse (GMHSA) agencies that serve this at-risk group. Our behavioral health team identifies members who agree to co-located behavioral health and PCP services and assigns them to a location. The approach improves access to care and fosters improved integration of medical and behavioral healthcare. Care1st provides behavioral health team contact information to MIHS and QCN, along with utilization data including pharmacy, ED, lab, transportation scheduling, and documented case management interventions. These integrated care management techniques increase appropriate use of services, improve compliance with treatment recommendations and enhance overall health. We'll track results by monitoring behavioral health outcomes, medical utilization and medication adherence.

Members with Social Service Needs: If basic social needs aren't met, members are more likely to seek care in acute settings or not at all. Area Agency on Aging (AAA) is a private non-profit organization that advocates, plans, coordinates, develops and delivers social support services for adults, and persons of any age with HIV/AIDS. Care1st partners with AAA to provide in-home social case management assessments and support services. Member social services needs are identified through health risk assessment, concurrent review rounds, hospital discharge planners, case/disease management, interdisciplinary care team referrals, and provider and member referrals. Once a member is identified, AAA sends a social worker to the home. Using the Arizona Standardized Client Assessment Plan, the social worker assesses financial need, activities of daily living, orientation, behaviors, environmental problems/barriers, medications, medical conditions, nursing services and treatment, hospitalization/ED use, fall risk, assistive devices and nutritional status. This assessment feeds critical information back to Care1st allowing us to address needs including transportation, home care, counseling, legal assistance, home making/chore assistance, adult day health care, home delivered meals, benefits assistance, and family caregiver support.

Homebound Members: Care Level Management (CLM) provides in-home PCP visits to members who have complex needs and can benefit from being seen in their home versus a PCP office. CLM focuses on improving quality of life for our frail elderly, chronically ill and members with disabilities, while reducing cost by decreasing hospitalizations and emergency room visits. Bringing medical care into the home ensures timely access to care, increases adherence to individual treatment plans, and improves outcomes.

Homeless Members: We understand the importance of contracting with providers that have expertise in caring for and providing services to the homeless. To care for this population, we contract with Healthcare for the Homeless, a walk-in clinic on the campus of a homeless shelter, John C. Lincoln's Desert Mission Community Health Center and Children's Dental Clinic, FQHCs, and FQHC look-alikes. These local partners are unique in their understanding of these members and their link to our underserved communities.

Strategies Used to Sustain and Support an Adequate Network

PNO Inquiry/Complaint Tracking: We pay special attention to provider inquiries, complaints and turnover related to network adequacy and access to care. PNO uses a dedicated database to track, trend, analyze and evaluate strategy effectiveness, and to improve operations related to network adequacy. A detailed provider inquiry process acknowledges all complaints and grievances, and feedback within 3 days, and resolves within 30 days. Functional teams coordinate and resolve issues. We communicate resolution to the member, provider or network, and internal staff. Between July 2010 and September 2012, only 1 contracted provider left our network due to dissatisfaction with Care1st.

JOCs: To monitor our service and ensure provider satisfaction, we hold monthly or quarterly JOC's with contracted hospital partners and key ancillary providers such as home health, Enteral, DME/Infusion, and transportation. Representatives from PNO, Claims, Medical Management, Prior Authorization, Finance, and Administration attend each JOC. In each meeting, we proactively engage our providers, listen to concerns, monitor timeliness and accuracy of claims payment, identify and resolve billing issues, system setup, and process gaps, and discuss other opportunities for improvement. The process promotes network stability and timely access to services by increasing provider satisfaction.

Care1st effectively uses quantitative, qualitative and GeoAccess tools to evaluate, measure, monitor and improve our network, ensuring timely access to care. We closely monitor quality indicators, and use them to address network deficiencies and make improvements. Our high-touch customer service results in excellent provider retention. Our unique strategies address the special needs of our members and enhance access to primary care services. **Our goal is to compassionately Care1st for our community...and to challenge ourselves every day to exceed the expectations of our members, providers and regulators.** We passionately invest time, energy and resources to meet this goal.

Program

Data and tools that:

increase care coordination

decrease costs

improve outcomes

Care1st uses data and a variety of support tools to maximize care coordination, improve outcomes and create cost efficiencies. Data and support tools assist us in guiding our members and contracted providers toward high-quality evidence-based care. Knowledge gained by analyzing data and monitoring industry trends helps us implement programs, partnerships and value-oriented payment models that reward desired care outcomes and cost efficiencies.

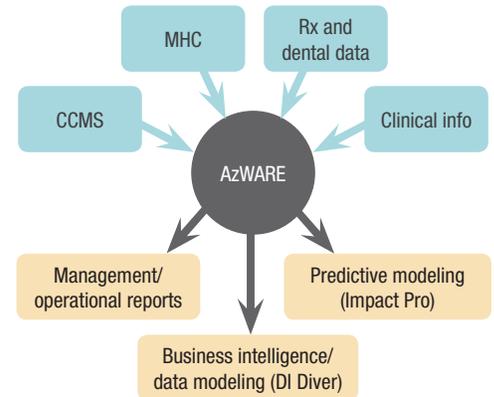
Our response discusses:

- Data sources
- Tools
- Initiatives to maximize care coordination, improve outcomes, and create cost efficiencies:

Data Sources

We collect and analyze medical, pharmacy and dental data to develop evidence-based conclusions. These conclusions drive care initiatives and interventions designed to improve wellness and outcomes, and decrease costs.

- MHC: Core information system
- CCMS: McKesson CareEnhance Clinical Management Software
- Rx: Pharmacy Benefit Manager, MedImpact
- Dental: Dental Vendor, Advantica
- AzWare: Oracle data warehouse
- Clinical information: SonoraQuest, HINAZ



Tools

Decision-support tools organize pertinent clinical and administrative information to allow Care1st staff to plan and manage care, coordinate services between multiple providers on an individual member basis, as well as identify gaps in care on an individual and population basis. We use multiple tools for consolidating and reporting data:

CCMS by McKesson	This robust data integration technology assists with care coordination by aggregating all case/disease management care coordination activities and post-discharge information in individual member profiles. Our care management team uses this real-time information to develop care plans and member interventions.
	Utilized for: Care planning; complex medical, behavioral and social case management; care coordination; concurrent review; SNF care management.
	Utilized by: Case/disease managers, care coordinators, concurrent review nurses (CRNs).
CareWebQI by Milliman	This interactive web-based tool provides easy access to evidence-based care guidelines and criteria, allowing the CRN to document day-to-day care management decisions for inpatient care and share with stakeholders. Documentation includes hospital stay justifications aligned with Milliman Care Guidelines, reasons for guideline variances, and care planning discussions during the stay.
	Utilized for: Inpatient concurrent review.
	Utilized by: CRNs, medical management staff.
Auto Auth by Milliman	Providers use this interactive web-based tool to submit prior authorization requests. Auto Auth uses the evidence-based Milliman Care Guidelines to direct the provider’s request, ensuring all pertinent information is provided, in most cases allowing for a real-time automated decision. Auto Auth notifies the provider if review by Care1st staff is required before approval. The interactive nature of Auto Auth improves efficiencies for providers and Care1st, and reduces delays in care due to insufficient and/or missing information.
	Utilized for: Outpatient service authorizations.
	Utilized by: Medical management staff, provider offices.
Impact Pro by OptumInsight	This powerful tool identifies at-risk individuals before they become high-cost by gathering care history, clinical information, and criteria such as social condition and authorizations. Impact Pro analyzes more than 1,000 clinical indicators and nearly 500 evidenced-based medical guidelines including NCQA, AQA and NQF.
	Utilized for: Predictive modeling, care management identification and risk stratification, medical policy recommendations.
	Utilized by: Medical management staff, case/disease management staff, senior management.

MedMeasures by VIPS	This tool offers efficient ways to measure quality and physician performance. Capabilities include provider profiling, physician dashboards and HEDIS measurements. Users may define criteria to generate customized reports. The HEDIS module allows for detailed analysis of trends; stratification of age, gender and disease state, as well as benchmark comparisons and gaps in care reporting.
	Utilized for: Provider profiling, physician dashboard, identifying gaps in care.
	Utilized by: Quality management staff, care management staff, customer service staff.
DI Diver by Dimensional Insight	This business intelligence tool puts data in the hands of the accountable party to identify, analyze, understand, resolve, and respond to operational, clinical, and financial issues. DI Diver allows data mining by users without IT support. It compiles data from AzWare and other sources to allow for detailed analysis, trend identification and decision-making.
	Utilized for: Routine reporting, ad hoc data analysis.
	Utilized by: Senior management, quality management staff, medical management staff; claims staff, finance staff; Provider Network Operations staff.

Initiatives to Maximize Care Coordination, Improve Outcomes, and Create Cost Efficiencies

Patient Centered Medical Home (PCMH) Initiative: In this initiative, Care1st uses data to maximize care coordination, improve outcomes and create cost efficiencies.

Care1st has PCMH partnerships underway with Cigna Medical Group, Maricopa Integrated Health System, and Banner Good Samaritan Family Medicine Center. Our collaborations rely on **sharing data to maximize care coordination driven by the provider – rather than the health plan**. In these partnerships, we share complete utilization data as well as gaps in care related to HEDIS quality measures with the PCMH, which the PCMH uses to update their disease registry. The result: A much more complete picture of the member’s health care services than the PCP typically has access to, which the PCMH then uses to coordinate needed member care.

Genesis	Our desire to collaborate with certified PCMH providers with a goal of supporting care coordination at the provider level, leading to improved outcomes and cost efficiencies.
Evidence	Patient Centered Primary Care Collaborative (http://www.pcpcc.net/evaluation-evidence) documents the value of primary care in improving health outcomes and patient experience, more efficiently using resources, and improving outcomes and lowering cost through comprehensive and coordinated care.
Outcomes	Enhanced care coordination, timely post-discharge follow-up, right care at the right time with the right provider, medication reconciliation, chronic disease monitoring and control, medical and behavioral care alignment.
Cost Efficiency	“...patients in the medical home experienced 29% fewer emergency visits and 6% fewer hospitalizations. We estimate total savings of \$10.30 per patient per month 21 months into the pilot...” (Source: The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers, Robert J. Reid, et al, Health Affairs May 2010 vol. 29 #5). Based on these results and our projected Maricopa County PCMH enrollment, we estimate an annual savings of \$1,450,000.
Payment Model	Fee for service for the services performed; quality performance incentive based payments for exceeding quality targets; care management fee for care coordination services; shared savings for exceeding utilization targets.

Predictive Modeling: In this initiative, Care1st utilizes data to predict future care needs of its population. After an RFP, Care1st chose OptumInsight’s Impact Pro predictive modeling software as our tool of choice. Care1st worked hard over the past 5 years on our inpatient concurrent review and case/disease management (CM/DM) process. Our inpatient days per 1,000 dropped from 800/k in October 2008 to 500/k as of September 2012. At the same time, we built up our internal CM/DM program, augmented with in-home social case management, in-home primary care services and telehealth home monitoring services. Because of this work and the results that we have achieved, we are confident in our ability to effectively manage members once they are enrolled in our CM/DM program and/or when admitted for inpatient care. Our logical next step is to proactively identify at-risk individuals before they become high-risk/high-cost. This information will help us engage members and providers in our efforts to positively impact member health and reduce medical expenses.

Genesis	Identify at-risk individuals early, when interventions have the most positive impact on health outcomes and can reduce future cost.
Evidence	Impact Pro’s clinical analytics engine utilizes over 1,000 clinical indicators and nearly 500 evidence-based medical guidelines including NCQA, AQA and NQF to direct focus on high risk members.

Outcomes	Early identification/stratification of member populations for focused care management interventions; improved health outcomes
Cost Efficiency	It is too early for us to quantify expected savings, however cost efficiency is expected to come from medical and administrative cost savings.
Payment Model	We foresee opportunities for pay for performance, gain sharing or other payment reform models when we begin using this tool.

Banner Rapid Care Clinic Partnership: Care1st has used data to identify an opportunity for cost efficiency, supporting a payment model that incentivizes the provider to offer alternatives to costly Emergency Department (ED) care.

Care1st contracts with the Banner Rapid Care Clinic (BRCC) on the Banner Estrella Medical Center (BEMC) campus. The BRCC, an ED alternative, receives patients with non-emergent symptoms triaged from the BEMC ED. The BRCC also provides post-discharge services to members unable to arrange timely follow-up with their PCP after an inpatient stay. Timely post-discharge follow-up reduces the likelihood of readmissions. The BRCC communicates with the member's PCP to ensure continuity of care.

Genesis	A desire to reduce inappropriate use of the ED; desire to reduce readmission rate by improving timeliness of post-discharge follow-up.
Evidence	Internal analysis of non-emergent use of the ED; concern for untimely follow-up care.
Outcomes	A shift in volume from ED to appropriate care settings. The Banner system has experienced improved efficiencies with this initiative. Early Banner data suggests success in shifting volume out of the BEMC ED. In the 3rd quarter of 2011, 53% of cases at the BEMC ED were levels 1 to 3. In the same quarter 2012, this declined to 48% with the BRCC. Banner expects continued improvement as triage procedures become more established and members experience the convenience and quality of BRCC services.
Cost Efficiency	From implementation through September 30, 2012, a 5-month period, the savings was \$61,228. Conservatively, we estimate savings of \$150,000 in year 1 from this 1 facility. Replicating this program would improve overall cost of care and enhance appropriate care levels across multiple facilities.
Payment Model	Gain sharing model uses the difference between the average cost of level 1-3 ED visits and the average cost of treating patients in the BRCC.

Emergency Department Diversion: In this initiative, Care1st identifies members with high ED utilization by monitoring utilization reports, face sheets, 24-Hour Nurse Line notifications, and taxi transportation logs. We analyze volume and frequency to stratify low-, medium-, and high-risk utilization, revealing opportunities for case management, service referrals, pharmacy restrictions and other interventions.

The primary goal is to develop interventions that increase compliance with recommended evidence-based treatment, leading to improved member health and reduced costs. Secondary goals include reinforcing the use of the PCP as the "medical home," reinforcing the use of extended hours and/or urgent care for non-emergent care, and, when appropriate, encouraging Behavioral Health (BH) and pain management (PM) specialists to act as a "specialist home" for high ED utilizers.

When we identify a high utilizer, our ED Diversion Coordinator evaluates the member's medication profile, contacts the member to complete an ED utilization assessment, and develops a member-specific care plan. This program has successfully reduced ED member visits.

Genesis	Internal analysis of the rate and frequency of ED usage by a subset of the population prompted a desire to reduce costs and increase compliance with recommended evidence-based treatment, thereby improving member health. We also hoped to ensure that members access care in the most appropriate setting.
Evidence	Stratification of volume and frequency of ED visits and ED-generated prescriptions.
Outcomes	CYE11 high ED utilizers averaged 21.59 ED visits, which decreased by 19.4% to 17.41 visits in CYE12 after ED Diversion Program intervention.
Cost Efficiency	We replaced ED visit costs with PCP, medical home and/or urgent care costs, with an average estimated savings of \$334 per visit.

Safe Narcotic Prescribing Initiative: Pharmacy utilization for PM is an area at great risk for inefficiencies. U.S. government statistics state that "non-cancer patients who are on continuous opioid therapy have healthcare-related excess costs of close to an order of magnitude greater than patients who are not on continuous opioid drugs". Through continuous medication monitoring, Care1st identified PM as the top therapeutic drug class, accounting for 13% of scripts for the measurement period.

Further analysis identified 97 members receiving medications in this category - approximately 10% of the total utilizing members in the PM class - were also utilizing multiple pharmacies and/or providers for their PM needs. With significant potential for fraud and abuse in this drug class, we initiated a complete review of PM prior authorization (PA) guidelines. A team including CMO Dr. Albenah Baharieva, Pharmacy Director Dr. Nirali Soni, and Behavioral Health Supervisor Donna Smith reviewed current clinical guidelines for managing members with chronic non-cancer pain and drafted new PA guidelines and recommendations. Highlights include:

- Use of the Arizona Board of Pharmacy’s Controlled Substance Prescription Monitoring Program. Providers can monitor member use of controlled substances throughout Arizona regardless of payer, including self-pay prescriptions.
- Use of random and/or scheduled urine drug screens for members on chronic opioids.
- Recommendations for long-acting narcotics when members are using high quantities of short-acting narcotics
- After evaluation by the BH Coordinator, restricting members to 1 physician and potentially 1 pharmacy if the members are using multiple physicians to obtain short-acting narcotics.

Genesis	The national epidemic of prescription opioid misuse and abuse and the important role that practitioners can play in preventing drug abuse and diversion; plus our desire to facilitate evidence-based PM treatment for our members.
Evidence	PM was Care1st’s top therapeutic drug class, accounting for 13% of scripts in the measurement period; 97 members (10%) receiving PM medications were also using multiple pharmacies and/or providers for their PM needs.
Outcomes	One year after implementation, PM therapeutic class claims decreased to 11.5%, and 33% of these members have been restricted to 1 physician/pharmacy.
Cost Efficiency	U.S. government statistics show that non-cancer patients on continuous opioid therapy experience excess healthcare-related costs greater (as much as 10 times greater) than patients who are not on continuous opioid drugs. We expect these initiatives to reduce total health care expenses for identified members.

Health Information Network of Arizona (HINaz): We support the design and implementation of an integrated statewide health information technology (HIT) and health information exchange (HIE). By meeting the information needs of all healthcare stakeholders in Arizona, an integrated HIT and HIE will improve outcomes, creating cost efficiencies through improved care coordination and reduced service duplication and waste. Care1st Chief Administrative Officer Scott Cummings serves on the HINaz Board of Directors and Executive Committee. Care1st is a major supporter of the work that HINaz and Arizona Health-e Connection (AzHeC)/Regional Extension Center (REC) are doing to facilitate the design and implementation of an integrated statewide HIT and HIE.

Genesis	A coordinated information exchange would improve safety, efficiency and continuity of care.
Evidence	In the current system, physicians do not have access to patient information they need at the time treatment decisions are made - what prescriptions is this patient on?; what tests has he/she received?, etc.
Outcomes	Timely access to admissions, ED visits, test results and medication information will reduce fragmentation, duplication of care, care delays due to lack of information, drug interactions and adverse drug events; and will improve care including prevention and disease management.
Cost Efficiency	System-wide cost saving projections are staggering and are generated by the improvement in outcomes as listed above as well as through increased efficiencies.
Payment Model	Through HINaz, we see opportunities to incentivize stakeholders, including providers and PCMH partners, for using this robust clinical repository to enhance care coordination, improve health outcomes and lower costs.

AHCCCS/RBHA Data Exchange: Care1st acts as co-lead on the collaborative effort between acute contractors, Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), and the Regional Behavioral Health Authorities (RBHA) to develop and implement a process for exchanging medication data related to members receiving services in the medical and behavioral health delivery systems.

Our leadership resulted in successful data exchanges between acute health plans and the RBHA(s) within their service area(s). This unprecedented collaboration provides clinical data that identifies members receiving multiple controlled substance prescriptions per month. This enables us to prioritize high-risk members and determine case management needs, pharmacy restrictions and/or other interventions designed to improve health outcomes.

Comparing pharmacy data from Magellan, Care1st identified members receiving 2 or more anxiolytic medications within 30 days. Data showed that 3.85% of members identified had duplicate anxiolytic prescriptions. The Care1st Behavioral Health Coordinator (BHC) worked proactively with the members, the PCP and the Magellan provider. We agreed that the Magellan

prescriber would manage treatment. The BHC completed a Care1st pharmacy restriction, identifying the Magellan provider as the exclusive prescriber to ensure member compliance with the treatment plan. Ongoing monitoring creates a safety net ensuring appropriate prescribing practices. The BHC continues telephonic follow-up with the members to address any issues or problems. Care1st will continue to use this data and expand our analysis and interventions related to other pharmaceuticals.

Genesis	Our desire to coordinate care with medical and behavioral health providers in the current “carve-out” environment led us to a co-leadership role when AHCCCS requested that acute plans assume control of the Acute-BH PIP.
Evidence	Care1st identified members with duplicate anxiolytic prescriptions.
Outcomes	We anticipate a reduction in members receiving duplicate prescriptions, resulting in improved patient safety, quality of care and avoidable morbidity and mortality.
Cost Efficiency	Although reduction in costs are expected by reducing duplicate prescriptions and improved quality of care – this is more of a patient safety initiative with cost efficiency as a byproduct.

Monitoring Gaps in Care: Using MedMeasures tools and reports, Care1st evaluates and monitors monthly HEDIS data. To coordinate and facilitate preventive care, we proactively reach out to members with the goal of improving health outcomes and reducing unnecessary cost.

Genesis	HEDIS measures identified members with gaps in preventive care.
Evidence	Monthly HEDIS measures identified needed services.
Outcomes	Improved care coordination and disease case management, reduced hospital admissions and readmissions, and a decline in emergency room visits.
Cost Efficiency	Reduced acute, preventable episodes of care for members with chronic conditions like diabetes.

Area Agency on Aging (AAA): Socio-economic challenges contribute to an inability to access services, and services being provided in less-effective environments at a higher cost. The Care1st/AAA program begins with in-home assessments to identify and coordinate social services, and to help members seek and receive the right care, at the right place, at the right time.

In 2010, Care1st implemented a pilot program with AAA. AAA social workers provide in-home assessments utilizing the Arizona Standardized Client Assessment Plan and feed critical information back to Care1st allowing us to address member quality of life and link members to appropriate services such as homecare, counseling, legal assistance, home making/chore assistance, day health care, home-delivered meals, benefits assistance program, and a family caregiver support program.

Mark R. Meiners, PhD, Professor of Health Economics and Policy at George Mason University, reviewed the program. A subset of 102 members referred to the program were selected, and 2 cohorts were identified: (a) 21 members who received in-home assessments and services and (b) 21 members who were referred but declined participation. The average PMPM cost of health care services were calculated for both groups. The results indicate that improved access to social services improved health outcomes. The decrease in PMPM costs among pilot participants was approximately 2.4 times the decrease seen among members who did not participate. Although the sample size was small, the data supports our belief that the AAA program improves overall health outcomes and reduces costs.

Genesis	Desire to extend Care1st CM/DM program with in-home assessments to members facing social needs that impact health and well being.
Evidence	The Meiners analysis supported our belief that serving the whole member—addressing their social service needs in addition to health care needs—improves outcomes and creates cost efficiencies.
Outcomes	In-home assessments connected members with services such as homecare, counseling, legal assistance, home making/chore assistance, adult day health care, home-delivered meals, benefits assistance program, and a family caregiver support program. These connections improved health outcomes.
Cost Efficiency	For those receiving full intervention, including assessment and services, the PMPM declined by \$1,530—38%—from the 3-month pre-intervention period to the 3-month post-intervention period.

By combining robust data and analytic tools with care management initiatives and processes, Care1st demonstrates an ability to maximize care coordination for members, and to improve outcomes and cost efficiencies. Our systematic approach to program development provides a platform for value-oriented payment models that encourage stakeholder engagement. Our positive results reflect our commitment to **Compassionately Caring1st for our community...challenging ourselves every day to exceed the expectations of our members, providers and regulators.**



Effective clinical programs
lead to:

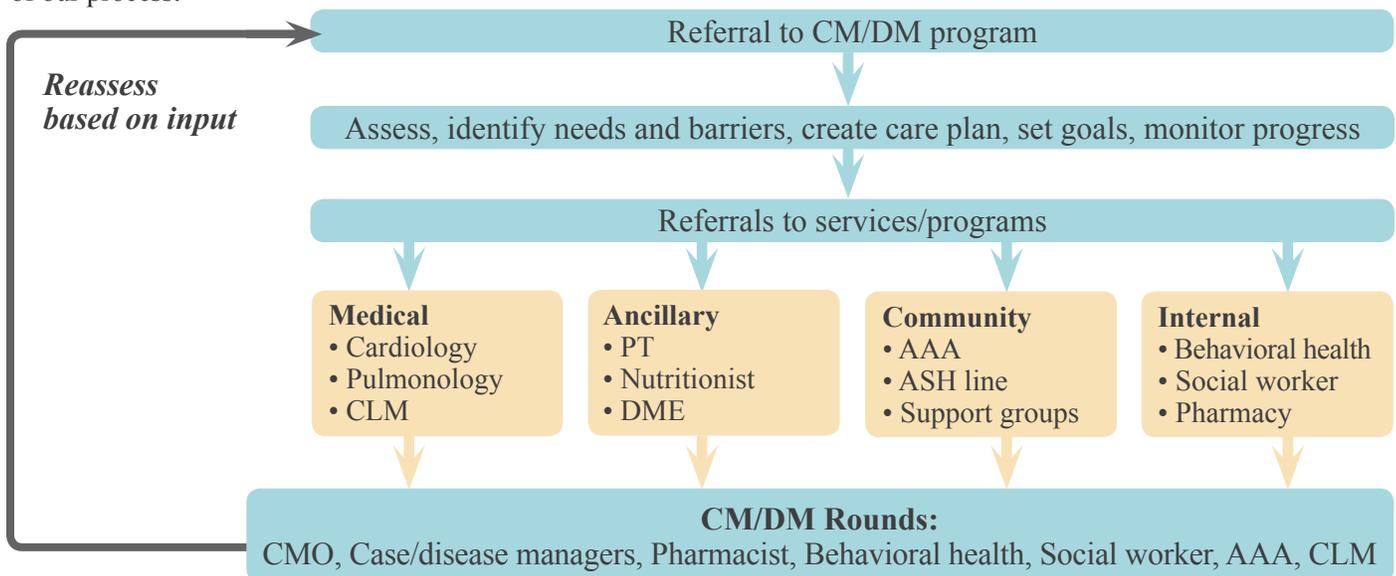
- **trust and rapport**
 - **improved outcomes for members**
-

Unfortunately, we often face cases similar to Mr. Andrews' (Mr. A). While each case is unique, Care1st offers robust programs, including well-defined case and disease management (CM/DM), designed to improve health outcomes.

Our response addresses:

- Processes for identifying and assessing members with 1 or more chronic illnesses in need of CM/DM
- Our comprehensive CM/DM programs and
- Use of our comprehensive CM/DM programs to address Mr. A's specific needs.

Member-specific care plans drive our CM/DM process. We develop the plan by assessing and reassessing a member's condition, understanding the member's knowledge of their condition and their ability to self-manage care, and identifying needs and barriers as a basis for interventions. Goals include improving a member's ability for self-care, controlling their chronic conditions, preventing future acute care episodes, and enhancing health status and quality of life. We monitor the care plan for progress, modifying it as necessary to meet the member's needs. Below is a schematic of our process:



We identify members for referral to CM/DM through:

1. **Health Assessment Survey (HAS) and Health Risk Assessment (HRA).** Care1st sends an HAS in the AHCCCS new member packet and an HRA to members enrolled in our dual-eligible SNP. We use this self-reported information to identify medical and behavioral health conditions and special healthcare needs. The assessments help us discover chronic conditions upon enrollment and direct members to needed services on a timely basis.
2. **Internal and external referrals.** Members may be referred to CM/DM through our pharmacy, prior authorization, member services, concurrent review, quality management and/or behavioral health (BH) areas. Concurrent review nurses are a valuable resource in identifying high-risk members and those with chronic conditions who would benefit from CM/DM. We also accept referrals from providers, members and caregivers.
3. **Predictive modeling.** We have contracted with OptumInsight for Impact Pro, the leading predictive modeling and care management analytics solution for both commercial and Medicaid. This will assist in identification of at-risk members early, when interventions have the most positive impact on health outcomes and can reduce future cost.
4. **Frequent ED utilization report.** Each month, we distribute a report to CM/DM of members with high Emergency Department (ED) utilization. We contact members not already in CM/DM and complete an ED utilization assessment to determine root cause(s) for high utilization.
5. **HEDIS reports.** To identify gaps in care, we monitor HEDIS indicators related to chronic disease monitoring and appropriate age-related preventive screenings, including flu and pneumonia vaccinations.
6. **Internal reporting.** We utilize multiple reports based on medical, pharmacy, and lab data to identify members for referral to CM/DM.

Care1st programs cover a wide range of chronic illnesses/diseases that impact diverse member populations. Programs include standard case/disease management, pharmacy-based interventions, and use of external resources, with the goal of improving member healthcare outcomes. We use McKesson's CareEnhance Clinical Management Software (CCMS) to manage members in CM/DM. CCMS brings us real-time data, and aggregates all CM/DM care coordination activities and post discharge information in an individual member profile used to develop care plans and member interventions.

We design 1st Tier programs to address specific disease/illness states or to respond to specific member behaviors:

Care Management Programs and Program Descriptions	Program Interventions	Desired Outcomes
<ul style="list-style-type: none"> • Asthma Disease Management • CHF/COPD Disease Management • Diabetes Disease Management Active processes assess, educate and communicate with members and providers, identifying opportunities for improved health outcomes.	<ul style="list-style-type: none"> • Telephonic outreach for a disease-specific assessment to identify needs and barriers to care, determine mutually acceptable goals and interventions, and monitor progress. • For diabetes, we partner with Nationwide Vision, providing telephonic outreach for eye exams. Our text-messaging pilot program will increase adherence with diabetic measures of LDL-C, HgbA1C and eye exams. 	<u>All: Improved...</u> <ul style="list-style-type: none"> • Knowledge of chronic condition • Self-management skills • Medication adherence • Access to community resources <u>Asthma and diabetes:</u> <ul style="list-style-type: none"> • Improved HEDIS measures <u>CHF and COPD:</u> <ul style="list-style-type: none"> • Decreased ED utilization and inpatient admissions/readmissions
<ul style="list-style-type: none"> • HIV Case Management • Transplant Case Management • Hepatitis C Case Management Collaborative processes assess, plan, implement, monitor, and evaluate options and services to meet member healthcare needs.	<ul style="list-style-type: none"> • Telephonic outreach to identify and resolve disease knowledge gaps and adherence issues with physician visits, medications and lab work. • Periodic follow up to monitor treatment plan progress and adherence. 	<u>All: Improved...</u> <ul style="list-style-type: none"> • Knowledge of chronic condition • Adherence with medications and provider follow-up <u>Hepatitis C:</u> <ul style="list-style-type: none"> • Successful completion of medication treatment course
Emergency Department (ED) Diversion Program Designed to decrease non-emergent utilization of ED.	<ul style="list-style-type: none"> • Identify members with multiple ED visits • Evaluate utilization and medication profile • Outreach to determine root cause for ED utilization • Facilitate a care plan with PCP/specialist/behavioral health provider 	<ul style="list-style-type: none"> • Reduced non-emergent ED utilization • Increased adherence to treatment plans • Increased use of extended hours or urgent care for non-emergent care
Behavioral Health (BH) Coordination Identify members with mental health and/or substance abuse issues; and foster collaboration with medical and BH providers for service coordination.	<ul style="list-style-type: none"> • Evaluate/assess focusing on BH issues and identify needs, barriers to care, educational opportunities, and adherence with BH treatment plans 	<ul style="list-style-type: none"> • Improved access to and utilization of BH services • Improved health outcomes

In addition, Care1st employs non-disease specific case management (CM) programs that focus on general adult and pediatric CM and high-risk OB CM. These programs follow standard CM/DM processes with goals such as improved knowledge and treatment plan adherence. High-risk OB CM goals target reducing the prevalence of low birth weight (LBW) and very low birth weight (VLBW) newborns, and completing the post partum visit. Our success is demonstrated by CY12 rates for LBW and VLBW newborns of 2.23% and .54%, respectively. These compare favorably to the most recent published statewide Arizona rates (2010) of 7.1% and 1.1%, respectively. In addition, we focus on preventive care and vaccinations by identifying and communicating gaps in care to providers and to members at all points of contact.

2nd Tier care management programs are pharmacy based. Medications are a critical component in managing many chronic diseases. We monitor and employ multiple programs to improve medication adherence. In many cases, we decrease the administrative burden on members and providers, and improve provider satisfaction:

1. **Medication re-authorization.** Care1st reviews existing approved prior authorizations (PAs) for maintenance medications set to expire. The pharmacist reviews fill history to determine adherence, notifies the provider of the PA expiration and any patterns of non-adherence, and assists in renewal.

2. **Pharmacy rejection monitoring.** Our pharmacy techs monitor point-of-sale rejections. Based on a combination of reject reasons and drug classes, including critical drugs for HIV or transplants, we work with the dispensing pharmacy and/or provider to resolve the rejection, which often includes updating a PA.

3. **Targeted medication review.** A Care1st pharmacist reviews medications to identify potential deficiencies, duplications or safety issues such as drug-drug interactions. Our pharmacy staff works directly with the PCP and/or specialist to facilitate PA requests and/or modifications.

4. **Medication adherence review.** The CM/DM manager assesses medication adherence. The CM/DM manager alerts the PCP of any issues, and discusses options for improvement, including enrolling the member in auto-refill programs, retail pharmacy text-message reminders, and/or home delivery through Avella and SunWest Pharmacy.

Our 3rd Tier care management includes these external programs:

External Programs	Program Interventions	Desired Outcomes
Area Agency on Aging (AAA) Care1st partners with AAA to provide in-home social, physical, and environmental case management assessments and support services.	<ul style="list-style-type: none"> • AAA social workers complete the Arizona Standardized Client Assessment Plan (ASCAP) and provide information back to our case/disease manager for inclusion in the care plan. • ASCAP identifies such items as activities of daily living, medications, medical conditions, hospitalization/ED use, fall risk, assistive devices and nutritional status. 	<ul style="list-style-type: none"> • Assessment recommendations are included in the care plan • Services through AAA or their contracted partners allow members to focus on managing their medical condition, resulting in improved adherence to treatment plan, better health outcomes, and better quality of life
Care Level Management (CLM) CLM provides in-home primary care visits to high-risk members or those who have difficulty in physically going to a provider office.	<ul style="list-style-type: none"> • Care1st identifies and refers to CLM from multiple sources including CM/DM, concurrent review, and/or trigger reports such as high ED utilizers and multiple readmissions. 	<ul style="list-style-type: none"> • Improved access to care • Reduced non-emergent ED visits • Decreased inpatient admissions/readmissions
AveryTelehealth Home Monitoring Programs This provides a 90-day post discharge home-monitoring program for members admitted with COPD, CHF, or AMI. Includes high ED utilizers with these conditions.	<ul style="list-style-type: none"> • Disease-specific home monitoring devices and intensive telephonic outreach and assessments. • Triage and interventions based on deviations of vitals signs such as blood sugar and blood pressure. 	<ul style="list-style-type: none"> • Decreased 30- and 90-day all cause readmission rate • Reduced non-emergent ED visits • Improved adherence to treatment plan and medication regimen

Our programs are effective – following are a few interventions for actual Care1st members:

1. Mr. G was enrolled in ED Diversion Program in 2010. In 2010, he visited the ED 75 times, with 11 inpatient admissions. These declined to 33 ED visits with 9 inpatient admissions in 2011; and to 10 ED visits and no admissions in 2012. **ED visits were reduced by 86% and inpatient admissions were reduced by 100%.**
2. In early 2011, Ms. L was referred to CLM due to a high volume of inpatient admissions and poor post-discharge follow-up. Prior to enrollment, she had 21 inpatient admissions that year. When followed by CLM, her admissions decreased to 11 in 2011, and 7 in 2012. **Inpatient admissions were reduced by 66%.**
3. Our medication re-authorization program identified that Mr. B’s script for Diovan was set to expire. The fill history was reviewed which identified that Mr. B had failed to consistently fill his scripts. We notified his physician outlining which months weren’t filled. The physician reviewed the information and subsequently completed a 1-year extension for approval of the drug.
4. Ms. G, who lives alone, was referred by CM/DM to AAA in 2011 for an in-home assessment. Information from the assessment was used in the development of her care plan which included a referral to the senior center for meals. When a 2012 hand surgery compromised her ability to drive, AAA set up home-delivered meals during her recuperation.

In addition to proven success with reductions in LBW and VLBW newborns, Care1st’s Hepatitis C case management program achieved 100% member compliance with treatment and lab work, and 91% of the members achieved sustained viral response.

Now that we’ve acquainted you with Care1st programs to improve member outcomes, we’ll address how we manage Mr. A’s specific needs. While PCP referrals are an excellent tool to identify members for CM/DM programs, we believe that our robust and proactive processes would have targeted Mr. A as an ideal candidate prior to the PCP’s request. Care1st employs a highly functioning, interdisciplinary CM/DM team to ensure high-quality cost-effective care for our members. Key participants in Mr. A’s case include:

Chief Medical Officer (CMO) Albena Baharieva, MD	Mr. A	Case/Disease Manager Barb Quaiife, RN
Case Manager/Social Services Susan Foster, LSW,		BH Coordinator Kathy Hernandez
PCP/Specialists/RBHA/AAA/CLM/Avery Telehealth		Pharmacy Director Nirali Soni, PharmD

Given Mr. A’s history and condition, to supplement our telephonic CM/DM, we initiate referrals to AAA and CLM for face to face assessments. CM/DM rounds, chaired by CMO Albena Baharieva, MD, provide an opportunity for members of our CM/DM interdisciplinary team, including AAA and CLM, to review information, provide input based on their specialty, and help direct member care.

Following the PCP’s request, Barb contacts Mr. A within 1 business day of referral. She explains the reason for her call and discusses CM/DM services available, along with their benefits. With Mr. A’s approval, Barb follows the standard CM/DM process: Initial assessment, identifying needs and barriers, creating a care plan, setting goals, monitoring progress, and reassessment. Barb works closely with Mr. A and all parties to ensure optimal coordination of care. Barb updates the team on Mr. A’s progress during rounds. Based on progress toward goals and input from team members, we modify Mr. A’s care plan as needed. Barb uses motivational interviewing techniques as she explains plan modifications and goal adjustments to ensure Mr. A’s continued engagement. Barb’s expertise helps determine a comfortable pace for interactions with Mr. A. We address urgent issues identified in the care plan first. The number and severity of Mr. A’s issues initially requires frequent follow-up. We adjust the intensity downward as issues are resolved and he stabilizes.

The assessment is a critical component in developing the care plan. It includes completing a comprehensive general care as well as a disease-specific assessment. Before Barb contacts Mr. A, she reviews his history in CCMS and our core system, MHC, to guide the disease-specific assessment. Based on Mr. A’s claims and authorization history, Barb works with him to understand the root cause for his frequent ED utilization, the onset and treatment for his obesity, and past medical history related to COPD and heart attacks. She uses the assessment to identify Mr. A’s knowledge of his medical conditions; inquire about co-morbidities such as diabetes, high blood pressure/cholesterol; and frequency of follow-up with his doctors. Barb also asks about medications and medication adherence, self-monitoring for his chronic conditions such as use of a peak flow meter for his COPD, adherence to an appropriate diet, smoking history, and social support. Based on what she now knows about Mr. A, Barb’s evaluation and care plan address these issues:

Multiple Chronic Conditions (COPD, CAD, Obesity)

Interventions: Appropriate telephonic education for Mr. A’s medical conditions begins during the 1st interaction. We mail him AHCCCS-approved educational materials to improve his understanding of his medical conditions, and reinforce the information during follow-up calls. Given assessment results, Barb determines appropriate referrals to internal resources, including Kathy for anxiety and Nirali for medication review. Also appropriate: external resources including AAA for completion of the ASCAP and links to their social support services, CLM for in-home PCP services, and Avery Telehealth. Remote home monitoring of Mr. A’s oxygen saturation and weight will be particularly beneficial. To address Mr. A’s obesity, which contributes to his health issues, Barb asks Mr. A about any ongoing dialogue with his doctors, and about any factors impacting his ability to lose weight. Barb offers to contact Mr. A’s PCP to recommend a referral to a nutritionist who can help develop a diet. If Mr. A smokes, Barb addresses associated health risks, counsels him, and provides options for smoking cessation, including formulary medications and referral to the Arizona Smoker’s Help Line (ASH Line).

Goals: Mr. A experiences improved disease control and improved compliance with a medically appropriate diet.

Outcomes Measurement: During follow-up phone calls, Barb determines if Mr. A’s understanding of his medical conditions/medications has improved, and if he’s following the diet recommended by his physician/nutritionist. Barb also determines if Mr. A understands the need for regular monitoring by his provider(s), and determines if he attends routine PCP/specialist/CLM follow-up appointments to ensure that his health status remains stable.

Adequate Specialty Care for Multiple Complex Medical Conditions

Interventions: Barb provides information to the PCP about covered services and recommends referrals for appropriate specialty services of cardiology, pulmonology, and nutrition counseling to address his CAD, COPD, and obesity. She lets the PCP know that we cover bariatric surgery if medically appropriate. Likely co-existing conditions include high blood pressure, high cholesterol and obstructive sleep apnea, which can be managed by the PCP or specialists. Upon PCP approval of referrals, Barb offers support to Mr. A to schedule appointments and arrange for transportation. She follows up with specialists, reviews recommendations and ensures recommended services are arranged, such as home oxygen, weight monitoring and DME.

Goals: Ensure that Mr. A and his PCP are aware of covered benefits and availability of specialty care. Ensure that Mr. A receives all necessary care services.

Outcomes Measurement: All specialist visits occur, and recommendations are incorporated into Mr. A’s care plan.

Frequent ED Utilization

Interventions: Based on root cause(s) identified in the assessment, Barb discusses ED alternatives with Mr. A including his PCP, CLM, urgent care and 24-hour support from the Care1st Nurse Line. Barb educates Mr. A on how to recognize symptoms that he can self-manage, and develops proactive strategies to control his chronic diseases. Barb assists Mr. A with scheduling regular PCP/specialist appointments to decrease non-emergent ED utilization. Since anxiety symptoms precede his ED visits, Barb refers Mr. A to Kathy for a BH assessment, and increases telephonic follow-up to reassure Mr. A and reduce his need to contact 911.

Goals: Reduce anxiety and non-emergent ED utilization.

Outcomes Measurement: ED reports show a decrease in Mr. A's non-emergent ED utilization.

Anxiety Symptoms

Interventions: Barb refers Mr. A to Kathy to assist in accessing BH services. Kathy contacts him to identify BH symptoms and provide information on psychiatric/counseling services and the RBHA/Maricopa Crisis Line, and facilitates RBHA referral. Kathy follows up with Mr. A and the RBHA provider to track intake/psychiatric/counseling appointment adherence. If Mr. A prefers his PCP to treat anxiety, Kathy contacts the PCP regarding anti-anxiety medication, sets up an appointment, arranges transportation and provides a reminder call. Kathy contacts Mr. A after the visit to assist with issues such as PA for medication, barriers to adherence or treatment concerns. Kathy provides verbal and/or written information regarding anxiety symptoms, self-management of panic attacks and relaxation techniques.

Goals: Reduce anxiety symptoms to allow more effective management of medical conditions.

Outcomes Measurement: Mr. A attends psychiatric/counseling/PCP appointments and reports decreased anxiety. This results in fewer 911 calls and non-emergent ED visits.

Lack of Social Support

Interventions: Without family, lack of social support is a potential issue. Barb refers Mr. A to Susan regarding a referral to AAA for an in-home face-to-face assessment. Results identify services beneficial for Mr. A, and an AAA case manager provides appropriate referrals. AAA case managers work closely with Barb and Susan to develop and update care plans, as well as Mr. A's goal-setting, self-care skills and care planning.

Goals: Adequate social support to improve Mr. A's adherence to his treatment plan, and his focus on his medical and behavioral health issues.

Outcomes Measurement: Complete the AAA evaluation and initiate recommended social services such as home delivered meals and housekeeping assistance.

Difficulty with ADLs and IADLs

Interventions: Barb assesses Mr. A's ability to safely care for himself and perform activities of daily living, such as walking, food preparation and hygiene. Depending on the outcome, she obtains information from his PCP and arranges referrals for physical therapy, evaluation of DME needs and a home safety evaluation. Barb follows up with the PCP, physical therapist and other parties to confirm DME requirements and facilitates delivery from Care1st's contracted vendors. Barb monitors proper use of DME and provides related education.

Goals: Ensure home safety and adequate performance of ADLs and IADLs.

Outcomes Measurement: Complete the home safety and physical therapy evaluation. DME is received and utilized to decrease difficulty with ADLs and IADLs.

The combination of CHF, COPD, obesity, anxiety, and lack of social support puts Mr. A at increased risk of high utilization of ED resources, readmissions and adverse health outcomes. By **Compassionately Caring1st for our Community...Challenging ourselves every day to exceed the expectations of our members, providers and regulators**, the Care1st CM/DM team establishes trust and rapport with members to positively impact their medical and behavioral health conditions and social needs.



Interdisciplinary
Arizona-based care team,
in-synch, ready to work.

With a patient like Mr. Robertson (Mr. R), the intensity of services and number of providers and agencies involved make the case complex, which requires proactive planning and careful coordination to avoid unnecessary costs, readmissions, duplication of services and poor outcomes. Care1st’s medical management team effectively coordinates high-quality, cost-effective care for members as they move along the continuum. The Chief Medical Officer (CMO) works with Care1st staff and Mr. R’s providers, making certain his care is managed effectively and compassionately with appropriate controls and oversight to ensure timely discharge, appropriate discharge disposition, effective post-discharge management, and improved health status.

Our response discusses Mr. R’s case, including:

- A summary of the Care1st interdisciplinary care team facilitating care and services
- Processes used to coordinate care across the care continuum
- Key risks and challenges facing Mr. R, and our proactive approach to address the risks.

While the facts in this case indicate that Mr. R was a direct discharge home following the first inpatient admission, **this would not occur with a Care1st member in Mr. R’s situation**. His physical injuries (fractured femur and trauma to the sternum), in conjunction with the second floor apartment, would result in a short term SNF stay to improve strength and mobility in order to ensure a safe discharge. In the event that Mr. R refused the SNF admission. Care1st would have approved a series of home health visits to monitor his ongoing functioning.

Care1st uses the following tools to manage member healthcare:

- Evidenced-based, clinically validated Milliman Care Guidelines® (Milliman) allow us to drive effective care. We use Milliman to determine the appropriateness of an inpatient admission and ongoing levels of care.
- CareWebQI®, an interactive web-based tool, provides easy access to Milliman and allows concurrent review nurses to document day-to-day care management decisions for inpatient stays, reasons for a variance when the stay strays from the guidelines, and discussions regarding the stay.
- McKesson’s CareEnhance Clinical Management Software (CCMS), our case management system, allows us to integrate care by housing all documentation for case/disease management, care coordination activities and post-discharge information in an individual member profile. Care management teams access CCMS to obtain real-time information regarding care plan development and related member interventions.
- We load data from our core system, MHC, to CareWebQI and CCMS daily, and transfer select information from CareWebQI and CCMS to MHC to facilitate timely and accurate claims payment in accordance with clinical staff decisions.

An inpatient admission triggers involvement by our interdisciplinary inpatient care team led by Albenah Baharieva, MD, Care1st’s CMO. The team follows all inpatient cases with the exception of normal maternity and nursery stays. We hold large group interdisciplinary inpatient rounds (inpatient rounds) three times per week. Inpatient rounds include all members of the care team—concurrent review, case/disease management, social work, behavioral health, and pharmacy. Twice weekly, 1-on-1 rounds with the concurrent review nurse (CRN) and CMO are held. Our goal is to oversee case progression, facilitate care coordination, identify potential risks, and deploy mitigation strategies in response to the risks. Post discharge, the case/disease management (CM/DM) team follows members like Mr. R. Dr. Baharieva also chairs CM/DM rounds, which include case/disease managers, social work, pharmacy, and behavioral health. CM/DM rounds offer an opportunity for interdisciplinary team members to review information, provide input based on their specialty, and to help direct care. Care1st leverages its partnership with the Area Agency on Aging (AAA), a private non-profit organization that advocates, plans, coordinates, develops and delivers social support services for adults, and persons of any age with HIV/AIDS to expand our social services reach. We also partner with Care Level Management (CLM), an in-home primary care provider, to expand our clinical services reach. Key members of Mr. R’s team include:

Chief Medical Officer (CMO) Albenah Baharieva, MD	Mr. R	Pharmacy Director Nirali Soni, PharmD
Concurrent Review Manager Tina Zikopoulos, RN		Behavioral Health Coordinator Tony Copelyn
Concurrent Review Nurse (CRN) Dawn Wilson		Care Coordinator Silvia Cuellar
Case Manager/Social Services Susan Foster, LSW		Mr. R’s PCP and Specialists
Area Agency on Aging, Care Level Management		Regional Behavioral Health Authority (RBHA)

With no medical history prior to the March motor vehicle accident (MVA), it’s unlikely that Mr. R would be in CM/DM for conditions other than substance abuse. During the inpatient stay, Mr. R would be followed by Care1st’s interdisciplinary inpatient team and post discharge by members of the CM/DM team.

We would take the following care-coordination steps related to Mr. R’s progression through the care continuum, although we might vary our focus based on his specific needs.

Continuum Step #1 – Inpatient (First and Second Admissions)

Concurrent Review: Care1st initiates concurrent review of inpatient stays beginning at admission and continuing throughout the stay to determine medical necessity for admission, appropriate care treatment levels, timely care progression, and quality of care. Arizona Licensed nurses perform concurrent reviews. While we reserve the right to conduct full on-site concurrent review, we prefer to partner with our hospital providers to jointly determine the most effective method for concurrent review – either on-site or remote. On-site review is conducted at most facilities that do not offer a remotely accessible electronic medical record (EMR); off-site review is conducted for facilities with an EMR that can be accessed remotely or that have a low volume of Care1st patients.

- Care1st receives notification of hospital admissions daily. Within 1 business day, Dawn begins reviewing Mr. R’s case. Using CareWebQI to access Milliman criteria, she confirms that Mr. R meets admission criteria and that the level of care is appropriate. Dawn also initiates discharge planning upon both inpatient admissions by establishing contact with the hospital case manager and the hospital treatment team.
- Each day, Dawn continues concurrent review, and presents her reviews at inpatient rounds or during 1-on-1 rounds with Dr. Baharieva. At inpatient rounds, Dawn provides a brief description of his history including factors that precipitated admission and his current clinical condition. Team members draw on their expertise and experience with Mr. R to identify internal referral needs, provide feedback/suggestions, and assist with coordination of care including review of discharge needs such as DME or home health. The team also recommends potential external referrals including CLM for in-home primary care or AAA for an in-home assessment and potential linkages to social services.
- Although the length of stay appears long for the first admission, Dawn’s ongoing concurrent review ensures that the case progresses appropriately. Open lines of communication—including peer-to-peer discussion between Dr. Baharieva and the treating team, Dawn, and hospital staff—reduce risks of delays and denials.
- In light of the traumatic brain injury (TBI) diagnosis in the second admission, Dawn confirms that the hospital initiated a competency evaluation to determine the need for a medical power of attorney or public fiduciary. She also confirms that a psychiatric consult assessed Mr. R’s cognitive functioning, psychiatric symptoms, and substance abuse. If these steps haven’t been initiated, Dawn discusses the need with the treating hospital team.
- Accommodations and changes to discharge plans are made as Mr. R’s medical condition and needs evolve. Dawn works closely with the hospital discharge planning staff as his clinical condition improves and discharge become imminent. As noted above, it is highly unlikely that Mr. R would have been discharged home following the first admission. Ongoing dialogue over the course of his stay would have brought to light the living situation, resulting in a more appropriate discharge disposition.

Behavioral Health Coordination: The goal of behavioral health coordination in an inpatient setting is to initiate a working partnership with the member, assist in discharge planning, establish care plan goals and facilitate collaboration between medical and behavioral health providers.

- During the initial admission, Tony contacts the Regional Behavioral Health Authority (RBHA) and obtains Mr. R’s RBHA provider name and contact information.
- To comply with federal law, Tony contacts Mr. R to request that he sign a release of information with his substance abuse provider so clinical information can be exchanged and a discharge plan established.
- Tony evaluates Mr. R’s current substance use, RBHA treatment compliance, barriers to care, treatment goals and discharge needs. He develops targeted interventions to address issues.
- Mr. R’s injuries may require ongoing pain management (PM) medication. Given Mr. R’s history of substance abuse, a risk exists for cross-addiction to opiates. As a result, we place him in ongoing behavioral health case management for chemical dependency and PM coordination.
- During the second inpatient admission, we address psychiatric symptoms resulting from the TBI—including depression, anxiety, agitation, irritability and combativeness—by referring Mr. R for a psychiatric evaluation. The psychiatrist recommends treatment to the hospital attending and initiates psychotropic medications as indicated.

Continuum Step #2 – Skilled Nursing Facility (SNF) Stay

Concurrent Review: Care1st conducts concurrent review of SNF stays using goals and processes similar to those for acute inpatient stays.

- Tina reviews the SNF admission and level of care to determine appropriateness of this particular level of care. While we prefer to use contracted facilities, we approve non-contracted facilities when necessary to meet care needs.
- Tina monitors Mr. R’s progression in the SNF to determine follow-up care required after discharge, and to notify AHCCCS when he reaches a total of 45 SNF days during the contract year. With Mr. R’s TBI, it’s possible he’ll need more than 90 days of SNF care. We monitor to ensure a timely ALTCS application and eligibility process.

Pharmacy SNF Intervention:

- Nirali completes a drug utilization review to ensure appropriate ordering and prior authorization of medications, and to avoid duplication when multiple providers are involved. If Nirali identifies a medication safety issue such as potential drug-drug interaction, Nirali alerts the facility and the long-term care pharmacy and coordinates ordering appropriate medication.

Behavioral Health Coordination:

- Tony contacts the RBHA to request a psychiatric follow-up evaluation at the SNF to assist the SNF attending physician with medication management recommendations for Mr. R's behavioral health and substance abuse symptoms.
- Tony provides contact information to schedule the psychiatric appointment and follows up with SNF staff to ensure completion. The RBHA psychiatric prescriber provides further treatment recommendations and adjusts Mr. R's psychotropic medication regimen as indicated.

Continuum Step #3 – Discharge Planning and Execution from Both Inpatient Stays and the SNF Stay

Discharge Planning and Execution: The goal is to ensure that members are discharged to the appropriate level of care and that post-discharge care needs are met in a timely manner, decreasing the risk of readmission.

Inpatient setting:

- During inpatient rounds, the care team evaluates Mr. R's post-discharge care needs, which include external referrals to physicians or other health care providers, AAA, RBHA, SNF; and internal referrals to pharmacy, CM/DM, or behavioral health.
- Dawn communicates with our pharmacy department regarding any post-discharge medication needs, and/or with the prior authorization (PA) unit for other needs such as DME, expediting the PA process and ensuring needed services are provided on a timely basis upon Mr. R's discharge.
- In light of Mr. R's new TBI diagnosis, discharge planning during the second admission also encompasses evaluating his level of functioning to determine placement options. The appropriate level of continued care in the appropriate setting mitigates readmission risks.

SNF setting:

- Susan reviews post-discharge alternatives including home and community based services, a general group home, a group home specializing in TBI, or another long-term placement, assuring that Mr. R may function as independently as possible. Susan evaluates other payer sources such as ALTCS or VA benefits, and community-based and social service resources. She involves Mr. R's support system, if any; facilitates connections to available resources; and participates in the discharge planning process.

Continuum Step #4 – Immediate Post-Discharge Follow-Up

Immediate Post-Discharge Follow-Up: Care1st conducts post-discharge follow-up after inpatient and SNF stays to ensure the timely provision of post-discharge services including physician visits, behavioral health appointments, receipt of medications, DME, and other ancillary services, with the goal of decreasing readmission rates.

Inpatient setting (first admission) and SNF setting:

- Within 2 business days after discharge, Silvia contacts Mr. R to complete a post-discharge assessment. She confirms that all discharge medications have been obtained, ordered home health or DME was received, and follow-up appointments have been scheduled.
- If Silvia identifies any potential issues/barriers for follow-up with PCP and/or specialists, she makes a referral to CM/DM, which follows standard protocols summarized in Continuum Step 5.
- Tony contacts Mr. R for behavioral health follow-up, assists in scheduling RBHA appointments, provides clinical information to RBHA providers, and coordinates care with the PCP and specialists for ongoing PM.
- Provider collaboration is essential to avoid duplication of opiate medication, especially if Mr. R is engaged in a methadone/suboxone maintenance program. Tony monitors medication compliance and potential overuse of narcotic medication by reviewing Mr. R's pharmacy prescription profile.

Continuum Step #5 – Outpatient Case/Disease Management and Behavioral Health Case Management

Outpatient Case Management: The goal is to coordinate care among all internal and external entities and to ensure appropriate services to meet the member's needs in the most cost-effective manner.

- Care1st’s case/disease managers are the key point of contact for members with high-risk and special ongoing healthcare needs. Based on the CM/DM protocol, our case/disease manager contacts the member within 1 business day of referral. The case/disease manager performs an assessment, identifies needs/barriers, and works with the member to create a care plan. The intensity and duration of CM/DM follow up is specific to the member’s needs and the member’s ability to meet care plan goals.
- Mr. R receives ongoing behavioral health case management for substance abuse, psychiatric symptoms and PM. Tony provides ongoing coordination of care with Mr. R and his medical and RBHA providers. This builds relationships between medical and behavioral health treatment teams, the member, and the member’s family and/or caregiver. The most important part of the collaboration is the member’s partnership in improving his own healthcare outcomes.

Risks and Challenges

The following table describes Mr. R’s greatest potential risks and challenges, along with Care1st’s proactive approach to risk mitigation.

1	<p>Physical Injuries</p> <p><i>Risks and Challenges:</i> Mr. R’s physical injuries include the fractured femur, trauma to the sternum and broken ribs.</p> <p><i>Proactive Response to Risk Mitigation:</i> Dawn performs daily concurrent review during each inpatient admission to monitor progress and ensure timely progression of services without delay. While Mr. R’s physical injuries are generally not risks, they contribute to potential risks and challenges.</p>
2	<p>Substance Abuse and Psychiatric Symptoms</p> <p><i>Risks and Challenges:</i> Mr. R’s substance abuse and psychiatric symptoms include non-compliance with treatment, chronic substance abuse, potential for relapse and ineffective symptom relief.</p> <p><i>Proactive Response to Risk Mitigation:</i> Mr. R’s illegal substance possession prior to the second admission, and his mental health vulnerability due to the TBI, increase his health risk and acuity level. His chronic substance abuse requires ongoing coordination with the RBHA, exchange of information among providers, and treatment compliance monitoring. All will increase the likelihood of positive health outcomes. Tony provides verbal and/or written education material on the psychiatric effects of TBI, substance abuse, relapse prevention, and self-management. If treatment compliance becomes an issue, Tony requests participation in Mr. R’s RBHA treatment team meeting to discuss options that might improve adherence. If interventions don’t succeed, Tony explores strategies with Mr. R, in conjunction with the Care1st PCP/Specialist and the RBHA provider. The team may reevaluate Mr. R’s case if more intensive services are required, such as inpatient detoxification, residential services, a sober-living home or a methadone/suboxone maintenance program. Tony continues to telephone Mr. R, encouraging him to participate in RBHA services, and monitoring his medication and treatment compliance.</p>
3	<p>Living Situation and Mobility</p> <p><i>Risks and Challenges:</i> Mr. R’s living situation and mobility issues include his second floor apartment and his ability to complete his IADLs and ADLs.</p> <p><i>Proactive Response to Risk Mitigation:</i> Based on case discussion during inpatient rounds, a referral is made to AAA. Care1st partners with AAA to provide an in-home case management assessment and linkages to supportive services. AAA sends a social worker to the home to perform an assessment utilizing the Arizona Standardized Client Assessment Plan, which looks at financial need, activities of daily living, orientation, behaviors, environmental problems/barriers, medications, medical conditions, hospitalization/ED use, risk for falls, assistive devices and nutritional status. The assessment identifies needs, feeds critical information back to Carest allowing us to coordinate additional services including transportation, homecare, counseling, legal assistance, home-making/chore assistance, adult day health care, home-delivered meals, a benefits assistance program, and a family caregiver support program. The assessments are utilized by Care1st’s case managers in development of the care plan. Silvia’s post-discharge assessment helps Mr. R obtain transportation if needed to his physician appointments. If Mr. R’s injuries sufficiently impact his ability to go to follow-up appointments, Care1st makes a referral to Care Level Management (CLM). CLM provides in-home PCP services and works closely with our case/disease managers and social worker to facilitate care to members with mobility issues.</p>

4	Non-Adherence
	<p><i>Risks and Challenges:</i> History of non-adherence to the appropriate plan of care.</p> <p><i>Proactive Response to Risk Mitigation:</i> During her post-discharge assessment, Sylvia determines post-discharge risk for non-adherence to treatment plan. If Mr. R's response to the assessment leads Silvia to believe it unlikely that he will follow up with the PCP/specialist, she makes a referral to CM/DM. CM/DM protocols include contact by a case/disease manager within 1 business day of referral to perform an assessment, identify needs, and create a care plan in conjunction with Mr. R. The intensity and duration of the CM/DM follow-up depends on Mr. R's needs and his ability to meet plan goals. Potential interventions by the case/disease manager include referral to CLM or to a provider who's part of Care1st's Patient Centered Medical Home program.</p>
5	Pain Management (PM)
	<p><i>Risks and Challenges:</i> Complexity of PM needs due to Mr. R's substance abuse, provision of adequate PM relief and the potential for chronic pain from his injuries.</p> <p><i>Proactive Response to Risk Mitigation:</i> Mr. R's pain issues following his initial inpatient admission are most likely acute, and should diminish with improvements in his health status. To address Mr. R's acute PM needs, Care1st coordinates with his PCP to treat his pain upon hospital discharge. If pain develops into a chronic condition, Tony refers him to a PM Specialist and provides written and/or verbal education regarding chronic pain and self-management techniques. Due to the high-risk potential for narcotic analgesic abuse, the PM Specialist develops a PM contract with Mr. R to facilitate appropriate opiate utilization. Tony monitors opiate medication compliance and potential narcotic medication overuse by reviewing Mr. R's pharmacy prescription profile. Tony alerts the PCP/PM Specialist and the RBHA provider of any issues. We support providers through the pharmacy restriction process to limit Mr. R's ability to obtain narcotic medication from multiple sources. If Mr. R's pharmacy profile indicates multiple opiate prescriptions, we revise the intervention plan with input from Mr. R, his PCP/PM Specialist and his RBHA provider. Tony continues to telephone Mr. R, encouraging him to comply with his PM contract and treatment plan.</p>
6	Traumatic Brain Injury
	<p><i>Risks and Challenges:</i> Mr. R's newly diagnosed TBI including level of functioning, psychiatric issues, substance abuse impacts, and the potential for unidentified or untreated psychiatric issues.</p> <p><i>Proactive Response to Risk Mitigation:</i> After the SNF discharge, Care1st continues to provide CM/DM services to Mr. R for his ongoing medical and behavioral health needs. Tony coordinates care with the RBHA provider on an ongoing basis. He offers verbal and/or written education material on the psychiatric effects of TBI and self-management techniques to diminish angry outbursts. If treatment compliance becomes an issue, Tony requests participation in Mr. R's RBHA treatment team meeting to discuss alternatives to improve adherence. Tony continues to telephone Mr. R and encourage him to participate in RBHA behavioral health services and comply with his psychiatric medication plan. If the TBI's impact is sufficient that Mr. R meets eligibility for ALTCS, an ETI is completed and sent to the receiving plan that outlines ongoing needs, providers involved in his care and any open authorizations for ongoing care. Once enrolled with ALTCS, Mr. R's case with Care1st is closed, and the ALTCS case management team assumes monitoring.</p>

Care1st follows all AHCCCS policies related to cost avoidance. During the first admission, Dawn notifies the Care1st Third Party Liability (TPL) Coordinator of the MVA, who follows required notification and authorization protocols before pursuing recovery. During the second admission, she notifies the AHCCCS incarceration e-mail address regarding potential incarceration due to police involvement related to Mr. R's illegal substance possession.

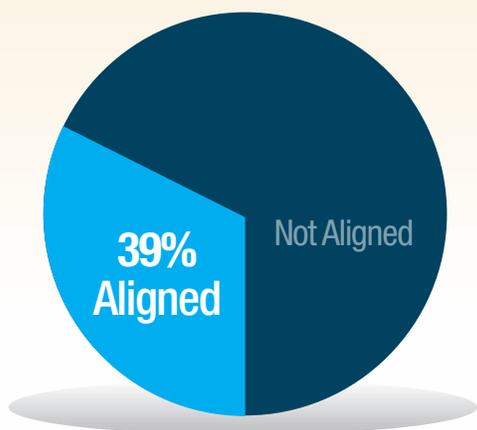
Mr. R's combination of traumatic brain injury, substance abuse and lack of compliance puts him at a high risk of additional trauma, high utilization of ED resources, readmissions and adverse health outcomes. Our interdisciplinary teams—including concurrent review, CM/DM, behavioral health and pharmacy—work to achieve optimal health outcomes by:

- Establishing trust and good rapport with the member
- Continuously monitoring medical, behavioral and social needs and
- Closely coordinating with physicians and RBHA.

Working as a team, we **Compassionately Care1st for our Community...challenging ourselves every day to exceed the expectations of our members, providers and regulators.**



Alignment:



AHCCCS

a national leader
in alignment



Care1st

an AHCCCS leader
in alignment

Care1st is committed to enhancing and maximizing care coordination and improving member experience for individuals eligible for Medicare and Medicaid services. We demonstrate our commitment through our successful alignment strategies as well as our initiatives in care management, behavioral health management, pharmacy management, patient centered medical homes, community resource centers and extended services through Area Agency on Aging (AAA) and Care Level Management (CLM). Our value proposition illustrates our dedication to these vulnerable members: **Compassionately Caring1st for our Community...Challenging ourselves every day to exceed the expectations of our members, providers and regulators.**

Our response discusses:

- Our experience in Medicare Advantage and Dual Eligible Special Needs Plans
- How we enhance and maximize care coordination and improve experience for Medicare and Medicaid members, as well as Medicare primary members served only for Medicaid coverage, and
- Our strategies to increase and maintain aligned Medicare and Medicaid enrollment, and our success in meeting these goals.

Experience

Care1st Health Plan has administered multiple product lines including Medicaid, Medicare Advantage Prescription Drug Plans (MAPD), and MAPD Dual Eligible Special Needs Plan (D-SNP) programs in Arizona and California.

ONECare by Care1st Health Plan Arizona (ONECare) began as a D-SNP when Medicare introduced the new Part D drug benefit more than 7 years ago. ONECare now serves approximately 1,650 dual eligible Medicare/AHCCCS beneficiaries in Maricopa County, Arizona, and carries a 3.0 2013 STAR rating.

Our parent organization, Care1st Health Plan California (Care1st CA), launched its D-SNP program in 2007 in Los Angeles, Orange and San Bernardino counties. Throughout the years, Care1st CA expanded its MAPD and MAPD D-SNP product lines, resulting in a plan landscape that covers 10 counties with 7 D-SNP programs. Today, Care1st CA serves approximately 21,000 MAPD and 8,000 D-SNP Medicare beneficiaries, and carries a 2013 STAR rating of 3.5. The California Department of Health Care Services selected Care1st CA to participate in the Coordinated Care Initiative (California’s Dual Demonstration) as a direct contractor in San Diego County. In addition, Care1st CA will participate in the initiative as a subcontractor under L.A. Care Health Plan in Los Angeles County.

Our combined experience in administering D-SNP plans allows us to create customized plan benefit packages that meet the unique needs of the Dual Eligible population. We collaborate with Care1st CA in program compliance, enrollment processing and formulary management, and share best practices in other areas.

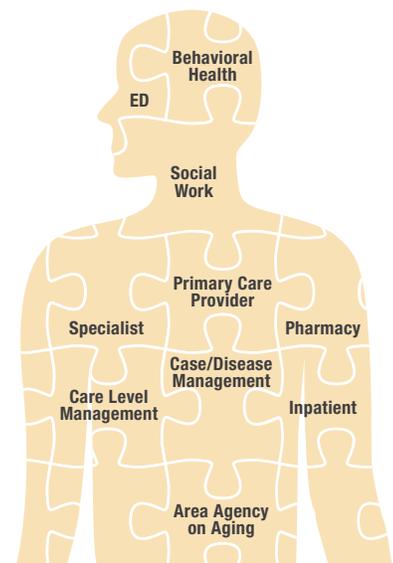
Care Coordination

Dual eligible members are the most vulnerable members—they have multiple co-morbid conditions, a 40% co-occurrence of behavioral health and substance abuse conditions, poly-pharmacy, and complex social and economic challenges. These members are at increased risk for health deterioration, exacerbation of chronic conditions, and adverse health outcomes. Their significant bio-psychosocial complexity, along with the healthcare system’s complexity, demand well-coordinated care to optimize health outcomes and improve member experience.

Care coordination deteriorates as the number of organizations sharing coverage of these members increases. We discuss 3 possible scenarios below, beginning with the greatest ability to maximize care coordination, and ending with the greatest potential for fragmentation of care.

ALIGNED – Medicare coverage by ONECare and AHCCCS coverage by Care1st

We believe that coordinated health care is a key element in achieving high-quality, cost-effective care. Care1st provides seamless coordination of care for members who are dual eligible enrollees with ONECare and Care1st. In this aligned model, 1 entity (ONECare/Care1st) provides both Medicare and Medicaid benefits. Although they are two separate programs, we strive to provide a seamless and transparent experience for members and providers. As the primary/sole payer, we ensure easy, unrestricted access to PCP services and initiate mental health and chemical dependency services when needed. We work closely with the member’s PCP, who serves as gatekeeper for all healthcare services.



Mr. Aligned

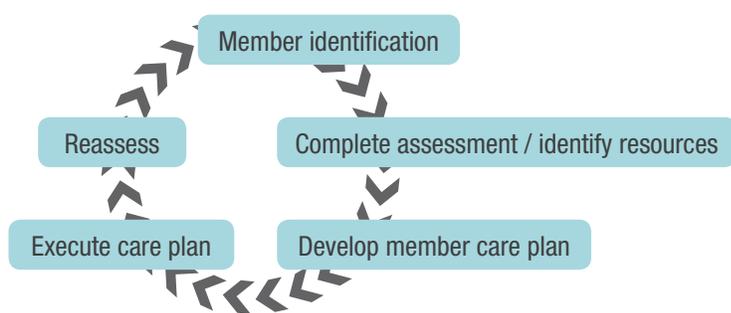
Our members may access a broad array of Medicare and Medicaid covered and supplemental services, including a \$300 annual over-the-counter benefit; dental; hearing; vision; and, in conjunction with AAA, our in-home social case management and fall prevention program. Under the direction of Chief Medical Officer Albena Baharieva, M.D., we administer these benefits in a coordinated fashion through cross-department collaboration between member service representatives, care coordinators, disease managers, case managers, pharmacists, behavioral health coordinators and our social workers. We identify gaps in care and encourage use of benefits, which leads to improved health outcomes and quality of life.

Recognizing that Medicaid only covers transportation to Medicaid-covered services, we also provide a transportation benefit that allows our members 10 1-way trips per year to access supplemental benefits. This demonstrates our flexibility and effort to improve the overall member experience.

Care Planning and the Integrated Care Management Program: The focal point of any coordination effort is the member with distinct healthcare risks. In this aligned model, we can access comprehensive information about the full range of services available to and utilized by the member. We maintain an in-depth understanding of each member’s medical and behavioral health conditions, proactively identify health risks and intervene to optimize outcomes.

Our care planning process involves the following steps:

Member Identification: ONECare applies the concepts outlined in our SNP Model of Care (MOC) for care management and care coordination. We identify health risks and members who will benefit from intensive care coordination and case management using both a **systematic and individualized approach**. The **systematic approach involves mining data and analyzing claims**. In this aligned model, data available to us includes inpatient; ED; pharmacy; and diagnosis history including physical, behavioral health problems and substance abuse.



The **Health Risk Assessment (HRA) represents an individualized approach** to determine care coordination needs. The HRA, based on member-reported information, provides a comprehensive assessment and evaluation of the member’s medical, psychosocial, cognitive and functional needs. We complete an HRA upon enrollment, and repeat it annually. Based on predefined criteria, we weight HRA responses to stratify members into low-, moderate- or high-risk categories. This stratification determines the type and frequency of ongoing contact. A low-risk member may be contacted quarterly, where a high-risk member may require weekly or daily contact. A Care Coordinator or Case/Disease Manager actively manages each member.

Direct referral represents another individualized approach. Referrals come from concurrent review nurses, member services, quality management, providers, and pharmacy. Members may also self-refer. Upon receipt of a referral, the Case/Disease Manager reviews the member’s history and contacts the member to initiate the case management process.

Complete Assessment and Identify Resources: Once we identify a member needing case/disease management, an assessment is completed by a care coordinator, nurse case manager, behavioral health coordinator or social worker. Assessments may include the HRA if the HRA was not the method of identification, a general case management assessment, a disease-specific assessment and/or a behavioral health assessment. The assessment(s) build the foundation of the individual care plan, which documents the member’s issues and problems, establishes mutually acceptable goals and identifies interventions to support the goals.

We manage a significant number of members in care management through our telephonic case/disease management program by our care coordinators and case/disease managers. When member needs are better served by face-to-face contact, we extend our care management capabilities through 2 important partnerships.

Area Agency on Aging (AAA) is a private non-profit organization that advocates, plans, coordinates, develops and delivers social support services for adults, and persons of any age with HIV/AIDS. Our partnership connects our case/disease managers with AAA case managers to provide the following member services:

- Comprehensive in-home assessments
- Links to home- and community-based services and
- Implementation of the In-Home Fall Prevention Program by case managers and AmeriCorps volunteers.

AAA social workers visit members’ homes to perform an Arizona Standardized Client Assessment Plan (ASCAP), and feed this information to our case/disease manager for inclusion in the care plan. Additional services which may be

provided by AAA to meet member social needs, including home-delivered meals, attendant services/support, homecare and adaptive equipment for bathrooms. This support allows members and their case/disease managers to focus on member medical issues; decrease high-cost utilization of hospital services including ED, admissions, and readmissions; and improve member quality of life.

Care Level Management (In-Home Primary Care) is another tool available to our case/disease managers. We partner with Care Level Management (CLM) to provide comprehensive in-home primary care services for diagnosis and treatment of the frail or elderly, members coping with disabilities, compromised activities of daily living, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues. Using CLM alone or in combination with social support services improves a member’s potential to successfully meet care plan goals.

When involved in managing these complex members, AAA and CLM function as an integral part of our Interdisciplinary Care Team (ICT).

Preparation of Member Specific Care Plan and Implementation

The ICT is a multi-disciplinary panel of internal and external care coordination experts that manages all D-SNP members. At a minimum, the panel includes ONECare case/disease managers, a social worker, a pharmacist, a behavioral health coordinator and the medical director. Other participants include the member’s PCP, specialists, and AAA and CLM if they’re involved. Others are invited to team meetings depending on a member’s special needs or at the member’s request. The ICT collaboratively reviews the care plan and provides recommendations to best meet the member’s medical, cognitive, psychosocial and functional needs. The team reviews and revises care plans to meet goals, reviews plans again when health status changes, and reviews plans annually to ensure that the plan remains valid and beneficial. Members, caregivers, and providers are strongly encouraged to participate in the ICT, but if they’re unable, the case/disease manager discusses the care plan with the member and/or caregiver and ensures mutually agreeable goals. The member and their PCP receive a copy of the care plan. The ICT works closely with the PCP to improve care coordination, decrease the potential for duplication of services, and improve member outcomes.

In our aligned model, all documentation related to care coordination and care management activities for each member is maintained in the McKesson CareEnhance Clinical Management Software (CCMS). CCMS allows for monitoring case management effectiveness. All discussions and subsequent action plans are documented in CCMS.

The aligned model demonstrates that when 1 organization (ONECare/Care1st) is responsible for both Medicare and Medicaid benefits, the organization has access to comprehensive member information and the full range of services available to the member. Our in-depth understanding of the member’s medical and behavioral health conditions allows us to proactively identify care needs and health risks, and implement interventions through comprehensive care coordination. The result: A member with improved health status, enhanced quality of life and reduced overall program cost.

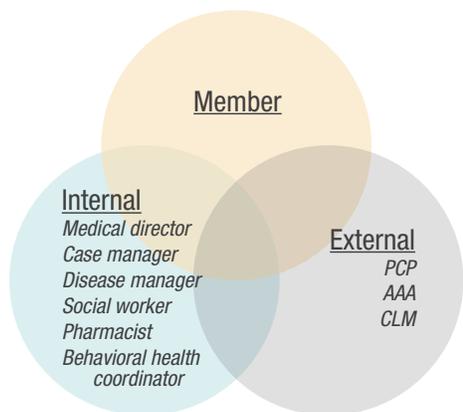
NON-ALIGNED – Medicare coverage with Traditional Medicare/Prescription Drug Plan and AHCCCS coverage with Care1st

Coordinated healthcare is a key element in achieving high quality, cost-effective care. In this non-aligned model, Traditional Medicare is the primary payer, a Prescription Drug Plan (PDP) covers pharmacy, and AHCCCS is secondary. With 3 payers, achieving care coordination and quality health outcomes becomes even more complex, and susceptible to disconnected care, poor outcomes and higher costs. In a worst-case scenario, our most vulnerable population attempts to direct their own care through a confusing, complex and fragmented system.

The Opportunity: Even in this non-aligned model, Care1st identifies members in need of care coordination through:

AAA Partnership

- » Expand case management capabilities for at-risk members
- » Provide the best possible quality of health
- » Reduce health care costs
- » Improve clinical outcomes
- » Provide access to home and community-based services and resources in the Aging Services Network
- » Prevent avoidable hospital admissions and re-admissions



» Member Touch Points:

- Inpatient facility stays
- New Member Health Assessment Survey (HAS); review of HAS results in referrals to case/disease management and/or behavioral health
- Member services
- Member education and outreach

» Data Identifiers:

- Claims (through COB claims)
- ED utilization reports
- Inpatient census
- Member-specific data/profiles
- Performance measure reports

To maximize every opportunity to impact each member in a meaningful way, we do not differentiate member experience based on our role as the secondary payer. Non-aligned members receive education, outreach, customer service and access to care management services just as any primary member. Recognizing the importance of PCP continuity, our care coordinators reach out to members with complex care needs identified through the HAS, and assist them in selecting a PCP in our network.

As with aligned dual members, we direct non-aligned members to AAA when needed. Strengthening the care continuum by managing all of a member's needs becomes of particular value to this vulnerable population. A special subset includes non-aligned members with behavioral health and substance abuse conditions who may have chosen Traditional Medicare to avoid the care management program of a Medicare Advantage plan. This complex and difficult-to-engage population can benefit greatly from care coordination services discussed above.

The Challenge: Identifying non-aligned members can be challenging because data, particularly pharmacy data, isn't complete. However, we strive to engage the Traditional Medicare primary/AHCCCS secondary member with the same care coordination activities afforded our aligned members. We're committed to aiding non-aligned members, since lack of care coordination affects quality of life, health care outcomes and overall healthcare costs. Without coordination, the member risks significant gaps in care, leading to sub-optimal health outcomes. Providing a positive member experience that promotes engagement in care management, education, and outreach services raises the likelihood that the member's overall status will improve.

NON-ALIGNED – Medicare and Pharmacy coverage with another MAPD plan and AHCCCS coverage with Care1st

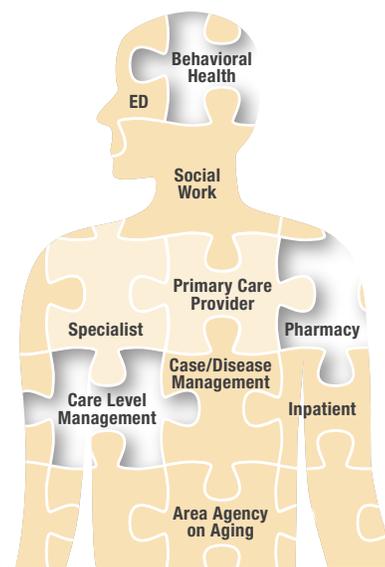
As with the Traditional Medicare/PDP/AHCCCS secondary non-aligned model discussed above, the MAPD/AHCCCS environment is not conducive to maximizing care coordination, outreach and education. MAPD plans are designed with managed care principles and engagement strategies similar to the AHCCCS program. Inherent barriers exist because of:

- Different provider networks
- Different prior authorization requirements and
- Different care, disease, and behavioral health management programs.

The Opportunity: Care1st removes barriers to meet non-aligned member needs. We work with members to identify common PCPs, as well as common specialists and ancillary providers. If there's no clear match, we approve out-of-network referrals. Our clinical care, case/disease management and behavioral health staff leverage every opportunity to engage with the MAPD plan to ease transitions and help the member navigate through this fragmented environment.

The Challenge: This non-aligned model results in less data than in the Traditional Medicare scenario. Cost-sharing in the MAPD plan reduces coordination of benefit claims filed with Care1st. As with Traditional Medicare, the lack of pharmacy data and timely care management data presents a significant challenge to managing member care. As with our approach to Traditional Medicare/AHCCCS enrollees, we use the same member touch points to maximize care coordination.

The MAPD/AHCCCS model creates significant gaps in accountability, leading to 1) dilution of responsibility, 2) fragmentation of care, and 3) erosion of the AHCCCS health plan's control of optimal care and services.



Mr. Non-Aligned

Alignment Strategy

A February 2012 presentation titled “AHCCCS Medicare/Medicaid Duals Discussion” delivered by Katrina Cope, AHCCCS Program Officer for Medicare Coordination and Integration, indicates that **39% of Acute Program dual eligible members are aligned with the same Acute Plan and their D-SNP**. Arizona is a leader in aligned duals with 40,000 of the 100,000 aligned members nationally.

Care1st participates in the Medicare Advantage Program as a Dual Eligible Special Needs Plan (D-SNP) because it’s our goal to align coverage for our dual members. We are proud that **66% of the Care1st members with Medicare A/B coverage are aligned with our D-SNP**. We accomplished this high alignment rate by focusing our sales efforts on the following three groups:

1. New Care1st members with Medicare coverage
2. Existing Care1st members who are aging into Medicare coverage and
3. Existing Care1st members covered by Traditional Medicare or a Medicare Advantage plan.

In addition, 91% of our D-SNP members are aligned with Care1st for Medicaid, while the remaining 9% are awaiting their opportunity to align on their AHCCCS anniversary date. We focus on aligning our members and maintaining our high alignment rate through our benefits and services. For 2013, we retained all of our existing supplemental benefits and added routine podiatry visits, which are not covered by Medicare and are no longer covered by AHCCCS for adults. We are one of a few plans that offer non-emergent transportation to enhance access to care for those services not covered by AHCCCS, including dental, vision, hearing, and podiatry. Since 2010, we have offered a generous over-the-counter (OTC) benefit that allows members to receive \$300 in OTC products per year. These and other benefits add value to our members’ lives and improve their health status.

Care1st supports AHCCCS’ Dual Demonstration initiative. If successfully implemented as proposed in January 2014, the initiative will greatly impact alignment through passive enrollment. If that happens, we will shift much of our focus to maintaining alignment through education, services and benefits.

With more than 7 years of experience in managing dual eligible populations in multiple states, Care1st understands that aligning member Medicare and Medicaid benefits presents the most effective way to enhance health outcomes while bending the cost curve. Our alignment strategies are effective: 66% of our members are aligned with Care1st/ONECare, compared to 39% alignment in the AHCCCS Acute Care Program. This leads to success on 2 fronts—maximum care coordination and improved member experience.

AHCCCS: a national leader in alignment



Care1st: an AHCCCS leader in alignment



Organization

WASTE

\$750 billion
wasted on
healthcare systems



Care1st—chipping away at waste:

\$150,000 from Banner Rapid Care Clinic

\$1.4 million from Patient Centered Medical Home partnerships

\$675,000 in administrative savings

\$42 million through Program Integrity efforts

The Institute of Medicine (IOM) says \$750 billion, the National Health Policy Institute says \$521 billion, and the PricewaterhouseCoopers Health Research Institute says \$402 billion. Whatever the number, significant opportunities exist to eliminate healthcare waste, lower costs and improve outcomes. Care1st is actively involved in local initiatives that align with IOM recommendations to reduce health care system waste. Our response discusses:

- Value-oriented payment models
- Increasing operational efficiencies and reducing excess administration
- Enhancing community linkages and reducing prevention failures
- Reducing unnecessary services.

Value-Oriented Payment Models

Care1st is actively developing value-oriented payment models that address IOM recommendations #6 Care Continuity and #8 Financial Incentives. In 2012, we began implementing models designed to reward effective, efficient care focused on continuous improvement of member health, and to decrease inefficient care and unnecessary services. We’re implementing processes that deliver care effectively by avoiding unnecessary hospital admissions, readmissions and emergency room visits. Our initiatives with Banner Health and our patient centered medical home partnerships represent examples of these new arrangements.

Care1st Initiative	Banner Rapid Care Clinic
IOM Recommendation	#8 Financial Incentives
Stakeholders	Banner Emergency Department and Banner Rapid Care Clinic, members, PCPs
Timeline	October 2011-ongoing
Desired Outcomes	Reduce unnecessary use of the ED, increase member satisfaction, reduce length of stay, facilitate timely follow-up post discharge, reduce preventable readmissions

Banner Rapid Care Clinic: Ensuring appropriate use of health care resources reduces cost and waste. We are one of a few AHCCCS plans that have collaborated with Banner Health on ways to reduce non-emergent use of the emergency department (ED). After months of collaboration, the Banner Rapid Care Clinic (BRCC) opened on the Banner Estrella Medical Center (BEMC) campus on May 1, 2012.

The BRCC markets its services to the community as an ED alternative and receives patients with non-emergent symptoms triaged from the BEMC ED. Average wait time at the BRCC is 15 minutes or less, versus 2 hours at BEMC ED. Positive member feedback gathered from post BRCC visit surveys supports the likelihood that members will return to BRCC instead of the ED for future non-emergent needs.

The BRCC is open 8 a.m. to 9 p.m. 7 days a week including holidays, and welcomes walk-ins

BRCC also serves as a place for members to receive timely follow-up care after an inpatient stay. For patients who cannot arrange timely follow-up with their PCP post discharge, an appointment is made at BRCC. The BRCC communicates with the PCP after the visit. This assures the discharging physician of timely follow-up care, leading to reduced preventable readmissions.

The collaboration with Banner created a safe, cost-effective alternative to the ED and sets up post-discharge follow-up care, which is expected to reduce ED visits, readmissions and length of stay. We anticipated reduced Care1st medical expense and dollars paid to BEMC for ED and inpatient admissions. As a result, we developed a gain-sharing model allowing Banner and Care1st to share in savings generated from moving ED visits to BRCC. The formula also offset Banner’s loss of ED revenue. We calculate savings as the difference between the average cost of level 1-3 ED visits and the average cost of treating BRCC patients.

Table 1	
Number of BRCC cases.	185
Average payment per case . .	\$84.81
ED level 1 to 3 cases	323
Average payment per case .	\$415.77
Savings per case.	\$330.96
Total savings.	\$61,228
Annual projection.	\$146,946

Care1st and Banner Health shared savings of \$61,228 between May and September 2012 (Table 1). An early review of data shows success in shifting material volume out of the BEMC ED. As a percent of total cases at BEMC ED, 53% were Level 1-3 (low acuity) in Q3 2011, decreasing to 48% in Q3 2012. During the same period, another Banner hospital, Banner Good Samaritan Medical Center (BGS MC), saw an opposite trend—a significant increase in lower acuity ER visits, from 40% to 52% of volume. We expect the shift to be even more pronounced as we get more data. **As a result of initial positive results, we are discussing a second BRCC on Banner’s BGS MC campus.**

Care1st Initiative	Patient Centered Medical Home
IOM Recommendation	#6 Care Continuity; #8 Financial Incentives
Stakeholders	Cigna Medical Group, Maricopa Integrated Health System, Banner Good Samaritan Family Medicine Center
Timeline	2012 - ongoing
Desired Outcomes	Increase access to preventive care, improve chronic disease management, improve treatment plan adherence, reduce non-emergent ED use, increase member satisfaction, facilitate timely follow-up post discharge, reduce preventable readmissions

We have 3 strategic initiatives underway related to the patient centered medical home (PCMH): partnerships with Cigna Medical Group, Maricopa Integrated Health System (MIHS) and Banner Good Samaritan Family Medicine Center. Based on industry trends, through PCMHs, we'll see reduced overall cost and a better use of overall dollars for prevention and wellness vs. the current individual PCP model.

In 2012, we implemented our PCMH **partnership with Cigna Medical Group**. We provide financial incentives through pay for performance to achieve improved outcomes and appropriate utilization. Our arrangement includes additional fee for service reimbursement, a per-member per-month care management fee, and shared savings by achieving AHCCCS performance and utilization measures. The per-member per-month payment provides additional resources to the PCMH to manage care coordination across its care team.

Also in 2012, we **partnered with MIHS** to contain costs and improve quality of care:

- We are increasing use of MIHS pharmacies to take advantage of 340B pricing. MIHS Care Coordinators and providers encourage Care1st/MIHS members diagnosed with HIV to fill scripts at MIHS pharmacies or through their mail-to-home program. By mid-2013, we'll expand this to Hepatitis C and other high-cost drugs.
- We implemented a process managed by our Behavioral Health Team that identifies and assigns Care1st Seriously Mentally Ill (SMI) members to MIHS PCPs embedded within the RBHA facilities *where the member receives their behavioral health services*. This allows for greater care coordination, improved compliance with medical and behavioral health care plans, greater medication adherence and reduced medication interference. We track results by monitoring behavioral health outcomes using the verbal RBHA report, medical utilization and medication adherence using the monthly RBHA/Health Plan Rx Data File.
- As part of discharge planning, with the goal of reducing 30-day readmissions, the MIHS Care Coordinators work with Care1st/MIHS members to ensure a PCP follow up visit within 7 days of discharge.

In Q2 2013, following review of initial results, we'll finalize a pay for performance and gain sharing model with MIHS, similar to the one with Cigna Medical Group. The partnership with Banner Good Samaritan Family Medicine Center, to be finalized in Q3 2013, will mirror Cigna and MIHS partnerships. These agreements benefit the AHCCCS program through improved quality of care, improved health outcomes and decreased medical expense. We'll measure the success of PCMH initiatives annually through utilization, quality outcomes, and improved member satisfaction in these areas:

- Reduced inpatient admissions per 1,000
- Reduced readmissions per 1,000
- Reduced ED visits per 1,000
- Improved quality measure outcomes aligned with AHCCCS performance measures and
- Improved member satisfaction as measured by a 2013 member survey.

"...patients in the medical home experienced 29% fewer emergency visits and 6% fewer hospitalizations. We estimate total savings of \$10.30 per patient per month, 21 months into the pilot..."

Source: The Group Health Medical Home At Year 2: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers

Robert J. Reid, et al, Health Affairs May 2010 vol. 29 #5

Increasing Operational Efficiencies and Reducing Excess Administration

Care1st Initiatives	Claims processing efficiencies, automated work flow distribution, prior authorization, credentialing alliance, pre-payment fraud detection tools
IOM Recommendation	#7 Optimized Operations
Stakeholders	All providers, Care1st employees
Timeline	2008 - ongoing
Desired Outcomes	Optimizing internal efficiency and effectiveness/accuracy, decreasing administrative burdens on providers, maximizing claim-related clinical editing and fraud detection pre-payment

Over the past 5 years, we've made an intense effort to build a strong infrastructure. Operational efficiency and effectiveness lie at the core of this effort. IOM states that healthcare delivery organizations should utilize systems engineering tools and process improvement methods to eliminate inefficiencies, remove unnecessary burdens on clinicians and staff, enhance patient experience, and improve patient health outcomes. Care1st employs these methods to continuously improve operating outcomes. We've achieved the following successes:

1. Provider offices are small businesses and rely on timely and accurate claim processing.

Care1st results	2008	2009	2010	2011	2012
% claims processed in 30 days	98%	99%	100%	99%	100%
Procedural accuracy	97%	93%	96%	97%	96%
Financial accuracy	98%	99%	99%	99%	98%
Auto adjudication rate	35%	49%	58%	61%	62%

The above results reflect superior claims processing and strong operations, including meticulous provider contract loading, system configuration/maintenance, and effective clinical operations. **Our goal: To get it right the first time**, and to make certain the underlying infrastructure, people and systems function accurately and efficiently. This ensures that providers receive timely, accurate claims payment.

2. We recently implemented a fully integrated customer service and workflow distribution application, Automated Workflow Distributor (AWD). AWD integrates with MHC, our core business application system. It includes robust tracking. Our customer service center call teams use the AWD customer service module to access everything they need to know about a member or provider, and to effectively complete calls using a single screen. As a result, we answer calls faster and more effectively. **We expect a 17% improvement in claim productivity, which translates to \$.95 per claim. Based on current claim volume, annual savings should reach more than \$675,000.** We also expect to complete 4 more calls per hour per Customer Service Representative, a 35% improvement within the 1st 6 months.
3. Our cross-functional workgroup analyzes code sets and utilization to set or reset prior authorization requirements and continually improve the authorization process. The Prior Authorization Cross Department Workgroup manages all changes to Prior Authorization Guidelines. Arizona-based Care1st experts from Medical Management, Administration, Claims, Provider Network Operations, and Information Systems participate in the workgroup, ensuring effective guidelines and continually review them for opportunities to reduce requirements. We're also implementing the Milliman web-based AutoAuth Module, an automated evidence- and rules-based system, to further streamline prior authorization and ensure accurate, consistent decision-making.
4. Care1st led an effort sponsored by the Arizona Association of Health Plans (AzAHP) to implement a new credentialing alliance that reduces credentialing burdens on Arizona providers. Nine participating plans are collaborating to reduce administrative waste. We helped establish the alliance, and maintain a vested interest in its success.
5. The IOM 2012 study attributes \$75 billion to fraud, and discusses strategies to eliminate it. We are committed to detecting and preventing healthcare fraud. We've invested heavily in tools to detect inappropriate billing for services provided (clinical editing), and billing for services not provided (fraud detection and investigative services)—and we maximize our efforts before claims are paid.

Clinical Editing: Care1st employs 2 levels of clinical editing. We perform the initial level during the claims adjudication process utilizing McKesson's ClaimCheck software, a clinically based editing system that fully integrates with our core business application system, MHC. We accomplish the 2nd level by sending adjudicated

claims pre-payment to Emdeon’s Program Integrity solution, Bloodhound Technologies, which powers their Clinical Integrity for Claims service. This service offers flexible and transparent claims edits that leverage more than 16 million rules based on protocols from the American Medical Association, Centers for Medicare and Medicaid Services and other industry sources.

Fraud Detection and Investigative Services: We use the Sentinel Group, Emdeon’s Program Integrity fraud detection and investigative solution, which combines retrospective claims analysis and prospective fraud detection techniques. It reviews and analyzes historical claims data, medical records, suspect provider databases and high-risk identification lists before we pay. Emdeon works with more than 1,200 payers, giving us access to discovered fraud and abuse schemes.

Additional program integrity activities include avoidance/savings such as: TPL/Subrogation, Coordination of Benefits, bundling due to case rates, outlier reductions, and Outpatient Pricing Fee Schedule (OPFS) bundling/edits.

Total savings realized from the CYE12 Care1st program integrity activities:

Program Integrity Savings CYE12	Savings PMPM	% of Total Care1st Medical Expense
\$42,126,260	\$74.78	30%

Enhancing Community Linkages and Reducing Prevention Failures

Care1st Initiative	Care1st Community Resource Centers (CRCs)
IOM Recommendation	#5 Community Links
Stakeholders	Health and human service agencies, Care1st members, southwest valley residents
Timeline	2009-ongoing
Desired Outcomes	Create greater access to community services by providing cost effective solution for participating agencies to reach constituents; assist in meeting the social needs of individuals, allowing them to focus on their health

Resource Centers: Care1st has made a significant investment in an innovative approach to develop access to community resources for underserved populations. Our award-winning CRCs (winner of WESTMARC’s 2010 Best of the West Public Private Partnership) in Avondale and Gila Bend provide a “sustainable model that improves outcomes.” We bring together more than 24 social services/agencies to offer easily accessible information and meet social, economic, medical, and behavioral health needs. By making more resources available, Care1st provides a cost effective way for participating agencies to reach their constituents, which increases efficiency and decreases waste and effort. **Our CRCs support members of undeserved communities who don’t have the transportation or resources to travel to multiple centers to obtain services. At the same time, we’re creating a culture of caring for the whole person, which helps improve overall health outcomes and lowers costs.**

Care1st Initiative	Text Messaging Pilot
IOM Recommendation	#4 Patient Centered Care; #7 Optimizing Operations
Stakeholders	Care1st members and providers
Timeline	March 2013-ongoing
Desired Outcomes	Improve use of primary and secondary prevention services, increase health literacy/member education, increase efficiency/effectiveness in communicating with members, increase member satisfaction

Text Messaging Pilot: According to a 2010 survey by PwC (formerly PricewaterhouseCoopers) Health Research Institute, 79% of Medicaid members who own a mobile phone text regularly. Text messaging is emerging as an effective strategy for communicating with patients to improve compliance with health services.

This initiative leverages wireless communication tools to engage members in their healthcare and to help them access prevention services. This streamlined, automated approach efficiently communicates with a large number of people. Initially, the project targets 2 populations expected to benefit most from improved access to primary and secondary prevention: Adolescents, and adults with diabetes. We’ll reach adults and adolescents ages 18 through 20 directly; we’ll contact those age 17 years and younger by texting parents. Based on studies involving Medicaid and other low-income patients in these groups, we expect to **increase adolescent well care visits by at least 10% among members whose parents receive texts, and we expect to improve compliance with Hemoglobin A1c testing among diabetic members by approximately 20%.**

Text messaging gives patients and families the opportunity to be fully engaged in all care levels, including individual care decisions, health system learning and improvement activities, and community-based interventions to promote health. By empowering members with more information and evidence-based resources to take better care of themselves, we expect to increase enrollee satisfaction and improve clinical quality measures identified as core metrics of patient health.

Care1st will facilitate member access to a free cell phone and minutes through the Federal Lifeline program under a partnership with an approved vendor. Text messages sent to these cell phones will not be subtracted from the user’s 250 free minutes.

In addition to service reminders, members will regularly receive health education tips. Each message will include an easy way to connect to Care1st for more information or to schedule an appointment. Text reminders will reinforce other performance measure strategies currently employed by Care1st, including phone contact, letters, member newsletter articles and provider outreach.

Reducing Unnecessary Services

Initiative	Arizona Health Information Technology (HIT)/Health Information Exchange (HIE)
IOM Recommendation	#3 Clinical Decision Support
Stakeholders	All providers, all Care1st members
Timeline	February 2012-ongoing
Desired Outcomes	Reduce unnecessary services, reduce fragmentation, improve information and safety, improve completeness of medication listing, improve efficiency and continuity of care

Arizona’s Health Information Technology (HIT)/Health Information Exchange (HIE): This important local initiative has the potential to cut waste and improve outcomes by reducing unnecessary services. Health Information Network of Arizona (HINAz) and Arizona Health-e Connection (AzHeC)/Regional Extension Center (REC) have combined to facilitate design and implementation of integrated statewide health information technology (HIT) and a health information exchange (HIE). HIT/HIE improves safety, efficiency and continuity of care in 2 ways: On the front end by providing the right information to the right place at the right time; and on the back end by providing information for care coordination and comprehensive care management.

Care1st signed a Participation Agreement with HINAz in February 2012 as a Data Recipient and Funder. Care1st Chief Administrative Officer Scott Cummings joined the HINAz Board of Directors in May 2012 and was elected to serve on its Executive Committee in August 2012. We look forward to health plan data feed functionality in Q1 2013. We are actively working with HINAz on an eligibility interface so we can move forward once data feeds are available. We have supported, and will continue to support, AzHeC and the REC, and regularly communicate with providers on activities and incentives. Our Provider Network Operations team reviews opportunities for participation during their regular visits, in provider mailings, and blast fax communications.

Care1st will use the data to 1) identify high-risk members; 2) augment care/case management information and decision-making; and 3) augment Concurrent Review and Utilization Review activities. Together, HIT and HIE support the information needs of all health care stakeholders and will reduce health care costs, improve patient safety, and enhance the quality and efficiency of healthcare and public health in Arizona. Benefits include:

- Providing timely access to test results and medication information
- Reducing fragmentation and/or duplication of care and delays due to lack of information
- Reducing the risk of drug interactions and adverse drug events and
- Improving care, such as prevention and disease management.

As the IOM report discusses, “we must build a continuously learning health care system in order to reduce waste and improve healthcare. . .this responsibility rests on all of our shoulders.” **Our strategies align with IOM recommendations, and will improve quality and contain costs.** Initiatives such as our partnerships with Banner Health, Cigna Medical Group and MIHS; our focus on operational efficiencies; the Care1st Community Resource Centers; the text messaging pilot; and our leadership in HINAz—all demonstrate that we are **Compassionately Caring1st for our Community...Challenging ourselves every day to exceed the expectations of our members, providers and regulators.**

Exceeding expectations



fraud extracts \$75 billion



Program integrity is about creating an environment where expectations and incentives promote efficiency and quality. The Care1st corporate culture, including our employee education endeavors, embodies our commitment to being a superior steward of public resources. We subscribe to the Centers for Medicare & Medicaid Services Center for Program Integrity antifraud activities to detect, prevent, recover, and increase transparency and accountability; and the National Association of Medicaid Directors recommendations to improve the effectiveness and efficacy of Medicaid program integrity efforts.

Our response discusses:

- Fraud and abuse prevention and detection activities
- Care1st/Provider Joint Operating Committee meetings
- Partnering with AHCCCS for program-wide impact
- Active participation in the National Benefit Integrity Medicare Drug Integrity Contractor’s Fraud Work Group
- Our Corporate Special Investigations Unit
- Standards of conduct for subcontractors

Fraud and Abuse Prevention and Detection Activities

Care1st goes beyond minimum contract requirements with our investment in software and services to identify and limit inappropriate billing and claim submissions. McKesson’s ClaimCheck software is licensed and integrated with our core business application, MHC. We also employ Emdeon’s Program Integrity solution to identify opportunities that ClaimCheck may miss, and to expand our review beyond clinical code editing. We partner with our dental and retail pharmacy vendors to discover abuse and fraud. We apply Medicare program integrity training to our AHCCCS line of business whenever possible. Two additional layers of protection include the Standards of Conduct for Subcontractors and the Care1st Corporate Special Investigations Unit, which may investigate members, providers, vendors, contractors, subcontractors, and our own personnel.

ClaimCheck: McKesson ClaimCheck (ClaimCheck) is a clinically based editing system that fully integrates with our core business application, MHC. ClaimCheck’s comprehensive code auditing solution provides a solid clinical foundation to assist Care1st with proper physician reimbursement. **ClaimCheck automatically evaluates claims via sophisticated clinical logic prior to payment.** ClaimCheck uses comprehensive clinical databases developed and maintained by a team of full-time physicians, registered nurses, coding experts and other healthcare professionals. Clinical coding sources incorporated into ClaimCheck include CPT, HCPCS, ICD-9/ICD-10, American Medical Association, CMS guidelines, specialty society guidelines, medical policy and literature research and standards, and academia. ClaimCheck software contains all current Correct Coding Initiative (CCI) edits, multiple surgery/multiple procedure reductions, multiple channel laboratory test bundling, global day bundling, Status B bundling, and Medically Unlikely Edits (MUE). We customized ClaimCheck to include AHCCCS specific rules, such as allowing both a sick and well office visit to be billed when components of an EPSDT well exam are performed during a sick visit.

Emdeon: Care1st utilizes Emdeon’s Program Integrity solution, in partnership with Bloodhound Technologies and The Sentinel Group, for post-adjudication/pre-payment claim review. Bloodhound provides clinical code editing, while Sentinel provides fraud detection edits/algorithms and investigation. Completing Emdeon review post-adjudication/pre-payment allows Care1st to utilize core system edits and processing guidelines, and then apply Emdeon edits to ensure enhanced program and clinical integrity of claims **before payments are made** to providers. We process batches daily to avoid delays. In addition, we submit weekly claim history files to Emdeon, allowing for claim editing against a historical universe. To ensure an effective, streamlined workflow to handle Emdeon response files, we employ a dedicated Fraud, Waste and Abuse Analyst in the Claims Department whose primary responsibility is reviewing, analyzing and applying Emdeon recommendations before claims are paid.

Emdeon’s comprehensive edits include:

Bloodhound Edits	Sentinel Edits
• Add-on codes	• No supporting documentation
• Administrative modifiers	• Misrepresentation
• Age/gender for CPT and HCPC	• Inappropriate services/charges
• Medicaid CCI	• Billing for services or supplies not provided
• Data validation of diagnosis and procedure codes	• Peer group profiling
• Duplicates – date range CPT and HCPC	• Unlicensed or sanctioned providers
• Duplicates – lifetime CPT and HCPC	• Deceased and retired providers

• Multiple units (inter and intra claim)	• High-risk addresses, using a database of 35,000 suspect addresses
• Global surgery	
• Multiple surgeons/assistant surgeons	
• Status codes (B, N, P, T)	

Additional program integrity activities include avoidance/savings such as TPL/subrogation, coordination of benefits, outlier reductions, and Outpatient Pricing Fee Schedule (OPFS) bundling/edits.

Total savings realized from the CYE12 Care1st program integrity activities:

Program Integrity Savings CYE12	Savings PMPM	% of Total Care1st Medical Expense
\$42,126,260	\$74.78	30%

Dental: We work closely with our dental claim administrator, Advantica, on program integrity. For example, in Q3 2012, Care1st Dental Director Walter Pfitzinger, DDS, analyzed dental claims data from June 2011 to July 2012. He identified network dentists whose practice patterns differed significantly from their peers. Not included in the review were specialists in endodontics, oral surgery and periodontics, as virtually all their services are prior authorized and coded in accordance to Advantica’s clinical guidelines. This review targeted 5 areas prone to abuse:

1. **Excessive claims for restorative dentistry.** Reimbursement is significantly lower for sealants than fillings and we identified practitioners who frequently billed for fillings rather than sealants, as well as practitioners who restored teeth that didn’t need treatment.
2. **Miscoding of extractions.** We identified providers who miscoded simple extractions as surgical extractions, or removed primary teeth that soon would have been lost through normal eruption.
3. **Excessive 2-surface restorations.** Some practitioners billed for excessive numbers of 2-surface restorations involving the lingual surface in upper 2nd primary molars and 1st and 2nd permanent molars and the buccal surface in lower 2nd primary and 1st and 2nd permanent molars.
4. **Pulpotomies.** We identified outliers who completed pulpotomies in a high percentage of cases where stainless steel crowns were placed on primary teeth.
5. **Restorations.** We identified outliers who placed restorations on a high percentage of newly erupted bicuspid and molars. Data indicated that in some cases, restorations were placed instead of sealants or, in the case of bicuspid, on teeth for which sealants are not covered.

On November 4, 2012, following review of the analysis, we mailed an introductory letter to all general and pediatric dentists informing them that Care1st and Advantica were reviewing utilization patterns and would notify providers who varied significantly from network utilization norms. On November 14, 2012, we mailed a letter to 42 providers. Each letter identified the area(s) in which the practitioner’s utilization patterns were questionable. Dr. Pfitzinger is in the midst of telephonic outreach to discuss utilization patterns and answer questions.

We plan a follow-up analysis in mid-2013 to determine if patterns have changed. If not, we’ll take further action, including removing practitioners from our network.

Pharmacy: Care1st and our Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. (MedImpact) have implemented a comprehensive approach to improve the integrity of drug benefit programs to reduce fraud, waste and abuse. MedImpact’s dedicated compliance team and auditing staff manage preventive programs, auditing processes and required research and investigations to monitor members, pharmacies and prescribers.

MedImpact’s team of pharmacy auditors regularly conduct desk and onsite pharmacy audits to verify prescription legitimacy and member receipt of prescriptions. The team runs proprietary fraud, waste, and abuse algorithms against their database to identify claims for audit. The algorithms include analysis of days supply, quantity and maximum daily dose. One component of MedImpact’s audits verifies that members are receiving the correct quantity or days supply as prescribed by the physician.

Each quarter, the team runs a metrics report that compares Care1st network pharmacies with their peers by number and percent of prescriptions, compounds, controlled substances, rejects and reversals. The comparison identifies pharmacies with potential issues, and these outliers are investigated. The first steps involve desk and/or onsite audits. The next steps depend on the situation – if the investigation finds no concrete evidence but concern remains, MedImpact places the pharmacy on its Watch List and follows the pharmacy for an additional 90 days. If potential issues are found,

MedImpact contacts MEDIC as well as Care1st, the state pharmacy board, and local, state and federal officials, particularly if it discovers problems that involve pharmacy practice.

Care1st/Provider Joint Operating Committee (JOC) Meetings

Care1st conducts monthly and quarterly JOCs with select providers. Provider Network Operations, Claims, Medical Management, Prior Authorization, Finance, and Administration attend each JOC. We use the JOC structure to proactively engage our providers, review operational processes, claim reconciliations and audit findings. For example, in early 2010, we implemented an exclusive contract for DME/infusion. The agreement included periodic claim reconciliations with an incentive/penalty component related to accurate and complete claims submission. This incentivizes our providers to bill services correctly and on a timely basis so we can submit encounters timely and accurately to AHCCCS.

Contractual incentives and/or penalties began in the 1st month of capitation, followed by evaluation periods every 6 months. We base the financial incentive and/or penalty on claims reconciliation results. At the end of each 6 month period, we give the provider time to self audit, ensure that all claim submissions are clean, and resubmit any corrected claims prior to reconciliation.

For the reconciliation, the provider generates a detailed claims report that we match up to claims that the provider submitted to Care1st. If the final match percentage is above a defined threshold, the provider receives additional capitation for all member months in the 6-month period in the form of a PMPM incentive payment. If the final match percentage falls below a defined threshold, Care1st deducts a specific PMPM amount for all member months in the 6-month evaluation period from a future payment. The result: After 2 reconciliations, the match percentage improved from 88% to 90.5%, and our cap rate for infusion services was reduced by 15%, for an annual savings of \$102,000.

We report results of each reconciliation and audit to the JOC; the JOC ensures that all issues are addressed and resolution is documented.

Partnering with AHCCCS for Program-Wide Impact

To find areas of potential abuse, Care1st actively identifies providers whose billing patterns differ significantly from their peers. When warranted, we reach out to the providers and to AHCCCS to share data and request clarification.

For example, in late 2010, we identified a non-contracted hospital system that owns 3 off-campus urgent care centers, licensed under the hospital. The system was billing urgent care services using emergency room (ER) visit codes. We compared claims billed by all hospital-owned urgent care centers, and our analysis indicated the majority of other hospital-owned urgent care centers consistently billed CPT codes describing office visit codes vs. ER visit codes. The urgent care centers in question did not meet the CMS criteria for ER visit codes, yet were receiving significantly higher reimbursement compared to other hospital-owned urgent care centers. We reached out to the system on 3 separate occasions to discuss our findings, provide the CMS guidelines and request further discussion, but the provider was not responsive.

Care1st provided documentation, including the CMS guidance, to AHCCCS in early 2011. We held several e-mail discussions with AHCCCS Rates and Reimbursement Administrator Jean Ellen Schulik. An AHCCCS workgroup reviewed our findings and concluded that an AHCCCS clarification of current coding guidelines would be provided. The October 1, 2011, AHCCCS Claims Clues and the September-October 2011 Encounter Keys documented the following:

- Only ERs that are open 24/7; subject to EMTALA, and licensed as ERs, can bill 99281-99285 (ER visit codes); and
- Urgent care centers—even those that are hospital affiliated—may not bill 99281-99285 as these codes are, by definition, only appropriate when billed for services in an ER.

As part of the clarification, AHCCCS wrote that submitting a claim using these codes for services provided outside of the 24-hour Emergency Department is prohibited under A.R.S. 36-2918 and constitutes the knowing presentation of a claim for medical services that were not provided as claimed. AHCCCS informed providers that it would monitor these codes and disallow payment for any inappropriately billed codes from urgent care centers. Providers submitting such claims are subject to civil monetary penalties and/or criminal prosecution. In addition, AHCCCS advised providers that non-emergency outpatient services in urgent care settings may be denied by the patient's health plan if the provider is not in the health plan's network. This is an example of Care1st's commitment to partnering with AHCCCS to identify and eliminate potential program abuse.

The National Benefit Integrity Medicare Drug Integrity Contractor

The National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) is the Medicare Part C and Part D program integrity contractor for the CMS. NBI MEDIC’s purpose is to detect and prevent fraud, waste, and abuse in the Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level. Each quarter, NBI MEDIC sponsors a Fraud Work Group meeting to share information with health plans regarding fraudulent activity, national fraud schemes and fraud cases referred to NBI MEDIC. CMS and law enforcement answer questions. The Care1st Compliance Team actively participates and shares information received with our managers and subcontracted vendors. In addition, we use the NBI MEDIC website as a training, education and fraud alert resource. For example, the May 2012 NBI MEDIC meeting revealed several fraud schemes, and we used the information to review our processes and implement fraud controls.

The process we implemented reviews utilization of various medications. We found that prescribing and utilization of opioids, namely Vicodin and Oxycodone, were frequently in the top five medications prescribed by PCPs (IM and FP providers) and pain management (PM) specialists. In light of the national epidemic of prescription opioid misuse and abuse, and the important role that practitioners can play in preventing drug abuse and diversion, we reviewed medical records of members with chronic non-cancer pain who were treated by the top 30 narcotic prescribers in our network, including PM providers and PCPs. The goal was to identify the adoption and implementation of safe narcotic prescribing practices and to find opportunities for improvement. Care1st CMO Dr. Albena Baharieva, in conjunction with a consultant who is a well-known addiction specialist in Arizona, completed the medical record review.

We also reviewed guidelines for managing chronic non-cancer pain issued by the American Pain Society and the American Academy of Pain Medicine. We identified common challenges and opportunities for improvement:

- Diligent and consistent review of prior medical records to identify patients at risk for opioid abuse and diversion and
- Consistent use of drug screening, narcotic contracts and the Arizona Board of Pharmacy’s Controlled Substance Prescription Monitoring Program (Arizona CSPMP).

Care1st adopted the national guidelines for management of chronic non-cancer pain, and we post them on our website. In addition, we wrote and disseminated guideline summaries to PCPs and PM providers. We also provided information about Arizona CSPMP, and we’re creating a CME educational video that we’ll post on our website. We’re committed to monitoring narcotic prescribing practices, and to addressing issues as they arise. **Why are we so concerned about opioid misuse and abuse?** Here are just a few reasons:

- Accidental drug overdose is the leading cause of accidental deaths in the U.S., and prescription opioids cause the majority of these deaths.
- Diverted prescription opioids have overwhelmingly become the gateway drugs to heroin addiction in children and young adults.
- U.S. government statistics show that non-cancer patients on continuous opioid therapy experience excess healthcare-related costs greater than patients who are not on continuous opioid drugs.

As part of our effort to combat opioid abuse, we’re involved in developing an innovative way to better manage high-risk members on prescribed opioid therapies. We facilitated an initial discussion with AHCCCS clinical and OIG leadership regarding this **solution, which will dramatically reduce opportunities to divert and/or abuse on a program-wide basis**.

Corporate Special Investigations Unit

Care1st is vigilant about eliminating healthcare fraud, waste and abuse, and we do all we can to detect, deter and report it. We created a Corporate Special Investigations Unit (SIU) responsible for establishing and operating a comprehensive, organization-wide integrated fraud control program. Currently, the SIU fully investigates Medicare and Medi-Cal (the California Medicaid program) fraud referrals and compliance. In Arizona, Compliance performs preliminary investigations of Medicaid fraud, and forwards the referral to AHCCCS. If AHCCCS begins to allow full investigations of Arizona Medicaid fraud, the SIU stands ready. The SIU team presents investigative report summaries, facilitates corrective action, and follows up.

A variety of sources communicate allegations of fraud to the SIU:

- Managers
- Employees
- Members
- The Care1st Compliance Hotline—our independent vendor is Global Compliance
- First-tier and downstream contractors
- Findings from internal audits
- Data analysis

The SIU holds a monthly sub-committee meeting focused on in-depth discussion of individual case files, investigation outcomes and corrective action recommendations. The SIU reports all cases investigated to the Compliance Committee and the Board of Directors.

Subcontractors Conduct Standards

We provide Care1st Standards of Conduct to all subcontractors. The document outlines expectations for ethical conduct, policies for legal compliance, and programs to prevent fraud, waste and abuse. It also addresses the subcontractor's role in achieving these basic values:

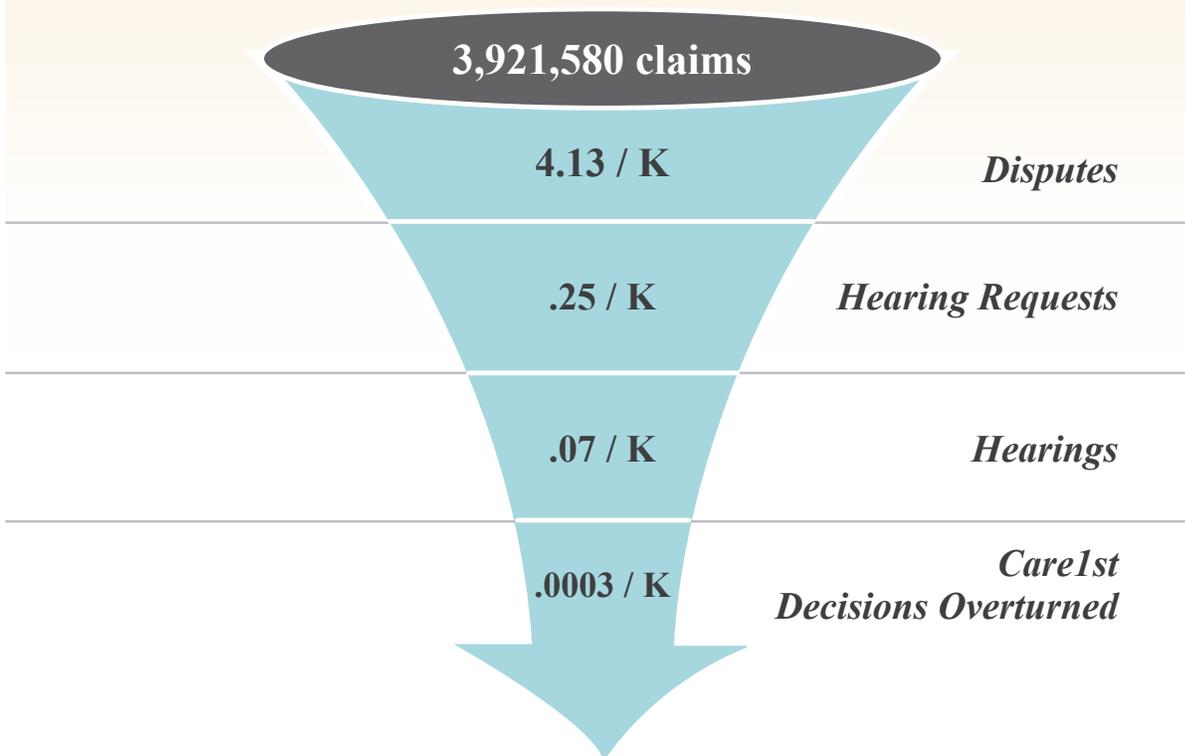
- Providing quality, cost-effective healthcare services to our diverse patient community
- Being honest, trustworthy and reliable in all relationships
- Being responsive to the needs and expectations of healthcare professionals who are part of our team
- Pursuing profitability and growth
- Treating all our providers, vendors, and employees with respect
- Complying with all applicable legal, regulatory, and contract requirements and
- Preventing fraud, waste and abuse in healthcare programs in which we are involved.

We take violations seriously. Violations may lead to contract termination. In addition, we report violations to federal, state and other entities as required by law.

Care1st's efforts to limit, identify, and address fraud and abuse exceed requirements outlined in the RFP and AHCCCS policies. Our proactive efforts resulted in overall program savings of **\$42,126,260** during the previous contract year. Our first priority is to identify and correct inappropriate billing **before payment is made**, and we have configured our system to maximize this capability. We augment our internal abilities with Emdeon's program integrity suite in a post adjudication/pre payment position. In addition, we work closely with our dental and pharmacy partners to prevent fraud, waste and abuse.

Care1st collaborates and leverages our tools to improve the effectiveness and efficiency of our operations and invests in program integrity efforts beyond what is contractually required. We partner with AHCCCS and CMS to improve Medicaid and Medicare programs on a program-wide basis. **We Compassionately Care1st for our Community...and we challenge ourselves every day to exceed the expectations of our members, providers and regulators in our role as effective stewards of public funds.**

From 2008 - 2012



For providers, the most frequent reason for claim disputes is inaccurate or untimely payment. Care1st's strategies and procedures assure accurate and correct system setup before we receive a claim. Regular and ongoing audits of data and staff, timely resolution of issues, and a tiered alternative resolution process mitigate the use of the AHCCCS defined dispute process. We've set up processes that help us exceed contract requirements and ensure provider and member satisfaction. Our claims processing system, MHC, serves as the foundation to ensure accurate claims adjudication, and we use it exclusively for our AHCCCS and Medicare D-SNP business. The achievements outlined below demonstrate our positive results.

Measure	2012 Results
Claim accuracy	Financial quality 98.3%; procedural quality 96.2%
Claim payment timeliness	99.8% processed within 30 days
Claim disputes	3.98 disputes/1,000 claims (.004% of claims received)
Alternative pre-dispute resolution	99.9%
Disputes resolved prior to hearing request	95%

Our response discusses:

- Preventing claim disputes through accurate system setup, training and monitoring
- A tiered resolution process that promotes win-win solutions through:
 - Pre-dispute resolution
 - Pay and educate
 - Alternative dispute resolution process
 - Pre-hearing resolution

Preventing Claim Disputes through Accurate System Setup, Training and Monitoring:

Our strategies to pay claims correctly begin prior to receipt of a claim. We focus on the following tools to ensure accuracy:

- A cross-functional workgroup structure that oversees provider contract loading, fee schedule and benefit setup/maintenance
- Meticulous testing prior to implementing system setups, and comprehensive documentation of each setup
- Thorough auditing following implementation and
- Ongoing process improvement.

Workgroup Structure Drives Setup and Maintenance: Care1st brings together experts from our Arizona team in workgroups focused on the AHCCCS line of business. Our workgroups agree upon provider contract loads, fee schedule and benefit setup/maintenance prior to system implementation. They evaluate options, design and run test scenarios, and review test results before final setup. Each workgroup documents details in a specific log, including the subject, the deliverable/action, responsible party and resolution date. Three workgroups focus on provider contract loading, fee schedule and benefit setup/maintenance:

Workgroup	Attendees/Department	Workgroup Focus
Claims/IS	Information Systems: <ul style="list-style-type: none"> • Director Kathy Thurman • Application Manager Ivy Boyer • Configuration Analyst Margie Alexander • Configuration Analyst Dan Ramirez Claims: <ul style="list-style-type: none"> • Director Steffanie Costal • Testing Lead Mike Alabado 	Defines and implements adjudication rules, benefits, and pricing to ensure claims are paid correctly the first time: <ul style="list-style-type: none"> • Discusses, plans, and thoroughly tests new configuration before moving it into production • Reviews all changes to adjudication rules, benefit setup and provider pricing before finalization • Monitors auto adjudication, benefit setup, and adjudication rules for accuracy and efficiency • Identifies improvement opportunities, manages project plans, and coordinates efforts between departments • Maintains documentation
System Implementation	Includes all attendees of Claims/IS workgroup plus: <ul style="list-style-type: none"> Provider Network Operations: <ul style="list-style-type: none"> • Director Jessica Sedita Igeneri • Representative Pat Lapp Finance: <ul style="list-style-type: none"> • Financial Analyst Dave Scheer 	Determines contract setup for accurate claims payment: <ul style="list-style-type: none"> • Reviews contract terms • Identifies system setup requirements • Tests system setup, reviews results and modifies as needed • Educates and implements improvements • Maintains change documentation

<p>Fee Schedule</p>	<p>Provider Network Operations:</p> <ul style="list-style-type: none"> • <i>Jessica Sedita-Igneri</i> • <i>Pat Lapp</i> <p>Information Systems:</p> <ul style="list-style-type: none"> • <i>Kathy Thurman</i> • <i>Dan Ramirez</i> • <i>Margie Alexander</i> 	<p>Manages fee schedule creation and maintenance to ensure accurate claims payment:</p> <ul style="list-style-type: none"> • Completes updates accurately and on a timely basis following regulatory and contractual fee schedule changes • Maintains documentation specific to each fee schedule including tracking of changes/updates
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Meticulous Testing and Comprehensive Documentation: Testing and documenting contract loads, fee schedule and benefit setup/maintenance is critical for consistent, accurate claims payment. We document details in a Specification Grid maintained by Configuration Analysts (CA). CAs initiate setup in the dedicated test environment of our core system, MHC, based on the Specification Grid. Our Testing Lead processes claim scenarios, and the Claims and IS directors document and review results. After testing and approval, we move setup into production.

We strictly adhere to internal system setup, contract loading, and benefit guidelines. In addition, our Provider Network Operations (PNO) Director coordinates closely with providers.

- Provider Data Maintenance (PDM) Specialists complete contract loads within 5 business days.
- We coordinate newly negotiated/renegotiated contracts requiring a new/updated fee schedule with the provider, allowing time to complete the fee schedule and testing process.
- CAs monitor the AHCCCS website for fee schedule changes. We complete updates within 5 business days of receipt and include file preparation, fee schedule updates and validation/quality check.

Contract and Fee Schedule Audit Process: A thorough audit process guarantees that claims are processed correctly and according to contract terms. We conduct audits for each component of contract loading, fee schedule and benefit setup. The PNO Auditor audits 10% of provider contract loads using a detailed checklist that covers each step of the process. The auditor documents each audit in the PNO Audit Log, and returns errors—along with the Audit Checklist—to the PDM Specialist for correction. Upon correction, the auditor signs off on the Audit Checklist and updates the Audit Log. The PNO Director reviews audit results and setup/update turnaround times monthly with each PDM Specialist. All completed loading forms not chosen for the random audit are returned to the PNO Representative for a quality check. The PNO Representative audits results against the system for accuracy, and returns errors to the PDM Specialist for correction.

Additional Contract Audits: Quality Assurance (QA) Auditors, who report to Chief Financial Officer (CFO) Deena Sigel, conduct monthly reviews of provider contract terms focused on provider contract load accuracy to ensure correct provider payments. We evaluate the monthly sample size annually based on contracted provider volume. Providers include large groups, individual practitioners, and ancillary providers. As we set pricing at the vendor level, our goal is to audit every active vendor at least once every 5 years. QA Auditors review payments against the provider contract setup in MHC, and against the physical contract file, to validate that the provider is loaded correctly and tied to the correct fee schedule. For non-contracted providers, the QA Auditors validate payment against the AHCCCS defined fee schedules. QA Auditors document results and forward discrepancies to the PNO Director, who coordinates resolution with the PDM Specialist and/or the CA.

Other QA Audits

- » Regulatory fee schedule updates
- » Non-standard vendor pricing and/or fee schedules
- » Management-requested ad hoc audits

Claims Training and Education/Reference Materials: New claims processors complete 8 weeks of rigorous training and are audited daily. Once on the floor, ongoing training and education continue. Our Claims Trainer is dedicated to enhancing and improving training material and providing individual and team training to improve performance and customer service. We email a daily Tip of the Day to claims staff to improve quality and productivity, and document the tips in a log easily referenced by the Claims Team. AHCCCS-specific claim analyst meetings are held monthly and a quarterly department meeting keeps staff up-to-date on procedures. In addition, we use email and ad hoc meetings to discuss and communicate changes. A formal job aid release process for claims training and documentation includes peer review prior to release and a standardized Tuesday release schedule. Analysts then review and apply the new guidelines Wednesday through Friday. On the following Monday, the team huddles to review changes and field questions. Analysts use a variety of online resources to facilitate accurate claim adjudication, including job aids outlining submission requirements, authorization, COB, specialty claim handling, AHCCCS guidelines, adjustment code requirements, and helpful hints.

Quality Focused Culture and Employee Engagement: Employee feedback drives our Claim Department’s quality improvement program—Success through Training, Acknowledgement, Recognition, and System improvements

(STARS). The STARS Committee suggests improvements. Since inception 2 years ago, we've implemented 61 suggestions, which helped streamline processing and improve quality through system edits and enhancements, documentation updates, additional monitoring reports and analyst training.

A quarterly Incentive Bonus Program rewards claims staff for exceeding AHCCCS and internal performance standards. Staff has exceeded standards every quarter since program inception. Individuals must exceed their minimum performance standards to qualify for a bonus. In addition, fun monthly incentives focused on quality and production, and employee recognition combine team and individual incentives with target goals and prizes to acknowledge the best performance. Beyond motivating employees to exceed standards, incentives empower employees to exceed Care1st and AHCCCS standards and provide excellent service to providers.

Performance Standards: Analysts are required to achieve specific quality and production goals designed to minimize rework and improve provider satisfaction. We analyze quality statistics weekly for trends and training needs. Care1st exceeds the AHCCCS timeliness standards and processed 100% of claims within 30-days between February and December 2012.

Accurate Claims Adjudication: We adjudicate claims in MHC, a HIPAA-compliant system that accurately processes claims in accordance with AHCCCS rules and regulations, Care1st policies and procedures, and provider contracts. MHC integrates enrollment, other insurance, benefit setup, prior authorization (PA), fee schedule and financial data, and provider coverage; validates member eligibility/benefits; and allows accurate claim pricing based on user-defined adjudication tables.

Automation: MHC automatically matches the PA to the claim, which streamlines processing and reduces errors. Extensive edits are built into MHC to allow auto-adjudication of a large percentage of claims. In 2012, 62% of medical claims were auto-adjudicated, which met our goal. Our 2013 target is to auto-adjudicate more than 65%. The Claims Report Analyst performs a post-adjudication/pre-payment review of 20% of auto-adjudicated claims as an additional quality check, and errors are corrected prior to payment. A Claims Analyst reviews manually processed claims prior to adjudication to ensure that required information is available to determine accurate benefits.

Accurate Coordination of Benefits (COB): We use a combination of data feeds, MHC system edits, and manual oversight to accurately coordinate benefits. We upload and reconcile AHCCCS 834 files to MHC daily/monthly. MHC tracks multiple COB carriers with date-defined segments to accurately apply COB. A full-time COB Analyst is dedicated to COB verification, system updates, and AHCCCS notification. We use reports received from AHCCCS to validate the accuracy of data loaded. The COB Analyst compares information on the AHCCCS website against the submitted COB data, transmits discrepancies to AHCCCS daily, and documents transactions in an internal database. Care1st coordinates benefits according to AHCCCS guidelines. For our dual-eligible Medicare and Medicaid members, we cross over claims to coordinate benefits from a single submission.

Quality Assurance, Communication and Follow-up: The independent QA Audit team, which reports to CFO Deena Sigel, performs random and focused audits to ensure accurate claims processing. Claims Analysts receive weekly audit reports summarizing individual results. Auto-adjudication audit results are issued to the Claims/IS Workgroup. Monthly audit results are distributed to Senior Management and Claims Management (Director and Supervisors). The Claims Director summarizes results in a monthly report to the Board of Directors. The audit team meets weekly with Claims Management and communicates audit trends. The audit team recommends improvements, including additional staff training, job aid updates, or Tip of the Day suggestions.

Since 2009

- » Procedural quality improved from 93.4% to 96.2%
- » Financial quality averaged over 98%

Additional MHC Edits/Audits

- » Medicaid CCI
- » MUE/AHCCCS limits
- » Multiple procedure/surgery reductions
- » Global day E&M bundling
- » Timeliness standards
- » Data validity
- » Provider qualifications/eligibility
- » Over-utilization standards

Audit Components

Pre-payment audit samples:

- » 100% of claims with payment > \$10,000
- » 100% of claims above analyst authority
- » 100% of auto adjudicated claims with a payment > \$750

Focused pre-payment audits (payment > \$100):

- » 100% for modifier 59/76/77
- » 100% for out-of-state claims

Post-payment random audit samples:

- » Sliding scale (10% to 100%) for new hires based on proficiency
- » 5% of claims processed by experienced analysts (after release from new hire pool)
- » 1% of all auto adjudicated claims

We correct claim errors found during pre-payment audit phases prior to release, and take a proactive approach to ensure post payment errors are corrected on a timely basis. Analysts correct all errors following issuance of weekly reports. Through their monthly report process, the audit team verifies that corrections have been completed. Any uncorrected error is sent to the Claims Director for follow-up, and the IS Director returns the monthly auto adjudication error report to the audit team with documentation of system corrections.

Medical Management: Prior Authorization. Care1st Medical Management staff minimizes the number of provider claim disputes by correctly reviewing, approving and inputting PA requests. We audit a minimum of 10 PA requests per month for each team member. The audit reviews the authorization request, data entry, and supporting documentation, and validates authorization criteria.

Concurrent Review. We actively manage members admitted for inpatient services. Chief Medical Officer (CMO) Alben Baharieva holds daily rounds with Concurrent Review Nurses and Case/Disease Management to medically review and discuss all inpatient cases. Outcomes are communicated to hospital case management, documenting benefit coverage for each stay. Peer-to-peer discussions prior to discharge result in agreement regarding medical appropriateness of services, and reduce claim disputes. Communication between the facility and Care1st is instrumental in providing the best possible care for our members, and assures provider satisfaction with reimbursement.

Submitted Claims vs. Prior Authorization. When we receive a claim for an authorized service and there's a discrepancy between the PA and claim, the claim is not denied. Instead, it's sent to Medical Claims Review, Certified Professional Coders, for review and to determine if an update to the PA is required. Medical Claims Review discusses disallowed days and charges for outlier reimbursement and Prior Period Coverage with facilities. Prompt and detailed pre-payment communication improves satisfaction by giving hospitals the opportunity to review payment reductions and discuss concerns, minimizing claim resubmissions and disputes.

Dental Administration: Care1st delegates dental authorization and claims processing/customer service to Advantica Dental Services, Inc. Advantica is Delta Dental's Medicaid-focused subsidiary. Advantica utilizes aQden to authorize and pay claims according to AHCCCS rules and regulations, Care1st policies and procedures, provider contracts, and PA requirements. aQden accurately edits for benefits, timeliness standards, data accuracy, provider qualifications, member eligibility and enrollment, COB/cost avoidance, and over-utilization standards. Advantica utilizes tools, processes and oversight for benefit setup/maintenance similar to Care1st's. Advantica performs rigorous testing and thoroughly documents policies, procedures, and benefit setup. Advantica provides Care1st/AHCCCS-specific training to employees. Care1st oversight includes a monthly Joint Operating Committee (JOC) meeting and validation of compliance with performance standards. Care1st collaborates with Advantica to create and review policies and procedures, and we audit each delegated function annually. The monthly Care1st claim processing audit results are consistent with internal QA audits conducted by Advantica. 2012 overall results reflect consistent compliance with Care1st and Advantica quality standards and AHCCCS timeliness requirements.

Claims Process Improvement: Care1st is dedicated to accurate payment the first time. We gather feedback from providers through phone inquiries and in-person visits. We also analyze claim dispute trends. Our workgroups discuss the root causes of issues, and develop resolutions including process changes, system setup improvements, and additional provider education tools. Adjustment and overpayment trends are discussed during monthly and quarterly research and recovery meetings attended by the Claims Director, Supervisors, Report Analysts, Testing Lead, and Refund and Recoupment Analyst. In addition, Claims Leadership (Director, Supervisors, Testing Lead, Trainer, and Educator) meets quarterly to review rework, customer service phone call trends, claims questions, and detailed quality statistics, with the goal of identifying training needed to improve results.

Claim Disputes & Appeals Process Improvement: We use several strategies to achieve our mission of exceeding provider expectations. Our Claim Dispute and Appeals Department (CD&A) independently reviews operations. CD&A studies dispute data each month to identify trends and outliers. When trends are identified, the CD&A Manager reaches out to providers and/or other Care1st departments to reduce future disputes. We leverage Care1st local subject-matter experts and workgroups to initiate and implement change. All overturned disputes are reviewed monthly with Claims and Medical Management to identify training needs and process improvements.

Encounters: An Encounters Workgroup, with representatives from Administration, Encounters, Claims, Finance, and Information Systems, meets monthly to discuss encounter submission results and fluctuations in pend/denial encounter volume. The workgroup identifies trends, analyzes root causes and finds ways to reduce encounter errors through system setup or process changes. The group identifies trends, which result in provider outreach and claims education.

Tiered Resolution

Pre-Dispute Resolution: Claims Customer Service (CCS). As part of providing excellent customer service to providers, we employ a local CCS Team dedicated to our AHCCCS and Medicare lines of business. Each member of our CCS

team becomes a fully trained claims processor, providing an elevated level of service compared to a standard customer service department. CCS researches and logs each incoming claim inquiry into our Customer Service Automated Work Distributor (AWD), which is fully integrated with MHC. We use a variety of tools to ensure that we offer accurate information in accordance with AHCCCS and Care1st policies and procedures—including internal policies, job aids, the Imagenet website (which houses claim images), the Emdeon website (which houses remittance advices), and the AHCCCS online website. When a claim requires an adjustment due to incorrect reimbursement, we automatically route the case, along with specific requirements, through AWD to appropriate Claims Staff for handling. We complete 85% of CCS claim adjustments within 7 calendar days, and complete all CCS adjustments within 2 weeks. When a provider disagrees with CCS, we escalate the call to our Claims Educator, who completes a 2nd review and discusses the claim’s handling with the provider. CCS also uses monthly feedback to identify outreach opportunities for our Claims Educator.

We take pride in the knowledge level of our CCS staff and their exceptional customer service. During the past 12 months, CCS achieved a 93% First Contact Call Resolution Rate, exceeding the AHCCCS standard of 70%. CCS makes it a top priority to follow up on any call not resolved at the time of 1st contact. When further research indicates an adjustment is not warranted, we contact the provider with specifics regarding the original claim payment. Taking time to have these discussions with the provider minimizes claim disputes.

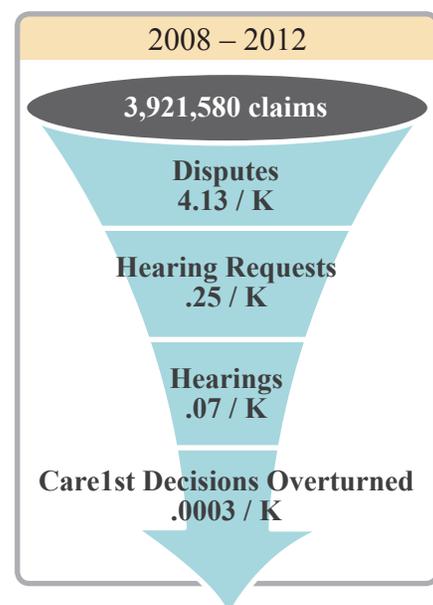
Partnering with our Providers and Provider Education. We assign a dedicated PNO Representative to contracted providers. The PNO Representative meets personally with their providers and staff, providing training on guidelines and assistance with claims questions and issues. This includes education on industry standards and AHCCCS-specific edits applied during the claims adjudication process. Blast-fax communications, provider reference materials and ongoing education help providers accurately submit claims, reducing claim disputes. When we identify billing errors, our Claims Educator provides a detailed explanation of the denied claim(s), and makes certain our provider understands the deficiency to avoid further denials. Monthly or quarterly JOC meetings with contracted hospital partners and key ancillary providers, including home health, Enteral, DME/Infusion, and transportation, monitor claim payment accuracy and timeliness and ensure provider satisfaction. PNO, Claims, Medical Management, Prior Auth, Finance, and Administration attend JOC meetings. This structure allows us to proactively engage our providers and hear concerns directly; to monitor timeliness and accuracy of claims payment; to identify billing and system setup issues and process gaps; and to discuss other opportunities for claim processing improvements.

Pay and Educate: For one-off claim disputes, we employ a pay and educate strategy, which includes coordinated provider education by the PNO Representative and Claims Educator. CD&A executes alternative payment strategies with contracted and non-contracted providers, settling disputes at a mutually agreed upon, medically appropriate level of care.

Alternative Dispute Process: CD&A manages our highly successful alternative dispute process with contracted hospitals, who account for 70% of our inpatient utilization. The team includes CD&A, Medical Claims Review, our CMO and CFO. They meet monthly or as needed with hospital staff. *Both sides are empowered to make decisions during the meetings. Since 2008, 1,568 out of 1,570 JOC cases (99.9%) have been successfully resolved.* This means Care1st and the hospital reached an amicable resolution and avoided the formal dispute process on 5,059 preliminarily disputed bed days.

Pre-Hearing Resolution: We know how to minimize disputes and hearings. Only 5% of our disputes result in a request for hearing, and 70% of requested hearings are resolved prior to hearing. CD&A’s Manager reviews each hearing request, audits the original decision and contacts the provider to work toward a win-win resolution. If the dispute results in a scheduled hearing, we conduct another review to weigh the hearing expense vs. resolution, and again discuss the issue with the provider. **Hearings are a last resort.** When they occur, our determination is upheld in 99.7% of cases.

We use a variety of approaches to minimize the need for providers to use the claim dispute and hearing process to obtain proper reimbursement. Local subject-matter experts, proactive monitoring, root-cause analysis, education, cross-functional workgroups, and exceptional communication contribute to our success. **Our results speak for themselves.**





Technology that delivers

- **effective and knowledgeable**
 - **accountable**
 - **flexible**
 - **innovative**
-

10. *Demonstrate, by participating in mock Information Systems scenarios over a 10-day period...*

Care1st Health Plan Arizona, Inc. (Care1st) acknowledges that its participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No.10.

Care1st acknowledges that it will comply with the stated guidelines and calendar for this process.

Care1st acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal.