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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

Subject:	*Page Number Reference*	*Offeror's Page No.*
Offeror's Checklist *(This Exhibit)*	Exhibit A	2 - 4
Offeror's Bid Choice Form *(Form provided below in this Exhibit and submitted with the checklist)*	See A1 below	2
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A1: OFFEROR'S BID CHOICE FORM

ACUTE CARE PROGRAM

☒ Checking this box indicates the Offeror is bidding on the ***Acute Care Program***.

Phoenix Health Plan
Offeror's Name

is bidding on the ACUTE Care Program in the GSAs checked below:

☐ **GSA 2 Yuma, La Paz**

☒ **GSA 4 Apache, Coconino, Mohave, and Navajo**

☒ **GSA 6 Yavapai**

☒ **GSA 8 Gila, Pinal**

☒ **GSA 10 Pima, Santa Cruz**

☒ **GSA 12 Maricopa**

☐ **GSA 14 Graham, Greenlee, Cochise**

Nancy Novick
Authorized Signature

1/24/13
Date

Nancy Novick
Print Name

Chief Executive Officer
Title

CHILDREN'S REHABILITATIVE PROGRAM
☐ Checking this box indicates the Offeror is bidding on the ***Children's Rehabilitative Program***.

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.*
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C. *CAPITATION SUBMISSION*

Capitation	*Requirement No.*	*Offeror's Page No.*
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CRS Program Capitation Bid Submission Including Actuarial Attestation	2	N/A

D. EXECUTIVE SUMMARY AND DISCLOSURE

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E. *ACUTE CARE NARRATIVE SUBMISSIONS*

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Program	*Requirement No.*	*Offeror's Page No.*
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Organization	*Requirement No.*	*Offeror's Page No.*
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F. CRS NARRATIVE SUBMISSIONS

Access to Care/Network - CRS	*Requirement No.*	*Offeror's Page No.*
	11	N/A

Program - CRS	*Requirement No.*	*Offeror's Page No.*
	12	N/A
	13	N/A
	14	N/A

Organization - CRS	*Requirement No.*	*Offeror's Page No.*
	15	N/A

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 SPECIFED 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.

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.: N/A

Federal Employer Identification No.: 62-1831567

E-Mail Address: nnovick@abrazohealth.com

PHOENIX HEALTH PLAN
Company Name

7878 North 16th Street, #105
Address

Phoenix, Arizona 85020
City State Zip

For Clarification of this offer, contact:

Name: Nancy Novick

Phone: (602) 824-3812

Fax: (602) 824-3857

Nancy Novick
Signature of Person Authorized to Sign Offer

Nancy Novick
Printed Name

Chief Executive Officer
Title

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

	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 **27th day of November, 2012**, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature Nancy Novick	**Date** 1/17/13	**Signature**
Typed Name Nancy Novick		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company PHOENIX HEALTH PLAN		**Name of Company** AHCCCS

	SOLICITATION AMENDMENT	AHCCCS
	Solicitation No.: **RFP YH14-0001** Amendment No. 2 (Two) 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, and supersedes any information previously provided that is inconsistent:

1. Section H: Instructions to Offerors, Paragraph 16, Capitation, *Acute Care Program Capitation Resources*, page 303 is amended as follows:

   On or about December 14, 2012, AHCCCS will publish an actuarially-sound capitation rate range for the medical component for each risk group that will be bid by GSA. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from ~~the~~ an adjusted minimum to the midpoint. The minimum of each published range was increased by 1% to account for the future Payment Reform capitation withhold of at least 1%. AHCCCS' actuaries set rate ranges based on average expenditures. The rate ranges will exclude reinsurance offsets and will not reflect any withheld amounts for payment reform initiatives.

2. The Bidders' Library, Information (IT) Technology Systems Demonstration *Provisions* and *Calendar* have been revised.

3. Section H: Instructions to Offerors, Paragraph 16, Submission Requirements, E. *Oral Presentations*, page 309, is amended as follows:

   All presentations will be scheduled to occur during the weeks of February 18 ~~and~~ through March 6, 2013.

4. 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 19th day of December, 2012, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature Nancy Novick	**Date** 1/17/13	**Signature**
Typed Name Nancy Novick		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company PHOENIX HEALTH PLAN		**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 4th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature Nancy Novick	**Date** 1/17/13	**Signature**
Typed Name Nancy Novick		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company PHOENIX HEALTH PLAN		**Name of Company** AHCCCS

	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

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.
   - 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.
   - 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:
   - 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
   - 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.
   - 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 10th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature Nancy Novick	**Date** 1/17/13	**Signature**
Typed Name Nancy Novick		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company PHOENIX HEALTH PLAN		**Name of Company** AHCCCS

Section G

This section considered Proprietary and uploaded under separate cover

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B. ATTESTATION #

ATTESTATION FORM 101

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.

Corporate Compliance	
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. ☒	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 *RFP Section D, Paragraph 62, Corporate Compliance*
Staffing	
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. ☒	Maintain a local presence within the State of Arizona as outlined in Section D, Paragraph 16, Staffing Requirements and Support Services, of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
3. ☒	Limit Key Staff to occupying a maximum of two of the Key Staff positions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
4. ☒	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 *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
5. ☒	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 *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*

Staffing - continued	
6. ☒	Screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal health care programs *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
7. ☒	Require all staff members to have appropriate training, education, experience and orientation to fulfill the requirements of the position *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
8. ☒	Have sufficient staffing levels to operate in compliance with the terms of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
9. ☒	Have an Administrator/Chief Executive Officer (CEO) who shall have the authority and ability to direct Arizona priorities. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
Information Systems	
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. ☒	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 *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
11. ☒	Maintain system upgrade and conversion processes which include appropriate planning and implementation standards *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
12. ☒	Have structures in place to ensure and support current and future IT Federal mandates *RFP, Section D, Paragraph 64, Systems and Data Exchange Requirements*
Claims/Encounters Processing	
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. ☒	Accept and process both paper and electronic submissions *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
14. ☒	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 *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*

Claims/Encounters Processing- continued	
15. ☒	Have the ability to generate encounter submissions and have the appropriate remediation processes in place when standards are not met *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
Quality Management	
The Offeror attests that, by the start date of the contract, it will have:	
16. ☒	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] *AMPM Chapter 900*
17. ☒	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 *AMPM Chapters 900 and 1000*
18. ☒	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 *AMPM Chapter 400*
19. ☒	A process that meets AHCCCS requirements for identifying, reviewing, evaluating and resolving quality of care or service issues raised by any source *RFP, Section D, Paragraph 23, Quality Management and Performance Improvement (QM/PI)*
20. ☒	A process to provide recurring scheduled transportation for members with on-going medical needs, including, but not limited to dialysis, chemotherapy, and radiation *RFP, Section D, Paragraph 11, Special Health Care Needs*
MCH/EPSDT	
The Offeror attests that it will have:	
21. ☒	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 *AMPM Chapter 400*
Medical Management	
The Offeror attests that it will have:	
22. ☒	A process in place for proactive discharge planning when members have been admitted to an inpatient facility *RFP, Section D, Paragraph 24, Medical Management (MM)*

Medical Management - continued	
23. ☒	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 *RFP, Section D, Paragraph 24, Medical Management (MM)*
24. ☒	A process in place to provide emergency services without prior authorization regardless of contract status of the provider *AMPM Chapter 310F*
25. ☒	A process to analyze utilization data and use the results to implement medical management changes to improve outcomes and experience *RFP, Section D, Paragraph 24, Medical Management (MM)*
26. ☒	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 *RFP, Section D, Paragraph 24, Medical Management (MM)*
Behavioral Health	
The Offeror attests that it will have:	
27. ☒	A process for identifying members with behavioral health care needs and assisting members in accessing services in the Regional Behavioral Health Authority system *RFP, Section D, Paragraph 12, Behavioral Health Services; AMPM Chapters 400 and 1000*
Access to Care ***(Only Offerors submitting a proposal for the CRS Program must attest to #29)***	
The Offeror attests that it will have:	
28. ☒	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 *RFP, Section D, Paragraph 27, Network Development*
29. ☐ ***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 *RFP, Section D, Paragraph 27, Network Development*
30. ☒	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 *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
31. ☒	A process for monitoring and addressing provider performance issues up to and including contract termination *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*

Finance	
The Offeror attests that it will:	
32. ☒	Have a separate entity established for purposes of this contract within 120 days of the contract award if the Offeror is a non-governmental *New Contractor.* *RFP, Section D, Paragraph 51, Separate Incorporation*
33. ☒	Meet the minimum capitalization requirements within 30 days of the contract award if the Offeror is a *New Contractor;* 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 *Successful Incumbent Contractor.* *RFP, Section D, Paragraph 45, Minimum Capitalization; Section H, Instructions to Offerors-Paragraph 14, Minimum Capitalization*
34. ☒	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. *RFP, Section D, Paragraphs 46, Performance Bond or Bond Substitute; 47, Amount of Performance Bond*

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: PHOENIX HEALTH PLAN 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.

Nancy Novick 1/17/13

Authorized Signature **Date**

Nancy Novick Chief Executive Officer

Individual's Printed Name **Title**

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C. CAPITATION #

ACTUARIAL CERTIFICATION 107
CAPITATION BID SUBMISSION 109

Actuarial Certification
Phoenix Health Plan
AHCCCS Acute Care Capitation Bids
Effective October 1, 2013 through September 30, 2014
GSAs 4, 6, 8, 10 and 12

The following page includes the actuarial certification for the rates bid by Phoenix Health Plan (PHP). The actuarial certification covers all GSAs for which PHP submits a bid, GSAs 4, 6, 8, 10 and 12. PHP has the report that supports the certification, which includes the data, methodology and assumptions used to develop the rates. This information is available upon request.

WAKELY
CONSULTING GROUP
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Actuarial Certification
Phoenix Health Plan
AHCCCS Acute Care Capitation Bids
Effective October 1, 2013 through September 30, 2014
GSAs 4, 6, 8, 10 and 12

I, Julie A. Peper, am associated with the firm of Wakely Consulting Group, Inc. (Wakely), am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. Wakely was retained by Phoenix Health Plan (PHP) to provide a certification of the actuarial soundness of its proposed capitation rates for the effective period October 1, 2013 through September 30, 2014 (CYE14) under the Arizona Health Care Cost Containment System (AHCCCS). This certification may not be appropriate for other purposes.

To the best of my information, knowledge and belief, the capitation rates provided with this certification are considered actuarially sound for purposes of 42 CFR 438.6(c), according to the following criteria:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and
- the capitation rates meet the requirements of 42 CFR 438.6(c).

The assumptions used in the development of the actuarially sound capitation rates have been documented in my correspondence with PHP. The actuarially sound rates that are associated with this certification have been established for GSAs 4, 6, 8, 10 and 12 for the effective period October 1, 2013 through September 30, 2014.

The actuarially sound capitation rate ranges are based on a projection of future events. It may be expected that actual experience will vary from the experience assumed in the rates.

In developing the actuarially sound capitation rate ranges, I have relied upon claim and eligibility data, adjustment factors, and information provided by AHCCCS and PHP. I did not audit the data provided; however, I did review the data for reasonableness and consistency.

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

Julie A. Peper, FSA, MAAA
January 24, 2013

Acute Care RFP Bid Template - Phoenix Health Plan

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	$0.00	$410.21	$427.22	$442.25	$427.17	$470.69	$0.00
TANF 1-13	$0.00	$91.38	$100.38	$88.02	$76.96	$94.16	$0.00
TANF 14-44 F	$0.00	$221.96	$267.10	$229.85	$189.06	$214.01	$0.00
TANF 14-44 M	$0.00	$154.93	$171.16	$143.37	$117.33	$139.78	$0.00
TANF 45+	$0.00	$372.31	$389.81	$405.83	$319.51	$381.64	$0.00
SSIW	$0.00	$103.12	$96.96	$115.66	$111.00	$149.85	$0.00
SSIW/O	$0.00	$846.82	$860.44	$673.01	$712.05	$757.97	$0.00
AHCCCS Care	$0.00	$384.75	$422.81	$373.02	$298.76	$393.53	$0.00
Delivery Supp	$0.00	$5,109.50	$5,209.47	$5,237.17	$5,161.69	$5,533.54	$0.00

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	$0.00	$28.71	$29.91	$30.96	$29.90	$35.30	$0.00
TANF 1-13	$0.00	$6.40	$7.03	$6.16	$5.39	$7.06	$0.00
TANF 14-44 F	$0.00	$15.54	$18.70	$16.09	$13.23	$16.05	$0.00
TANF 14-44 M	$0.00	$10.85	$11.98	$10.04	$8.21	$10.48	$0.00
TANF 45+	$0.00	$26.06	$27.29	$28.41	$22.37	$28.62	$0.00
SSIW	$0.00	$7.22	$6.79	$8.10	$7.77	$11.24	$0.00
SSIW/O	$0.00	$59.28	$60.23	$47.11	$49.84	$56.85	$0.00
AHCCCS Care	$0.00	$26.93	$29.60	$26.11	$20.91	$29.51	$0.00
Delivery Supp	$0.00	$357.67	$364.66	$366.60	$361.32	$415.02	$0.00

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Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Annualized Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	2,671	$1,020.32	$227.13
Outpatient Facility	511	$182.52	$7.77
Emergency Room	1,053	$266.72	$23.40
Primary Care	21,788	$49.05	$89.06
Referral Physician	362	$215.28	$6.50
Other Professional	3,584	$52.46	$15.67
Pharmacy	3,980	$30.75	$10.20
Emergency and Non-Emergency Transportation	318	$830.06	$22.02
Dental	185	$46.07	$0.71
Laboratory, X-Ray, Med Image	3,772	$14.73	$4.63
Physical Therapy	-	$0.00	$0.00
DME and Oxygen	694	$52.37	$3.03
NF and Home Health Care	42	$25.96	$0.09
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$410.21**
		Administrative Component	$28.71

Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Annualized Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	66	$1,514.79	$8.37
Outpatient Facility	189	$414.61	$6.53
Emergency Room	449	$296.92	$11.10
Primary Care	3,918	$48.97	$15.99
Referral Physician	236	$164.12	$3.23
Other Professional	1,359	$49.71	$5.63
Pharmacy	3,020	$30.99	$7.80
Emergency and Non-Emergency Transportation	108	$413.89	$3.74
Dental	6,266	$48.05	$25.09
Laboratory, X-Ray, Med Image	1,685	$13.32	$1.87
Physical Therapy	-	$5.74	$0.00
DME and Oxygen	569	$42.78	$2.03
NF and Home Health Care	-	$28.44	$0.00
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$91.38**
		Administrative Component	$6.40

Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Annualized Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	230	$1,830.74	$35.10
Outpatient Facility	891	$414.87	$30.80
Emergency Room	973	$436.29	$35.37
Primary Care	4,566	$65.41	$24.89
Referral Physician	1,900	$133.75	$21.18
Other Professional	2,133	$56.31	$10.01
Pharmacy	11,947	$29.50	$29.37
Emergency and Non-Emergency Transportation	398	$326.88	$10.83
Dental	1,539	$53.17	$6.82
Laboratory, X-Ray, Med Image	8,062	$22.70	$15.25
Physical Therapy	6	$19.98	$0.01
DME and Oxygen	436	$49.30	$1.79
NF and Home Health Care	42	$155.76	$0.54
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$221.96**
		Administrative Component	$15.54

Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Annualized Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	171	$2,177.25	$31.03
Outpatient Facility	387	$500.08	$16.12
Emergency Room	658	$435.46	$23.87
Primary Care	3,650	$65.85	$20.03
Referral Physician	429	$219.76	$7.86
Other Professional	1,291	$57.16	$6.15
Pharmacy	6,601	$42.21	$23.22
Emergency and Non-Emergency Transportation	269	$391.91	$8.80
Dental	2,114	$53.70	$9.46
Laboratory, X-Ray, Med Image	2,845	$22.65	$5.37
Physical Therapy	-	$6.90	$0.00
DME and Oxygen	485	$51.45	$2.08
NF and Home Health Care	43	$264.54	$0.94
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$154.93**
		Administrative Component	$10.85

Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Annualized Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	517	$2,001.89	$86.17
Outpatient Facility	1,363	$474.44	$53.89
Emergency Room	651	$498.92	$27.08
Primary Care	8,593	$75.49	$54.06
Referral Physician	1,357	$190.51	$21.55
Other Professional	2,588	$52.77	$11.38
Pharmacy	22,854	$39.90	$75.99
Emergency and Non-Emergency Transportation	1,000	$173.10	$14.42
Dental	110	$23.94	$0.22
Laboratory, X-Ray, Med Image	8,887	$26.21	$19.41
Physical Therapy	27	$22.10	$0.05
DME and Oxygen	799	$59.76	$3.98
NF and Home Health Care	235	$209.93	$4.11
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$372.31**
		Administrative Component	$26.06

Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Annualized Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	960	$241.68	$19.33
Outpatient Facility	1,235	$178.95	$18.41
Emergency Room	854	$110.55	$7.87
Primary Care	11,110	$19.29	$17.86
Referral Physician	1,522	$44.70	$5.67
Other Professional	1,632	$20.30	$2.76
Pharmacy	4,293	$18.73	$6.70
Emergency and Non-Emergency Transportation	5,248	$37.84	$16.55
Dental	75	$24.03	$0.15
Laboratory, X-Ray, Med Image	3,882	$9.18	$2.97
Physical Therapy	32	$3.76	$0.01
DME and Oxygen	659	$16.03	$0.88
NF and Home Health Care	477	$99.53	$3.96
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$103.12**
		Administrative Component	$7.22

Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Annualized Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	1,361	$2,390.10	$271.16
Outpatient Facility	1,702	$544.14	$77.19
Emergency Room	1,485	$518.57	$64.19
Primary Care	14,160	$78.56	$92.70
Referral Physician	1,848	$199.42	$30.71
Other Professional	2,787	$68.67	$15.95
Pharmacy	42,407	$51.77	$182.95
Emergency and Non-Emergency Transportation	4,352	$144.86	$52.53
Dental	1,066	$51.23	$4.55
Laboratory, X-Ray, Med Image	12,424	$24.89	$25.77
Physical Therapy	26	$32.62	$0.07
DME and Oxygen	2,449	$77.62	$15.84
NF and Home Health Care	794	$199.69	$13.21
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$846.82**
		Administrative Component	$59.28

Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Annualized Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	598	$2,332.81	$116.19
Outpatient Facility	1,060	$510.65	$45.12
Emergency Room	897	$496.13	$37.10
Primary Care	7,609	$71.35	$45.24
Referral Physician	1,318	$196.61	$21.60
Other Professional	1,979	$59.42	$9.80
Pharmacy	15,530	$45.28	$58.60
Emergency and Non-Emergency Transportation	1,441	$182.96	$21.97
Dental	520	$62.80	$2.72
Laboratory, X-Ray, Med Image	8,011	$25.21	$16.83
Physical Therapy	22	$27.11	$0.05
DME and Oxygen	755	$78.79	$4.96
NF and Home Health Care	318	$172.67	$4.57
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$384.75**
		Administrative Component	$26.93

Acute Care RFP Bid Template - Phoenix Health Plan

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 4**

Service Categories:	Units per Delivery	Cost per Unit	Cost per Delivery
Hospital Inpatient	2	$1,505.74	$3,101.83
Primary Care	2	$770.34	$1,835.71
Emergency and Non-Emergency Transportation	0	$2,691.68	$118.43
Laboratory, X-Ray, Med Image	1	$47.46	$27.72
Miscellaneous	1	$21.33	$25.81
		Gross Medical Component	**$5,109.50**
		Administrative Component	$357.67

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	2,805	$913.08	$213.43
Outpatient Facility	448	$305.60	$11.40
Emergency Room	1,210	$270.35	$27.25
Primary Care	26,435	$48.84	$107.59
Referral Physician	297	$218.27	$5.40
Other Professional	4,531	$45.76	$17.28
Pharmacy	4,477	$45.46	$16.96
Emergency and Non-Emergency Transportation	323	$628.98	$16.91
Dental	123	$44.78	$0.46
Laboratory, X-Ray, Med Image	4,175	$15.06	$5.24
Physical Therapy	-	$0.00	$0.00
DME and Oxygen	743	$84.62	$5.24
NF and Home Health Care	36	$20.10	$0.06
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$427.22**
		Administrative Component	$29.91

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	54	$1,386.70	$6.26
Outpatient Facility	156	$510.41	$6.63
Emergency Room	587	$278.09	$13.60
Primary Care	5,357	$48.86	$21.81
Referral Physician	233	$167.64	$3.26
Other Professional	1,548	$51.71	$6.67
Pharmacy	3,295	$42.65	$11.71
Emergency and Non-Emergency Transportation	154	$292.39	$3.76
Dental	6,007	$43.71	$21.88
Laboratory, X-Ray, Med Image	2,134	$13.89	$2.47
Physical Therapy	15	$23.23	$0.03
DME and Oxygen	531	$51.93	$2.30
NF and Home Health Care	-	$19.41	$0.00
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$100.38**
		Administrative Component	$7.03

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	211	$1,672.07	$29.39
Outpatient Facility	515	$735.64	$31.60
Emergency Room	1,385	$372.61	$43.01
Primary Care	5,522	$67.47	$31.05
Referral Physician	2,351	$122.01	$23.90
Other Professional	2,656	$58.42	$12.93
Pharmacy	15,056	$39.46	$49.51
Emergency and Non-Emergency Transportation	609	$218.98	$11.11
Dental	1,368	$56.74	$6.47
Laboratory, X-Ray, Med Image	11,001	$27.64	$25.34
Physical Therapy	152	$18.11	$0.23
DME and Oxygen	558	$50.13	$2.33
NF and Home Health Care	117	$23.50	$0.23
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$267.10**
		Administrative Component	$18.70

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	153	$1,533.51	$19.50
Outpatient Facility	274	$851.98	$19.44
Emergency Room	802	$376.38	$25.16
Primary Care	4,620	$73.56	$28.32
Referral Physician	536	$216.88	$9.68
Other Professional	1,921	$57.54	$9.21
Pharmacy	8,485	$43.77	$30.95
Emergency and Non-Emergency Transportation	521	$169.76	$7.37
Dental	2,037	$54.08	$9.18
Laboratory, X-Ray, Med Image	4,069	$27.34	$9.27
Physical Therapy	92	$16.99	$0.13
DME and Oxygen	602	$54.06	$2.71
NF and Home Health Care	2,400	$1.20	$0.24
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$171.16**
		Administrative Component	$11.98

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	366	$2,004.33	$61.17
Outpatient Facility	758	$742.35	$46.92
Emergency Room	778	$453.90	$29.43
Primary Care	9,267	$76.94	$59.42
Referral Physician	1,746	$200.69	$29.20
Other Professional	3,570	$58.49	$17.40
Pharmacy	26,401	$39.49	$86.88
Emergency and Non-Emergency Transportation	1,589	$128.68	$17.04
Dental	114	$24.24	$0.23
Laboratory, X-Ray, Med Image	11,168	$32.45	$30.20
Physical Therapy	264	$10.89	$0.24
DME and Oxygen	1,330	$89.96	$9.97
NF and Home Health Care	497	$41.30	$1.71
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$389.81**
		Administrative Component	$27.29

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	772	$199.61	$12.84
Outpatient Facility	827	$167.01	$11.51
Emergency Room	723	$96.73	$5.83
Primary Care	11,111	$17.82	$16.50
Referral Physician	1,880	$42.07	$6.59
Other Professional	2,827	$18.42	$4.34
Pharmacy	3,015	$14.29	$3.59
Emergency and Non-Emergency Transportation	6,270	$43.33	$22.64
Dental	67	$26.74	$0.15
Laboratory, X-Ray, Med Image	4,623	$11.55	$4.45
Physical Therapy	509	$4.48	$0.19
DME and Oxygen	1,308	$21.01	$2.29
NF and Home Health Care	693	$104.54	$6.04
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$96.96**
		Administrative Component	$6.79

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	1,028	$1,817.49	$155.71
Outpatient Facility	1,129	$984.90	$92.67
Emergency Room	1,586	$475.50	$62.84
Primary Care	14,565	$85.63	$103.93
Referral Physician	1,989	$211.80	$35.10
Other Professional	4,341	$73.78	$26.69
Pharmacy	47,745	$58.81	$233.99
Emergency and Non-Emergency Transportation	6,446	$118.94	$63.89
Dental	773	$49.68	$3.20
Laboratory, X-Ray, Med Image	16,746	$31.00	$43.26
Physical Therapy	301	$19.53	$0.49
DME and Oxygen	3,136	$89.32	$23.34
NF and Home Health Care	2,024	$90.88	$15.33
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$860.44**
		Administrative Component	$60.23

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	459	$2,099.00	$80.35
Outpatient Facility	693	$841.89	$48.62
Emergency Room	1,091	$436.84	$39.71
Primary Care	8,647	$76.98	$55.47
Referral Physician	1,591	$199.06	$26.40
Other Professional	3,350	$60.47	$16.88
Pharmacy	21,169	$49.00	$86.44
Emergency and Non-Emergency Transportation	2,170	$131.39	$23.76
Dental	377	$64.28	$2.02
Laboratory, X-Ray, Med Image	11,046	$33.57	$30.90
Physical Therapy	313	$21.44	$0.56
DME and Oxygen	1,118	$76.87	$7.16
NF and Home Health Care	576	$94.62	$4.54
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$422.81**
		Administrative Component	$29.60

Acute Care RFP Bid Template - Phoenix Health Plan

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 Delivery	Cost per Unit	Cost per Delivery
Hospital Inpatient	2	$1,286.43	$2,872.60
Primary Care	3	$864.56	$2,167.45
Emergency and Non-Emergency Transportation	0	$2,176.18	$124.04
Laboratory, X-Ray, Med Image	0	$47.17	$17.12
Miscellaneous	1	$22.86	$28.26
		Gross Medical Component	**$5,209.47**
		Administrative Component	$364.66

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	3,139	$888.07	$232.32
Outpatient Facility	392	$302.44	$9.87
Emergency Room	1,466	$209.19	$25.55
Primary Care	26,117	$51.12	$111.26
Referral Physician	342	$240.22	$6.85
Other Professional	4,169	$39.15	$13.60
Pharmacy	5,482	$39.29	$17.95
Emergency and Non-Emergency Transportation	634	$269.37	$14.23
Dental	116	$32.99	$0.32
Laboratory, X-Ray, Med Image	4,152	$16.01	$5.54
Physical Therapy	-	$0.00	$0.00
DME and Oxygen	610	$91.65	$4.66
NF and Home Health Care	62	$19.28	$0.10
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$442.25**
		Administrative Component	$30.96

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	58	$1,312.10	$6.34
Outpatient Facility	145	$512.91	$6.21
Emergency Room	646	$208.50	$11.23
Primary Care	5,093	$49.67	$21.08
Referral Physician	220	$162.75	$2.99
Other Professional	1,337	$48.66	$5.42
Pharmacy	3,769	$32.06	$10.07
Emergency and Non-Emergency Transportation	222	$193.78	$3.58
Dental	5,788	$34.75	$16.76
Laboratory, X-Ray, Med Image	1,847	$14.23	$2.19
Physical Therapy	-	$11.08	$0.00
DME and Oxygen	533	$48.36	$2.15
NF and Home Health Care	-	$19.33	$0.00
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$88.02**
		Administrative Component	$6.16

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	274	$1,537.19	$35.16
Outpatient Facility	775	$465.82	$30.10
Emergency Room	1,130	$318.93	$30.02
Primary Care	5,231	$68.45	$29.84
Referral Physician	2,181	$111.86	$20.33
Other Professional	2,047	$66.96	$11.42
Pharmacy	11,853	$30.12	$29.75
Emergency and Non-Emergency Transportation	745	$193.63	$12.02
Dental	1,277	$43.59	$4.64
Laboratory, X-Ray, Med Image	10,509	$27.93	$24.46
Physical Therapy	19	$12.68	$0.02
DME and Oxygen	428	$40.94	$1.46
NF and Home Health Care	83	$90.90	$0.63
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$229.85**
		Administrative Component	$16.09

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	191	$1,615.34	$25.67
Outpatient Facility	287	$662.51	$15.83
Emergency Room	705	$319.95	$18.80
Primary Care	4,195	$63.54	$22.21
Referral Physician	437	$216.49	$7.89
Other Professional	1,349	$62.55	$7.03
Pharmacy	7,059	$35.14	$20.67
Emergency and Non-Emergency Transportation	406	$270.65	$9.15
Dental	1,853	$41.83	$6.46
Laboratory, X-Ray, Med Image	3,408	$25.60	$7.27
Physical Therapy	10	$11.61	$0.01
DME and Oxygen	515	$51.52	$2.21
NF and Home Health Care	22	$91.06	$0.17
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$143.37**
		Administrative Component	$10.04

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	546	$1,437.80	$65.44
Outpatient Facility	1,249	$612.80	$63.78
Emergency Room	716	$384.57	$22.94
Primary Care	11,197	$79.19	$73.89
Referral Physician	1,793	$167.34	$25.01
Other Professional	2,695	$74.19	$16.66
Pharmacy	27,876	$33.13	$76.96
Emergency and Non-Emergency Transportation	2,037	$88.96	$15.10
Dental	133	$20.81	$0.23
Laboratory, X-Ray, Med Image	12,860	$36.97	$39.62
Physical Therapy	56	$8.63	$0.04
DME and Oxygen	825	$57.59	$3.96
NF and Home Health Care	293	$90.09	$2.20
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$405.83**
		Administrative Component	$28.41

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	1,009	$225.43	$18.96
Outpatient Facility	1,338	$208.63	$23.27
Emergency Room	835	$91.68	$6.38
Primary Care	13,622	$19.09	$21.67
Referral Physician	1,784	$39.08	$5.81
Other Professional	2,014	$17.64	$2.96
Pharmacy	3,492	$14.16	$4.12
Emergency and Non-Emergency Transportation	7,224	$35.20	$21.19
Dental	120	$24.03	$0.24
Laboratory, X-Ray, Med Image	7,176	$10.92	$6.53
Physical Therapy	59	$4.05	$0.02
DME and Oxygen	847	$26.93	$1.90
NF and Home Health Care	388	$80.79	$2.61
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$115.66**
		Administrative Component	$8.10

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	1,184	$1,650.84	$162.95
Outpatient Facility	1,283	$622.32	$66.54
Emergency Room	1,326	$408.22	$45.11
Primary Care	14,224	$81.04	$96.06
Referral Physician	1,757	$178.72	$26.17
Other Professional	2,934	$73.17	$17.89
Pharmacy	37,027	$46.38	$143.11
Emergency and Non-Emergency Transportation	5,336	$116.02	$51.59
Dental	1,289	$36.22	$3.89
Laboratory, X-Ray, Med Image	13,008	$33.94	$36.79
Physical Therapy	61	$17.64	$0.09
DME and Oxygen	1,975	$75.21	$12.38
NF and Home Health Care	888	$141.08	$10.44
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$673.01**
		Administrative Component	$47.11

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	585	$1,892.57	$92.34
Outpatient Facility	868	$685.68	$49.60
Emergency Room	943	$392.75	$30.86
Primary Care	8,445	$77.47	$54.52
Referral Physician	1,437	$183.41	$21.96
Other Professional	2,088	$74.09	$12.89
Pharmacy	15,048	$42.09	$52.78
Emergency and Non-Emergency Transportation	1,729	$150.08	$21.63
Dental	462	$51.21	$1.97
Laboratory, X-Ray, Med Image	9,384	$33.95	$26.55
Physical Therapy	35	$13.76	$0.04
DME and Oxygen	653	$72.79	$3.96
NF and Home Health Care	348	$135.10	$3.92
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$373.02**
		Administrative Component	$26.11

Acute Care RFP Bid Template - Phoenix Health Plan

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 Delivery	Cost per Unit	Cost per Delivery
Hospital Inpatient	3	$1,261.65	$3,274.00
Primary Care	2	$745.66	$1,836.55
Emergency and Non-Emergency Transportation	0	$1,241.05	$76.94
Laboratory, X-Ray, Med Image	0	$47.94	$23.87
Miscellaneous	1	$23.72	$25.81
		Gross Medical Component	**$5,237.17**
		Administrative Component	$366.60

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	3,156	$880.39	$231.54
Outpatient Facility	875	$121.84	$8.88
Emergency Room	1,281	$162.61	$17.36
Primary Care	28,717	$50.65	$121.21
Referral Physician	385	$224.82	$7.22
Other Professional	3,145	$43.35	$11.36
Pharmacy	4,988	$30.29	$12.59
Emergency and Non-Emergency Transportation	596	$138.75	$6.89
Dental	185	$35.10	$0.54
Laboratory, X-Ray, Med Image	3,798	$16.87	$5.34
Physical Therapy	-	$26.08	$0.00
DME and Oxygen	632	$78.38	$4.13
NF and Home Health Care	66	$20.08	$0.11
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$427.17**
		Administrative Component	$29.90

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	57	$1,303.31	$6.17
Outpatient Facility	298	$218.79	$5.43
Emergency Room	517	$164.25	$7.07
Primary Care	5,073	$45.58	$19.27
Referral Physician	226	$162.03	$3.05
Other Professional	966	$52.40	$4.22
Pharmacy	3,434	$34.63	$9.91
Emergency and Non-Emergency Transportation	194	$106.59	$1.72
Dental	5,998	$33.43	$16.71
Laboratory, X-Ray, Med Image	1,674	$13.55	$1.89
Physical Therapy	-	$17.79	$0.00
DME and Oxygen	426	$42.00	$1.49
NF and Home Health Care	29	$12.30	$0.03
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$76.96**
		Administrative Component	$5.39

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	193	$1,400.55	$22.51
Outpatient Facility	1,006	$321.10	$26.93
Emergency Room	943	$308.24	$24.22
Primary Care	4,224	$67.05	$23.60
Referral Physician	2,124	$116.90	$20.69
Other Professional	2,153	$58.20	$10.44
Pharmacy	11,783	$27.09	$26.60
Emergency and Non-Emergency Transportation	666	$121.93	$6.77
Dental	1,204	$39.36	$3.95
Laboratory, X-Ray, Med Image	9,085	$28.53	$21.60
Physical Therapy	66	$10.88	$0.06
DME and Oxygen	307	$53.16	$1.36
NF and Home Health Care	121	$32.77	$0.33
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$189.06**
		Administrative Component	$13.23

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	121	$1,457.43	$14.72
Outpatient Facility	423	$393.88	$13.88
Emergency Room	589	$278.15	$13.66
Primary Care	3,575	$66.49	$19.81
Referral Physician	385	$224.27	$7.20
Other Professional	1,219	$58.85	$5.98
Pharmacy	6,124	$44.62	$22.77
Emergency and Non-Emergency Transportation	305	$173.41	$4.41
Dental	1,933	$39.55	$6.37
Laboratory, X-Ray, Med Image	2,957	$25.28	$6.23
Physical Therapy	43	$11.22	$0.04
DME and Oxygen	399	$56.19	$1.87
NF and Home Health Care	84	$55.96	$0.39
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$117.33**
		Administrative Component	$8.21

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	389	$1,402.63	$45.43
Outpatient Facility	1,382	$422.01	$48.61
Emergency Room	590	$365.54	$17.97
Primary Care	8,351	$80.12	$55.76
Referral Physician	1,603	$185.53	$24.78
Other Professional	2,943	$52.15	$12.79
Pharmacy	23,989	$33.63	$67.23
Emergency and Non-Emergency Transportation	1,190	$89.45	$8.87
Dental	134	$19.74	$0.22
Laboratory, X-Ray, Med Image	11,385	$32.96	$31.27
Physical Therapy	115	$10.47	$0.10
DME and Oxygen	650	$62.39	$3.38
NF and Home Health Care	414	$89.87	$3.10
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$319.51**
		Administrative Component	$22.37

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	818	$301.94	$20.57
Outpatient Facility	1,303	$152.71	$16.58
Emergency Room	510	$96.63	$4.11
Primary Care	13,282	$23.96	$26.52
Referral Physician	1,851	$49.08	$7.57
Other Professional	2,412	$20.55	$4.13
Pharmacy	3,280	$13.50	$3.69
Emergency and Non-Emergency Transportation	6,233	$21.85	$11.35
Dental	100	$20.44	$0.17
Laboratory, X-Ray, Med Image	8,571	$12.88	$9.20
Physical Therapy	168	$2.86	$0.04
DME and Oxygen	840	$34.87	$2.44
NF and Home Health Care	2,665	$20.85	$4.63
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$111.00**
		Administrative Component	$7.77

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	1,211	$1,431.13	$144.46
Outpatient Facility	1,911	$451.65	$71.91
Emergency Room	1,445	$409.99	$49.38
Primary Care	13,259	$88.57	$97.86
Referral Physician	1,795	$204.86	$30.65
Other Professional	2,793	$82.50	$19.20
Pharmacy	39,551	$58.43	$192.58
Emergency and Non-Emergency Transportation	5,776	$82.02	$39.48
Dental	819	$34.71	$2.37
Laboratory, X-Ray, Med Image	13,057	$32.24	$35.08
Physical Therapy	102	$11.78	$0.10
DME and Oxygen	1,983	$76.48	$12.64
NF and Home Health Care	2,882	$68.03	$16.34
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$712.05**
		Administrative Component	$49.84

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	468	$1,486.78	$58.01
Outpatient Facility	1,068	$410.03	$36.48
Emergency Room	916	$352.03	$26.87
Primary Care	6,803	$78.57	$44.54
Referral Physician	1,310	$197.37	$21.55
Other Professional	2,266	$58.20	$10.99
Pharmacy	14,891	$43.17	$53.57
Emergency and Non-Emergency Transportation	1,251	$128.90	$13.44
Dental	466	$45.61	$1.77
Laboratory, X-Ray, Med Image	8,720	$31.90	$23.18
Physical Therapy	104	$11.56	$0.10
DME and Oxygen	570	$72.63	$3.45
NF and Home Health Care	485	$118.97	$4.81
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$298.76**
		Administrative Component	$20.91

Acute Care RFP Bid Template - Phoenix Health Plan

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 Delivery	Cost per Unit	Cost per Delivery
Hospital Inpatient	2	$1,204.32	$2,901.21
Primary Care	3	$763.43	$2,155.92
Emergency and Non-Emergency Transportation	0	$421.63	$31.62
Laboratory, X-Ray, Med Image	0	$53.02	$25.29
Miscellaneous	2	$19.78	$47.65
		Gross Medical Component	**$5,161.69**
		Administrative Component	$361.32

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	3,010	$973.22	$244.10
Outpatient Facility	735	$238.15	$14.59
Emergency Room	1,269	$284.90	$30.12
Primary Care	31,774	$49.13	$130.09
Referral Physician	454	$210.99	$7.98
Other Professional	1,773	$54.68	$8.08
Pharmacy	5,038	$41.02	$17.22
Emergency and Non-Emergency Transportation	1,154	$69.75	$6.71
Dental	137	$34.13	$0.39
Laboratory, X-Ray, Med Image	4,156	$16.66	$5.77
Physical Therapy	-	$20.38	$0.00
DME and Oxygen	775	$81.26	$5.25
NF and Home Health Care	169	$27.63	$0.39
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$470.69**
		Administrative Component	$35.30

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	63	$1,376.62	$7.26
Outpatient Facility	257	$333.93	$7.14
Emergency Room	474	$284.87	$11.25
Primary Care	6,068	$47.84	$24.19
Referral Physician	238	$158.72	$3.15
Other Professional	802	$60.89	$4.07
Pharmacy	3,640	$37.71	$11.44
Emergency and Non-Emergency Transportation	353	$56.08	$1.65
Dental	7,262	$32.85	$19.88
Laboratory, X-Ray, Med Image	2,097	$12.59	$2.20
Physical Therapy	-	$12.88	$0.00
DME and Oxygen	466	$48.91	$1.90
NF and Home Health Care	11	$32.67	$0.03
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$94.16**
		Administrative Component	$7.06

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	248	$1,451.96	$30.00
Outpatient Facility	735	$350.66	$21.48
Emergency Room	924	$353.42	$27.22
Primary Care	5,850	$67.94	$33.12
Referral Physician	2,566	$113.02	$24.17
Other Professional	1,841	$68.82	$10.56
Pharmacy	12,012	$29.31	$29.34
Emergency and Non-Emergency Transportation	1,256	$55.13	$5.77
Dental	1,763	$38.93	$5.72
Laboratory, X-Ray, Med Image	9,394	$30.94	$24.22
Physical Therapy	53	$13.48	$0.06
DME and Oxygen	397	$52.03	$1.72
NF and Home Health Care	144	$52.34	$0.63
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$214.01**
		Administrative Component	$16.05

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	161	$1,645.94	$22.10
Outpatient Facility	289	$528.06	$12.71
Emergency Room	528	$342.58	$15.08
Primary Care	4,703	$63.97	$25.07
Referral Physician	472	$200.15	$7.88
Other Professional	1,332	$62.43	$6.93
Pharmacy	6,558	$48.91	$26.73
Emergency and Non-Emergency Transportation	526	$85.85	$3.76
Dental	2,798	$37.49	$8.74
Laboratory, X-Ray, Med Image	3,304	$27.57	$7.59
Physical Therapy	33	$11.03	$0.03
DME and Oxygen	479	$60.42	$2.41
NF and Home Health Care	121	$74.12	$0.75
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$139.78**
		Administrative Component	$10.48

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	538	$1,554.03	$69.62
Outpatient Facility	1,005	$532.40	$44.58
Emergency Room	603	$401.88	$20.19
Primary Care	11,984	$72.78	$72.68
Referral Physician	2,008	$174.14	$29.14
Other Professional	2,918	$57.25	$13.92
Pharmacy	25,028	$38.62	$80.55
Emergency and Non-Emergency Transportation	2,252	$41.40	$7.77
Dental	132	$18.17	$0.20
Laboratory, X-Ray, Med Image	11,885	$35.42	$35.08
Physical Therapy	139	$11.25	$0.13
DME and Oxygen	819	$59.66	$4.07
NF and Home Health Care	541	$82.24	$3.71
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$381.64**
		Administrative Component	$28.62

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	1,373	$319.69	$36.59
Outpatient Facility	1,360	$182.14	$20.65
Emergency Room	608	$100.70	$5.10
Primary Care	17,768	$22.20	$32.87
Referral Physician	2,221	$50.14	$9.28
Other Professional	3,129	$19.10	$4.98
Pharmacy	3,019	$16.97	$4.27
Emergency and Non-Emergency Transportation	7,881	$19.14	$12.57
Dental	132	$19.06	$0.21
Laboratory, X-Ray, Med Image	11,097	$14.08	$13.02
Physical Therapy	209	$3.44	$0.06
DME and Oxygen	1,218	$26.31	$2.67
NF and Home Health Care	1,883	$48.30	$7.58
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$149.85**
		Administrative Component	$11.24

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	1,453	$1,589.41	$192.49
Outpatient Facility	1,522	$593.41	$75.26
Emergency Room	1,152	$409.10	$39.29
Primary Care	16,442	$84.89	$116.31
Referral Physician	2,054	$197.24	$33.76
Other Professional	2,940	$91.07	$22.31
Pharmacy	35,661	$59.80	$177.71
Emergency and Non-Emergency Transportation	6,699	$44.64	$24.92
Dental	1,741	$33.56	$4.87
Laboratory, X-Ray, Med Image	12,766	$35.57	$37.84
Physical Therapy	92	$16.95	$0.13
DME and Oxygen	1,972	$83.42	$13.71
NF and Home Health Care	1,993	$116.62	$19.37
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$757.97**
		Administrative Component	$56.85

Acute Care RFP Bid Template - Phoenix Health Plan

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 Units per 1000	Cost per Unit	PMPM
Hospital Inpatient	659	$1,667.46	$91.55
Outpatient Facility	861	$537.67	$38.59
Emergency Room	948	$389.13	$30.75
Primary Care	9,938	$78.08	$64.66
Referral Physician	1,773	$181.49	$26.82
Other Professional	2,506	$67.81	$14.16
Pharmacy	16,805	$50.90	$71.28
Emergency and Non-Emergency Transportation	2,435	$60.47	$12.27
Dental	599	$49.86	$2.49
Laboratory, X-Ray, Med Image	9,563	$35.70	$28.45
Physical Therapy	96	$13.77	$0.11
DME and Oxygen	717	$75.44	$4.51
NF and Home Health Care	745	$127.06	$7.89
Miscellaneous	-	$0.00	$0.00
		Gross Medical Component	**$393.53**
		Administrative Component	$29.51

Acute Care RFP Bid Template - Phoenix Health Plan

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 Delivery	Cost per Unit	Cost per Delivery
Hospital Inpatient	3	$1,234.49	$3,429.41
Primary Care	3	$738.14	$2,032.10
Emergency and Non-Emergency Transportation	0	$287.78	$24.46
Laboratory, X-Ray, Med Image	0	$45.92	$21.90
Miscellaneous	1	$18.52	$25.67
		Gross Medical Component	**$5,533.54**
		Administrative Component	$415.02

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Executive Summary

Phoenix Health Plan (PHP) has been contracted with the Arizona Health Care Cost Containment System (AHCCCS) to provide medical and dental services to the Arizona Medicaid population for 29 years. PHP currently provides services in nine counties: Maricopa, Pinal, Gila, Yavapai, Cochise, Mohave, Apache, Navajo, and Pima. Its provider network includes more than 7,900 participating providers in these nine counties.

PHP has grown from serving 30,000 members in the early 1980's to more than 185,000 members today. After successfully submitting a response to the 2008 AHCCCS Request for Proposal, PHP doubled in size from 75,000 members to approximately 150,000 members after being awarded additional counties, all while providing the same high-level quality care to each and every member.

PHP believes that a well-defined mission statement is critically important to the success of the organization. PHP's mission statement, "We are committed to the administration of fiscally responsible quality health care management services," makes the strategic intent clear: to exceed our customers' expectations, administer quality health management services and do so in a fiscally responsible manner.

Nancy Novick, PHP's chief executive officer, established a vision to be "Plan of Choice" for providers, members, regulators and employees. For 18 years, Nancy has built an organization committed to excellence; embracing continuous improvement, strong regulatory compliance and full transparency. She has been an active leader within the AHCCCS program and has made a significant contribution to operational excellence and efficiencies. Nancy has challenged the organization to meet performance standards that exceed those set by AHCCCS. She recognizes that the providers are a critical and valued partner in successfully serving AHCCCS members. To better serve providers, PHP conducts on-site visits to PCPs and OB-GYNs four times per year and in 2004, established the position of provider Claims Educator, which AHCCCS later adopted as a required staff position. PHP currently exceeds AHCCCS provider inquiry standards, acknowledging 80% of inquiries on the same business day and 100% by the second business day and resolving 98% of inquiries within five business days and 100% within 20 business days. Nancy also set goals for clean claims payments to occur within 10 days of submission and a 48 hour turnaround time for prior authorization. PHP strives to be a good partner with AHCCCS by complying with all program requirements and promotes the goal of 100% compliance throughout the organization. PHP is proud of achieving an overall 99% compliance in the 2011 Operational Financial Review.

There are several ways PHP achieves its mission on a daily basis, one being the company operates locally in Phoenix, Arizona. This includes all facets of the business including claims processing, network management, member services, medical management, quality management, information systems and technology, compliance, fraud, waste and abuse, grievance and appeals and all financial operations. PHP takes pride in effectively and efficiently operating its business directly where it provides service to its members, which also allows for better market intelligence, deep community roots, and cultural knowledge of the members served.

Although PHP is operated in Phoenix, the health plan has access to many large scale resources and assets in Arizona and across the country, as an affiliate of Abrazo Health Care and owned by Vanguard Health Systems (VHS). With resources such as local affiliated and employed physicians, affiliated business best practices and tools, national negotiating power, and a local hospital system with hospitals situated in the communities PHP serves, Abrazo Health Care and VHS assist and support PHP's goals while allowing PHP to maintain independent local operations.

Based in Nashville, Tennessee, VHS was founded in 1997 by an experienced management team in partnership with private equity firm Morgan Stanley Capital Partners. In July 2004, Blackstone Partners acquired a majority interest in Vanguard; and with management and Morgan Stanley reinvesting in the company, they together own approximately 30 percent. In June 2011, Vanguard became a publicly traded company listed on the New York Stock Exchange as "VHS."

VHS and Abrazo Health Care have contributed significantly to the Arizona community and economy through local job creation and charitable care including in 2012: 4,835 employees; $43.2 million paid in sales, property and income taxes; $18.5 million in charity care; and $77 million in uninsured write offs.

While financial and material resources are beneficial, there is no greater resource than the people who serve the members…talented human resources. The employees and leadership team are PHP's most valuable resource and in essence have made the plan successful throughout the past 29 years. PHP's executive team has more than 100 years of combined health services, finance and business leadership experience in Arizona.

PHP knows that having both effective and engaged leaders and staff are what make the member experience exceptional. The employee culture and experience is a key focus for PHP and is integrated into both the hiring process and retention programs. The company utilizes Gallup to add talent-based hiring assessments to the employee selection process. Placing talent at the center of the recruitment process is based on over 30 years of research that shows an individual's talents are strongly predictive of future performance. At the core of this philosophy is a commitment to finding the right individual for each specific job opportunity. The goal is to find the best fit between a person's talents and the company's needs.

The Gallup tool is also used to determine "Employee Engagement." Since using this tool, PHP has improved its score by 12%, and is currently ranked in the 82nd percentile in the country, a top performer in the Vanguard Health System and the health care industry, where the standard is 75th percentile. The Gallup Company defines PHP's achievement as "World-Class Status." PHP attributes this performance to the professional, yet fun and friendly working environment, employee/supervisor effective communication, and finding and fostering the right talent.

In addition, PHP was the proud recipient of The Phoenix Business Journal's Best Places to Work and honored with the Gallup Great Workplace Award—another testament to the level of employee engagement PHP possesses.

With world-class employee engagement and an effective leadership team, it's no surprise that PHP has experienced great growth and success over the past years. What makes the team and its work unique, however; is the focus on population health management, creating life-long relationships by changing the way health care services are delivered in communities, coupled with its values: Excellence, Respect, Integrity, Accountability, and Innovation.

Although all of the values are equally important, innovation has been the key for the plan, specifically over the past three years. Innovation, demonstrated through embracing new ideas to improve the plan's services by challenging the status quo, being a courageous change agent, inspiring others to share new ideas, committing to wellness, and collaborating to find new and creative solutions to problems is what has differentiated the plan from the rest.

Each department is accountable not only for its direct area of responsibility, but also for the operations of the entire organization, ensuring that the company functions efficiently and effectively as possible while maintaining excellent customer satisfaction. Each and every employee is encouraged and challenged to take full ownership of their actions and their outcomes, and to balance short term financial results with long term organization building initiatives.

It is the combination of innovation and accountability that make the teams at PHP so powerful, but the company would be remiss if they forgot to mention the power of relationships as well. The established collaborative, integrated partnerships with providers and stakeholders are truly what have made care coordination for the members seamless.

PHP engages its stakeholders to listen to the challenges and barriers faced in the program. Provider and member surveys are performed each year and the feedback is used to optimize operations across all departments.

The combination of experience, historical knowledge and tenure that have made PHP well versed in managing a Medicaid contract and in turn, a great added value. PHP knows firsthand the intricacies of the program and is nimble to understand and lead change in the program. PHP has continually demonstrated value to the Arizona Medicaid program by its performance, results and transparency.

PHP's business actions and outcomes are continuously measured to determine plan effectiveness and success in achieving its mission. There are many ways PHP measures its results, the following are just a few highlights to note:

- Quality Measures – 16 of 21 quality measures are above HEDIS Medicaid Mean
- AHCCCS Operational Financial Review Standards - Met 124 out of 125 standards in CY2011
- Member Satisfaction – More than 98% of members continue membership with PHP, more than the statewide average
- Member Satisfaction Scores (Scale 1-5) – 4.53 overall satisfaction
- Employee Turnover Rate 2012 – Less than 11%; Industry average is 15%
- Financial Performance Measures –Met all contractual financial viability standards in fiscal year 2012
- Employee Engagement (scale 1-5) – Overall score of 4.48
    - "I know what is expected of me at work" 4.69
    - "The mission or purpose of my organization makes me feel my job is important" 4.5
    - "My fellow employees are committed to doing quality work" 4.46
- Virtual/Telecommuting Workforce – 17% of employees work from home resulting in higher morale, lower turnover, fewer cars on the road, and better air quality for the Valley.

With world-class engagement and results comes service excellence for PHP members. In 2010, the Service Excellence (SE) department was established to examine health plan operations utilizing multi-disciplinary teams at all levels in the organization evaluating information compiled from our primary stakeholder members, providers and employees. The SE department employs Lean Strategies and leads "Kaizen" events that are focused examinations of an identified process. The desired outcome is to create efficiencies by eliminating waste, improving process and communication flow, and error proof by replacing manual processes with automation and standardized work. The newly identified process is monitored for continuous improvement ensuring PHP is meeting contract requirements in the most efficient manner. PHP will continue to utilize Lean Strategies as a proposed approach to meet the contract requirements and eliminate waste in the program. In addition, PHP uses best practices such as the Plan, Do, Study, and Act cycle (PDSA) for the evaluation of activities, to help understand barriers, select interventions, and improve outcomes.

Another way PHP is able to meet contract requirements is by integrating compliance into every aspect of its operations. PHP has a comprehensive compliance program that rigorously meets the industry recognized "7 elements" in order to sustain an effective compliance program. The PHP compliance program operates a sophisticated and comprehensive platform that drives accountability to meeting contract requirements. Additionally, PHP proactively detects fraud, waste and abuse through data mining tools, deep diving analysis and cross department initiatives.

In addition to service excellence and compliance oversight, PHP employs a diverse team of analysts who utilize technology and analytics to drive the operations of the organization. The plan uses unique analytic tools that combine elements of care opportunities, risk and provider effectiveness to provide a complete member assessment. These state-of-the-art tools evaluate risk factors for predictive modeling including likelihood of hospitalization and member specific data to detect gaps in care and medication adherence. In its continued quest to increase healthy outcomes, PHP uses these tools to promptly identify and case manage members with a specific disease or condition.

While PHP's expertise and longevity has been in serving the Medicaid population, its affiliated yet separate corporation, Abrazo Advantage Health Plan (AAHP), also operated in Phoenix, is no newcomer. AAHP is a Medicare Advantage Health Maintenance Organization that began operations on January 1, 2006. AAHP is currently contracted with the Centers for Medicare and Medicaid (CMS) and offers two Medicare Advantage

Prescription Drug (MAPD) products: an HMO for Medicare beneficiaries and an HMO Special Needs Plan (HMO SNP) for persons dually eligible for Medicare and full-benefit Medicaid. AAHP has more than 4,000 members in the two Arizona county service areas of Maricopa and Pinal. The SNP population is approximately 3,000 members and the Medicare only population is approximately 1,000 members. AAHP is expanding its Medicare products to all the counties where PHP currently holds contracts with AHCCCS, starting with CMS awards in Pima, Mohave and Yavapai in January 2013, and targeting CMS application and award in Navajo, Apache, Coconino, Gila and Santa Cruz in January of 2014.

PHP and AAHP have been integrating and coordinating the care of dual eligible members since 2006. PHP and AAHP are successful in the joint operations of all functions of the business including network management, member services, quality management, medical management, compliance, information systems, financial management and grievance. The leadership team is skilled in managing dual eligible members and integrated operations for Medicaid and Medicare Parts C and D and is proficient in navigating CMS' complex and highly regulated requirements. Members in both the Medicare and Medicaid program experience case management that is designed to meet or exceed the National Committee for Quality Assurance standards. PHP strives to partner with members and all stakeholders to achieve healthy outcomes while reducing costs.

AAHP has filed a Notice of Intent to Apply with CMS and is prepared to participate in the Medicare Demonstration plan or continue to operate the AAHP SNP plan for both Medicare and Medicaid. PHP and AAHP meet and exceed the state and federal contract requirements to continue operating high functioning and efficient plans for both Medicaid and Medicare.

At the end of the day, it all comes back to the succinct yet powerful mission and vision that PHP and AHCCCS share, to provide quality health care to Arizona communities through efficient, innovative means and effective care coordination. It is a promise that PHP has kept and delivered for 29 years, and in the process has touched and enhanced many Arizonans' lives. PHP would be honored to be awarded the responsibility of serving Arizona communities by empowering health for life.

Moral or Religious Objections

Phoenix Health Plan exercises no moral or religious objections to the provision of AHCCCS covered services.

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E. ACUTE CARE – NARRATIVE SUBMISSIONS #

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Question 1: What steps will the Offeror take to ensure access to care to support the influx of members? In addition to network management, how will the Offeror ensure its operational and administrative structure is sufficient to efficiently implement all program operations to accommodate the membership growth?

Phoenix Health Plan (PHP) a locally operated Arizona Health Care Cost Containment System (AHCCCS) plan with 29 years of experience in Arizona is well positioned to address the unique challenges of serving a large influx of members throughout the state. After the 2008 acute care bid, Arizona Health Care Cost Containment System AHCCCS awarded PHP an additional six counties adding 75,000 members, doubling the membership. PHP's organizational and administrative structure was prepared and efficiently transitioned these members into the plan resulting in immediate access to care. PHP gained additional expertise and enhanced its processes and procedures with the invaluable information learned from the transition. PHP currently executes and will continue to take the following steps to ensure access to care:

- continuously assess and enhance the network
- accurately load member eligibility
- immediately identify members' health care needs
- proactively outreach to members

These steps in concert with a strong leadership team that is committed to continuous improvement strategies will accommodate membership growth. Furthermore, PHP will continue to monitor operational analytics and scorecards to ensure it is structured to efficiently implement all program operations.

Assess and Enhance Network

PHP continuously evaluates the network to ensure its network can support the current membership, as well as any influx of members. The process for availability analysis identifies and predicts future network demands, using both AHCCCS and Centers for Medicare and Medicaid standards for all provider types. To determine provider availability, PHP examines membership data to ensure expansion, viability, and sustainability of the network. PHP uses a GeoAccess radius analysis to determine appropriate geographic distribution of PHP's contracted network. To supplement this analysis, PHP conducts a periodic review of member complaints, feedback from other departments, prior authorizations issued to non-contracted providers, and competitor networks. PHP actively recruits new providers and contracts with the majority of providers requesting to participate in the PHP network.

There is currently a 93% open panel capacity for primary care physicians (PCP) and PHP believes the current provider network has the ability to handle an influx of additional members ensuring all members will have timely access to care. PHP will enhance the provider appointment monitoring methodology to include third party secret shopping to assess availability. The results will be used to further assess network adequacy and open panel capacity. Predicated on market demand and influx of membership, PHP will incentivize PCPs who are new to the Medicaid program in an effort to increase PCP availability and ensure access to care. The incentives would include evidence-based care performance measures and prescribe quality indicators parallel to the National Committee for Quality Assurance standards. With the adoption of the DST Health Solution's analytical tools, PHP will manage the incentive program through the provider profile module.

PHP leverages the size of the membership to negotiate rates that drive cost containment and increase access to care. PHP holds contracts statewide for vision, laboratory, durable medical equipment, home infusion, prosthetics/orthotics, non-emergency medical transportation and home health services. PHP conducts quarterly Joint Operating Committee meetings with statewide providers to ensure the delivery of services meet contract requirements and service standards. Access to care is a standing agenda item. The providers are essential partners in the delivery of health care services and PHP will work with each statewide provider in preparation for membership growth as was done in the 2008 expansion. As information is available about the membership impact from the Health Exchange and the Affordable Care Act, PHP will work with these providers on member projections and request action plans to demonstrate their readiness for an influx of membership.

Telemedicine is a cost-effective alternative to the more traditional face-to-face provision of medical care. It eliminates distance barriers and improves access to medical services that are not consistently available in rural and underserved communities. PHP contracts with North Country Healthcare to provide telemedicine services to rural communities. An agreement with University of Arizona's Telemedicine program, Tuba City Regional Health Care Corporation and Maricopa Integrated Health Systems is in process and PHP will pursue an agreement with Northern Arizona Healthcare upon implementation of its telemedicine program. Aggregating telemedicine into the network will improve access to care for the influx of membership.

PHP is prepared to support and partner with the provider community as they experience the increased demands of the new AHCCCS and Health Insurance Exchange members. Provider Service Representatives (PSR) visits each PCP and OB/GYN offices four times a year and each specialist and dentist offices twice a year. PHP will rely heavily on this best practice, obtaining information from providers to determine if they are experiencing any challenges associated with membership growth and work with them on appropriate interventions. The PSRs will query provider offices to gain information about best practices for operational efficiencies that can be shared with stakeholders to increase access to care. Contract compliance for hours of operation, 24/7 emergency care availability, appointment availability and wait time standards will continue to be monitored to make certain members have access to care.

Member Eligibility and Health Plan Systems

The process to obtain access to care begins with enrolling the member properly into the PHP's health information system, MC400, which is a software application operating on an IBM AS/400 technology platform. The system is scalable and efficient allowing for expansion by adding additional disk storage and concurrent users without degrading system performance. The information system is easily adaptable to accommodate configuration required to accommodate membership growth. PHP has accurately enrolled thousands of members into the system and uses an integrated tool that auto-assigns member to a PCP. PHP will continue to use these proven work process. The AHCCCS Benefit and Enrollment transaction file is loaded into the information system with verification and quality checks in place to validate any potential errors. The MC400 system automatically loads members' eligibility into the Pharmacy Benefit Manager's system to ensure immediate access to care at the point of sale. This process is audited periodically for accuracy, efficiency and continuous improvement. Additionally, PHP has a newborn team that reports births timely and helps mothers report the birth immediately to ensure access to care and coverage.

Member's Health Care Needs

Identifying the member's physical health status and needs is a critical step to ensure members have the appropriate access to care. PHP staffs, equips, and empowers the Medical and Quality Management Departments to be flexible and adaptable to a changing health care environment. PHP employs an expertly led team of health care professionals who have the appropriate education, training, background, experience, and skill to respond efficiently and effectively to the demands of a rapidly expanding membership. PHP's history proves this point. In 2008, PHP almost doubled its membership without disrupting the medical care or services of these members. PHP modified its prior authorization (PA) process to become more flexible to ensure the continuity of care for new members. For example, PHP temporarily suspended its requirements for PA to allow new members to continue with existing critical care plans or to complete necessary services that were authorized by the exiting health plan. As required, PHP permitted the use of non-contracted providers without requiring a new PA. This approach maintained the important doctor-patient relationships of new members, while helping PHP recruit additional providers for its contracted network. PHP's pharmacy team created a "critical medication list" that included anticonvulsants, antineoplastic drugs, and some specialty drugs. By granting a special 90-day authorization to new members needing one of these medications, PHP guaranteed the care continuity and enhanced the identification of high risk members for the case management program. In addition to sending health risk assessment questionnaires, PHP found that adapting its PA processes for a large new member influx contributed to the identification of new member needs and facilitation of their access to care.

With PHP's experience and expertise, the medical team was able to triage new member needs preventing lapses in care and implementing work processes to improve patient care in the future.

PHP's medical team uses continuous quality improvement methods to ensure members receive the care they need, when they need it. The medical team uses end-to-end work process flow analysis and "Kaizen" rapid cycle improvement methods to eliminate non-value added work, thus streamlining its services and making them more responsive to new member demands. This systematic approach to managing health care is scalable, responsive, and dynamic. Time and motion studies help PHP's management team appropriately staff its medical department by establishing staffing ratios. The staffing ratios guide the staffing intervention, which includes hiring new employees, and if required, temporary health care personnel to ensure program capacity. Utilizing specific operational and outcomes metrics, PHP's medical team monitors the achievement of required goals and objectives, even in a chaotic environment. With this approach, PHP is able to do more with less, empowering the health plan to respond to changes in membership, while assuring care quality and member satisfaction.

Member Outreach

PHP's chief executive officer's vision to become "Plan of Choice" motivates and inspires the organization to deliver services in accordance with the vision. The Member Services Department, guided by this vision, vigilantly operates in a member-centric manner assisting members in navigating the health care system to access care and program covered services. Members are immediately "onboarded" and receive PHP specific educational materials. Member service representatives receive extensive training on AHCCCS benefits and PHP operations, so they are prepared to assist members. This ongoing training program is continually updated to include changes in the AHCCCS program and plan operations. PHP's phone systems is equipped with call recording features, allowing management to perform individual monitoring and coaching to ensure members receive accurate information in a manner consistent with PHP's values. The department operates efficiently adapting and adjusting to peaks in call volumes by maximizing technology and systems to augment the operations.

An example of efficiency was the evolution of the "Welcome Aboard" program to educate members on how to access services, verify enrollment status and PCP assignment. This program was automated and has proven to achieve its goal. This technology allows PHP to take additional calls, while ensuring that all members receive accurate information and offers a scalable solution. The "Welcome Aboard" program prepares PHP to onboard an influx of members immediately. Wherein technology offers scalable and reliable solutions, PHP continues to have staff available to answer any and all questions from members.

Member communication is continually being evaluated for effective and efficient improvements. Case in point, PHP's is implementing an Interactive Voice Response (IVR) system to promote self-service in a friendly and useful manner. The implementation of the IVR system will be completed in the Spring of 2013. The IVR system will support the operations by implementing key functions in an automated and scalable fashion. The IVR will provide members and providers real time eligibility status, assignment of PCP, claim status and payment information. Using a member/provider IVR typically reduces live operator call volume by 19% - 25%. Implementation of this capability will improve service and create capacity for handling additional call volume anticipated with an influx of members.

PHP has a member-centric program aimed to ensure members obtain access to preventive care. A dedicated member service outbound team calls members to help set up the well visit appointments. In addition, PHP recently contracted with DST Health Solutions, increasing the outbound program efficiencies. DST provides analytic tools that support lower administrative costs while improving customer satisfaction and health outcomes. The member profile analytical tool identifies gaps in care and is used to support the outbound team. With the implementation of DST's sophisticated analytical tools in conjunction with the IVR system, the outbound call program will by far accommodate additional membership and ensure access to care.

PHP operates in a flexible manner and will make adjustments to reflect with the needs of the membership, particularly during a transition period and/or an increase of membership. Obviously, flexible staffing is a key component to meeting the demands of the current and future membership and PHP makes extensive use of staffing models that are driven by both membership levels as well as resource demands.

Monitoring and Continuous Process Improvement

PHP is a high performing organization intentionally designed to achieve excellence by bringing out the best in people, thereby increasing organizational capacity to deliver sustainable results. PHP integrates standards of excellence into their governance, management and program operations. PHP has a well-defined mission, "We are committed to the administration of fiscally responsible quality health care management services" and vision to be "Plan of Choice" that guides and inspires the organization. PHP anticipates change that will impact the organization and employs leaders and experts who have proven experience to plan and implement such change strategies and interventions in a way that is consistent with the organization's vision, mission and values. PHP recognizes that achieving excellence is a never ending process and fosters a culture of continuous learning. These qualities and attributes are why PHP can ensure access to care and efficiently implement all program operations to accommodate membership growth.

This operational excellence was demonstrated in the 2008 award of the six additional counties. PHP successfully transitioned approximately 75,000 members into the health plan by following its principle philosophy of "disciplined execution." Certified project managers who are trained in change management are employed and lead critical and complex projects to efficiently implement program operations. Project managers utilize highly structured processes that include a defined scope of work, timelines, milestones, dependencies, major risk and mitigation strategies. In 2008, PHP worked with AHCCCS to ensure all processes, workflows and operations were sound to receive the electronic files appropriately. The leadership team and representatives from each department successfully designed a transition plan and assigned a dedicated team to coordinate the implementation. If issues were identified, the team would huddle to address any immediate concerns, while a root cause analysis was performed. The team would test the new process and ensure the root cause of the issue was corrected. Mass communication was performed to ensure teams were informed of identified issues and corresponding resolution. This tactical approach has been a tried and true method of optimizing the operations to achieve excellence and would be applied to accommodate membership growth.

PHP is a data-driven decision making organization using exhaustive metrics and tools to drive operations. The Business and Application Analysis team consists of expert analysts who create customized analytical reports that serve to trend, monitor and improve operations. The leadership team uses data on inventory, volumes, and production for each operational area along with time and motion studies to determine staffing ratios and resources. Monthly scorecards and dashboards with key indicators for all operational areas are monitored by the executive management team for performance. PHP compliments its internal systems and decision support tools by contracting with vendors when needed. The phone system was recently upgraded with a sophisticated call recording software system, Telstrat Engage, which provides data mining, forecasting algorithms, live desktop monitoring and analytics. Compliance 360 is another data driven tool that provides real-time graphical reports of all compliance and risk management activities with extensive drill down capabilities. The organization also contracts with DST Health Solutions that provides a single integrated tool with predictive modeling to effectively target individual high-risk patients and estimate their resource use based on clinically relevant classifications. These are just a few of the decision support tools used to augment the data. The combination of the internal and external data sources powerfully positions PHP to operate in an efficient and effective manner.

To compliment the data driven culture and deliver on the Plan of Choice vision, the Service Excellence Department was formed as an innovative approach to becoming best of class and delivering world class service to stakeholders. The Service Excellence Department examines health plan operations utilizing multi-disciplinary teams at all levels in the organization including information from its primary stakeholders - members, providers and employees. The Service Excellence Department organizes "Kaizen" events that are focused examinations of an identified process. The desired outcome is to create efficiencies in the operational

and administrative structure by eliminating waste, improving process and communication flow, and error proof by replacing manual processes with automation and standardized work. The team documents the end-to-end processes and identifies inventory, cycle time, barriers, and areas for improvement. The identified process improvement items are documented into a work plan which includes responsible party and timeframes. PHP constantly examines workflows and invests in system enhancements to replace manual processes with automation. In 2012, PHP implemented 154 projects related to automation and process efficiencies, and an additional 42 projects are currently in process. These efforts equated to over $750,000 in process improvements and efficiencies in 2012. PHP is advancing on the automation commitment by employing more programmers with specialized training to accelerate the momentum of efficiency. By continually examining and improving operational processes, PHP ensures efficient operations to sustain an influx of members and maintain stakeholder satisfaction.

In summary, PHP will assess and enhance the network, accurately load member eligibility, immediately identify member health care needs, and proactively outreach to members to ensure access to care. PHP was successful in meeting the member increase experienced with the 2008 acute care award. PHP is confident that its high performing qualities and attributes, specifically its continuous improvement approach will ensure its operational and administrative structure is sufficient to efficiently implement all program operations to accommodate any membership growth. PHP is excited and eager to be part of shaping the future of health care and the Arizona AHCCCS program.

2. Describe how the Offeror evaluates and measures its network in order to ensure timely access to care to underserved populations, identify deficiencies in the network, manage the network, make improvements to the network and sustain an adequate network.

Phoenix Health Plan (PHP) manages its contracted provider and facility network with the goal of sustaining and constantly improving that network to ensure its membership has access to covered services that are reasonably accessible in terms of location and hours of operation equal to community norms. The PHP network is designed to provide a geographically convenient distribution of members among network providers and to reflect the needs and service requirements of a culturally and linguistically diverse member population. Additionally, the network design aims to maximize the availability of community based primary care and specialty care, and to reduce unnecessary utilization of emergency services, one day hospital admissions, hospitalization for preventable medical problems and hospital based outpatient surgeries, when lower cost surgery centers are available.

It is PHP's expressed vision to be "Plan of Choice" for members and contracted providers. To that end, operations are organized to assure that members receive needed assistance in accessing covered services and providers experience positive efficient interactions with PHP. PHP has the desire to be recognized as being value added to the communities PHP serves.

Evaluation of Access to Care

PHP defines underserved populations as those members living in rural areas with no or limited local community availability of medical services; members in service areas where geographic barriers, distance and transportation resources or seasonal climatic extremes effect their ability to safely and efficiently access the closest medical service centers; or members with special health care needs that require subspecialty services in type and number that may be in limited supply statewide or only in major metro services areas. Populations may also be underserved due to cultural or language preferences or living arrangements, such as the homeless.

PHP routinely estimates future healthcare service needs in contracted Geographic Service Areas (GSA) based upon several factors, starting with the analysis of general population and impact of economic trends. This analysis includes review of statewide population growth, distribution statistics and projections. Most recently, statewide unemployment has caused an increase in the Medicaid eligible and medical service utilization. Also included in the analysis is any anticipated or predictable change to AHCCCS membership in each contracted GSA and county. In the last few years, changes have included increases in enrollment as a result of legislative mandates such as the expansion of the Breast and Cervical Cancer Treatment Program and KidsCareII program. PHP monitors legislative actions that affect populations served, service or benefits and eligibility. In addition to the adjusted Federal poverty levels, Federal healthcare regulation such as the Affordable Care Act can produce an influx of members who have previously been uninsured and may experience high service utilization that can strain the service delivery systems statewide and require systematic expansion of PHP's network. PHP has dedicated resources to review regulations and participate in implementation planning activities in relation to the AHCCCS program, Health Insurance Exchange, commercial insurance reform, and the Medicare/Medicaid Dual Eligible Demonstration project. All of these regulatory changes impact the demand on the Arizona healthcare market and service delivery systems especially for the uninsured and underserved populations.

Another important predictive factor in projecting future medical service needs relates to the advances in medical technology. Typically these changes are slow to develop and are multi-year in nature, allowing PHP time to make extensive use of per member per month unit cost and utilization trending data in an effort to predict and plan for the impact on network resources.

Measure Access to Care

GeoAccess radius analysis is an invaluable tool for evaluating the distribution and accessibility of PHP's contracted network. GeoAccess maps member location by zip code, cross referenced to the provider network service locations and across specialty. PHP also routinely evaluates its Primary Care Provider (PCP) network

panel assignment percentages to quantify the existing PCP capacity. AHCCCS' report of total PCP plan assignments over 1800 is also reviewed quarterly to ensure adequate accessibility to high volume AHCCCS providers. PHP uses this report to identify which providers need more scrutiny on member complaints, appointment availability, etc. This analysis is vital to the quality and cost effectiveness of the managed care service delivery model.

PHP applies AHCCCS minimum network criteria in determining network provider accessibility. The PHP network is maintained to provide covered services within designated location or time and distance limits for each GSA. For Maricopa and Pima counties, PHP ensures that 95% of its members residing within the metropolitan Phoenix and Tucson areas do not have to travel more than 5 miles to visit a PCP, dentist or pharmacy. PHP's 2013 Network and Development Plan demonstrates the current network far exceeds minimum requirements in meeting all the network requirements in the five contracted GSA's with the exception of two dentists and one New Mexico PCP. All requirements for hospital contracts and hospital treating privileges are currently being met. Based on current performance in meeting network standards, PHP has the ability to meet the AHCCCS requirements for CYE 2014 by having a contracted network that ensures 90% of members residing in Pima and Maricopa Counties do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a Multi-Specialty Interdisciplinary Clinic.

PHP reviews the age and gender of the membership to ensure there is a sufficient ratio and availability of PCP type including Family Practice, Internal Medicine and Pediatric providers. This analysis assists in efforts to assign members with complex medical conditions, who are age 12 and younger, to board certified pediatricians. In an effort to optimize PCP availability, PHP permits mid-level nurse practitioners to contract as PCPs, except in Maricopa County. Members diagnosed with specific complex medical conditions may be assigned to physicians with special trainings such as AIDS or HIV positive, which are assigned to PCPs that meet specialty criteria and standards for AIDS/HIV care management. In determining accessibility to network specialists, PHP adheres to the standard of one specialty location within 15 miles for urban counties, and within 50 miles in rural locations. Availability of high volume specialty types as determined by claims volume and/or claims dollars include Cardiology, Obstetrics, General Surgery, Hematology, Neurology and Orthopedics are analyzed by GeoAccess using the specialty criteria.

AHCCCS's 30 years of experience has proven the PCP gatekeeper model is the best for the coordination of member's medical care. PHP supports the PCP gatekeeper model as the primary point of access in obtaining medical services. PHP's Open/Closed PCP Panel report is utilized in conjunction with GeoAccess to evaluate and measure accessibility in the network. PHP currently has a 93% open panel capacity. To better assist both members and providers in embracing the PCP gatekeeper model, PHP assigns all members to a PCP within the member's geographic area or zip code, taking into consideration the member's age, family continuity, language and other special conditions or needs of the member. Members have the right to choose a PCP from PHP's provider network and can request a PCP change by contacting PHP's Member Services Department. Additionally, the Member Services Department assists the members in scheduling appointments with their PCPs and arranging non-emergency medical transportation if needed. The administrative process of member assignment is measured and evaluated using physician open/closed panel reports, an algorithm weighting based upon quality metrics, appointment availability, and wait-time monitoring.

During visits to provider offices, Provider Service Representative (PSR) confirms the hours of operation, and verifies the provider office adherence to PHP's and AHCCCS' appointment availability and wait time standards. Currently, based on the onsite evaluation, all providers are compliant with the standards. Provider offices that do not meet standards are re-educated and reassessed to determine if a corrective action plan is warranted.

Identification and Resolving Network Deficiencies

Current or projected network deficiencies identified with the network analysis tools described above are critical inputs in the development and modification of PHP's Network "Needs List". This list is used in ongoing network review and recruiting. This focused attention on current and potential network deficiencies allow

PHP's Network Management to address deficiencies and ensure covered services are provided timely and are reasonably accessible in terms of location, hours of operation, amount, duration and scope as compared to non-AHCCCS persons within the same service area.

When a network deficiency is identified, PHP begins working on a resolution immediately. In partnership with the Medical Management department, PHP assesses the availability of other providers in the community and determines whether a long term resolution is feasible. If a timely long term resolution proves difficult, PHP institutes one the following temporary solutions:

- Recruitment of new provider(s) - In the event a contract with a new provider is needed, PHP allows for provisional or expedited credentialing to accelerate the providers' availability. This practice allows a provider to be temporarily credentialed and serve PHP members for up to 60 days while progressing through the standard credentialing process.
- Referral to/recruitment of a non-contracted provider - If the needed service provider(s) is available but unwilling to become contracted, PHP will offer a Letter of Agreement as a short term solution until a contract can be secured with another provider.
- Transportation to an alternate provider - If an appropriate provider is unavailable within the member's immediate community, PHP will transport the member to the nearest contracted provider.

Manage and Improve Provider Network

PHP contracts with all provider types amenable to contracting at cost-effective and fiscally-responsible reimbursement levels to ensure continued provider accessibility for all members. PHP is currently contracted with five Graduate Medical Education programs through the following organizations; Phoenix Baptist, Banner Good Samaritan, Maricopa Integrated Health Systems, University of Arizona Health Network and Tucson Medical Clinic. Additionally, all Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC) and FQHC look-alikes in PHP's GSAs are under contract. PHP strives to build strong partnerships with these valuable community healthcare service delivery systems that are vital to underserved rural populations. PHP is also expanding its network by contracting with Multi-Specialty Interdisciplinary Clinics (MSIC) for specialty care. Pediatric specialists that work in the MSICs are in limited quantity in Arizona. Contracting with the MSICs provides PHP members with increased access to these pediatric specialists. PHP also has negotiated contracts with homeless clinics in Maricopa and Pima counties.

PHP uses multiple sources to identify and recruit potential providers for network participation including; MD/DO licensing boards, recommendations from contracted providers, requests from members, competitor's provider directories, prior authorizations for non-network consultations, and hospital staff rosters. All provider letters of interest are considered in order to adequately capture new graduates, providers opening new practices or providers relocating to Arizona. PHP departments are consulted to ascertain if there are any geographic areas with new member assignments or member referral issues. The Network Management Department is responsible for these activities and includes PHP departments, community partners and contracted providers to complement recruitment efforts.

In rural or underserved areas, PHP actively reaches out to clinic networks and hospitals to ensure coverage and access to care. PHP partnered with FQHCs and RHCs to expand services and service sites in rural communities. Results of these successful partnerships include North Country Healthcare's expansion into Lake Havasu City, Show Low, Bullhead City and Kingman and addressing the lack of OB/Gyn services at Cobre Valley Regional Medical Center in Globe to prevent emergency transport of members presenting for delivery.

PHP recognizes many of its current and future members require unique services and/or interventions. PHP meets those challenges through a combination of network strategy and medical management protocol, by making extensive use of nurse case managers. The case manager ensures the provision of prompt, cost-effective and medically-appropriate services to members who are dual eligible, seriously mentally ill, homeless, border community residents, and who may require a medical home, Arizona Early Intervention Program services or an alternative to a skilled nursing facility placement.

In managing and improving the network, PHP recognizes AHCCCS' cost containment goals while simultaneously focusing on both innovation and partnerships with providers. Contributing to that goal are PHP's statewide service contracts including vision, laboratory, durable medical equipment, non-emergency medical transportation, home infusion, prosthetics/orthotics and home health. PHP leverages its statewide membership to implement aggressive service levels and rate negotiations, while fostering an environment of innovation and partnership. PHP has Joint Operating Committee (JOC) meetings with these statewide providers where access to care, particularly in underserved areas, is a standing agenda item. PHP will conduct readiness reviews and require specific action plans from statewide vendors and provider as soon as CYE 2014 awards are announced to ensure continued and expanded access to care. PHP's partnership with Nationwide Vision provides an excellent example of innovation that enhanced access to care for members. PHP negotiated real time access to provider appointment calendars for direct scheduling of member's diabetic eye exams. This activity is expected to positively impact member's access to needed healthcare preventative services and result in improved performance measures and Healthcare Effectiveness and Data Information Set (HEDIS) scores. Another example is the development of risk band corridors that rewards appropriate utilization while penalizing inappropriate utilization which was negotiated with the contracted statewide non-emergency medical transportation vendor.

Another innovative program PHP has implemented with key hospital partners is a quarterly Hospital Report Card. This report card examines specific hospital performance metrics and PHP's services to identify trends or isolate a particular concern related to claim denials and payment turnaround time. Review of this information encourages administrative efficiencies by both parties.

Telemedicine is a viable option for improving access to care in underserved areas in the State, particularly in northern Arizona. PHP currently has a telemedicine agreement with North Country Healthcare. The telemedicine service they provide allows members in rural areas to receive care when a provider is not available at the member's clinic. It also allows members to receive care when roads are closed due to weather prohibiting providers travel to the clinics. In addition, PHP is actively pursuing telemedicine contracting opportunities with University of Arizona, Tuba City Regional Health Care and Maricopa County Integrated Systems. PHP will also pursue an agreement with Northern Arizona Healthcare when they begin offering a telemedicine program.

PHP's commitment to continuously improve the provider network is evidenced by PHP's utilization of DST Health Solutions (DSTHS) CareAnalyzer. DSTHS is an analytic solution, which is a certified National Committee for Quality Assurance (NCQA) HEDIS solution. DSTHS integrates NCQA's provider performance measurement specifications for evaluating provider effectiveness and efficiency. Forty-two measures evaluate the effectiveness of acute, chronic and preventive care and access to care. Cost efficiency is evaluated for PCPs in terms of total cost of care with additional detail describing the relative use of specific service categories such as inpatient, outpatient, professional, and pharmacy. For both the efficiency and effectiveness assessments, providers are benchmarked against their peers and placed into quartiles by performance. The provider reporting module offers drill-down capabilities to support case review.

Central to continuous improvement in the network is PHP's review, evaluation and resolution of quality of care concerns reported by members and providers. Quality of care concerns are identified through prospective, retrospective, and concurrent case review, discharge planning, medical record audits, member and/or member's representative grievances, information obtained during provider office visits, committee meetings, pharmacy data, and communication from staff. Cases that are perceived to involve significant risk or injury to members, or which may represent a departure from the community standard of care, are referred to the Quality Management Department. Outcomes of these concerns are used to evaluate provider performance and continuation of contract.

Sustaining a Quality Provider Network

Essential to sustaining a viable, accessible network is the development of strong partnerships with the contacted providers. This successful partnership begins with PHP's commitment to open communication, ongoing education, continuous support, and the creation of operational incentives to ensure providers remain active network participants and engaged proponents of the AHCCCS program. Chief among these incentives is timely and accurate claims payment. PHP has established a goal of 10 day turnaround time for claims payment to contracted providers. PHP recognizes cash flow is critical to all providers, but especially to those providers operating in rural areas servicing the underserved populations. Equally important are provider-friendly medical management policies and procedures supported with clear prior authorization guidelines. PHP measures and evaluates the effectiveness of these incentives through annual provider surveys and face-to-face provider office visits which occur four times a year for PCPs and OB/GYNs and twice a year for specialists and dentists.

Network Management continually strives to provide excellent communication to the contracted network utilizing various methods such as blast faxes, provider office visits, quarterly talking points, newsletters and initial and custom comprehensive office in-services. PowerPoint presentations and web-based demonstrations are used for provider in-services. Topics include behavioral health services, integration of PHP and PHP's affiliated Special Needs Dual Medicare Advantage Plan, Abrazo Advantage Health Plan (AAHP), PHP and AAHP provider manuals and prior authorization guidelines, navigation of the both plan websites, cultural competency, fraud, waste and abuse.

A crucial component in sustaining provider satisfaction is PHP's electronic solutions. These solutions include the Automated Voice Response System (AVRS) and website which offer real time information to assist the providers in providing access to all members. The website contains the following information; real-time eligibility verification, claims status, provider directory lookup, including MapQuest directions providers can print when member are referred to other providers, remit review, and the opportunity to review and print detailed reference tools, such as the provider manual, formulary, Hot News, blast faxes, member handbook, evidence-based medical guidelines, prior authorization criteria and other recent communications. Provider use of these tools is measured and evaluated based on information obtained during provider visits and from the annual provider surveys to allow for continual improvements.

In addition to conducting JOC meetings, PHP will increase the current provider forums to quarterly in all geographic service areas as required to further enhance provider communication. All providers, including dental providers will be invited to these forums. Issues and ideas presented at these forums will be reviewed by PHP executive management for the development of collaborative and appropriate interventions.

Although these methods of communication are important, to become the Plan of Choice, service excellence from the provider's perspective is critical. The most effective form of communication and the critical component in managing and partnering with the network is the frequency of the PSR face-to-face visits with network providers. This is one area where PHP is superior to other plans. Equally valuable is PHP's provider inquiry resolution, where PHP exceeds AHCCCS response and resolution standards. PHP currently acknowledges 80% of inquiries on the same business day and 100% by the second business day and resolves 98% of inquiries within five business days and 100% within twenty business days.

In summary, PHP subscribes to a continuous improvement philosophy and utilizes information from a variety of sources to set standards and measure and evaluate performance. These activities ensure timely access to care for all AHCCCS members with special attention to the underserved populations, identify network deficiencies and manage, improve and sustain the PHP provider network.

3. How will the will the Offeror use data and evidence based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies? How will these tools and data be used to implement outcome- and value-oriented payment models? Describe the Offeror's experience and specific results.

Phoenix Health Plan (PHP) utilizes state of the art analytic tools and evidence-based practice guidelines to work with providers and stakeholders to improve care outcomes and create cost efficiencies. The "Plan, Do, Study, Act" (PDSA) method effectively evaluates clinical and administrative activities, allowing PHP to detect and better understand barriers to care and to plan interventions to improve outcomes. Root cause analysis facilitates the planning process thus setting meaningful goals, formulating relevant plans, and enabling PHP to work collaboratively with providers.

The PHP Business Analysis and Applications Department employs highly skilled project managers, application coders, and analysts who ensure data integrity and create reports with usable information from data analysis. PHP uses HIPAA/5010 compliant transactions to protect member and health plan data, storing it in a high-tech relational database, and is able to produce relevant operational information, using data queries, report engines, and other tools. This approach to transforming data provides easy access to *ad hoc* information supporting continuous quality improvement. Guided by evidence based clinical practice guidelines and an information-rich environment, PHP staff is empowered to successfully manage health care delivery in a dynamic environment to achieve process and health outcome improvement.

PHP focuses resources on the inpatient care setting because our members are the most fragile and vulnerable when in the hospital and skilled nursing facility environments. Nearly 40% of the total PHP expenditure for health care is spent in the inpatient setting. The medical management team consists of PHP's hospital concurrent review nurses (HCRN), medical directors, and other relevant staff who monitors inpatient utilization and quality of care on a daily basis. The concurrent review staff enters authorizations for clinically appropriate hospital services into the claims system and enters clinical notes and care plans into PHP's Medical Management System. PHP uses evidence-based clinical practice guidelines, such as the Milliman™ Criteria, to guide the assessments and interventions contained in care plans. The combination of clinical skills of an experienced team together with best practices optimizes inpatient care quality and cost-effectiveness.

PHP uses a suite of inpatient utilization reports and analytic tools to understand and manage acute hospital and skill nursing facility (SNF) utilization and quality. The PHP medical management team uses the daily bed day report to adjust care management processes. Monthly Inpatient Care Management Committee meetings focus on systematic analysis of the data to improve inpatient care, using continuous quality improvement and the "PDSA" method.

Several examples of PHP's care management reports illustrate the variety of information that is available to its medical team.

- The "Daily Inpatient Census Report" - a detailed list of all known inpatients, by facility, that includes their admitting diagnosis, current length of stay (LOS), primary care provider (PCP), treating inpatient physician, case management status, and inpatient benefits limit status.
- The "Daily Prospective Bed Day Report" - measures and reports normalized, month-to-date, annualized bed days and admitting rates, by county and by level of care, along with the average lengths of stay (ALOS) for that reporting period.
- The "Weekly Inpatient Pended Authorization Report" - monitors tier level authorization status of inpatients. This report ensures that HCRNs assign the appropriate inpatient bed days in a timely manner.
- The "Monthly 13-month Bed Day Trend Report"- summarizes and trends the "Daily Prospective Bed Day Reports" over the previous 13 months, by county and by level of care. The report is used to detect trends and patterns in utilization, which can trigger additional *ad hoc* analysis and planned interventions.
- The "Monthly Hospital Dashboard Report" - measures inpatient utilization by facility and level of care, sorted by county. This report monitors the following data; number of admissions, bed days, ALOS, number of one or two day LOS, percentage of admissions through the emergency room (ER), the

percentage of bed days spent at the intensive care level, and the number of readmissions to the hospital within 30 days for any reason. The report compares monthly data to the annualized month-to-date data and to previous year's data. This allows the medical team to understand and intervene in hospital-specific trends in care, such as lengthy or increasing ALOS. When a hospital has a high readmission rate, the medical team looks for evidence of premature hospital discharges or poor discharge planning.

- The "Daily Inpatient Bed Day Report" - monitors and measures HCRN productivity, bed day denials by facility, facility census, individual HCRN caseloads and other data. This report allows medical management to focus on the distribution of the HCRN workload and performance.
- "The Monthly ALOS Outlier Report" - identifies members who had complicated hospitalizations or long lengths of stay, allowing them to be referred to PHP's complex case management program. PHP defines a hospital ALOS outlier as any inpatient with a length of stay more than 3.5 days. In addition, outlier patterns trigger *ad hoc* root cause analysis of the data to devise needed management interventions.
- The "Monthly Diagnosis Admission Report" - monitors and measures the month-to-date, annualized admissions and length of stay, by diagnosis-related group, by county, trended over time.

Other inpatient analytic tools and reports are available to the PHP's medical team to help manage our members' care. Using this information and continuous quality improvement, PHP achieved and sustained significant care efficiency. For example, the systematic use of information caused PHP to adjust the HCRN caseload to improve hospital review effectiveness. PHP's HCRN and medical directors conducted more frequent inpatient rounds, ensuring more timely intervention in care to meet inpatient member needs and ensure placement in the least restrictive, most cost-effective setting. This approach decreased PHP's inpatient utilization each year over the last 3 years, demonstrating continuous improvement in the inpatient review process, prior to the 25 day inpatient limit, which further enhanced the reduction achieved. Likewise, the SNF ALOS has decreased from 28 days to 18 days in the last two years, producing a savings of over $2 million over that same time.

Using continuous quality improvement, health information, accepted standards of care, and practice guidelines, PHP identified an opportunity to improve the efficiency and quality of care to its neonates. In the course of monitoring and managing member care, PHP noted its Neonatal Intensive Care Unit (NICU) ALOS was 21 days, compared to 15 days, suggested by the literature as the benchmark for best practice (Kornhauser, *Managed Care*, January 2010). PHP gathered a multidisciplinary team to analyze its data, discuss practice guidelines, and plan interventions to improve care efficiency and outcomes. This team consisted of PHP's medical directors, several providers, including an obstetrician, neonatologist, perinatologist, PHP's maternal-child health case managers, and others. Following root cause analysis of the information and reports provided to it, the team elected to dedicate a single HCRN with prior clinical NICU experience to managing all level three NICUs. Previously, each HCRN would conduct reviews in their assigned facilities that included a NICU. The team concluded a dedicated HCRN with more NICU expertise would complete superior reviews and better outcomes. Because premature neonates were a significant cause of a long NICU ALOS, the team worked with PHP's Maternal Child Health Case Management Program to increase the use of 17-Alpha hydroxyprogesterone (17-P) in the care of pregnant women who have a history of premature labor. This intervention improved coordination of care between Maternal Fetal Health Specialists and Obstetricians and increased member education on premature labor. As a result of this targeted effort, the use of 17-P to prevent premature labor in at-risk mothers improved from a baseline of 7% to 56% of members enrolled in the PHP's pregnancy case management program. PHP's multidisciplinary team approach to improving NICU care efficiency and outcomes relied on relevant data and analysis, practice guidelines, standards of care, and the PDSA method. As a result, during the last 2 years, PHP's NICU ALOS improved from 21 days to 18 days. PHP estimates the savings due to care efficiency to be about $750,000 per year for its membership.

Recently, using data and practice guidelines, the multidisciplinary team recommended that PHP promote the use of the standardized Neonatal Abstinence Syndrome (NAS) clinical practice guidelines in selected NICUs because of emerging evidence that unwarranted practice variation in caring for drug-addicted babies was causing inefficient care. PHP is developing a project to promote the use of the NAS guidelines in selected Maricopa County NICUs at this time, as part of a pilot project. The project is still in development.

PHP also uses data, clinical practice guidelines, and standards of care to manage the hospital readmission rate, which is an indicator of both care quality and efficiency. A high readmission rate can indicate premature hospital discharge, poor discharge planning, or faulty discharge plan execution. Avoidable hospital readmissions also waste valuable inpatient resources. PHP measures, tracks, and manages the hospital readmission rate, using industry standard metrics. In addition to the "bed days" reports, discussed earlier, PHP developed an array of hospital readmission reports that are used by its quality and medical management teams to improve performance. Examples of readmission reports used by the team include the following.

- "Normalized Readmission Report" – shows all-cause hospital readmissions that occur within 30 days of a previous admission, expressed as a percent of admissions. This data is reported month-to-date, by county.
- "Trended Normalized Readmission Report" – shows the same information as the "Normalized Readmission Report", but is trended over a rolling 13-month period.
- "Member Readmission Report" – shows specific member information and demographics, with hospital readmissions during the previous quarter.

PHP's medical and quality teams discovered opportunities for improved discharged planning during root cause analysis of the reports presented above. As a result of this analysis, PHP developed a discharge planning template to prompt the HCRN to address all post discharge needs. The discharge plan is documented in PHP's integrated health record, used by PHP's inpatient and outpatient care managers. Consistent with continuous quality improvement, the Concurrent Review Manager audits the quality and comprehensiveness of discharge plans. High-risk members are targeted for ambulatory case and disease management. PHP's case management coordinator calls these members after being discharged from the hospital within 5 days of discharge to monitor their progress, answer any questions, and ensure members are engaged in an appropriate discharge plan. As a result of its efforts so far, PHP's acute hospital readmission rate has fallen from 10.2% of admissions in 2011, to 9.3% of admissions in 2012.

PHP's systematic approach to using data, tools, standards, and practice guidelines improves outcomes and care efficiency through case management. PHP developed a system for proactively detecting members who are unstable, have care gaps, and/or are predicted to be unstable or have a potential for care gaps in the future. These members can be targeted for risk mitigation and case management or disease management. This system is like a "broad funnel" that includes regularly produced analytic reports extracted from claims, authorizations, member demographics and provider data. *Ad hoc* reports also enrich the data used to guide case management and care coordination. Likewise, PHP's system includes formalized referral methods and communications from providers, care givers, and departments within the health plan such as Member Services, Appeals and Grievances, and Quality Management. In addition, Health Risk Assessment (HRA) questionnaires are completed by the member or caregiver. These HRAs are designed to identify high risk members with care gaps or potential care gaps. Another case finding tool is PHP's monthly "High Utilizing Member Report", an analytic tool developed from the health information system, identifies members with frequent ER use and high costs for several high-risk diseases such as diabetes, hypertension, COPD/asthma, congestive health failure and ASHD.

PHP uses DST Health Solutions (DSTHS), a certified Healthcare Effectiveness and Data Information Set (HEDIS®) data vendor, to monitor performance measures, gaps in care, and high-risk members. The DSTHS CareAnalyzer™ application is an analytic solution that combines elements of member risk, care opportunities, and provider performance to proactively identify high-risk members for case management. CareAnalyzer™ predicts a population's future utilization and cost, using the Johns Hopkins "Adjusted Clinical Groups Predictive Modeling System". It measures performance based on NCQA guidelines, allowing PHP to identify care gaps such as: missing immunizations, inadequate adolescent care or well child care, and care for specific diseases, such as diabetes and asthma. Targeted interventions by PHP's Case Management Department improved the use of controller drugs in asthmatics from 76% to almost 97% over the most recently measured four years. PHP utilizes DSTHS information to develop proactive interventions, such as member call campaigns and educational mailings targeted to specific members and providers. DSTHS also helps to identify members for enrollment in

PHP's complex case management program. PHP's case managers use evidence-based clinical practice guidelines for all phases of its medical management programs, including its case and disease management programs. All guidelines are reviewed and approved by PHP's Quality Improvement Committee and are available to the provider network.

The case management team maximizes care coordination, improves health outcomes, and delivers cost effective quality care, by using evidence-based interventions and measuring clinical metrics. PHP conducted a recent study of the total cost of care of 450 members who were continuously enrolled in case management during 2011 and 2012. These members experience an average of $2,862 per member per year less than members who are not case managed. Analysis showed that although ambulatory and pharmacy costs increased in the members who were case managed, these costs were more than offset by reduced hospitalization costs. Although the study metrics may include some regression to the mean, the outcomes are consistent with other published studies of effective case management programs. (Noris, *et. al*., *Am J Prev Med*, 2002; Bernabei, *et. al*., *BMJ*, 1998). This evaluation of the effectiveness of PHP's case management program is evidence of successful cost containment and higher quality member health status.

PHP's Pharmacy Department also uses data, analytic tools, and practice guidelines to work with members and stakeholders to improve care efficiency and outcomes. Work processes and interventions are guided by analysis of real-time information, member medication profiles, PHP's pharmacy benefit manager data, polypharmacy and multiple prescriber reports that are extracted from PHP's Health Information Systems, to improve member safety and care outcomes. To improve drug cost containment, PHP compares generic drug utilization to higher cost brand name drugs, for effectiveness. PHP uses its formulary, which is published to providers and approved by the Pharmacy and Therapeutics Committee, to ensure adequate medications are available in all of the therapeutic categories. As a result of these efforts, PHP's generic drug utilization rate is 88% and formulary compliance is 99%.

Quality efficient health care also depends on the services rendered by PHP's contracted provider network. The Network Management Department uses its "Appointment Availability Report" to identify providers who are not readily available to their patients, allowing the department to take corrective action, when required. Additionally, the Network Management Department uses GeoAccess radius analysis to ensure PHP maintains the required access to appropriate specialists and primary care providers in contracted geographic service areas. Network Management collaborates with the Credentialing Department to ensure its contracted providers are trained, qualified and licensed to care for PHP's members. This credentialing process collects data from a certified credentials verification organization, providers, state medical boards, the National Provider Data Bank, PHP's own quality and utilization management programs, and other sources, to optimize the care and services provided by the contracted network. PHP's Credentialing and Peer Review Committee, a committee of practicing network providers that is chaired by a Medical Director, oversees the credentialing program and helps ensure integration of care quality issues into the credentialing process.

PHP deploys an interdisciplinary team to analyze the results of the annual Provider Satisfaction Survey to identify opportunities for improvement, and intervene, when appropriate, using the "PDSA" method. For example, the survey showed room for improvement for provider satisfaction with PHP's prior authorization (PA) process. As a result, the Network Management Department collaborated with select providers and PHP's Medical Management Department, using "Kaizen" lean work process analysis, to make PA easier for providers by dropping PA requirements for specified services, when they are performed in the Ambulatory Surgery Center, or office, as appropriate. This intervention reduced medical cost by driving procedures to the least restrictive, most cost effective setting, and simplifying the work processes thus reducing administrative costs.

PHP's Grievances and Appeals and Department (G&A) also works collaboratively with members, providers, and other stakeholders to improve care outcomes, using data, tools, and performance standards. The G&A Department aggregates member grievance and appeal data, analyzing for trends and root cause. Trends are discussed in a weekly grievance committee meeting, leading to implementation of planned interventions based on the nature and severity of the issues. Typical interventions include providing assistance to members,

educating providers, implementing internal process change, and imposing a corrective action plan (CAP), or when necessary terminating a provider contract. For example, PHP's Grievance Trend Report indicated poor service by PHP's contracted non-emergency medical transportation vendor. The department collaborated with Network Management and the vendor to develop and impose a CAP to improve member service and satisfaction. The contract with the vendor was terminated when the CAP was not satisfactorily completed. A new vendor was retained to provide these transportation services, resulting in a significant reduction in transportation related grievances. During the months of July 2011 through October 2011, PHP received a total of 555 transportation grievances from 408 individuals. After the new vendor began, the grievances significantly decreased. For the quarter of April 2012 through June 2012, a total of 83 grievances were received for the entire quarter. In another instance, a PCP in PHP's network began to accrue a number of member grievances because members' perception of rude behavior and poor bedside manner. After a meeting between the provider and PHP's Medical Director failed to resolve this reoccurring problem, PHP instituted a freeze on the provider's patient panel and required completion of continuing medical education on patient relations. This educational intervention resolved this provider's problems with poor patient relations and member grievances.

In the constantly changing health care arena, the trend is toward more collaboration with the member and provider while using evidence based decision support tools to maximize care coordination. Providers are open to exploring new methodologies for payment for their services. New innovations regarding medical home, pay for performance, and other value-oriented payment models are being developed to improve outcomes while creating cost efficiencies.

The medical home concept although not new, is still in its infancy. PHP is currently working on establishing two medical home programs, one in Maricopa County and the other in the northern GSA. Each provider group has requested custom changes to their program. The ability to construct programs on an individualized basis gives the provider the incentive to direct patient care in the best interest of the member. Programs that pay providers based on goal oriented outcomes are part of PHP's arsenal of tools to maximize care coordination.

PHP is creating a Pay for Performance (P4P) program to enhance our immunization results and other evidence-based care performance measures/quality indicators that parallel AHCCCS and National Committee for Quality Assurance standards. Although PHP had a P4P program in the past, we experienced little success. Today we are better equipped with our systematic decision based tools to drive a new program.

PHP is exploring an innovative pilot program partnering with a hospital system to reduce readmissions. Since both the hospital and PHP benefit from avoiding unplanned readmissions, PHP believes the cost savings and improved quality outcomes also could be shared. Although this project is in its early phase, planned interventions include:

- Creating a readmission metric and report that tracks performance specifically for that hospital system,
- Creating a shared discharge plan template, or checklist,
- Engaging periodic multidisciplinary hospital-health plan team meetings to proactively plan the discharge for members with challenging or complex needs,
- Clarifying and facilitating communication between the health plan and the hospital, through the use of a specific shared procedure, to manage difficult discharge plans on an ad hoc basis.

If this pilot project is effective, PHP plans on expanding the program to other hospital systems.

PHP will continue its innovative approach to implementing outcome, value-oriented payment models by reviewing other programs that have been successful, such as; the "The California Pay for Performance Program" initiated by the Integrated Healthcare Association, funding an incentive pool with incurred savings from improved utilization. Funds from the pool would be distributed to stakeholders, based on quality outcome metrics, risk contracts with Accountable Care Organizations and paying for telemedicine to improve specialty coverage in underserved counties. This in conjunction with other evidence based support tools will move PHP to the forefront of cost effective care coordination and P4P programs.

4. Please describe how the Offerer would address the needs of Mr. Andrews. Describe what systematic processes the Offerer will use to improve health care outcomes for members with one or more chronic illnesses.

Phoenix Health Plan (PHP) uses a holistic, proactive approach to care management to ensure members gets the *right* care by the *right* team of providers and other health care professionals, in the *right* setting(s), at the *right* time(s), and at the *right* cost. Aligning these "5-Rights" guides our approach to helping Mr. Andrews and other members like him. This approach depends on evidence-based clinical practice guidelines, national standards of care, objective health care metrics, care coordination across all settings, and continuous quality improvement. It seeks to close care gaps, optimize health care outcomes, wellness, and member satisfaction. PHP forms an interdisciplinary care team (ICT) that includes the member and/or his representative(s), assigned case manager, primary care provider (PCP), specialists, social workers, clinical pharmacists, and other stakeholders, as may be required. The membership and composition of the ICT varies to accommodate the member's changing needs over time. This team conducts the following activities to improve Mr. Andrews' health outcome; evaluates his needs, plans and coordinates his care, identifies key metrics to measure progress, facilitates communication among his providers, and promotes best practices, based on accepted, standardized guidelines of care, among other things.

Based on the scenario, Mr. Andrews was referred to PHP for disease management by his PCP, but PHP's continual care surveillance system may have identified Mr. Andrews and enrolled him in its complex case management program already. PHP developed a system that proactively detects members who are unstable, have care gaps, or are at risk for future medical problems. These members are targeted for care management, disease management, and risk mitigation, which improves health care outcomes for members with one or more chronic illnesses. This system is like a "broad funnel", designed to find as many "at-risk" members as possible and guide them into PHP's care management process. The process includes regularly produced analytic reports extracted from claims, prior authorizations, member demographics, and provider data that reside on the PHP's health information system. *Ad hoc* reports, when necessary, can be obtained from PHP's health information system, thus enriching the information used to guide case management and care coordination for members. Likewise, PHP's process includes formalized referral methods and case referrals from providers, caregivers, and departments within the health plan, such as Member Services, Appeals and Grievances, and Quality Management departments. PHP also uses Health Risk Assessment questionnaires, completed by members or caregivers, to proactively identify care gaps, active disease processes, or risk factors that predict future clinical problems. To augment the effectiveness of PHP's case finding process, it uses the Johns Hopkins Adjusted Clinical Groups Predictive Modeling System to identify future high-risk and high cost members. This predictive modeling tool allows PHP to profile individual members to isolate gaps in their care and to close them by using case management interventions. Provider profiling tools augment the value and utility of this system, allowing PHP to work collaboratively with providers who have medically complex members, thus assisting them to optimize patient care. PHP's monthly "High Utilizing Member Report", an analytic tool developed from the health information system, highlights members with frequent emergency room (ER) visits. It also identifies members who incur high costs for several high-risk diseases, including diabetes, hypertension, chronic obstructive pulmonary disease, asthma, congestive heart failure and atherosclerotic heart disease. Mr. Andrews likely would have appeared in the ER section of PHP's "High Utilizing Member Report" report, or in one of the Johns Hopkins predictive modeling reports, thus flagging him for case management attention, engaging PHP's care management processes.

Mr. Andrews has complicated medical, behavioral and social problems that initially require rapid assessment and acute stabilization, as evidenced by his shortness of breath while at rest, frequent use of 911 and the ER. Although PHP seeks to meet the member's care needs in the least restrictive and most cost effective setting, Mr. Andrews' instability and complexity probably would require a brief hospitalization or stay in the observation setting. This hospital admission, or planned observation stay, allows a more closely monitored environment that is richly resourced with health care professionals, specialists, and technology designed to provide a prompt and thorough evaluation and address his acute, unstable clinical conditions. Initially, this would be a safer care setting in which to begin Mr. Andrews care management. The PHP case manager would coordinate this admission, after expeditious consultation with Mr. Andrews and his PCP. At this point, the ICT is formed in

collaboration with Mr. Andrews. Plans and notes made by Mr. Andrews' case manager in PHP's integrated health record, part of PHP's health information system, is available to PHP members of his ICT, including the PHP Hospital Concurrent Review Nurse (HCRN), who would assume responsibility for overseeing and coordinating his inpatient care management.

The HCRN would begin frequent review of Mr. Andrews' inpatient stay within one business day of being notified of his admission. The HCRN would closely monitor Mr. Andrews' inpatient care and would work collaboratively with his hospitalist(s), consulting specialist(s), ancillary service departments, and hospital case managers or social workers to ensure that his care progresses according to standard guidelines. In the acute inpatient setting, the HCRN would consult the Milliman™ Guidelines to assess Mr. Andrews' care. PHP conducts frequent hospital care management rounds involving PHP's medical directors, Hospital Concurrent Review Manager, and other members of Mr. Andrews' ICT. The HCRN acts as a liaison between Mr. Andrews' inpatient provider team and the ICT while he is in the hospital. In addition, PHP's medical director(s) often confer with Mr. Andrews' inpatient providers to ensure that his care conforms to evidence-based guidelines and national standards of efficiency and quality. PHP's information-rich hospital census, a tool extracted from its health information system, assists the HCRN to coordinate his care. This census is available to PHP's members of Mr. Andrews' ICT, during hospital team rounds. The census includes the member's demographics, known major clinical problems, prior use of acute and skilled inpatient resources, ambulatory case management status, PCP, and other useful information. In addition, the census helps the HCRN better coordinate Mr. Andrews' benefits coverage, should he have other payers, such as Medicare. The HCRN also documents Mr. Andrews' inpatient care plans and progress in the integrated health record, making this information available to the member's ambulatory case manager, and other members of his ICT, once he is discharged from the hospital or transferred to another level of care.

The HCRN would develop a plan and goals for Mr. Andrews' inpatient stay that are consistent with the Milliman™ Guidelines and the clinical facts documented by his inpatient providers in his hospital record. The HCRN documents the plan and goals in PHP's integrated health record and communicate them to Mr. Andrews' providers. In Mr. Andrews' case, these acute inpatient goals could include the following; resolving his cardiopulmonary status, clarifying and addressing the treatable causes and complications of his obesity, assessing, and beginning therapy for his limited functional status and activities of daily living The HCRN, in consultation with the ICT, would ensure that the right specialists become engaged in Mr. Andrews' inpatient care, since he is at risk for a number of co-morbid conditions, such as diabetes, hyperlipidemia, obstructive sleep apnea, alveolar hypoventilation syndrome, and others. Consultation, patient education, interventions by a dietician, physical therapist, and other ancillary providers, are an important component of the member's inpatient care plan. In addition, Mr. Andrews would have been evaluated for behavioral health disorders.

The HCRN begins discharge planning upon member admission, taking into consideration Mr. Andrews' cultural and social preferences. The discharge plan is part of Mr. Andrew's integrated health record, and readily available to his ambulatory case manager, who will need it to develop or amend his individual care plan. PHP's discharge planning template and checklist guides the HCRN in the development of a thorough discharge plan in conjunction with the hospital case manager. In general, the discharge plan augments the HCRN's documentation of Mr. Andrews' hospital course, principal diagnoses, and discharge information so that this information is available to the PHP ICT across the continuum of care. In addition, in collaboration with the hospital case manager, the discharge plan would detail Mr. Andrews' post-hospital evaluation and treatment plans, medications, durable medical equipment (DME) or supplies, physical therapy requirements, and any needed transportation. If recommended by his providers, Mr. Andrews' discharge plan may include cardiac or pulmonary rehabilitation. Since Mr. Andrews has no known family, PHP would work with him to prevent social isolation that may hinder his recovery or progress. For example, his discharge plan may require home care visits for Mr. Andrews to reinforce his diet, improve medication compliance, monitor his status and progress, stress healthy choices, and facilitate communication between him, his case manager, and his providers. In summary, without being able to detail all that it may enumerate, Mr. Andrews' discharge plan would ensure that he can progress safely to the next level of care without risking hospital readmission or becoming medically unstable.

Because of the severity of Mr. Andrews' medical problems and his functional and social support limitations, it is unlikely that he can be discharged safely back to his home environment from his acute hospitalization. Mr. Andrews would probably require a Skilled Nursing Facility (SNF) stay after his acute hospitalization. This may be required because, although he may have been stabilized in the hospital, he would still require close monitoring and skilled care thereafter. Furthermore, the member has multiple medical problems and profound functional impairment that could not be resolved in a single acute hospitalization, nor safely addressed in the ambulatory setting. Mr. Andrews' extreme exercise intolerance would require more physical therapy than his adult AHCCCS benefit would provide him in the ambulatory setting. For this reason, physical therapy sessions could be initiated in the skilled setting until it is appropriate to transition care to the ambulatory setting. A SNF stay would give the ICT more time to evaluate, understand, and address Mr. Andrews' social needs, so they can be addressed adequately when he is discharged to home. His social needs are complicated by his lack of family. Finally, the SNF stay allows Mr. Andrews' ICT to monitor his condition and clinical progress more closely during this vulnerable phase of his care. While in the SNF, Mr. Andrews would be evaluated for ALTCS eligibility. If appropriate, PHP would assist with the initiation of his application for ALTCS, while continuing to support his skilled care.

PHP's SNF Concurrent Review Nurse (CRN) focuses exclusively on the SNF, thus more effectively managing the special requirements of members like Mr. Andrews. The SNF CRN participates in team rounds with the medical directors, and others, using the same integrated health record as the rest of the PHP ICT, to manage Mr. Andrews's care. This care management process is designed to promote seamless coordination and communication transparency across the different care settings and the continuum of care. The SNF CRN guided by the Milliman™ Criteria, works in collaboration with the ICT, plans and documents the management of care milestones, and follows processes mirroring those in the acute inpatient concurrent review. The SNF CRN responsible for case managing Mr. Andrews' skilled nursing care would have developed a discharge plan, in collaboration with his ICT, to address all the transportation, logistics, and communications needs of his transfer to next level of care either to home or into an Assisted Living Facility *in lieu* of continued SNF stay. The discharge plan would identify and address any barriers to Mr. Andrews' ongoing successful care, as mentioned earlier.

PHP's case management coordinator would contact Mr. Andrews within two business days of his discharge notification from the SNF. The post-discharge call is part of PHP's "Welcome Home Program". This program is designed to ensure that Mr. Andrews is stable, understands his ambulatory care plans, has all he needs to comply with these plans, and is engaged sufficiently in his own care. Any issues or concerns discovered by PHP's "Welcome Home" call would be addressed and remedied by Mr. Andrews' case manager. Since Mr. Andrews would continue to have complex care needs following his SNF discharge, his ambulatory case manager would contact him to conduct a comprehensive telephonic assessment of his status and needs. As a result of this assessment, the case manager would develop an individualized care plan (ICP), in collaboration with Mr. Andrews, his PCP, providers, and the ICT. The ICP is a dynamic document that changes with the member's circumstances and needs, and addresses cultural and personal preferences, beliefs, resources and knowledge. The ICP resides in PHP's integrated health record. Among other things, the ICP could:

- Set measurable health care outcome goals for Mr. Andrews' care, specifying critical lab values, levels of function, and other metrics, that are predictors of health and wellbeing, designed to assess his wellbeing and progress,
- Facilitate scheduled and *ad hoc* communication between Mr. Andrews, his case manager and providers, and when required,
- Plan interventions, guided by evidence-based clinical practice guidelines, designed to improve Mr. Andrews physical, emotional, behavioral, and functional health,
- Proactively identify and remove or mitigate impediments and barriers to Mr. Andrews care and compliance,
- Educate and improve Mr. Andrews' engagement in his own care and empower him to be more self-sufficient,

- Coordinate Mr. Andrews' care among his various providers, including the Regional Behavioral Health Authority (RBHA), if needed,
- Assist in coordinating Mr. Andrews' benefits in a way that is transparent and seamless to him, should he have coverage from multiple sources, including Medicare, and
- Improve Mr. Andrews' satisfaction with the case management process and his own health care services.

In Mr. Andrews' case, the case manager's ICP and efforts specifically would focus on the following;

- Assist Mr. Andrews in coordinating and maintaining compliance and close follow-up with his PCP, cardiologist, pulmonologist, the RBHA, or other providers. This assistance may include making arrangements for transportation, calling him to remind him of his appointments, and educating him on his condition and therapeutic interventions. It may also involve facilitating communication between providers, if this is required.
- Help Mr. Andrews improve his level of function and independence, by planning and supporting his use of physical therapy or cardiopulmonary rehabilitation. The case manager would document and appropriately address his activities of daily living (ADL) or any pain that may be limiting his functional progress.
- Assist Mr. Andrews with his dietary compliance, documenting his weight and body mass index, and encouraging him when he loses weight. If Mr. Andrews did not make progress in his physician-directed and monitored weight loss program, or if the metabolic consequences of his morbid obesity required it, the case manager would assist him in getting evaluated for possible bariatric surgery. This assistance would include obtaining any needed authorizations for this care, if approved.
- Engage Mr. Andrews' PCP to evaluate and treat his anxiety or coordinate a referral to the RBHA for this problem, if appropriate. The case manager uses AHCCCS Behavioral Health Tool Kit for guidelines for managing anxiety. Mr. Andrews' case manager would involve PHP's behavioral health coordinator, a member of his ICT, to promote closer follow-up with him and to facilitate care coordination with the RBHA and/or his PCP. Finally, stabilizing Mr. Andrews' medical problems and educating him about his conditions and prescribed treatments, may reassure him greatly and reduce his understandable anxiety.
- Ensure that Mr. Andrews has the DME needed, such as a wheel chair, functional assistive devices in the bathroom, or home oxygen.
- Arrange for Home and Community Based Services (HCBS) home care monitoring and services, as required *in lieu* of SNF stay.
- Assist, educate, and encourage Mr. Andrews to comply with his treatment and medication regimen. For complicated members, like Mr. Andrews, the case manager would consult PHP's ICT when there appears to be unwarranted polypharmacy or medication side effects. The case manager and/or medical director would confer with Mr. Andrews' providers to resolve any issues with his medication or treatment regimen, if needed.
- Reduce Mr. Andrews' use of the ER, especially for non-emergent care. The case manager would establish a working relationship with Mr. Andrews, becoming his single point of contact to assist him with his care. The case manager would verify that Mr. Andrews' PCP and providers have adequate appointment availability during offices hours, and are available to him after office hours. The case manager would ensure that Mr. Andrews knows how to contact his PCP during and after office hours, knows the locations of urgent care centers that are near his home and how to access them. Mr. Andrews will be supplied the telephone number of PHP's after-hours nurse advice line, managed collaboratively with CareNet Health Care Services, to advise and assist him, when needed. When possible, the case manager will assist the member with programming his telephone or cell phone with the phone numbers of his PCP, nearby urgent care centers, and PHP's CareNet nurse advice line.
- Identify and eliminate or mitigate potential barriers to Mr. Andrews care, such as resolving difficulties with needed transportation, reviewing the suitability of his living arrangements in light of his health and social constraints and ADL levels or addressing his fears and questions about tests or treatment.
- Periodically survey Mr. Andrews on his satisfaction with his care management services. The case manager uses this information to better serve Mr. Andrews' specific needs, while the Case Management

Department uses this data systematically to improve its care management programs using continuous quality improvement methods.

- Assist Mr. Andrews in developing advanced directives, a living will, or complete other forms of life events planning.
- Assist Mr. Andrews with coordinating his care and benefits with other payers, commercial or Medicare.
- Assist Mr. Andrews in obtaining needed services from community resources, such as food banks, low or no cost dental clinics and the Life Enhancement Assistance Program among others. PHP will coordinate Mr. Andrews' community services with the care of his providers.

Some members have a challenging array of problems that seem to be refractory to traditional care models. Although Mr. Andrews has a PCP who seems to be informed and engaged in his care, the member's poor health status appears to have resisted his best efforts. With the consent of the member and the PCP, it may be advantageous for PHP to establish Mr. Andrews' care with a multiservice, multispecialty medical group that uses a team of clinicians, electronic medical records, and e-prescribing, to integrate his many care needs more seamlessly in a single medical home. PHP provides financial support and administrative collaboration to several multispecialty medical groups with emerging or mature patient-centered medical homes. With more specialties and ancillary services under one roof, and with dedicated case management resources affiliated with the member's multidisciplinary clinical team, members with many medical problems, like Mr. Andrews, may have better compliance with care and improved clinical outcomes when being cared for in this setting. PHP believes a partnership between its medical and case management resources and the patient-centered medical home of a sophisticated multispecialty group might be Mr. Andrews' best option for an excellent outcome.

While this case is certainly complex, it is not atypical. Mr. Andrews' circumstances and medical conditions mirror the complexity of many members who have been successfully managed by PHP. It is the aspiration of PHP to improve health care outcomes for all members, particularly individuals like Mr. Andrews. The "5-Rights" will continue to be the guiding approach that relies on evidence-based clinical guidelines and member-centric care coordination. PHP is committed to continuously evaluating the outcomes of this approach to ensure individuals like Mr. Andrews experience the most effective care coordination.

5. Describe what process would be used to coordinate care for George as he moves through the continuum of care related to these documented health issues. What does the Offeror see as the greatest setback risks/challenges for George and how will the Offeror proactively address these concerns?

George Robertson has complicated medical, behavioral and social problems. His substance abuse and medical non-compliance appear to be the primary causes of many of his issues. Mr. Robertson's chronic substance abuse can cause secondary behavioral health disorders that can further complicate his care (Moore, *The Lancet*, July 2007; Westriech, *Primary Psychiatry*, January 2005). Patients with this set of clinical problems often have an undiagnosed primary behavioral health condition, such as bipolar disease or antisocial personality disorder (Conway, Compton, Stinson, and Grant. *J. Clinc. Psychiatry*, February 2006). The case scenario does not mention such disorders for Mr. Robertson, but since the member has been receiving his care from the Regional Behavioral Health Authority (RBHA), an assumption cannot be made that a preexisting undiagnosed behavioral health condition exists. If the RBHA failed to detect and address an underlying behavioral health problem, it could have contributed to Mr. Robertson's noncompliance with his substance abuse program, which seems to have led to his automobile accident. In addition, Mr. Robertson's chronic substance abuse can cause secondary behavioral health disorders that can further complicate his care (Moore, *The Lancet*, July 2007; Westriech, *Primary Psychiatry*, January 2005). Failing to detect and treat such emerging secondary behavioral health disorders as a result of his ongoing substance abuse would be a major setback, thus highlighting the necessity for continual vigilance in caring for Mr. Robertson as a "whole person". For these reasons, Phoenix Health Plan (PHP) deploys a holistic, proactive approach to care management to ensure that Mr. Robertson gets the *right* care by the *right* team of providers and other health care professionals, in the *right* setting(s), at the *right* time(s), at the *right* cost. Aligning these "5-Rights" describes the care management process that guides our approach to helping Mr. Robertson. This approach depends on evidence-based clinical practice guidelines, national standards of care, objective health outcomes metrics, care coordination across all settings, and continual quality improvement (CQI) to address gaps in Mr. Robertson's care and to optimize his health care outcomes, wellness, and member satisfaction.

According to the scenario, it appears PHP first became engaged in coordinating and managing Mr. Robertson's care after an automobile accident that resulted in an unplanned acute hospitalization. Contracted hospitals are required to notify PHP of new admissions within one business day of hospitalization. PHP's Hospital Concurrent Review Nurse (HCRN), a member of PHP's interdisciplinary care team (ICT), would monitor Mr. Robertson's care by frequently reviewing his inpatient medical record(s) and progress. Working in collaboration with the member's hospitalist(s), consulting specialist(s), ancillary service departments, hospital case manager/social workers, PHP's medical director, and others on the interdisciplinary team, the HCRN would ensure that Mr. Robertson's hospitalization was progressing in accordance with best practices and accepted standards of care. In this scenario, the HCRN would have used the Milliman™ Guidelines, peer-reviewed, evidence-based clinical practice guidelines, to guide their assessment of Mr. Robertson's inpatient care efficiency and effectiveness. The HCRN also monitors hospitalizations for quality of care concerns, such as hospital-acquired conditions, working collaboratively with PHP's Quality Management Department, to ensure ongoing care quality.

PHP conducts frequent telephonic hospital care management rounds involving the HCRN, medical directors, and other members of the interdisciplinary team, as appropriate for the member's care. These rounds guide and assist the HCRN in setting and monitoring goals for Mr. Robertson's acute inpatient care and subsequent discharge plan. Mr. Robertson's clinical milestones are set by the HCRN in collaboration with the expertise of the ICT based on his clinical needs, the recommendations of his managing clinicians, and the Milliman™ Guidelines. Typical inpatient care milestones for Mr. Robertson would include treating his orthopedic and internal injuries, initiating physical therapy, assessing his psychiatric needs, and support ongoing education about his substance abuse issues. In addition, Mr. Robertson would have been monitored for drug withdrawal symptoms, ensuring that his inpatient providers addressed these promptly.

The HCRN documents the progress of Mr. Robertson's inpatient care in PHP's health information system, which includes a patient-centered integrated health record. This record assists the ICT in coordinating Mr.

Robertson's care between the ambulatory and inpatient care settings. It also provides an information-rich hospital census of all PHP's inpatient members, which would include Mr. Robertson's member demographics, known major clinical problems, prior use of acute and skilled inpatient resources, ambulatory case management status, assigned PCP, and other key information. This enriched census assists the HCRN in the management of Mr. Robertson's possible coordination of benefits, communication with his clinicians, RHBA providers and review of his care processes. The HCRN documents future care plans, such as the discharge plan, in the integrated health record.

The HCRN begins discharge planning on the day of admission or as soon as possible thereafter, taking into consideration Mr. Robertson's ongoing needs and his cultural and social preferences and current living arrangement. PHP's discharge planning template and checklist guides the HCRN in developing a thorough discharge plan. In general, the discharge plan would summarize Mr. Robertson's hospital course, principal diagnoses, and discharge medications. The HCRN, in collaboration with the ICT, would assess and document Mr. Robertson's cognitive and functional status, including his durable medical equipment (DME) and physical therapy needs. Integral to the discharge plan, the HCRN would work with the ICT reviewing Mr. Robertson's social and community supports to ensure a safe discharge to the least restrictive setting and avoid future unplanned hospitalizations.

In this case, the member was not safely discharged from the hospital after this first hospitalization. After a 21-day acute hospital stay for trauma, Mr. Robertson went home to his apartment, accessible only by two flights of stairs. He would have had significant physical therapy and DME needs following his first prolonged hospitalization. Mr. Robertson's orthopedic issues, functional impairment, living arrangements and lack of social support following his trauma would have compromised his ability to be safe and self-sufficient at home. Other appropriate housing for his needs was not secured. The case scenario identified no caregiver or social support to help Mr. Robertson. It did not address his unresolved substance abuse problem or his medical non-compliance. Moreover, the member had a possible ongoing need for opioids for pain relief in the immediate post-operative interval. This is especially challenging and potentially hazardous for a member with a substance abuse problem. Even if Mr. Robertson could have resided safely in the ambulatory setting without risk to future substance abuse, medical non-compliance, and falls, his outpatient physical therapy benefits would have been inadequate for his needs. As an adult AHCCCS member, Mr. Robertson is limited to 15 outpatient physical therapy visits within the same benefit year, unless there was another payer with which PHP could coordinate benefits – another key function of managing his care.

Under the care of PHP, the discharge plan from Mr. Robertson's first hospitalization would have addressed all his needs, communicating them to the rest of his ICT. In addition, the HCRN would have worked with the hospital case manager or social worker to communicate and coordinate the member's post-hospital care with the Regional Behavioral Health Authority (RBHA). This is especially important because of his ongoing substance abuse and consistency with treatment. The adverse experiences and consequences, created by Mr. Robertson's automobile accident may have rendered him more inclined to comply with his substance abuse program – an opportunity that should not be lost in his care. Also, it is likely that Mr. Robertson would have been fully detoxified from his illegal substances during his acute hospitalization, facilitating continued abstinence under RBHA supervision. Of course, the RBHA would be well suited to evaluate and care for Mr. Robertson's primary or secondary behavioral health problems, should there be any. A safe home environment that was accessible to the member would have been a vital component of his discharge plan. In the past, PHP has worked with the management of apartment complexes to secure a first floor apartment temporarily for members with physical limitations or disabilities. The HCRN would also ensure that the apartment building itself was configured for Mr. Robertson's physical limitations. The member's DME needs, such as ambulation or bathroom aids, would have been addressed in Mr. Robertson's discharge plan. Home care would have been engaged to monitor his welfare and progress and render assistance with wound care, compliance adherence, and patient education. Medication issues would have been reconciled in the discharge plan, including polypharmacy, multiple prescribers, therapeutic duplication, drug-drug interactions, medical noncompliance, and substance abuse. PHP's medical directors and clinical pharmacists collaborate with the ICT on medication reconciliation when complex patients are being managed. Finally, Mr. Robertson's discharge plan would have transitioned

oversight of his ongoing care to PHP's ambulatory complex case manager, another member of his ICT. The complex case manager would have contacted Mr. Robertson within 5 days of his hospital discharge to monitor his welfare, answer any of his questions, to provide needed patient education, and to oversee his case management in the ambulatory setting.

Mr. Robertson would have benefited greatly from PHP's comprehensive ambulatory complex case management program following his first hospitalization. Medical directors, registered nurses, social workers, care coordinators, and others, would have been part of his ICT. For the ambulatory setting, Mr. Robertson would have been assigned his own individual case manager, who would have worked with him and his providers to coordinate and facilitate his care. PHP's ICT includes a licensed substance abuse counselor, who has the expertise to collaborate with the RBHA and PHP's case manager on the assessment of Mr. Robertson's medical, behavioral, and social needs, which includes the member's rights and preferences. The case manager would assess and document in PHP's integrated health record, Mr. Roberson's clinical history, medications, cultural and linguistic needs, care giver resources, activities of daily living, mental health status, and cognitive function. The case manager also would assist Mr. Robertson with life-planning activities, such as formulating advanced directives. An evaluation of his available AHCCCS or other insurance health care benefits would assist his ICT in coordinating his care. A care management plan, complete with short and long term goals, would have been developed by the case manager as a result of Mr. Robertson's comprehensive case management assessment. This plan would be designed to coordinate his care, mitigate known health risks and barriers to care, close care gaps, and educate the member and his authorized caregivers on his conditions and treatment. Empowering Mr. Robertson to make healthy choices and to be more engaged and satisfied with his own care would be an important goal in his plan.

The PHP case manager would have access to Mr. Robertson's inpatient care notes, and would have documented in the integrated health record by his HCRN during his first hospitalization. The case manager would also facilitate communication between Mr. Robertson and his various providers. Mr. Robertson's case manager, as with all members of his ICT, uses evidence-based clinical practice guidelines to ensure best practices in care and to achieve cost-effective, quality outcomes. Analytic reports and tools that are part of PHP's health information system would have helped Mr. Robertson's case manager to monitor his care for medication and treatment adherence and to track and manage key health care metrics. For example, PHP's health information system includes the Johns Hopkins Adjusted Clinical Groups predictive model program, which provides a member-specific medical profile that highlights care gaps and risks. These tools, together with PHP's whole-person approach to complex case management, would have optimized Mr. Robertson's chance of recovery, sense of wellbeing, and would have minimized his cost of care. In a recent study of over 400 of PHP's members who were case managed over a 2 year period, the average total health care cost was reduced by over $2,800 per managed member per year, compared to members who were not case managed. Even greater health care cost savings could have been realized in Mr. Robertson's case because effective case management would have avoided his second acute hospitalization, traumatic brain injury (TBI), and subsequent skilled facility admission, with their associated costs.

Given all Mr. Robertson's medical, behavioral, and social problems, skilled nursing facility (SNF) placement after his first hospitalization would have been a better discharge plan to meet his needs. The member's history of active substance abuse can present a challenge in finding a SNF that will accept him. PHP has considerable experience in dealing with this issue, having developed relationships, contracted rates and terms with SNFs that are prepared to accommodate members with these issues. The HCRN responsible for case managing Mr. Roberson's inpatient care would have developed a discharge plan, in collaboration with his ICT, to address all the transportation, logistics, and communications needs of his transfer to a SNF.

The SNF Concurrent Review Nurse (CRN), a member of PHP's ICT would have reviewed Mr. Robertson's care in the skilled setting. The SNF CRN participates in team rounds with the medical directors, and others, using the same integrated health record as the rest of the PHP's employed ICT, to manage Mr. Robertson's care. This system of care management is designed to promote seamless coordination and communication transparency across the different care settings and the continuum of care. Like the acute setting, the SNF CRN is guided by

the Milliman™ Criteria, works in collaboration with the ICT, plans and documents the management of care milestones, and follows processes mirroring those in the acute inpatient concurrent review. PHP's CRN who focuses exclusively on SNF care has the expertise to effectively manage the special requirements of members like Mr. Robertson.

Unfortunately, this member did not receive the benefits of skilled care following his first hospitalization. Instead, Mr. Robertson was discharged from the hospital to an unsafe environment because of inadequate planning or execution of his discharge plan. As a result, his post-hospital support or care coordination did not meet all his needs. Four weeks after Mr. Robertson's discharge, a maintenance worker found him at the bottom of the apartment stairs, having sustained a head injury and broken ribs. The fall precipitated a second unplanned hospitalization that was potentially avoidable.

Mr. Robertson's second acute hospitalization, an unplanned transition of care under emergency conditions, would have triggered a second round of inpatient concurrent review and engagement by the ICT. All of the personnel, processes, systems, planning, and communication previously described for the member's first hospitalization would have been deployed for his second hospitalization. In addition, PHP would use the lessons learned from Mr. Robertson's first discharge planning to improve his care and prevent future problems. According to the case scenario, Mr. Robertson's substance abuse problem and medical non-compliance remained unaddressed at the time of his readmission. Unfortunately, these problems are now complicated by TBI, which further complicates his discharge planning and care coordination.

The 4-day stay of Mr. Robertson's second hospitalization suggests his care may have been abridged by the hospital to avoid unfunded costs that would have been incurred beyond his AHCCCS acute benefit limitation of 25 inpatient days. PHP has contracted SNFs with a TBI program, but the member ended up in a SNF that was not contracted or credentialed by PHP. The transfer to a non-contracted SNF suggests the hospital social worker did not consult or collaborate with PHP. The member's TBI indicates the need for neuropsychiatric and functional status evaluations to guide his discharge planning prior to post-acute care placement. The scenario does not say this was completed prior to Mr. Robertson's discharge to the non-contracted SNF. Also, his substance abuse appears to be unaddressed at the time of his transfer.

Mr. Robertson's care coordination would have been initiated by a prompt evaluation of the non-contracted SNF and its TBI program. PHP's designated SNF CRN would conduct this assessment, in collaboration with the ICT, the Credentials Department, and the Network Management Department. If the SNF or its TBI program were determined to be inadequate, the SNF CRN would consider transferring him to a contracted facility with a TBI program that would meet all of needs. If the non-contracted SNF was appropriate and best suited for Mr. Robertson's needs, PHP would pursue a letter of agreement with the non-contracted facility to avoid disrupting his care. This would have been a particularly viable solution for Mr. Robertson because of the SNF's specialized TBI program and the challenges associated with placing members with active substance abuse problems in SNFs. PHP would also initiate a complete quality of care investigation to address deviations from standards of care and care coordination. The SNF CRN would have conducted an ongoing review of Mr. Robertson's care, in collaboration with the ICT. Development of Mr. Robertson's discharge plan would have begun as soon as possible and would have been modified based on his care progression and changing needs.

The member's newly acquired TBI may have made his post-SNF care placement and future care management more difficult. Barriers to future care for Mr. Robertson would include any newly acquired deficits in cognitive, behavioral or functional status. If appropriate, the SNF CRN would have initiated an application for Arizona Long Term Care System (ALTCS). PHP would have paid the SNF a custodial rate if the member no longer requires skilled level of care but was awaiting approval of the ALTCS application. If ALTCS assumed Mr. Robertson's medical coverage, PHP would have cooperated and collaborated fully in his transition of care to his assigned ALTCS program contractor. PHP would determine if Mr. Robertson had any other insurance coverage including Medicare or Veteran's Administration and resolve any coordination of benefits (COB) with Mr. Robertson's other payers in a manner that would have been transparent to the member and receiving plan. If Mr. Robertson would have been discharged to the ambulatory setting from the SNF, another discharge plan

would have addressed his physical, behavioral, social, and cultural needs and preferences, as previously described. If Mr. Robertson were to remain a PHP member, his case manager would continue to be his single point of contact to the ICT. PHP would facilitate communication of his medical history, care progress, and future needs to his Primary Care Provider (PCP), other specialists and providers, and other health plans, if required. Mr. Robertson's possible legal problems, including possible future incarceration for substance abuse, may require some elements of COB and care collaboration.

Aligning the "5-Rights" of Mr. Robertson's care requires PHP to integrate its quality management processes with all aspects of its utilization and care management programs. In the event of a potential quality of care (QOC) concerns, such as Mr. Robertson's unsafe discharge which occurred after the first hospitalization, PHP would have initiated a QOC referral to our Quality Management Department for further investigation, root cause analysis, and corrective action. PHP would have analyzed its own care management processes, including discharge planning, and the care Mr. Robertson received from his providers. PHP would have reported any findings associated to the PHP Quality Improvement Committee (QIC), which is chaired by the Medical Director, attended by contracted network providers and representatives of PHP departments. The QIC oversees all aspects of PHP's programs and services, working with the health plan to achieve continuous quality improvement. QOC concerns related to Mr. Robertson's providers would have been reported to PHP's Credentials and Peer Review Committee. This committee, chaired by the Medical Director, assesses clinician care quality and directs and monitors corrective action, as required. Network Management is also included in corrective discussions as in this case, the hospital did not discharge Mr. Robertson to a PHP contracted facility, thereby indicating a knowledge gap in discharge planning protocol.

While this case is complex, it is not atypical. PHP has successfully managed many members like Mr. Robertson. Since PHP seeks to be a learning organization that constantly improves its performance, its quality management processes follow CQI methods including the PDSA cycle. In addition to care quality, PHP uses these methods to improve care efficiency. For example, PHP's inpatient utilization has improved continuously over the last three years, producing an annual reduction in acute bed days per thousand members per year (BD/K/Year) of about 4% and a reduction in acute hospitalizations per thousand members per year (Adm/K/Year) of about 2%. PHP's SNF average length of stay decreased from about 26 days to about 18 days over the same time period. Effective discharge planning and post-discharge case management has reduced PHP's readmission rate from 10.2% in 30 days in 2011 to 9.3% in 2012. The readmission rate is an indicator of both care quality and efficiency. Improving the efficiency of inpatient care is important to members like Mr. Robertson, since it serves to preserve their limited inpatient benefits for essential care. In this case scenario, Mr. Robertson used 21 days of his acute inpatient adult AHCCCS benefit during his first hospitalization, leaving him with only 4 additional hospital days for care in that benefit year. Mr. Robertson's 4 day second hospitalization exhausted the rest of his acute inpatient benefit, which may have adversely affected his care. For this reason, PHP believes it is vital to the welfare of its members to partner with members, family members, care givers, providers, and other stakeholders, to prevent unnecessary procedures and hospitalizations, manage chronic medical conditions, to provide cost-effective care in the most appropriate setting. This collaboration optimizes outcomes and costs with no adverse impact to health care's quality or service.

6. Describe the Offeror's experience in Medicare Advantage and/or Medicare Special Needs Plans. Describe processes that will be utilized to enhance and maximize care coordination and improve member experience for members being served for both Medicare and Medicaid services by the Offeror and for members who will only be served for Medicaid by the Offeror. What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment?

Medicare Experience

Abrazo Advantage Health Plan (AAHP) is an established Medicare Advantage Health Maintenance Organization that began operations in January 1, 2006. AAHP is currently contracted with the Centers for Medicare and Medicaid (CMS) and is experienced in offering two Medicare Advantage Prescription Drug program (MAPD) products: an HMO for Medicare beneficiaries and an HMO Special Needs Plan (HMO SNP) for persons dually eligible for Medicare and full-benefit Medicaid. The SNP product is available in Maricopa, Pinal, Pima, Yavapai and Mohave counties. The HMO product is offered in Maricopa, Pinal and Pima counties. A Notice of Intent to Apply for a special need plans for Apache, Coconino, Gila and Navajo counties has been filed to align the AAHP service areas with the Phoenix Health Plan (PHP) contracted geographic service areas. AAHP has a network of 1,600 primary care providers, 5,700 specialists and 43 hospitals. The AAHP network is 95% aligned with PHP's network.

The AAHP leadership team has over 100 combined years of Medicare managed care experience. AAHP is privileged to employ some of the best talent in the industry in key positions. The leadership team is responsible for both the PHP and AAHP (the Plans) lines of business resulting in efficiencies and integrated operations. The leadership team also includes a Director of Medicare Operations and a Compliance Officer who directly oversee the operations to ensure compliance with CMS contract requirements and that members have access to care. The health plan operates locally and employs onsite AAHP staff which allows for expediency and flexibility.

AAHP was awarded a 3-year contract as a result of the latest submission of the Model of Care (MOC). In October 2012, CMS completed an onsite review of the plan's execution of the MOC, resulting in the highest possible score, "Superior." A core philosophy shared by AAHP and PHP is to achieve 100% regulatory compliance at all times. The compliance team champions this goal and uses Compliance 360 as the tool to lead an effective compliance program. This industry leading solution enables a comprehensive approach to regulatory compliance and risk management through a single enterprise-wide platform. The Compliance 360 solution includes policy management, centralized regulation repository, incident management, reporting, contract management, surveys, remediation projects, audit management, self assessment, and enterprise risk management. In 2012, CMS performed eight reviews/audits and AAHP successfully completed and passed the reviews. The Compliance Officer and Director of Medicare Operations meet monthly with the CMS regional office account manager. This industry best practice creates the opportunity for both parties to discuss concerns and clarify regulatory understanding, increasing transparency.

Enhanced Care Coordination

<u>Medical Management</u>

The Medicare experience is evident in the medical management department whose mission is ensuring members receive "the *right* care, by the *right* provider, in the *right* setting, at the *right* time and at the *right* cost." The Plans believe that managing by these *5 Rights* improves the member experience, a value present in the Care Transition Program for the dual eligible members. The Care Transition Program maximizes care coordination and ensures the safety of members as they transition between various healthcare settings, while reducing the incidence of unnecessary hospital readmissions.

A deficiency in health care today is the lack of coordination with the primary care provider (PCP) upon member discharge. The Plans recognize how the member's care and experience can be impacted and therefore enhanced by the transition programs implementation of immediate PCP notification of every inpatient hospital and skilled

nursing facility admission. A dedicated Care Transition Nurse simultaneously reviews the inpatient stay and calls the member/and or member's representative to explain the purpose and scope of the transition program, build member rapport, and prepare the member for discharge. Discharge preparation includes coaching the member on the post discharge follow-up PCP visit to include discussion of medications, and identify and resolve any concerns. Upon member discharge, AAHP notifies the PCP of the discharge date, name of the facility, discharge instructions and medications. The Care Transition Nurse verifies that the discharge summary, instructions and order are completed and sent home with the member or to a receiving facility if the member is transferred to another facility or setting. These communications improve the member experience and increases care coordination.

Quality Management

The Plans are committed to ensuring the delivery of affordable quality health care to members. The Quality Management (QM) Department ensures members receive essential medical, mental health and social services though coordination and collaboration with internal staff, contracted providers and community partners.

The QM Department develops an annual work plan and program description that contains the Model of Care interventions to increase preventive health services and improve health outcomes for dual eligible SNP members. In an effort to maximize care, PHP has adopted many of the elements in the MOC for members in need of complex case management to maximize care. The Plans enhance the quality and case management programs by using a comprehensive analytic tool, DST Health Solutions (DSTHS). DSTHS' CareAnalyzer application is an analytic solution which combines elements of patient risk, care opportunities and provider performance to meet operational and regulatory reporting requirements. As an integrated tool, CareAnalyzer proactively identifies high risk members for case management, measures performance based upon industry-accepted standards, provides reports to engage providers on quality performance, identifies inefficient and ineffective providers and more effectively manages risk contracts. CareAnalyzer utilizes industry accepted performance measures from the National Committee for Quality Assurance (NCQA). The Johns Hopkins' Adjusted Clinical Groups Predictive Modeling System enhances care opportunities by identifying patients who are at risk for future high costs and medical services. The Case Manager also uses information from the Health Risk Assessment, medical and pharmacy claims data, inpatient utilization reports, and other information to manage the member's care and to develop an individual plan of care. Case managers use state of the art assessments, care plans and interventions to engage members and to coordinate cost effective care.

The Plans follow standard guidelines and best practices set by the Case Management Society of America and design programs that are member centric. Several identification mechanisms are in place to identify members in need of case management, including but not limited to; utilization reports, planned and unplanned transition reports, provider, self, health plan and department referrals, and Health Risk Assessments (HRA). HRAs are performed telephonically for the Dual SNP population allowing for higher response rates. The Plans also use DSTHS to identify members who may be at risk for higher care needs and develops proactive interventions to improve outcomes.

When dual eligible members are identified as needing case management, an Interdisciplinary Care Team (ICT) is established to collaboratively develop, implement and monitor an individualized care plan. Participants of the ICT include as appropriate, the member, member's PCP, Specialists, PHP Case Manager, family member/caregiver, Medical Director, Behavioral Health Coordinator, Social Worker, Utilization Nurse, Pharmacist, Pastor, Nutritionist, and any person or entity requested by a team member to assist with the member's care. The ICT and the member prioritize care needs and determine what benefits, services and resources are available. The Case Manager, along with the member, determines whether the goals continue to be appropriate and realistic, and what interventions may be implemented to achieve or enhance successful outcomes. If there is no progress, the case manager, the member and the ICT reassesses the plan of care to identify any barriers to meeting the established goals. This process is followed for all members in an ICT. PHP adopts and follows this approach when members meet the established criteria.

Pharmacy Department

The Plans Pharmacy Department designs a pharmacy benefit to ensure that its members have access to needed medications and implements programs to improve the members' health while keeping costs under control. The Pharmacy Department ensures that the pharmacy drug benefits are delivered in a safe and cost-effective manner and that members receive the most appropriate medications.

The Plans recognize the value of medication adherence and have created a program and strategy to increase adherence and care coordination of dual eligible members. AAHP utilizes a Medication Adherence Database to identify dual eligible members who are one day beyond having their prescription filled. The pharmacy prior authorization staff calls these members to ascertain and address any barriers that may be impacting their ability to refill a prescription. Members are encouraged to take advantage of refill reminder programs offered by network pharmacy providers, 90-day fills at retail and by mail service where appropriate. PHP's Clinical Pharmacists are available to advise the pharmacy prior authorization staff on any issues encountered during these conversations.

The Plans strive to maximize opportunities for care coordination. As an example, when AAHP receives prior authorizations for Medicare excluded drugs such as Vitamin D3 they are appropriately denied on the AAHP side. However, the pharmacy prior authorization team simultaneously notifies the retail pharmacy that it is available on PHP and to file the claim with PHP. This enhanced workflow removes a barrier that would prevent the patient from receiving their prescribed drug therapy without unnecessary delays, and therefore, improves the member experience. This process is performed for all Medicare prior authorizations for the dual eligible members.

Clinical pharmacists work with the PBM and network department to drive data to providers regarding high risk medications, drug-drug interactions and controlled substance utilization. AAHP sends a letter to providers with the patient's history of utilization of controlled substances and a list of the prescribing providers to maximize care coordination, thus allowing for better health outcomes. Additionally, The Plans have access to the Arizona Board of Pharmacy Controlled Substance Prescription Monitoring Program Database. This program provides more information than what is available in claims history providing The Plans with a complete picture of the member's history with controlled substance utilization furthering better outcomes for the member.

Additionally, The Plans periodically analyzes its pharmacy claims data, linking information from Medicare and Medicaid medication claims, to find instances of drug misuse and intervene to minimize these prescription drug diversions. This integrated data is provided to the ICT to help drive better outcomes and maximize care coordination.

Grievance and Appeals

The Plans' Grievance and Appeals (G&A) systems are fully integrated in order to provide the most seamless experience for the member who may be enrolled in PHP, or the AAHP Plus, Special Needs Plan. When a member contacts PHP with a complaint or appeal, G&A staff checks the member's complete eligibility history. Since the staff is cross trained in the complaint, grievance and appeals process for both plans, the dual eligible member does not need to determine which entity to contact.

Increasing and Maintaining Alignment

PHP leads a mature managed care model and believes aligning the Medicaid and Medicare plan is in the best interest of the dual eligible member, AHCCCS, CMS, PHP and the tax payers. Achieving alignment improves care coordination and health outcomes for the dual eligible member, increases program efficiencies, reduces the complexity experienced by the member and increases member satisfaction. Thus, the Plans are focused on strategies to improve and will develop additional tactics to support this critical initiative.

Over the years, The Plans found that members lack a fundamental understanding of how managed care works and how to coordinate Medicare and Medicaid benefits. Approximately 40% of PHP's dual eligible members are on Medicare Fee for Service (FFS) with a Part D plan resulting in a lack of coordinated care and potential waste. The Plans found that dual members often remain on FFS, not because of the freedom FFS offers, but not knowing a coordinated option is available. For this reason, The Plans have proactively been working on increasing membership alignment by 1) offering competitive supplemental benefits and network, 2) understanding the reasons members remain on FFS and presenting the benefits of enrolling in a managed care model, and 3) guiding members to programs that pay for Part B premiums and co-insurance.

The Plans strategically began by designing a product that offers supplemental benefits attractive enough to influence a member to move into a managed care model. Without supplemental benefits, alignment is a difficult undertaking. For 2013, the Abrazo Advantage SNP plan includes $2,000 of comprehensive dental coverage, $700 of a hearing aid benefit, $175 eyewear benefit and an over the counter benefit. Coupled with strong benefits, AAHP aggressively worked to expand its network, resulting in 57% increase in 2012. The Plan representatives contact all PHP members on FFS and outlines the reasons why being in a managed care model is beneficial to increasing good health outcomes and the overall experience of the member. In this process, The Plans discovered several barriers. One of the barriers identified is that some PHP members choose not to pay for the Part B premiums because they did not understand the process or the premium was challenging to pay. As a result, the representatives share the Medicare Savings Programs that helps the member with limited resources and income pay for Medicare expenses. PHP members may not understand that the Medicare Savings Program helps pay for the Medicare Part B premium and cost sharing. The representatives direct the members on how to apply for the Extra Help program at the local Social Security Office. This combined approach and process has helped increase alignment and move PHP members into complete integrated care. In 2011, 17% of PHP members were aligned with Abrazo Advantage SNP and in 2012, 20% of PHP members are aligned.

Dual eligible members receive an AAHP ID card that includes their AHCCCS ID number to ease the coordination for providers. Claims adjudication is also coordinated by first adjudicating the AAHP claim and then internally transferring the Medicaid portion of the claim for payment, thus increasing ease and satisfaction for the providers and members. A dedicated AAHP member services team proactively listens to members to identify potential dissatisfaction. The team collaboratively works with the member's one point of contact in the Transition Team to ensure information is shared across departments. The Plans additionally examined the policies and procedures for dual enrollees and operate in the best interest of the dual eligible member to increase ease of use and deliver superior service.

This is a momentous time in history when the dual alignment demonstration will have a significant impact to the program and the members. Moving forward, The Plans will establish a comprehensive retention program by considering the lessons learned from the passive enrollment of Part D in 2006 and engaging members in the process. The program will be designed with the umbrella perspective of "One Member at a Time." This approach will compel The Plans to discover all the possibilities that make a difference to the member. The program will be designed with stakeholder input and The Plans will employ experts in the on-boarding process. The Plans' systems will be evaluated and enhanced to support shared knowledge and immediate access to member information in an endeavor to increase member satisfaction. Emailing, texting and social media avenues will be used to meet the member where they communicate. The Plans are evaluating naming conventions to easily brand a dual product in the demonstration and will use approved marketing channels to heighten awareness and recognition of the dually aligned product. Robust data analytics will be used to understand member's experience. The data will include unfavorable plan decisions to better identify the causes of dissatisfaction from the member's perspective. This approach will help understand what operational challenges may have caused a specific member to leave the plan and what strategies can be created to realign the member. In addition to data analytics, a disenrollment survey will be performed. Member and provider feedback loops will be in place in the form of focus groups and/or stakeholder meetings to continually consider opportunities to increase member and provider satisfaction. The Plans will employ representatives who have an affinity in serving the special needs population and take ownership in resolving all inquiries to completion.

The Medicare experience coupled with The Plans strong mission statement "We are committed to the administration of fiscally responsible quality health care management services" and operational fortitude positions The Plans favorably to continue to manage the care of this highly complex population. The Plans welcome the evolution of the program, and are prepared to continue delivering exceptional services and innovative solutions to enhance and maximize care coordination while maintaining and increasing aligned enrollment.

7. Provide specific initiatives and efforts your organization will pursue to deal with "waste" that exists within the existing system and improve outcomes. Provide specific information describing the initiatives that would be pursued to improve quality and enhance cost containment including but not limited to the stakeholders involved, the timelines for implementation and the desired outcomes.

Phoenix Health Plan's (PHP) mission statement, "We are committed to the administration of fiscally responsible quality health care management services" was established over 20 years ago. This mission couldn't be more relevant than it is today. PHP's objective is to provide the highest quality of care to members and obtain the lowest price for goods and services. To galvanize the mission, PHP has adopted the Lean Process as a continuous quality improvement strategy to reduce waste, remove redundancies and improve quality and outcomes for our members and providers. Lean thinking continually examines and improves operational processes to ensure efficient operations to serve members and providers and promote best practices throughout the organization.

Clinical Initiatives

PHP's has designed clinical initiatives to improve quality and outcome, enhance cost containment, and reduce inefficient, unnecessary care. PHP institutes a number of valuable initiatives such as, use of clinical decision support tools and medical data, sharing knowledge and best practices, promoting member centered care models, and creating incentives through payment and contracting strategies. PHP will continue to improve on the quality of cost effective care members receive by promoting evidence-based practice guidelines, best practices, and continuous quality improvement efforts.

For example, in 2011, a review and analysis of utilization data indicated PHP's Neonatal Intensive Care Unit (NICU) length of stay (LOS) was 21 days, compared to literature suggesting a benchmark of 15 days. A root cause analysis of its data identified premature labor and delivery and drug addicted neonates as contributors to the high LOS. The PHP medical team analyzed the NICU data, hospital concurrent review process, and high-risk maternal-child health case management program. PHP then assembled a multidisciplinary taskforce of contracted network providers, including a neonatologist, a perinatologist, and an obstetrician, to help the health plan. PHP's data revealed that only 7% of mothers with a history of premature labor received 17-*alpha*-hydroxyprogesterone (17-P), a treatment known to prevent premature labor and delivery. PHP acted on this information by intensifying communication with members and obstetricians to promote the use of 17-P in at-risk mothers, raising the use of this critical drug to 56% and reducing NICU ALOS from 21 days to 15 days, saving about $750,000 in hospital costs per year. Over the last year, as a result of PHP's 17-P campaign, the gestational age of babies born to mothers with a history of premature birth increased from 36 weeks to 39 weeks. In fact, since the inception of the program, not one at-risk mother placed on 17-P has gone into premature labor. It also improved health care outcomes, quality of care, provider engagement and reunited the baby with the mother and family sooner. Due to the success in the 17-P project, in the first quarter of 2013, PHP will institute a best practice educational program to promote standard clinical practice guidelines for managing drug-addicted neonates. PHP anticipates similar outcomes in decreased LOS, costs and better health outcomes.

Another example of how PHP is looking to reduce ineffective care and improve health outcomes while minimizing costs is by partnering with providers to develop medical homes. The medical home is an important solution to health care fragmentation that is caused partially by the increasing complexity and specialization of medicine. By moving medically complex members to medical homes, PHP promotes the seamless integration of care across the health care continuum. Interdisciplinary health teams, enhanced communication and transparency via electronic health records, e-prescribing to reduce medical errors, standardized outcome metrics, evidence-based clinical guidelines, and continuous quality improvement makes medical homes effective. PHP's analytic tools, including the Johns Hopkins predictive modeling system, proactively identifies high risk, high cost members allowing PHP's Case Management Team to triage them to a medical home. PHP pays providers with competency in medical homes a stipend to support communication and administrative functions. PHP will contract with providers to establish medical homes with the goal of adding two or more each year, which will improve care coordination and reduce medical costs for complex patients.

An unscheduled readmission to the hospital often represents a waste of medical resources and an opportunity to improve health care quality. In late 2010, PHP intensified its focus on preventing hospital readmissions and found improvement opportunities in the discharge planning process. PHP has implemented effective discharge planning and post-discharge case management which has reduced PHP's readmission rate from 10.2 % of admissions in 30 days in 2011, to 9.3% in 2012. In 2014, PHP will implement an innovative pilot program in partnership with a hospital system to continue the focus of reducing readmissions. This partnership will improve outcomes and allow hospitals an opportunity to share in the cost savings generated by the reductions in readmissions. PHP members will benefit through the reduction of needless hospitalizations and unplanned transitions of care. Although this project is in its early phase, planned interventions include: Creating a readmission metric and report that tracks performance specifically for that hospital system,

- Creating a shared discharge plan template, or checklist,
- Engaging periodic multidisciplinary hospital-health plan team meetings to proactively plan the discharge for members with challenging or complex needs,
- Clarifying and facilitating communication between the health plan and the hospital, through the use of a specific shared procedure, to manage difficult discharge plans on an ad hoc basis.

The pilot program's effectiveness will be evaluated to determine potential expansion with additional hospitals or hospital systems.

Unwarranted and dangerous overutilization of radiology can also contribute to waste in the form of unnecessary services. PHP analyzed radiological utilization and cost data and found costs from high-tech radiology tests were accelerating faster than other health care cost, primarily from increasing utilization. Although, PHP's overall denial rate for all prior authorized services is approximately 10%, the denial rate for high tech radiology services is many times higher. For example, recent analysis revealed PHP's denial rate for lumbosacral spine (LS) MRI's exceeded 80%. PHP analyzed the causes for the high denial rate and found providers were not practicing evidence-based medicine. In fact, some providers were ordering high tech radiology tests in *lieu* of completing a history and physical examination. With this understanding, PHP began to educate contracted providers on the appropriate use of LS MRIs, using guidelines documented in medical literature. To reinforce national evidence-based guidelines for ordering high tech radiology, PHP medical directors use standardized excerpts from the Milliman™ Criteria when communicating denial reasons to ordering physicians. This strategy reinforces the requirements of the clinical standards. In the summer 2013, PHP will study the impact of these interventions. PHP will expand its educational outreach to providers to encourage them to practice evidence-based medicine. Even this early effort, when combined with similar interventions to reduce overutilization of OB ultrasounds, reduced wasted health care resources by over $1 million per year. It also enhances care quality and patient safety, outcomes that will continue to pursue in the future.

Following AHCCCS's initiative to redirect radiology services from hospitals, the location of services will continue to be addressed as cost for radiology in the hospital setting is significantly higher than the same service at an outpatient facility. PHP's goal is to additionally reduce radiology expenses by 10% a year for the next 3 years, not only as a cost containment measure but to also reduce unnecessary radiology procedures, thereby minimizing patient exposure to needless radiation and further inappropriate procedures. In 2013, PHP will improve quality outcomes and reduce waste by ensuring contracted outpatient radiology vendor's equipment meets or exceeds national standards.

Medication therapy is a vital component to modern health care; it is also expensive and increasingly dangerous. The Pharmacy Department works in collaboration with the Pharmacy Benefit Manager (PBM), to monitor and manage the medication used by AHCCCS and Medicare members. Patients with complex care requirements, such as dually-enrolled Special Needs Plan (SNP) members, receive intensified program supervision and benefits coordination. PHP's Medication Therapy Management Program (MTMP) identifies potential medication errors, adverse drug interactions, and overutilization, proactively to correct these problems before they occur. In the second quarter of 2013, the Pharmacy Department will produce the Prescriber Report Card,

based on the MTMP's findings. The Prescriber Report Card will provide patient-specific recommendations for medication treatment, based on guidelines to targeted PHP providers, when their practice patterns require it. PHP will evaluate this project within a year to determine if it changes prescribing practices and warrants expansion as a potential pay-for-performance structure.

PHP's clinical pharmacists conduct reviews of PA requests, utilization reports and member medication histories to identify opportunities to reduce waste and improve health outcomes. Reports indicate providers often add medication to a member's drug regimen without having the member taper off the failed medication. Maintaining drugs that have failed and continuing to expose members to drug interactions and adverse effects is detrimental to the member's health and increases medical costs. In the spring of 2013, PHP will implement an educational campaign for providers and members regarding the continued use of failed medications and polypharmacy in general. PHP will assess the success of the campaign in the summer of 2014 to determine if the providers are eliminating duplicate therapy which is the desired outcome of this initiative.

When multiple prescribers participate in a member's care, there is a risk of unplanned polypharmacy, causing drug interactions and adverse drug reactions. In addition, dispensing unneeded drugs wastes precious medical resources. Combating this issue, PHP identifies members with prescriptions from five, or more, prescribers per month. This causes PHP to send a letter to the Primary Care Provider (PCP), along with their patient's drug history, empowering the PCP to intervene in the patient's care and assist PHP in coordinating the member's medication treatment. Following this initiative, 76% of the continuously enrolled members with multiple prescribers identified in May 2011, were no longer filling prescriptions written by five or more prescribers. With the proven success of this program, it will be repeated in 2013 to improve outcomes and reduce unnecessary services.

PHP also will also continue its effective polypharmacy management program. Using its PBM data, PHP sends PCP's a report identifying members who fill thirty, or more, prescriptions in a 3-month period. This report also details the member's prescription purchase history. The high-level snapshot of their patient's medications enables providers to better manage their patients' care. The data for this study will be analyzed in the second quarter of 2013, when PHP will evaluate the effectiveness of the program, to determine if the desired outcome of a reduced drug burden for the member was achieved.

PHP's Pharmacy Department will continue to use prospective and retrospective drug utilization work processes to ensure members are getting the proper drugs. PHP's Prior Authorization (PA) program will continue to specify a formulary of approved drugs, ensuring members have access to all therapeutic classes. PHP's clinical pharmacists and medical directors will continue to use evidence-based clinical practice guidelines to evaluate drug prior-authorization requests. Each member's prescription history will continue to be available to the Pharmacy Department staff at the time of the PA request. Step therapy protocols, based on the medical evidence, will promote the safest medications before other drugs are authorized. PHP will continue to use this systematic approach to manage medication services as it has been proven to improve care quality, while reducing the costs. For example, in PHP's experience, pharmaceutical detailing induces providers to prescribe more expensive brand name drugs when less expensive generic medications are just as effective. PHP will continue to enforce the use of cost-effective generic medications, which has resulted in a generic utilization rate of 88%. Pharmaceutical detailing also appears to induce providers to ignore evidence-based clinical practice guidelines in favor of newly-marketed drugs. For example, PHP found many providers initially prescribed Advair® and Symbicort® to treat asthmatics, instead of safer, less expensive controller drugs. PHP instituted evidence-based step therapy for asthma, which will continue, resulting in an annualized savings of about $600,000 while improving patient safety and care quality. Also, PHP's medication utilization program will continue to minimize drug diversion, based on the program's proven effectiveness. Following a 2010 study of OxyContin® use, PHP instituted improved step therapy guidelines that decreased the use of this narcotic by 29%, reducing opioid therapy costs by 19%. In the spring of 2013, PHP will implement an educational campaign for providers and members regarding the continued use of failed medications, and the dangers of polypharmacy, in general. The health plan will assess the effect of this campaign on the polypharmacy rate in the summer of 2014 anticipating improved outcomes and containment of pharmacy costs.

Members who do not take their medications, as prescribed, risk poor health outcomes and incur needless costs. PHP will reach out to providers to facilitate medication compliance. Also, PHP will use its newly-acquired profiling and predictive modeling software, by DST Solutions™, to find lapses in patient compliance and intervene as appropriate. Dual-eligible diabetic members with adherence issues will benefit from PHP's new diabetes disease management program partnership with Alere™. Alere provides education on preventative examinations and screenings, medication adherence, lifestyle behaviors and self-care to empower members to better manage their diabetes. PHP will implement these initiatives fully by the third quarter of 2013 to achieve the desired outcome of increased adherence.

Technology Initiatives

PHP understands the contribution technology makes to medical outcomes and cost containment by capturing clinical and financial data to guide policy and best practice development. Enhanced technology supports PHP's Lean initiatives of optimizing operations by creating efficiencies; eliminating waste; improving process and communication flow and error proofing by replacing manual processes with automated and standardized work flows.

To further optimize business technology, PHP is developing a 24-hour, self serve Web Portal, scheduled to go live in the first quarter of 2013. This robust, dynamic solution will create a seamless integration of technology and customer service, ensuring the delivery of reliable, real-time information to members and providers. This maximizes operational efficiencies while simultaneously reducing administrative costs and can accommodate growth in membership.

Based upon information obtained during on-site provider visits, PHP will make improvements to two PA systems; the web authorization system and PA request workflow. By August 2013, enhancements to the web authorization process will allow providers to attach electronic records to the e-authorization request, develop custom PA request templates specific to their practices' most commonly requested procedures, and identify all authorizations related to an episode of care. These enhancements will increase use of on-line authorizations, reduce administrative burden for the providers and the plan, decrease volume of phone calls and faxes, and introduce real time response via the web while improving turnaround time. Both initiatives will contribute to increased provider, member and employee satisfaction.

Another technological advance is a telephone upgrade for members and providers. PHP is upgrading the telephone system to implement an Interactive Voice Response (IVR) feature in the Spring of 2013. This advanced phone system includes blended communications and real time access to health plan information. Using a member/provider IVR typically reduces the call volume for live operators by 19% to 25%. Members will have 24 hour access to retrieve recorded messages and receive updated plan information. The system includes intelligent call routing, automated outbound call campaigns, interactive menus and enhanced self serve options that allow callers to obtain eligibility status, claim status, and claim payment information. PHP expects higher levels of member and provider satisfaction.

Technology also enhances the claims process by increasing accuracy and efficiency through electronic claim submission. PHP evaluates Electronic Data Interchange percentages and works directly with identified providers to increase electronic submission and improve overall results. In the third quarter of 2013, system changes will be made to enable attachments (i.e., EOB, medical records, etc) with electronic claims. Desired outcomes include an increase in auto adjudication, provider satisfaction, electronic claim submission rates, improved workflow, and faster turnaround time.

PHP recently adopted a fraud, waste and abuse forensic editing tool that examines and compares claims history. The tool includes health care industry edits to detect outliers that can be investigated for potential waste. Through this process, claim edits are identified to enhance the PHP system to prevent waste. PHP's system includes the Overpayment and Recovery System (OaRS) interactive claim auditing program that performs claim

editing and evaluation to determine outliers against specific parameters. The edits discovered through the investigation tool are adopted into OaRS to prevent future waste. Use of the software has resulted in an average monthly savings of $500,000 or more related to the specific edits incorporated into the software including duplicate claims, invalid modifiers, age inappropriate for diagnosis, age inappropriate for procedure, gender inappropriate, etc. PHP will continue to enhance the OaRS system with edits discovered in the detection tool and anticipates a significant prevention of waste in 2013.

Administrative Initiatives

Through PHP's commitment to cost containment, PHP discovered a trend in high level evaluation and management service coding. Providers utilizing their Electronic Health Records (EHR) tools to determine the billing level for each visit may have contributed to higher coding or upcoding. In the summer of 2013, PHP will develop a partnership with providers and PHP's Claims and Network Management Departments to expand and document the understanding of EHR use to establish best practices to prevent inflated pricing. This partnership will eliminate excessive denials, reduce requisite medical record requests and provide a more accurate assessment of the member's visit, which will ultimately reduce claims expense.

Lastly, in early spring 2013, to improve outcomes, PHP will examine the member experience in both lines of business, PHP and Abrazo Advantage Health Plan. PHP will evaluate all member communications (written and oral) during the first 90 days of enrollment. PHP will determine if any gaps or duplication exists, identify opportunities for improvements in the onboarding process and ensure communications enhance members' understanding of their covered services and access to those services. The desired outcome is to create consistent and meaningful member communications that help the member to navigate PHP's systems, exceed member health care service delivery expectations and ensure regulatory requirements are being met.

PHP has developed a culture of continuous improvement and cross-functional learning. PHP supports this culture through empowering established multidisciplinary teams to propose and implement solutions when an opportunity for improvement has been identified. The teams have access to clinical and financial data, member and provider survey results, and expertise to impact health plan performance. The following committees are examples demonstrating PHP's operational model that supports collaboration, teamwork and open communication. Many of the specific initiatives covered in this submission emerged from these committees.

- The Medical Expense Ratio Committee's overarching strategy is to manage costs and identify waste by reviewing and analyzing health care cost trends, deploy lean tactics, implement cost containment strategies, and assess results for continuous improvement.
- The Contract Implementation Committee with participants from Claims, Network Management, Prior Authorization, Appeals and Grievances reviews current contracts that require manual interventions and new contract reimbursement terms to increase auto adjudication opportunities. This committee has proven to be an excellent source of information for the design of future contracts.
- The Joint Operating Committee works with high volume providers to address issues and opportunities to optimize operations and service delivery. This committee is attended by provider entity representatives and a variety of key PHP departmental staff.
- The Provider Claims Dispute Reduction Committee consists of staff from Grievance and Appeals, Network Management, Claims, Business Analysis and Analytics, and Medical Services. The goal of the committee is to reduce waste by analyzing and trending the types of disputes received, create and implement solutions to decrease reoccurring or subsequent dispute submissions.

PHP will use these committees as a vehicle to continuously throughout 2013 and beyond to proactively identify administrative and medical waste and develop interventions to combat the issue.

PHP clearly understands that the health care industry is on an unsustainable path and is concerned about the viability of the program. Consequently, PHP will ensure that its initiatives are significant to eliminate waste and positively impact the AHCCCS program. PHP will continue to enhance these initiatives and seek out new strategies to advance efforts to achieve efficiencies, eliminate waste, increase provider and member satisfaction, and ultimately reduce cost.

8. The Offeror is required to develop a compliance program designed to guard against fraud and abuse. Beyond the requirements outlined in the RFP and AHCCCS policies, describe additional activities your compliance program will take to limit, identify, and address fraud and abuse. Describe the Offeror's experience using these methods and include examples of successful application.

Phoenix Health Plan (PHP) prides itself on the high quality of services provided to members and providers and the long-standing commitment to conduct business in accordance with the highest ethical principles. PHP's mission, "We are committed to the administration of fiscally responsible quality health care management services" is carried out in the Compliance Program led by the Compliance Officer (CO). The CO is responsible for developing, operating and monitoring the compliance program and reports directly to the CEO and Board of Directors, who have a long-term commitment to fostering an environment of corporate responsibility that protects PHP's mission. The Compliance Committee includes leaders and subject matter experts from all departments who assist the CO in the development of the compliance plan. An effective compliance program is not static, it continually embraces improvements. The compliance program builds upon seven elements that include: 1) policies, procedures, and standards of conduct, 2) a compliance infrastructure, 3) continuous training and education, 4) open lines of communication, 5) well-publicized disciplinary standards, 6) a system for routine monitoring, and 7) prompt response to fraud and abuse issues.

The Compliance Committee created and developed the compliance plan to identify a method that limits and addresses fraud and abuse with the seven elements as the foundation. The plan methodology includes identifying outliers, building modifiers and edits in the system, conducting reviews/audits, surveying members, and conducting training and education for all stakeholders.

Identifying Outliers

PHP recently contracted with Health Management Systems (HMS), a health care industry leader in prevention and detection programs. These programs include the Automated Claims Evaluator (ACE) tool and the Special Investigation Unit (SIU). The ACE tool provides a comprehensive all-in-one web-based forensic editing system that can compare claims history to identify potential fraud, waste and abuse. The ACE tool can apply any combination of rules to each transaction line to verify whether claims are adjudicating based on those rules. The results from ACE can easily be manipulated to identify outliers. The SIU team is a group of industry experts who conduct preliminary and extensive investigations by using the ACE system and their collective industry experience when investigating for potential fraud, waste and abuse. Together, these components provide an unparalleled system of prevention and detection. HMS' health care industry results have been a breakthrough in scrutinizing claims by identifying beneficiaries and providers who may be involved in fraud or abuse.

Recently, over 100 of the AHCCCS edits from the reference file were applied to the ACE system. The successful application of just one edit resulted in a $10,000 savings. Although the program is in its infancy, PHP anticipates a significant impact to the program.

To limit or address potential fraud and abuse, identifying outliers is imperative. For instance, the new standards of the AHCCCS Minimum Required Preferred Drug List limits the number of short-acting narcotics, reducing the drug costs associated with potentially fraudulent emergency department utilization. This does not prevent members from visiting multiple prescribers to acquire long and short-acting opioids or benzodiazepines and stimulants, however. PHP developed the "*Three Plus Three Group"* program to close this gap by identifying potential fraud and abuse related to controlled substance prescriptions. A monthly report is generated to identify members who fill three or more controlled substance prescriptions, by three or more prescribers, at three or more pharmacies. The report is reviewed against the Arizona State Board of Pharmacy Controlled Substances Prescription Monitoring Program to identify additional controlled substance prescription claims. PHP shares the results with the member's primary care physician, behavioral health coordinator, and the fraud and abuse compliance specialist to address and limit any fraud or abuse. The "*Three Plus Three Group"* program is a successful application of the methodology used by PHP to identify, limit and address medication outliers.

PHP partners with contracted Pharmacy Benefit Manager, Express Scripts, Inc. (ESI), to create additional strategies to limit, identify, and address fraud and abuse. As part of the strategic use of data and advanced analytics, ESI provides innovative, industry-leading solutions to help combat fraud and abuse. Since 2010, ESI has completed more than 3,300 investigations, leading to recoveries of more than $154 million for their clients. ESI's Enhanced Fraud and Abuse Investigative Services identify prescribers and members with unusual or excessive utilization patterns, leveraging key components including; The *Advanced Analytics*: a proactive approach to identify relationships, patterns, and scenarios to help mitigate risk; and The *Investigative Services*: a diverse team of subject matter experts that investigate, validate, document, and report suspected fraud and abuse. The Compliance Committee is evaluating and finalizing the enhancements to the program for implementation in the first quarter of 2013. PHP predicts that this program will substantially augment the fraud and abuse efforts.

Building System Modifers and Edits

PHP has invested in several technological tools to identify, limit and address fraud and abuse. One significant investment has been in a prospective claims editing tool called Overpayment and Recovery System (OaRS.) PHP has customized and integrated OaRS with its claims processing system allowing real time updates to occur. The methodology used for the claims editing tool identifies and limits fraud and abuse by building edits into OaRs such as duplicates, invalid modifiers, obsolete procedures, inappropriate place of service, lab unbundling, maximum units, medically unlikely services, inappropriate age and gender for both procedure codes and diagnosis codes, secondary and repeat procedures, global surgery editing, evaluation and management (E&M) frequency edits, critical care as well as hospital admission and discharge frequency. These edits allow for claims to deny and/or identify recoupment opportunities. Use of the software has resulted in an average monthly savings of $500,000 or more related to the specific edits incorporated into the software including duplicate claims, invalid modifiers, age inappropriate for diagnosis, age inappropriate for procedure, gender inappropriate, etc.

AHCCCS' Office of the Inspector General has identified durable medical equipment (DME) providers as an area of high risk for fraud and abuse. PHP responded by including Medicare modifers in the system as methodology to monitor DME. PHP monitors and tracks rental items that have a capped rental price retrospectively to ensure that rental payments do not exceed the purchase price. To improve this process, PHP works with its DME providers to require submission of DME claims to include the Medicare approved modifiers for capped rental claims. The Medicare modifiers include; KH modifier signifying month one, KI modifier signifying month two and three and the KJ modifier signifying month four through thirteen. Additionally, PHP is in the process of enhancing OaRS to include these edits allowing the ability to track the rental cycle month. DME provider claim submissions with the incorrect rental month modifier or an attempt to submit past the thirteenth month, results in a denial. These changes allow PHP to limit fraud and abuse. Furthermore, to realize savings on DME, PHP utilizes Medicare rates for all "by report codes" that do not have an AHCCCS fee schedule versus paying a percentage of billed charges which customarily are higher than Medicare rates.

Conducting Audits and Reviews

PHP has implemented an audit and review strategy to identify, limit and address fraud and abuse. These audit and reviews may be scheduled and some may be ad hoc depending on the business needs. PHP uses The Plan, Do, Study, Act (PDSA) cycle, to ensure continuous improvement of the results from each audit or review. Successful applications of the audit and review strategy include the dental review/audit and the evaluation and management coding review.

<u>Dental Review/Audit</u>

PHP's contracted Dental Director, Dr. Walter Pfitzinger, DDS, conducted a review of all the dental claims to identify utilization patterns and outliers. The review included one year of claims data for PHP contracted dentists, who were unaware of the review. The results identified twelve providers with high utilization patterns.

In August 2012, PHP communicated the review methodology and general findings with the entire dental network. The twelve providers subsequently received separate unique letters outlining their specific results notifying them of their outlier status. This notification alert was to compel the providers to evaluate their practice patterns for potential fraud and/or abuse. PHP continues to monitor the twelve providers to determine if a change in utilization practices occurs and will conduct another formal utilization review in February 2013. The review resulted in PHP submitting one formal fraud and abuse referral to the AHCCCS Office of the Inspector General.

This review prompted PHP to update the dental compliance plan and begin monitoring the following services discovered in the report.

- Occlusal composite restorations on newly erupted teeth and an unusually low utilization of dental sealants;
- Pulpotomies associated with crown procedures;
- Occlusal lingual and occlusal buccal composites on second primary molars and first and second permanent molars;
- Restorative claims compared to all dental claims; and
- Extractions noted as D7140 (extraction, erupted tooth or exposed root) when compared to the conversely low utilization of D7111 (extraction, coronal remnants-deciduous tooth)

Evaluation and Management (E&M) Review

PHP reviewed E&M coding and identified provider outliers who had a common practice of using electronic health records (EHR). Many of the providers adopted EHRs to coordinate care, improve quality and reduce paperwork. However, it appears that providers may be using technology to determine the billing level for each visit which, in some cases, may result in a higher coding (known as up-coding) submission than is appropriate. PHP representatives visited with several providers to investigate further and concluded:

- Regardless of whether the EHR software template was being customized or not, the up-coding results proved consistent.
- The EHR software automatically prompts for higher and often unnecessary documentation in cases where the medical decision making is minimal.
- Practices having certified coders on staff didn't change the end result, as the software was driving the coding.
- All provider locations felt they were utilizing the software to the best of their ability with quality results.
- Providers were 'cloning' records by cutting and pasting information and at times it appeared medical information was copied from a different patient.
- Accurate coding was best achieved when manual intervention was implemented at the point of medical decision making.

These findings mirror the recent warnings from the U.S. Department of Health and Human Services to the hospital community. The November 12, 2012 response from the American Hospital Association included the statement that discussions and a greater understanding of functionalities embedded into EHRs and automated tools would lead to mutual understanding of the rules. As a result of the findings, the Network Management Department immediately communicated to the network the potential risk of inappropriate billing of E&M visits when utilizing EHRs. PHP also included the monitoring of EHR claims into the compliance plan due to the high risk of potential fraud or abuse for physicians that utilize EHR software. To address this national issue, PHP will partner with several providers to better understand the EHR software. PHP will observe, research and determine best practices for EHR documentation to ultimately identify, limit and address fraud and abuse in the areas of EHR software. These best practices will be shared with the network to help providers limit their exposure to potential fraud. It will also help providers who will be adopting EHRs to understand the potential risks.

Surveying Members

PHP performs the Verification of Receipt of Paid Services as required by AHCCCS. PHP found that this process was limited in detecting fraud and abuse. Therefore, PHP is in the process of enhancing the verification of receipt of paid services program as a continuous improvement project. The program will increase the number of verifications conducted for services where the potential risk for fraud and abuse is high. The verifications will include not only an outbound call to members; it will also include a medical necessity review from the claim's registered nurses, who are also certified coders. Additionally, PHP will focus on high cost equipment and will require providers to submit documented proof that the equipment was delivered and received by the member. PHP will further monitor the claims associated with the equipment for the accompanying supplies to insure that the equipment is being used.

Conducting Training and Education for all Stakeholders

PHP guards against fraud and abuse by continuously training and educating stakeholders, an element of an effective compliance program. PHP takes this element seriously by providing annual and ongoing specialized training and responding immediately to new developments.

PHP staff is required to complete the annual compliance training within 90 days of hire, and annually thereafter. The training includes a description of the compliance program, how to identify and report fraud and abuse, as well as other regulatory requirements such as False Claims Deficit Reduction Act and Health Insurance Portability and Accountability Act. The training program defines and provides examples of fraud and abuse. Employees are instructed on how to make a referral or report suspicious activity directly or anonymously, and are informed of the disciplinary consequences for failure to make good faith reports of potential fraud and abuse, including up to termination of employment or contract. The training also reinforces PHP's commitment to ensure there is no retaliation for good faith reporting. PHP is in the process of formalizing specialized training for specific staff members who have greater opportunities to detect potential fraud and abuse such as a claims analyst. PHP fosters a culture of continuous training by incorporating public and private resources including but not limited to, American Academy of Professional Coders (AAPC) coding webinars, Noridian Webex seminars, and Centers for Medicare and Medicaid Services.

The Network Management Department continually strives to conduct training and education to providers, which includes fraud and abuse. PHP understands the limitations or barriers providers face with communication tools and resources. Therefore, PHP established an internal standard for the Provider Services Representatives to visit each PCP and OB/GYNs four times a year, two visits per year to specialists and dentists to increase partnerships and communication. This is practiced in all the counties where PHP holds a contract. PHP utilizes various methods of communication to educate providers on fraud and abuse such as initial in-service education for all new providers, notifications via fax and quarterly visits. A multidisciplinary team of people including the chief executive officer establishes the quarterly talking points utilized during the quarterly on-site provider visit. The goal of these communications is to inform, train and educate.

Another tool used for education is predictive modeling software that produces a provider profile. The profile outlines utilization trends and member patterns. These profiles will be shared with the providers to help with the identification of outliers and potential risks.

The website is another tool PHP uses to provide education to members, providers and subcontractors regarding Fraud and Abuse. The member website includes examples of fraud and abuse and tips for prevention. A "Frequently Asked Questions" guide is provided. The member site also presents easy to find information on how to report fraud or abuse anonymously. A member can submit their incident online or call the hotline directly. PHP adopted the Compliance 101 education via the Office of Inspector General's (OIG) website for providers and subcontractors. Free educational resources and roadmaps are available for new physicians on how to comply with the federal fraud and abuse laws. PHP placed the OIG link on the website for easy access to current and comprehensive webcast, modules and presentations. Providers are encouraged to review the materials and remain current on how the federal fraud and abuse law affects the medical community.

Fraud and abuse is an ever-growing problem in health care today, and PHP is committed to limiting this heavy burden on the health care system. It is not only imperative for the sustainability of the program, but it is PHP's fiduciary obligation to innovate, evolve and continuously improve the compliance program to limit, identify and address fraud and abuse.

9. Describe in detail the ongoing processes and strategies the Offeror will implement to minimize the need for providers to utilize the claims dispute process to obtain proper reimbursement. In addition, describe the interventions and strategies the Offeror will employ to resolve claims disputes without resorting to the hearing process.

Phoenix Health Plan (PHP) employs a straightforward strategy to ensure proper claims reimbursement and minimize the need for providers to file claims disputes and request subsequent state fair hearings. This strategy includes partnerships with providers, open communication, timely provider education, access to in-house staff experts, cross department collaboration and accurate provider, prior authorization and claims system configuration and adjudication. PHP is driven by the goal to be the AHCCCS network's "Plan of Choice," by striving to exceed our providers' expectations for timely, accurate claims processing. This goal is shared by the entire organization and includes claims payment review processes that are instituted at the beginning of contract negotiations and continues through the entire claims reimbursement cycle.

PHP realizes that the first step in maximizing provider satisfaction and reducing provider claim denials leading to disputes is to ensure that claims are billed correctly. To that end Network Management provides timely communication to contracted providers regarding PHP claims processes and policies, AHCCCS billing guidelines and the appeal and grievance process. Provider Services Representatives (PSRs) visit PCP and OB/GYN offices four times a year and specialty and dental offices twice a year to educate providers on a variety of topics. Quarterly talking points for these visits are developed collaboratively across PHP departments, and contain information regarding billing and coding requirements, error trends, helpful hints for proper billing, AHCCCS coding and benefit updates and changes. Other pertinent information such as; changes related to PHP's prior authorization requirements, performance measure results and medical management policy changes are presented at these visits. In addition, "blast faxes" notifying providers of relevant changes to AHCCCS or PHP billing guidelines are sent to the provider network.

PHP's PSRs provide an additional established point of contact for alternative resolution processes regarding claims issues. PSRs, along with the Network Management Managers work with the Claims Department to establish a "claims project" to resolve trended claims issues on the provider's behalf. One such example of a project occurred, when Southwest Radiology submitted a claim for the insertion of the pharmaceutical drug along with the radiology procedure. The insertion portion of the claim was denied resulting in the filing of claim disputes. The Network Management and Claims Departments worked with the provider on a process to pay the claims and avoid resubmissions and future denials. These projects eliminate the claims resubmission and offer a provider friendly alternative for timely resolution thus avoiding the potential for large volumes of provider claim disputes.

PSRs also have the ability to produce detailed provider claims history reports. After these reports are analyzed for payment and denial trends, the results are shared with the provider and their staff. This detailed information increases understanding of what contributes to claim denials, so providers can correct their billing systems and resubmit claims for proper payment instead of formally disputing the denials and prevent future issues.

PHP defines and clearly communicates which services require prior authorization (PA) by developing and publishing a PA Guideline for the provider network. This guideline details the elective clinical services that require authorization for benefit payment. Moreover, PHP has a multi-disciplinary PA Taskforce that specifically assesses PA guidelines to ensure the published guidelines match internal claims and PA workflows as well as system configurations. This team proactively addresses any inconsistencies to facilitate proper claims payment and provider reimbursement.

In order to reduce the risk of error, the PA data entry system was enhanced by creating protocols. These protocols are rules that determine how authorizations should be entered into the system given a set of circumstances such as provider type and place of service. The protocols increase the generation of proper claims payment thereby decreasing the potential for PA related claims disputes. Another way PA contributes to the potential reduction of PA related claim disputes is through provider education. When a PA request is denied,

the clinical guidelines supporting the denial accompany the denial notice. This explanation helps the provider understand why a service request is denied and reduce inappropriate requests or performance of a service before obtaining a PA which will contribute in a reduction in disputes.

When a claims issue arises, the PHP Claims Customer Service Unit is dedicated to responding to the provider. When interacting with providers, claims customer service representatives assist providers by either making a real time adjustment or reprocessing the claim and explain how the claim was processed. PHP employs a full-time Claims Educator (CE) in Claims Customer Service who works collaboratively with PHP's, Network Management and Grievance and Appeals departments. The role of the CE includes providing expert level education related to claims processing systems and requirements to internal staff and contracted and non-contracted providers. PHP departments utilize the CE to help prevent disputes by educating providers. The CE receives calls and emails directly from individual providers regarding billing and payment issues. Claims and Member Service Representatives may also forward technically difficult calls to the CE. The CE frequently attends joint plan/provider meetings to provide expert input on claims issues and may accompany the PSRs or Network Managers on scheduled provider visits and/or new provider in-servicing. The CE constantly monitors claims data for trends and issues to develop strategies to further improve provider satisfaction with PHP claims processing. The CE's responsibility of creating and disseminating billing information contributes to the reduction of incorrect billing practices, which further reduces claims problems and thereby dispute volume.

PHP's claims processing system has numerous editing protocols designed to provide efficient and accurate adjudication. In addition, there are a number of processes incorporated in the post adjudication function that provide additional validation. A claim scrubber is run prior to claims being released for payment. The scrubber defines edits utilizing the parameters of encounter pend results and other predefined areas of concern to automatically pend or deny claims that would otherwise be paid. After the claim scrubber edits are applied, any pended claims are submitted for secondary review and verification. For claims adjudication relying on manual processing, reports containing items such as; PPC denial reports, $0.00 paid, anesthesia unit discrepancies, and hospital claims with 450 revenue codes that can deny in error are produced to ensure claims are not released inappropriately. Utilizing these additional tools has provided the necessary support to minimize post payment adjustment requests and has increased overall accuracy of payments to the provider community.

Regularly scheduled cross departmental work committees and meetings described below, are used for discussion and oversight of internal processes. The focus is to identify opportunities to improve claims processing outcomes and thereby systematically reducing claim disputes and improving provider relationships.

The process to ensure correct claims payment begins with the provider contracting phase. PHP has established a bi-weekly Contract Implementation Committee (CIC) to ensure PHP is able to properly administer contract terms based on all AHCCCS regulations and within any current claims system adjudication constraints. The CIC's charter is to increase auto adjudication, facilitate timely and accurate claims payment, and establish reasonable contract effective dates that allow for system configuration specific to the contract payment structure. Attendees include representatives from Network Management, Claims, Business Applications and Analysis, Prior Authorization and Grievance and Appeals. The meeting is chaired by the vice president of Network Management. In addition to addressing the specific goals above, the meeting has proven to be an excellent vehicle for Network Management to become aware of trended and individual situations arising in Claims, Prior Authorization, or Grievance and Appeals that affect providers and require communication or education targeted to specific providers or the entire network.

Once provider contracts are actuated, the pricing terms of contracts must be accurately entered, audited and tested in the claims payment system to ensure payment according to the provider contract. PHP utilizes a proprietary electronic process control tracking system for pricing record audit. Using this technology, PHP has developed the work flow process. The pricing control record contains standardized contract reimbursement information and parameters. Network Management initiates the process by submitting an electronic copy of the contract pricing and pricing control record to Business Analysis and Applications to create the pricing record in the system. Business Analysis and Applications tests the pricing before approving and returning the pricing

control record to Network Management for comparing the system pricing record to the contract terms. Following a successful audit, the pricing control record is sent electronically to the Claims department for testing, auditing and documentation in the Claims Processing Manual. After the pricing control record has passed the Claims testing and auditing process, it is returned to Network Management to complete the implementation and loading of contractual pricing. This process generates a permanent audit trail for the review of system pricing.

Throughout this process, each department has the ability to route the pricing control record to a department when clarification or additional information is needed or an audit has failed. All transactions and routings are recorded electronically. The development and implementation of the pricing control record process improves the accuracy and reliability of system pricing records. The pricing control record process is continuously evaluated and enhancements are made to ensure a controlled process which is comprehensive and thorough. The end result is accurate provider reimbursement and a decrease in the utilization of the claims dispute process. This process control tracking system process is also used to manage the accuracy of loading and configuration of individual and group provider demographic information necessary for proper claims adjudication. All of this information is checked against the AHCCCS PMMIS system data to ensure accuracy.

Rapid resolution to operational concerns which may impact provider claim disputes are addressed in PHP's Cross Functional meeting attended by the chief executive officer and other key management team members. In addition to technical operational topics, this team addresses regulatory updates and communications to identify impact to current processes and workflows. If necessary, work groups are deployed to develop solutions and bring recommendations back to Cross Functional for closure. One example of a trended issue resolved at Cross Functional was incomplete AHCCCS Category of Service (COS) registrations by several obstetric providers. This registration issue created claims denials and generated claims disputes. Once the root cause was determined, PHP contacted the affected providers and aided them in pursuing correct COS assignment with AHCCCS, allowing the disputes to be settled and claims reprocessed for payment.

Another important forum that PHP utilizes to preempt and resolve provider claims issues is the Joint Operating Committee. Joint Operating Committees were established with high volume providers, such as statewide providers or vendors and large hospital networks or provider groups. The regularly scheduled Joint Operating Committee meetings are attended by key personnel from both entities to discuss any issues that may be arising between the two parties. Topics such as; contract compliance, changes in the AHCCCS program, claims billing and payment, prior authorization, discharge planning and concurrent review issues may be discussed. For example, University Physician Hospital had a large volume of claims that were denied for either "no prior auth" or "not billed by contracted lab" for their laboratory services. Network Management worked out a process to have these claims submitted as a project directly to the Claims Educator in the Claims Department. With this new process in place, these claims are no longer denied and submitted as provider claim disputes. The Joint Operating Committee meeting provides PHP and the contracted provider the opportunity to collaborate on an agreed upon course of action for resolving claim issues and eliminating the need for the provider to resort to the formal claim dispute process.

The PHP Grievance and Appeals Department is dedicated to the reduction of administrative waste and works to reduce the number of provider claims disputes needing to be researched and resolved by staff. The PHP Grievance and Appeals Department consists of a provider claims dispute lead, a member appeals and grievances lead (who is also responsible for representing PHP at state fair hearings), two grievance coordinators, two provider claims dispute coordinators, and a member appeals coordinator. Bi-weekly staff meetings are held to discuss trends and issues and propose solutions. These discussions promote consistency among the provider claim dispute coordinators an example is the development of disposition letter templates to ensure consistency in the communication to the provider. Grievance and Appeals has invited other department key personnel to attend the staff meetings. These meeting guests give the Grievance and Appeals team the opportunity to learn about the functions of each department and gain an awareness of the interdependency of both departments, particularly when decisions are made or processes are changed. These exchanges have assisted in preventing provider claims disputes.

The provider claims dispute coordinators have direct access to PHP's medical directors and medical claim review nurses. The coordinators are able to consult with these medical experts when a medical necessity issue is in question to ensure consistency in dispute resolutions. In addition, Grievance and Appeals has meetings with the medical directors to analyze and discuss provider claim dispute trends. Identified trends are also presented to other departments such as Claims, PA, Medical Services and Network Management to put practices in place to help prevent future disputes. One example resolved through this collaboration involved a non-par provider billing for neonatal care. The provider was disputing claims denied for lack of authorization. Once the pattern was identified, the Grievance and Appeals Department worked with the medical directors to determine the root cause of the issue and worked with the provider on the resolutions as well as the future process for claim payment.

The Grievance and Appeals Department has also implemented a Provider Claims Dispute Reduction Committee. The committee consists of staff from various departments within the organization including Grievance and Appeals, Network Management, Claims, Business Analysis and Applications, Prior Authorization, and Medical Services. The goal of the committee is to reduce waste by trending and analyzing the types of disputes that have been received, conduct a root cause analysis and work toward solutions to prevent provider claim dispute submissions in the future. The committee's process includes review of a dashboard produced by the Grievance and Appeals Department that identifies trends in various categories of disputes such as waste, processing and systems errors, etc. The committee develops a work plan and identifies the owner(s) and the action needed to improve the process to eliminate the waste created by the potentially unnecessary dispute. The owner reports the actions taken to the committee to close the loop. The Grievance and Appeals Department monitors the work plan to ensure that the actions have the desired outcome of eliminating future disputes. The committee also reviews available data and the reporting structures to improve the communication of the information presented.

Prevention of initial claims disputes by increasing correct billing, ensuring accurate payment and employing alternative dispute resolution processes is obviously the most efficient methodology for reducing the number of dispute cases that could potentially result in a state fair hearing (SFH). PHP experienced a 35% decrease in claims dispute volume in 2012, specifically due to strategies outlined above. PHP will continue to evolve its processes and interventions to prevent SFHs. Once a case is at the SFH level, PHP works closely with the provider and its attorney to reach a settlement agreement in an effort to vacate the hearing. If new information is presented by either party, it is discussed and analyzed to determine if a reversal of an original dispute decision can be justified. PHP diligently continues to try to resolve the dispute, up to the scheduled hearing date. As a result, PHP was able to resolve nearly 1,500 hearing requests in the first quarter of CYE 2013, in which the cases were either withdrawn or vacated by the providers. A continued decrease in SFHs hearings is anticipated.

PHP makes every effort to operate in a manner consistent with the AHCCCS mission and is committed to developing and sustaining positive relationships with the provider network. PHP strives to minimize the need for providers to utilize the claims dispute process and aims to reduce provider claims disputes and state fair hearings by continually evaluating current processes for improvement.

10. **Information Technology (IT) Systems Demonstrations** -*These mock scenarios will begin on Tuesday, January 29, 2013. For this Submission Requirement, the Offeror shall provide written acknowledgement as follows*:

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

Phoenix Health Plan acknowledges that it will comply with the stated guidelines and calendar for this process.

Phoenix Health Plan acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's proposal.