ACUTE CARE/CHILDREN'S REHABILITATIVE SERVICES RESPONSE

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A. General Matters

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	N/A
Offeror's Signature Page	1 and 2	5 - 6
Signed Cover Sheets of Solicitation Amendments, if any	289	
Completion of all items in Section G: Representations and Certifications of Offeror	Section G	7 - 350

A1: OFFEROR'S BID CHOICE FORM

ACUTE CARE PROGRAM

[X] Checking this box indicates the Offeror is bidding on the ***Acute Care Program***.

UnitedHealthcare Community Plan
Offeror's Name

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

- [X] **GSA 2 Yuma, La Paz**
- [X] **GSA 4 Apache, Coconino, Mohave, and Navajo**
- [X] **GSA 6 Yavapai**
- [X] **GSA 8 Gila, Pinal**
- [X] **GSA 10 Pima, Santa Cruz**
- [X] **GSA 12 Maricopa**
- [X] **GSA 14 Graham, Greenlee, Cochise**

Authorized Signature	January 28, 2013
	Date
Kent Monical	Chief Executive Officer
Print Name	Title

CHILDREN'S REHABILITATIVE PROGRAM	
☒ Checking this box indicates the Offeror is bidding on the ***Children's Rehabilitative Program***.	
Authorized Signature	January 28, 2013 Date
Kent Monical Print Name	Chief Executive Officer 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*

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D. EXECUTIVE SUMMARY AND DISCLOSURE

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E. *ACUTE CARE NARRATIVE SUBMISSIONS*

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

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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.:

86-0813232

E-Mail Address: kmonical@uhc.com

UnitedHealthcare Community Plan
Company Name

1 East Washington, Suite 900
Address

Phoenix	AZ	85004
City	State	Zip

For Clarification of this offer, contact:

Name: Kent Monical

Phone: (602) 255-8255

Fax: (602) 255-8736

Signature of Person Authorized to Sign Offer

Kent Monical
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 Solicitation No.: **RFP YH14-0001** Amendment No. **1 (One)** Solicitation Due Date: **January 28, 2013** **3:00 PM (Arizona Time)**	**AHCCCS** 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	**Date**	**Signature**
	January 28, 2013	
Typed Name Kent Monical		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company UnitedHealthcare Community Plan		**Name of Company** AHCCCS

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 2 (Two) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** 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	**Date** January 28, 2013	**Signature**
Typed Name Kent Monical		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company UnitedHealthcare Community Plan		**Name of Company** AHCCCS

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 3 (Three) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** 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	**Date** January 28, 2013	**Signature**
Typed Name Kent Monical		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company UnitedHealthcare Community Plan		**Name of Company** AHCCCS

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 4 (Four) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** 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 Solicitation No.: **RFP YH14-0001** Amendment No. 4 (Four) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** 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 KM	**Date** January 28, 2013	**Signature**
Typed Name Kent Monical		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company UnitedHealthcare Community Plan		**Name of Company** AHCCCS

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 5 (Five) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** 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 must be received by AHCCCS no later than the Solicitation due date and time. Notwithstanding, Section H: Instructions to Offerors, Paragraph 15, *Contents of Offerors Proposal*, for Amendment No. 5 only, one copy of signed Amendment No. 5 is required which may be submitted separately from the remainder of the proposal. However, the signed Amendment No. 5 must still be submitted by 3:00PM (Arizona Time) on the January 28, 2013 deadline. Offerors may submit the signed amendment electronically to the Offeror's SFTP folder noted in Section H: Instructions to Offerors, Paragraph 15, *Contents of Offerors Proposal*, or by hard copy to the Solicitation Contact Person.

This solicitation is amended in response to the following question which was received by the Technical Support Help Desk regarding the Capitation Bid Template:

> *It appears that macros within the Bid Template are rounding unit costs entered with more than two decimal places to two decimal places. Are we limited to two decimal places for unit cost entry?*

AHCCCS Response:

> Offerors are not limited to two decimal places when entering unit cost. The first time you enter and store a risk group/GSA you have unlimited decimal places. However, if you retrieve that same risk group/GSA the model will round to two decimal places for unit cost.

No questions will be accepted by the Technical Support Help Desk regarding the Capitation Bid Template on or after January 25, 2013 at 12:00PM (Arizona Time) .

OFFEROR		**AHCCCS**
Signature KA M	**Date** January 28, 2013	**Signature**
Typed Name Kent Monical		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company UnitedHealthcare Community Plan		**Name of Company** AHCCCS

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B. Attestation

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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	Maintain system upgrade and conversion processes which include appropriate planning and implementation standards *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
12. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	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. [x]	A process in place to provide emergency services without prior authorization regardless of contract status of the provider *AMPM Chapter 310F*
25. [x]	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. [x]	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. [x]	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. [x]	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. [x] ***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. [x]	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. [x]	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. [X]	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. [X]	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. [X]	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: UnitedHealthcare Community 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.

Authorized Signature	**Date** January 28, 2013
Individual's Printed Name Kent Monical	**Title** Chief Executive Officer

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C. Capitation Submission

Acute Care RFP Bid Template - UnitedHealthcare Community 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	$388.80	$410.21	$427.22	$472.05	$427.17	$463.43	$395.52
TANF 1-13	$84.18	$91.38	$100.38	$91.01	$76.96	$92.76	$86.22
TANF 14-44 F	$180.31	$221.96	$267.10	$237.66	$189.06	$210.74	$216.06
TANF 14-44 M	$102.01	$154.93	$171.16	$148.24	$117.33	$137.66	$146.09
TANF 45+	$285.65	$372.31	$389.81	$419.60	$319.51	$375.78	$353.68
SSIW	$152.66	$103.12	$96.96	$119.59	$111.00	$147.57	$128.94
SSIW/O	$793.11	$846.82	$860.44	$695.85	$712.05	$746.20	$821.80
AHCCCS Care	$318.31	$384.75	$422.81	$398.16	$298.76	$387.44	$350.68
Delivery Supp	$4,593.29	$5,109.50	$5,209.47	$5,414.94	$5,161.69	$5,447.17	$4,998.15

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	$29.16	$30.77	$32.04	$35.40	$32.04	$34.76	$29.66
TANF 1-13	$6.31	$6.85	$7.53	$6.83	$5.77	$6.96	$6.47
TANF 14-44 F	$13.52	$16.65	$20.03	$17.82	$14.18	$15.81	$16.20
TANF 14-44 M	$7.65	$11.62	$12.84	$11.12	$8.80	$10.32	$10.96
TANF 45+	$21.42	$27.92	$29.24	$31.47	$23.96	$28.18	$26.53
SSIW	$11.45	$7.73	$7.27	$8.97	$8.33	$11.07	$9.67
SSIW/O	$59.48	$63.51	$64.53	$52.19	$53.40	$55.97	$61.64
AHCCCS Care	$23.87	$28.86	$31.71	$29.86	$22.41	$29.06	$26.30
Delivery Supp	$344.50	$383.21	$390.71	$406.12	$387.13	$408.54	$374.86

1/24/13 14:45

UnitedHealthcare®
Community Plan

January 28, 2013

Actuarial Attestation

I, Kevin Francis, as a qualified actuary who is a Member of the American Academy of Actuaries, have prepared the capitation rate submission in UnitedHealthcare Community Plan's response to Contract/RFP No. YH14-0001 for the Acute Care Program. I attest that the capitation rates for each category/risk group in each GSA are reasonable in relation to medical services and administrative costs expected to be incurred for the period beginning on the contract performance start date and ending at contract year one.

Kevin B. Francis, FSA, MAAA
Vice President, Actuarial Services

CRS RFP Bid Template
Enter Offeror's Name
UnitedHealthcare Community Plan
Enter Administrative Expenses PMPM
$59.80
This bid represents the average CYE14 administrative expenditure for all CRS members in any of the four coverage types. All bids must be provided as a per-member-per-month (PMPM) amount. Bids above $60.00 PMPM will receive zero points in competitive scoring.

UnitedHealthcare
Community Plan

January 28, 2013

Actuarial Attestation

I, Kevin Francis, as a qualified actuary who is a Member of the American Academy of Actuaries, have prepared the administrative component bid submission in UnitedHealthcare Community Plan's response to Contract/RFP No. YH14-0001 for the CRS Program. I attest that the total medical component rates set by AHCCCS and the administrative component bid by UnitedHealthcare Community Plan are reasonable in relation to medical services and administrative costs expected to be incurred for the period of October 1, 2013 through September 30, 2014.

Kevin B. Francis, FSA, MAAA
Vice President, Actuarial Services

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D. Executive Summary and Disclosure

1. <u>Executive Summary</u>: The Offeror must provide an Executive Summary that includes an overview of the organization and its relevant experience, a high-level description of its proposed approach to meeting contract requirements and a discussion of how it will bring added value to the program. In the final portion of the Executive Summary, the Offeror must describe how it will meet the requirements specified in Section I, Exhibit D, Medicare Requirements, Section 2. The Executive Summary will not be scored, but may be used in whole or part by AHCCCS in public communications, following contract awards. (4 page limit)

Organizational Overview and Experience

As the nation's largest Medicaid health plan providing services to over 3.8 million members in 24 states and the District of Columbia, United Healthcare will bring innovative solutions to Arizona Health Care Cost Containment System (AHCCCS) members by leveraging our knowledge, experience and evolving best practices from our clinical, operational, and cost containment efforts from the other states. We strive to live our mission ***to help people live healthier lives***. The dedication our employees have to living our core values of ***Integrity, Compassion, Relationships, Innovation and Performance*** are evidenced by our successfully retaining every competitive re-procurement in our existing states.

Locally, Arizona Physicians IPA doing business as **UnitedHealthcare Community Plan** has become ingrained into the many communities we serve throughout Arizona. We truly value our 30-year, continuing partnership with AHCCCS in the service of Acute, ALTCS, Children's Rehabilitation Services (CRS) and Medicare-Medicaid Dual-Special Needs Program (D-SNP) eligible populations; we have contracted with the Arizona Department of Health Services Division of Developmentally Disabled (DD) Program since its inception; and did submit our intent to contract with the Medicare/Medicaid Dual Eligible (MME) Demonstration Model. Our local leadership team, led by Kent Monical, has over 250 years of combined experience in health care, over 100 of which are dedicated to serving AHCCCS populations. The team is committed to ***improving access, cost and quality*** of healthcare services in Arizona through the development of integrated care models, adoption of shared community digital infrastructures, and deployment of leading technologies. We understand how the integration of benefits and operational structures can fundamentally improve convenience and satisfaction of system stakeholders. The opportunity to continue to serve AHCCCS and other Arizona healthcare stakeholders is a true privilege, and we commit to improving the cost and quality of care for Arizona's neediest citizens.

Approach to Meeting Contract Requirements

UnitedHealthcare Community Plan complies with all A.R.S. and AHCCCS rules and policies and procedures. As an existing program contractor and one that has been part of the AHCCCS program since its inception, we have continued to evolve our policies and procedures in order to remain compliant with the statutory and regulatory requirements related to the administration of Medicaid in Arizona as directed by AHCCCS. We continue to leverage national resources for the benefit of the State by providing access to leading health care innovation, collaboration with thought leaders and tools. Our approach to meeting all Contract Requirements includes:

- Identify and engage the **Right People** that are **Proven** to have the knowledge, experience, and aptitude to deliver on every AHCCCS and CMS contractual commitment.
- Leverage the optimal **Combination of Local Resources and Tools with National Expertise** to continually improve clinical and administrative performance.
- ***Operate in a Financially and Operationally Disciplined Manner*** – monitor/track contractual and performance metrics, continually improve Operational and Financial Review audits; measure outcomes of initiatives.
- ***Deploy Rapid Cycle Improvement*** in our clinical and quality initiatives to improve outcomes.
- ***Self-Monitor and Report*** issues.
- ***Leverage Technology*** for efficiency in being a steward of public funds.
- ***Seek Alternatives to Improve Administrative Efficiency***, including developing and leveraging shared community resources.

Bringing Added Value to the Program

Access to Care - Network Relationships

We understand that the starting point for network access is full compliance with both AHCCCS and Centers for Medicare and Medicaid (CMS) network requirements – we exceed those standards in every GSA with more than 14,000 physicians, 94 hospitals, 1,047 pharmacies, and a full continuum of other practitioners and ancillary services available to members. In addition, our experienced local leadership team has developed innovative, evidence-based, data-driven care tools and has established community partnerships capable of improving access to care beyond traditional network measurements. These innovative alternatives to improving core network access and efficiency include:

- ***Telemedicine and Telemonitoring*** – We are using telemedicine and telemonitoring to connect members with providers that otherwise would not be accessible.
- ***Network Expansions***: We leverage our broader (commercial and Medicare) network relationships to expand the Community Plan network. During the past 12 months, this has resulted in the addition of 3 hospitals and over 1,000 physicians.
- ***Non Traditional Provider Engagement*** – We are advancing the use of community healthcare workers (e.g. promotoras) and other non-traditional practitioners to ease the burden on the healthcare system.
- ***Health Information Exchange and Electronic Medical Records (eMR):*** We have been a driving force in the implementation of a statewide HIE via our relationship with HINAz and the expanded adoption of eMR systems. Not only will this improve the information by which providers make decisions; it will simplify administrative functions, ultimately leading to more time for direct care.
- ***Community Relationships***: We have established relationships with community organizations such as: the Arizona Healthcare Association, Indian Health Services, Quality Care Network, Raising Special Kids Tuba City Regional Health Center and District Medical Group. All of which will enable us to further build capacity in those GSAs with projected provider shortages.
- ***Tribal Populations:*** Although tribal populations have the option of receiving their care through Indian Health Services (IHS) facilities, they often float between IHS, Medicaid and CRS programs. In order to meet these needs and prepare for the health exchange, we are actively pursuing contracts with tribal IHS/638 facilities.

Access to Care - Network Accessibility

We recognize that network access to care alone doesn't assure member accessibility. Through a combination of ***Provider and Member Convenience Initiatives***, ***Data Informatics, Health Literacy, Financial Alignment, and System Modernization*** we are assuring that members are able to access the networks that have been established for their care. Examples of the processes and tools that enable accessibility include:

- ***Member Convenience*** – Working with Accountable Care Communities to expand Primary Care Physician Open Scheduling, allowing members to access care when it is most critical.
- ***Over/Under Utilization Assessments*** – Tracking areas where network resources do not appear to be deployed efficiently.
- ***System Modernization*** – Facilitating the improvement of both Provider Infrastructures, (e.g. CRS MSICs) and Digital Infrastructure, (e.g. HIE/HINAz) to make care more accessible.
- ***Health Literacy*** – Deploying tools to assist members navigate the healthcare system.
- ***Cultural Sensitive Solutions –*** Assuring network access and accessibility solutions are evaluated for the entire membership we serve, recognizing variability in how people of different cultures access services.

Care Coordination

We continually identify and implement industry-leading tools, technology, and strategies that are capable of improving clinical and administrative outcomes associated with care coordination for individuals with special health care needs and chronic conditions. We have established effective and well-defined processes driven by actionable real-time data delivery and strong community-based collaborations with providers and stakeholders. The following initiatives are a few of the ways we maximize member care coordination, improve outcomes and create cost efficiencies for our most vulnerable members.

- ***Risk Stratification Tools –*** We identify the highest risk members through advanced clinical algorithms to assure care for the most at risk population is prioritized.
- ***Provider Data Sharing*** – We believe the best way to impact care delivery is by providing timely, actionable information to primary care providers at the time and site of treatment. We have deployed a **Population Registry** that provides clinical history and open care opportunities to treating physicians. This information is being used today to lower readmissions and decrease gaps in care for our members.
- ***Care Transitions -*** We have 28 hospitals providing daily admission/discharge/transfer (ADT) information electronically that we use to identify our members' inpatient and emergency room visits in virtual real-time. Our medical management tools, processes, and resources have been re-engineered to transition these members from the hospital services back to their primary care providers within 7-days of the hospital discharge. We monitor the results of these transitions in care and use quality improvement processes to reduce future adverse events within the healthcare system.
- ***Dual Eligible Alignment -*** We are currently at 99 percent alignment with our network for dual eligible Medicare/Medicaid members and continue to advance clinical and administrative processes integration.

Provider Involvement

We maintain a provider engagement clinical model that leverages technology to share evidence-based, actionable information at the site of care. This model is most evident in the development of integrated medical models, examples being:

- ***Accountable Care Communities:*** Our Arizona Accountable Care Communities partnerships now include **28 hospitals providing daily data**, **64 physical health clinic sites** and **six behavioral health clinics,** caring for approximately 75,000 members in three counties. Through alignment with hospital and practices leaders, we have achieved success on measurable goals for access to care for the population; reduction in emergency visits and avoidable inpatient stays; and improvement in care of high-risk members.
- ***Value Based Contracting:*** We are piloting several new payment models that align provider compensation to patient outcomes. Results clearly indicate the combination of incentive alignment, with process change and information has tremendous potential to improve practice patterns.
- ***Administrative Simplification*** – Easing the administrative burden of providers is critical to improving their ability to engage in system transformation. The range of opportunities is from shared community alternatives, (e.g. Credentialing Alliance - single provider credentialing verification organization) to payor specific administrative changes, (e.g. our new provider call system)

Performance Improvement

UnitedHealthcare Community Plan recognizes that we need to continuously self-monitor and self-correct our performance, both for providers and for services delivered to members to maintain our operational excellence. To that end, the following are a few of the measures/strategies we have in place:

- ***Provider Ombudsman:*** Created in 2011 to offer additional assistance to providers, our Provider Ombudsman, Monica Husband, works with providers and health plan staff to resolve provider issues, and serves as an additional resource to providers who are unaware of the usual channels of communication or who need a critical escalation point. She provides our Claims Management team with the opportunity for self-correction/reporting of claims issues and open communication with AHCCCS providers.
- ***Contracting Simplification***: We seek to contract with providers for all lines of business (e.g., Acute, CRS, DD and D-SNP). This allows the member and provider to participate in the full continuum of benefit offerings since, as medical needs change, the member can move between our plans without experiencing disruptions or continuity of care issues with their provider.
- ***Credentialing Simplification:*** We are a driving force in the development and deployment of a consolidated credentialing initiative in the State. By reducing the "hassle factor" which required providers to credential and recredential with each individual AHCCCS Plan, the Credentialing Alliance model allows the provider to complete initial and recredentialing one time for all health plans in the Alliance, thereby increasing the provider's ability to accept additional membership.

Stewardship

UnitedHealthcare Community Plan's 30-year history with AHCCCS demonstrates our proven commitment to operate in a manner consistent with the public trust. We believe in addition to our stewardship of the public funds provided by AHCCCS, we have an obligation to identify additional means of improving alternative funds to improve the healthcare system.

- ***Community Partner Initiative (CPI):*** We bring community partners together to engage our collective resources in advancing integrated, community-based, coordinated system of care for Arizona residents. We have seen the relationships we establish through CPI provide alternative funding opportunities, (e.g. community and national grants), to improve Arizona community health.
- ***Community Infrastructures:*** We see the healthcare system as a community asset and seek opportunities to share systems and infrastructures in improving the health of Arizonans. Examples of sharing infrastructure costs range from administrative functions, (e.g. credentialing verification) to development of digital statewide infrastructures (e.g. HINAz/HIE). We are committed to advancing community infrastructures, resources and services to reduce system duplication and moderate overall costs.

How we will meet Medicare Requirements

UnitedHealthcare Community Plan is currently certified by AHCCCS and CMS to function as a Medicare Advantage Special Needs Plan (D-SNP) for dually eligible members residing within all Arizona counties except Gila; (a 2014 expansion to Gila has been filed with CMS). The D-SNP product operates under the brand name, ***UnitedHealthcare Dual Complete***. UnitedHealthcare Community Plan did submit the Notice of Intent to Apply for the AHCCCS Medicare-Medicaid Integration for Dual Eligible Members Demonstration within the required timeframes and are prepared to submit the required CMS provider tables by the February due date. Based on such, we are fully prepared to align Medicaid and Medicare enrollees either through D-SNP alignment or MME processes, as directed by AHCCCS and CMS.

Regardless of the path AHCCCS ultimately pursues – Demonstration or integration through D-SNPs – successfully serving dual eligible individuals is dependent on several key UnitedHealthcare Community Plan processes and member and provider benefits, including:

- ***Network Management/Provider Relations:*** Our provider networks (Medicaid/Medicare) are 90% aligned with an integrated provider servicing team. The network alignment will be completed in 2013.
- ***Member Services:*** Upon enrollment we identify those members that are D-SNP eligible and appropriate cost share rules and care flags are registered in our enrollment, claims and care coordination systems.
- ***Quality Management:*** We offer a 3.0 STAR Medicare quality plan to members.
- ***Medical Management:*** Prior authorization and concurrent inpatient review programs are managed from a primary payer perspective and coordination of benefits rules are utilized in managing ongoing health services usage for those Medicare-eligible members that are enrolled with UnitedHealthcare for only their Medicaid benefits.
- ***Corporate Compliance:*** Compliance activities are centralized wherein all AHCCCS-related and CMS-related compliance requirements are monitored and reported from a single resource, on a local, Arizona-basis, and nationally.
- ***Grievance System:*** The grievance and appeals processes are established to comply with Grievance process requirements of all regulatory entities including AHCCCS and CMS.

Product Branding

We recognize that product branding is important in member and provider participation and standardized our national Medicaid-related product identity as UnitedHealthcare Community Plan and the D-SNP identity as **UnitedHealthcare – Dual Complete**. Should Arizona proceed with the Financial Alignment Demonstration, we are prepared to participate. **UnitedHealthcare Connected** is our product brand for our integrated care program for the Medicare-Medicaid Financial Alignment Demonstration.

2. <u>Moral or Religious Objections</u>: The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may propose a solution not already contemplated by this Contract to allow members to access the services. The Contractor must identify solutions pertinent to the Acute Care Program and the CRS Program if submitting proposals for both. AHCCCS does not intend to offer the services on a fee-for-service basis to the Contractor's enrollees. The proposal must be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.

We do not restrict coverage for any services because of moral or religious objections, nor do we place any constraints on the coverage, reimbursement or delivery of services based on moral or religious principles. We provide access to all Medicaid services covered under our contract with AHCCCS. All of our provider agreements contain a clause that allows the provider to refuse to provide any service they find objectionable because of moral or religious grounds. In that situation, we assist the member to access another provider who is willing to provide the service.

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E. Acute Care Narrative Submissions

Acute Care

Access to Care/Network

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

Ensuring the adequacy of our provider network in supporting the current membership as well as the potential influx of new Arizona Health Care Cost Containment System (AHCCCS) members is the responsibility of our Chief Executive Officer, Kent Monical. The daily operations related to securing and ongoing monitoring of our comprehensive provider network are directed by our Chief Operating Officer, Sheila Shapiro and managed by our Provider Services Manager, Wendella Howell-Bell. With the expansion of health coverage by the implementation of the Affordable Care Act (ACA), the demand for physicians in Arizona will increase. Since the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986, hospitals have been required to provide care to anyone needing emergency health treatment regardless of ability to pay. Therefore, the expanded health coverage mandated by ACA will primarily result in an increase in physician services. In particular, a greater demand will be placed on primary care and specialty services with the increased emphasis on delivering care in the most cost-effective setting before conditions become acute. We recognize an adequate number of health care workers who will provide comprehensive care to these members plays an important role in ensuring that Arizonans have ready access to care given the current shortage of providers, especially in rural communities.

UnitedHealthcare Community Plan has developed specific steps to ensure access to care to support the influx of members. These steps have been developed based upon our **extensive experience and success in expanding provider networks to address membership growth, geographic expansions, member transitions, working in Arizona rural communities and implementing new provider incentives such as medical home and same day appointments**. Through our history with other program expansions in Arizona, we have demonstrated our ability to implement new programs, populations and service areas within required timeframes, with minimal operational interruptions and most importantly, with minimal member disruptions. The steps to support influx are described in the following sections.

Steps to Ensure Access to Care to Support the Influx of Members

To ensure access to care for the AHCCCS enrollment, we have developed a provider network that is **fully compliant with the distance, appointment and accessibility standards for each of the Geographic Service Areas (GSAs)** outlined in Section D1, Paragraphs 27–33 of this Request for Proposal (RFP). Our network includes **more than 14,000 statewide primary care and specialty providers**. Additionally, our provider network is fully compliant with all physician specialists, hospitals and ancillary provider requirements and is capable of providing access to care to the current AHCCCS enrollment throughout the seven GSAs **as well as capacity to provide access to care for the influx of ACA expansion members.** While our current network is capable of serving these members, we will continue to enhance our network through the following steps.

Step 1: Leverage the Capacity in Existing Network

As network needs are identified, **we leverage our existing Medicaid, Medicare, and Commercial networks to increase our provider base and to support membership growth**. Our current network meets the AHCCCS standards in all seven GSAs and consists of the following number of available key providers types in each of the GSAs.

	GSA 2	*GSA 4*	*GSA 6*	*GSA 8*	*GSA 10*	*GSA 12*	*GSA 14*
Primary Care Providers	230	543	232	244	1,932	4,961	223
Dentists	84	126	68	105	416	1,752	46
Pharmacies	27	79	36	48	171	659	27
Hospitals	2	11	4	4	12	55	6
	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

Step 2: Expand Appointment Availability within the Existing Network

UnitedHealthcare Community Plan promotes a strong primary care practice base in the state by championing the implementation of Patient Centered Medical Homes (PCMH) through our Accountable Care Communities (ACC)

model. Our ACC model has been implemented in 12 practices, representing 64 physical health clinics and six behavioral health sites, caring for approximately 75,000 members for all programs in three counties. The ACC model assists practices to increase their capacity to schedule more members through the use of such technology as our secure web-based Accountable Care Population Registry (Population Registry) and open appointment setup, allowing for same day appointments and expanded office hours. The Population Registry provides clinical outcome measurements, as well as care coordination and management supports. **Our tools, consulting and incentives have enhanced practice efficiency, resulting in increased practice capacity enabling access to care to more members.** The ACC model enables practices to expand their same day appointment to 35 percent or more. Historically, most practices experience 'No Show' rates of 20 percent or more. The ACC model has reduced this rate, resulting in enhanced access. For example, our Pima ACC with more than 29,500 members is experiencing an average 'No Show' rate of only 12 percent, a reduction of eight percent after the implementation of an ACC model. We are expanding our ACCs.

Step 3: Expansion-Non-Contracted AHCCCS and Commercial Providers

Due to the expected expansion in membership**, we have begun the process of expanding our network to include non-contracted AHCCCS providers.** We have added two hospitals, Payson Regional Medical Center and John C. Lincoln Health Network and have commitment from a third - St. Joseph's Hospital and Medical Center and affiliated physician practices, which will **immediately increase our network by approximately 350 primary care physicians (PCPs) and specialists**. We successfully moved the St. Joseph's Children's Rehabilitative Services (CRS) contract to a direct relationship with us adding another 700+ pediatric specialists to our network.

To ensure continuity of care for members transitioning between the Exchange and AHCCCS, we are aligning our network with the UnitedHealthcare commercial network which will serve Exchange members. In addition, to support existing and new members in remote rural areas, our network includes physicians and hospitals in border communities where the established pattern of care includes crossing state borders to receive services. We currently have existing contracts with providers in neighboring states and have the ability to expand to other available providers in these areas given UnitedHealthcare operations in Utah, Nevada, California, New Mexico and Colorado

Step 4: Build Overall Capacity within the State

We recognize that Arizona suffers from a shortage of physicians that is compounded by the downturn in national and state economies. The health of Arizona citizens depends on an adequate supply of health care providers to meet their health care needs. To expand overall capacity for current and future members**, we will increase our contracting with additional mid-level providers** (e.g., physician assistants, certified nurse practitioners and certified nurse midwives), allowing them to practice to the fullest extent of their licensure. Many of these mid-level providers, including the nurse practitioners are able to practice independently without physician oversight.

To address Arizona's shortage of physicians, we need to bring more medical students to Arizona. Over the past five years, the UnitedHealth Foundation has sponsored a Diverse Scholars initiative, providing scholarships to Arizona students. Since 2007, **it has provided more than $5.6 million in national scholarships and 54 scholarships in Arizona**. By cultivating health professionals from diverse, cultural backgrounds, we hope to increase culturally competent health care delivery, closing the disparities gap and impacting the physician shortage.

In addition to bringing more medical students to Arizona, we need to keep them here after they graduate. To increase the number of residency training programs in Arizona, we will work with the legislature and other stakeholders to address funding issues; we will collaborate with our state medical schools and our provider network to identify and address potential solutions; and we will join forces with businesses and other community leaders to develop new, innovative approaches for addressing this problem. To this end, we have already begun conversations with District Medical Group (DMG) about providing residents a CRS rotation to add to the very limited specialty services within the state. Last year in Nevada we successfully recruited physicians from Mexico using TN/NAFTA provisions to employ qualified physicians; we will work with practices to employ similar recruiting strategies as necessary. Finally, UnitedHealth Group itself has been investing in creating physician capacity though Optum Collaborative Care. We created a physician practice in Phoenix and are looking to expand.

Step 5: Use Non-Traditional Providers

In addition to traditional approaches, we use non-traditional methods such as mobile imaging and telemedicine to increase our members' access to care. When our members are unable to access care in their local community, we bring

the services to them. These **non-traditional providers enable us to rapidly respond to increases in populations as well as increase access to rural and remote areas**. Non-traditional providers we use to increase access to care include:

- ***Mobile Mammography:*** With an influx of new members, imaging centers may not be easily accessible in certain areas of the state or may not have timely appointment availability. To ensure that members receive mammography services in a timely manner, we have used and will have the ability to use mobile mammography to increase access to care to support the influx of members.
- ***Providers who make Home Visits:*** We currently use non-traditional providers to address members' needs who are unable to leave their homes. Dr. Joel Cohen of MD Room Service provides home visits for these members. As we bring on new members with various medical needs, use of such non-traditional providers such as Dr. Cohen will allow us to support the needs of new members with specific health concerns.
- ***Community Health Workers (CHWs) e.g., Promotoras:*** We work with more than 12 organizations and 35 individual CHWs across the state today to assist members in accessing appropriate care. This is beneficial to providers as it enables members to establish continuity of care with their practice rather than seeking services at the ER. As an example, we have a partnership with San Luis Walk-In Clinic to identify, prioritize and more effectively reach the most vulnerable and at-risk members in Yuma County. Additionally we developed a pilot with Keough Health Connection (KHC), a community-based organization, to connect people to programs and services. KHC assists members with setting appointments to get one-on-one assistance with their eligibility recertification process to avoid any lapse in coverage.
- ***Tribal Indian Health Services (IHS)/638 Providers:*** We are familiar with the unique requirements related to contracting with tribal IHS/638 facilities and are in the process of contracting with the Tuba City Regional Health Corporation, an IHS facility. **We are currently working with the Navajo Nation, the largest tribal organization in the United States, to contract and build an infrastructure to serve members using their facilities and telemedicine.** Our current expansion of IHS and Tribal 638 contracts will serve to expand our network sufficiency which will prepare us to participate in the federal exchange. We are also contracted with **16 of the 17** Federally Qualified Health Centers (FQHCs) and one Rural Health Center, San Luis Walk-In Clinic, some of which already serve the Native American population.
- ***E-Visits:*** UnitedHealthcare offers electronic visits to its commercial members through kiosks, called "the Well". Provider capacity is accessed virtually. With the approval of AHCCCS we will pilot a similar program.
- ***E-Consults:*** UnitedHealthcare is working with Project Echo sponsored by CMMI in WA and NM which does primary care rounds with specialists electronically. We are also doing this in CA with the University of California. In Arizona we held preliminary conversations with U of A and would undertake this to address specialty shortages.

Step 6: Leverage Technology to Increase Capacity and Access to Care

We are proud of our leadership in using state-of-the-art technology to **improve provider operational efficiency, thereby increasing their capacity to serve current and future members.** We have worked closely with community stakeholders and providers to implement electronic medical records (eMR), the data information exchange (HINAz) and increase our appointment availability through investments in the use of telemedicine.

Manpower and other resources are freed for the actual delivery of care to members by easing providers' administrative burdens. We offer a number of technological solutions to help ease these burdens such as: electronic claims submission and verification; electronic funds transfer; electronic health records for CRS; real-time data on emergency room and inpatient discharges from hospitals; secure SharePoint website to exchange collaborative information; and the use of telemedicine. Below are additional initiatives we have implemented to reduce provider administrative burden:

- ***Health Information Exchange (HIE):*** UnitedHealthcare Community Plan has established and is continuing to strengthen a robust suite of integrated health information technology solutions which facilitate integrated accountable care. **The solutions are modular and scalable, as such, they are designed to grow as membership expands and the needs and mix of services used by member populations change or become more complex**. Moreover, we are committed to work closely with the entities responsible for state-level health information exchange (HIE) and to establish HIE capabilities to link and facilitate communication between us, our members, family caregivers and the providers serving our members to augment HIE capabilities being deployed at the state

level. An innovation championed by UnitedHealthcare Community Plan is the Health Information Network of Arizona (HINAz) which will result in a statewide health exchange.

- ***Electronic Medical Record (eMR):*** We championed the use of eMR for the CRS Program. We funded the implementation of the eMR and practice management software for the CRS program. This provides statewide secure access that is critical to treat the CRS member holistically.
- ***Telemedicine:*** We implemented and extended the reach of specialty provider services by offering telemedicine clinic services in Yuma, Flagstaff, Tucson and Tuba City. We have the technology and medical resources to provide telemedicine in additional counties, if needed. In addition, to secure high-speed Internet connections, new *cloud-based* service options are being implemented that offer secure, scalable coverage for a fraction of the cost. Video capture via iPhone is another way in which we are using technology to increase access to care via telemedicine services. We are participating in a pilot that allows the use of iPhones to capture video images in behavioral health-related situations. This will increase providers' ability to participate in telemedicine at little or no cost and increase their capacity to provide care to accommodate an influx of members, especially in rural areas.

Ensure Administrative and Operational Structure to Accommodate Membership Growth

UnitedHealthcare Community Plan has extensive experience ensuring our administrative and operational structure is able to accommodate membership growth in a timely and efficient manner. We have a proven record of responding to expanding staffing needs and have an already strong and experienced management team and staff that support more than 237,000 AHCCCS members statewide. Our strong workforce and stable network is due in part to the following components:

Administrative

- ***Infrastructure Scalability:*** UnitedHealthcare Community Plan's current infrastructure is completely scalable and able to support significant membership changes and growth. Our information systems, processes and systems are extremely scalable, enabling us to handle an influx of members in an efficient and timely manner.
- ***Workforce Planning:*** Named one of Arizona's top places to work in 2012, we are able to attract and retain the necessary employees to scale in very rapid fashion; we currently have eight offices around the state of Arizona and remote working capabilities that allow employees to work virtually. We use a standardized Workforce Management Projection Model (WMPM) that accommodates membership changes and can project the number of full-time equivalent (FTE) personnel required by functional area, to support membership growth. For example, metrics and planning models have been created for member and provider call center, claims, and appeals and disputes, to calculate workforce projections. This model allows us to plan for the hiring, training and location of each required FTE, ensuring we have the resources we need, when and where we need them.
- ***National Resources:*** UnitedHealthcare has a national implementation team which can be deployed to assist us on a local level. These national resources can be relocated to Arizona to assist in the implementation process while efforts are undertaken to hire and train our local staff. These national resources also allow our local executives and staff to focus on the members, expansion of our operational infrastructure, and seamless transition of members.
- ***Stable Community Partner:*** We are one of the largest employers in the state of Arizona and do not anticipate any difficulties in hiring additional employees to meet our contract requirements. We have been recognized as a "*Top Company to Work For*" by the Arizona Chamber of Commerce, which also helps us to attract quality candidates.

Operational

- ***IT Flexibility and Scalability:*** We have sufficient, scalable, enterprise-wide information technology resources to handle membership growth including backup servers to handle information increases and system redundancy. Server platforms are scalable and allow for the dynamic reallocation of system resources to different applications as necessary to support demand fluctuations. This scalability enables us to add additional members, provider networks, reporting and care management transactions for AHCCCS quickly and often, without adversely affecting the platform or requiring downtime.
- ***Credentialing Simplification:*** UnitedHealthcare Community Plan was a driving force in the deployment of a consolidated credentialing alliance in Arizona by our formation of the AzAHP, then making credentialing a top

priority and then engaging Optum deliver the services. This initiative will aid both providers and the health plan in simplifying the credentialing process and gaining operational efficiencies.

- ***Contracting Simplification:*** Our contracting strategy is to contract with providers for all programs whenever possible. We have recently streamlined our contracts to allow us to offer our full spectrum of programs on one contract template. This has simplified the provider contracting process and it has also allowed us to further align our networks.
- ***Secure Business Operations:*** The Enterprise Resiliency and Response Program, part of our Business Continuity and Disaster Recovery Planning process, includes processes and controls to protect our business; the life and safety of employees; resources of the organization; and appropriately allocate resources in the event of a sudden change or emergency.

Experience with Supporting an Influx of Members

As previously stated, we have demonstrated our ability to expand into new areas, transition members, implement new programs and provide adequate networks within a short period of time. Below are examples of member influx:

- ***Capstone-DDD:*** In August, 2012, the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) asked us to transition a competitor's Developmentally Disabled (DD) membership in Mohave, Coconino, Navajo and Apache counties into our plan within a short 60-day window. We held open member meetings within the four-county area in order to respond to questions and alleviate any member concerns. Despite the short time frame and the complexity of member need, the transition was completed on time. Additionally, we successfully established new or amended contracts with approximately 100 PCPs and frequently used specialists; we educated members and providers; and we transitioned care for this membership from their previous health plan with a minimum of inconvenience or disruption to this population of members. As a result, we received a letter from the DES/DDD as a formal recognition of our "attentive and responsive" efforts.
- ***Phoenix CRS-MSIC Transition:*** On April 6, 2012, we entered into a **new contract** with the Children's Rehabilitative Services Medical/Dental Staff IPA, Inc. (CRS IPA). We also entered into a **new partnership** with District Medical Group (DMG) to build and manage a new CRS Multi-Specialty Interdisciplinary Clinic (MSIC) in Phoenix, Arizona. DMG consists of more than 350 physicians and health care professionals representing all major medical and surgical specialties and sub-specialties. On October 1, 2012, more than 16,000 CRS members **moved** from the St. Joseph's MSIC to the DMG MSIC and began receiving care in DMG's state-of-the-art facility. The transition went smoothly and there was no disruption in member care.
- ***Long-Term Care Population:*** In October, 2011, we expanded the Arizona Long Term Care Services (ALTCS) program into five additional counties as a result of a successful bid award, **doubling the number of counties served from five to 10 counties**. To aid in this expansion, we leveraged existing networks (AHCCCS and Commercial) to broaden the ALTCS network and now have a significant alignment between the two programs. The expansion of the network along with our other transition efforts resulted in a smooth transition of members with no disruption of care.
- ***Children's Rehabilitative Services (CRS) Transition:*** In 2008, we transitioned management of the CRS program and the four regional MSICs from ADHS to UnitedHealthcare Community Plan. We **smoothly transitioned 20,000 members in a four-month period with no member disruption of care** to this special needs population. We maintained continuity of care with the MSICs who transitioned from a CRS program administrator's role to a participating provider role. The transition also afforded CRS members access to our statewide network of hospitals, pharmacies, specialty and ancillary providers.

Summary

Based upon our extensive provider network, our experience and our expertise with large influxes of members, we are fully prepared to address the increase in members and the increased demand for provider accessibility. Our expansive provider network serves all seven GSAs and meets or exceeds the AHCCCS accessibility standards. We have the tools, resources and capabilities to expand our administrative and operational infrastructures to accommodate membership growth in a timely and seamless manner.

2. Describe how the Offeror evaluates and measures its network in order to ensure timely access to care…

Our **Chief Executive Officer, Kent Monical**, is responsible for ensuring the adequacy and sustainability of our provider network. Network development and management activities are directed by our **Chief Operating Officer, Sheila Shapiro** and managed by our **Provider Services Manager, Wendella Howell-Bell**. Our in-depth processes to evaluate and measure the strength, stability and compliance of our network have been **developed and enhanced over the past 30 years of experience and uses proven data sources to evaluate network adequacy**. The processes we use to evaluate and measure our network to ensure timely access to care, to identify deficiencies in the network, to manage the network, make improvements in the network and to sustain an adequate network are described below.

Evaluation and Measurement of Network

We align resources with member needs and preferences in all seven Geographic Service Areas (GSAs). This includes understanding and providing access to care for underserved populations where member acuity and gaps in care may be the greatest. We continually analyze, evaluate and implement changes to discover and address gaps in care. To meet the service needs of members and their families, we continually collaborate with member, family, service providers, primary care physicians (PCPs) and community resources to proactively assess and review changing service needs.

We use several methods to evaluate and measure the adequacy and compliance of our network providers. Based upon Arizona Health Care Cost Containment System (AHCCCS) and Centers of Medicare and Medicaid Services (CMS) minimum network standards we can identify, project and address potential network deficiencies as noted below:

- ***Quarterly GeoAccess Reporting:*** Our quarterly GeoAccess reports verify the adequacy of the network including PCPs, specialists, hospitals, Federally Qualified Health Centers (FQHCs), skilled nursing facilities, dentists, and pharmacies.
- ***Utilization Analyses:*** We conduct analyses of members' access to specialty services by monitoring out-of-network and out-of-service-area utilization in addition to regular GeoAccess. These analyses help us understand any patterns of access to care issues that may need attention by our provider recruitment staff.
- ***Panel Capacity Reporting:*** We evaluate the member-to-PCP ratios that take into account PCP capacity, panel size and status (e.g., accepting or not accepting new patients). Reports are generated to measure capacity by program for each PCP (e.g., AHCCCS, DD and Medicare).
- ***Provider Compliance:*** Provider compliance with accessibility standards is evaluated based upon such benchmarks as appointment availability, office wait time, telephone access and after-hours accessibility.
- ***Physician Coverage:*** We review and evaluate the number of physicians who have privileges and practice in hospitals and the adequacy of specialist coverage at each contracted hospital for all major specialties.
- ***Member Population Studies:*** We review and evaluate membership in terms of future needs based upon membership growth; expected utilization of services; and characteristics of the population such as special health care needs.
- ***Member and Provider Input:*** Member and provider feedback is obtained through a variety of mechanisms including analysis of satisfaction surveys; inquiries, grievances, complaints, disputes and appeals; meetings with providers or members; and meetings of our Rural Advisory Councils. In addition, we solicit provider feedback through the Provider Advisory Committee (PAC). The PAC is chaired by Dr. Chakmakian, our Chief Medical Officer, and consists of community physicians from various specialties. The committee evaluates physician performance through peer review activities and the credentialing and recredentialing processes. All quality of care concerns are immediately escalated to monitor provider performance and determine their continued participation in the network. The PAC reports to the Quality Management Committee and ultimately to the Board of Directors.
- ***Network/Care Team Input:*** We use input from staff who are actively involved in working with members and the provider community to identify up-to-date information concerning network issues.
- ***ER Utilization and Monitoring:*** We monitor emergency room (ER) usage for the network to ensure members' access to care and identify any provider capacity and availability issues.

Timely Access to Care for Underserved Populations

Providers are essential partners in ensuring timely access to quality health care for all of our membership. Our providers extend care to underserved populations using community supports and technological innovation. Bi-lingual providers and their staff are able to communicate with members or they access the Language Line to ensure appropriate and accurate communication. They provide services to all members including those with special needs and provide care at our contracted clinics for homeless individuals. Telemedicine is also available for those individuals in rural, border and tribal communities where the need for care can be the greatest.

Our Network Management and Development Plan address the need for culturally sensitive care for populations which are frequently underserved. We will review membership demographic data, which includes ethnicity, language, age and sex to identify the cultural needs of the population and recruit providers as appropriate. Below are some examples of the populations in need of culturally specific care and some examples of how we provide timely access to care for these populations:

- ***Childless Adults:*** One of the member populations where we expect to see significant member growth is childless adults (e.g., adults without dependent children**).** In anticipation of the increased membership, we have contracted with a robust and diverse provider network to address the membership's cultural needs. We will leverage our national experience from New York, Pennsylvania, and New Jersey to educate our network on the unmet needs and chronic conditions of this population.
- ***Homeless Members:*** We contract with several providers who have expertise in caring for the needs of our homeless members, most notably the Maricopa County Health Care for the Homeless (HCH) and Circle the City. Other providers such as FQHCs and Rural Health Clinics (RHC) also serve a significant number of homeless members throughout the state.
- ***Tribal Populations:*** Although tribal populations have the option of receiving their care through Indian Health Services (IHS) facilities, they often move between IHS and the AHCCCS and Children's Rehabilitative Services (CRS) programs. This adds another layer of complexity to coordinating the care for these members. Cultural differences magnify the challenges in obtaining appropriate health services and demonstrate an increased need for a model that must be uniquely adapted to fit diverse members' needs. We have used telemedicine to help bridge this gap for this population. We have developed contracting paper and are actively pursuing multiple contracts with tribal IHS and 638 facilities.
- ***Limited English Speaking Members:*** We work with providers and members to ensure they have adequate access to care which includes recruitment of bi-lingual providers, providing interpretative services via the Language Line, sign language interpreters and telephonic relay services through Arizona Relay Service. The AHCCCS Contractors Cultural Competency Committee (C3) led to the development of the Interpretive Services Guide that provides instructions on how to obtain interpretive services for each of the health plans. In 2012 we conducted our annual C3 Seminar for health plan staff and providers to educate on C3 and the Interpretive Services Guide. We continue to explore additional ways to provide services to these and other underserved populations.
- ***Remote Rural Area/Border Community Members:*** Providing specialty services to medically complex members close to home improves outcomes by shortening the time it takes to see a specialist. We successfully use telemedicine technology to expand timely access to clinical services and close service delivery gaps in rural areas where specialty provider services are difficult to obtain. We use telemedicine to extend the reach of specialty provider services in Yuma, Flagstaff, Tucson and Tuba City. With the planned service expansion to the Navajo Nation, we will offer clinical services to Tuba City and are expanding services to Fort Defiance and Chinle. We have been nationally recognized for the successful expansion of this program into the Navajo Nation. In certain areas, the established pattern of care may include crossing state borders to receive care. In these areas, we have expanded the network to encompass providers in neighboring communities.

Performance - Telemedicine

Telemedicine has been instrumental in the rural areas in terms of providing access to care. Our 2011 telemedicine survey results:

- **95.87%** of members rated telemedicine overall as "very good/excellent"
- **94.15%** of members would either "probably/definitely" repeat a telemedicine visit
- **Average Distance Traveled** for a face-to-face provider visit: **250.43 miles**
- **Average Distance Traveled** for a telemedicine visit: **12.05 miles**

- ***Appointment Availability Surveys:*** We contract with CareCall, LLC to conduct quarterly telephonic Appointment and Availability Surveys of providers. We provide CareCall with a file of the survey universe every six months. CareCall, LLC selects a random sample of five percent of our provider network in each of the audit categories. We also identify providers whose panels exceed 1,800 total AHCCCS members and non-contracted providers who provided service within the previous six months and we forward them to CareCall to be audited. Below is a sample of the results of the 2012 Appointment and Availability Survey for participating (contracted) providers.

Appointment and Availability Survey Summary and Comparison Participating Providers				
Category	*Q1 2012 CYE Oct-Dec*	*Q2 2012 CYE Jan – Mar*	*Q3 2012 CYE Apr – Jun*	*Q4 2012 CYE Jul - Sep*
Routine	97.60%	97.30%	97.88%	97.29%
Urgent	93.46%	90.88%	91.65%	89.59%
Emergent	91.29%	87.75%	89.20%	86.02%
Maternity Care	92.24%	92.23%	92.31%	95.54%
Wait Time	95.83%	95.40%	96.62%	97.86%

Monitoring the Network to Identify Deficiencies

We have established in-depth processes to monitor timely access, the current status of our network, project future needs and readily identify any network deficiencies or gaps. We measure our network against AHCCCS and CMS standards and **are compliant with all standards**. Our monitoring activities include the following.

- ***Surveys:*** We conduct periodic member and provider surveys to assess areas of satisfaction or improvement with the provider network. These results are analyzed and escalated to the appropriate departments for implementation of process improvement. We use annual provider satisfaction and CAHPS member satisfaction survey results to help identify areas for improvement to access to care. We conduct CAHPS surveys at the provider level as well. We also use the quarterly appointment and availability surveys for this purpose.
- ***Physician Profiles:*** We profile our providers and benchmark them across the health plan, utilization outliers (providers with utilization patterns that fall outside the expected range for service delivery). The profile contains preventive care, access to care and utilization management measures. The PAC reviews the outliers and offers assistance to providers to address the issues.
- ***Member and Provider Feedback:*** We monitor member and provider complaints, incidents and inquiries to identify actionable improvements to the network. The Network Strategy and Provider Relations Team works in collaboration with other departments to gather, evaluate and trend input and to develop effective intervention strategies to address issues identified. In 2012, we received two member complaints against providers related to access to care. In both instances, our investigation indicated the complaints were related to appointment availability. The circumstances causing the complaints were isolated incidents due to physician vacation or high patient volume due to seasonal illness.
- ***Utilization Data:*** We use utilization data as part of our annual business planning and Network Management and Development Plan process to identify and close network gaps. We review out-of-network prior authorization data by specialty type, location and program to help identify network needs. For example, after analysis in 2012, we recruited additional physical therapists and speech therapists for our AHCCCS Acute, CRS and DD programs.
- ***GeoAccess Analysis:*** We perform a quarterly analysis of provider availability using GeoAccess software. Information obtained through the availability analysis is used to manage and monitor the network throughout the year and to focus recruiting efforts. We continually maintain a **fully compliant network.**

Managing and Improving the Network

UnitedHealthcare Community Plan uses an integrated, cross-functional approach in developing, maintaining and managing the provider network. We consider this critical activity a health plan-wide endeavor, integrated by interdepartmental monitoring processes and activities, business application systems accessibility and oversight committees structured with representatives from across the health plan. We continuously improve our network through member and provider feedback, innovation and routine monitoring. Below are several tactics we use to manage and improve the network:

- ***Build and Manage Network Operations:*** The Network Team works continuously to maintain a network of providers capable of providing care in compliance with all AHCCCS/CMS guidelines and requirements. The Provider Relations Team oversees provider education and training, our provider call center, all of our high-touch provider service programs and monitoring of provider satisfaction. They ensure data points collected through day-to-day provider relations activities are applied to our operations.
- ***Educate and Train PCPs:*** We conduct trainings including new provider orientation and provider forums to educate providers on the benefits and requirements for all programs. In 2012, 18 Provider Forums were conducted. Our provider relations staff communicates rules, regulations, resources and best practices with the provider's practice manager and designated office staff. The Provider Administrative Guide is reviewed with all contracted providers prior to implementation and is available on the UnitedHealthcare Community Plan website. It includes comprehensive information related to care requirements, service specifications, provider responsibilities, billing information and practice guidelines. The Provider Administrative Guide is formally reviewed annually and off-cycle updates are made as needed.
- ***Establish Provider and Community Relationships:*** Our Provider Relations Team educates hospitals and ancillary providers. In collaboration with other functional areas, we conduct Joint Operating Committee (JOC) meetings with large volume hospitals, large physician groups and ancillary providers on at least a quarterly basis. JOCs for smaller volume providers are conducted at a minimum of twice per year or as needed. **Additionally, partnering with the March of Dimes, we funded the Pertussis (whooping cough) training via grand rounds at major hospitals.** We are the only health plan to have a **Provider Ombudsman**; **Monica Husband** has been in this role for one and one-half years and has more than 25 years of experience specific to AHCCCS health care. She works with providers and appropriate health plan staff to resolve provider issues, and serves as an additional resource to providers who are unaware of the usual channels of communication or who need a critical escalation point. It provides our Network Management Team with the opportunity for self-correction/self-reporting of network issues to AHCCCS as well as open communication with AHCCCS and our provider community.
- ***Stringently Manage Vendor Relationships:*** Our best-in-class Vendor Relationship Management (VRM) program, led by **Lisa Waggoner**, builds relationships and monitors the performance of our vendors, such as Preferred Homecare, to ensure contract compliance. Our structured VRM program includes the development of performance scorecards which monitor key performance metrics. The review of these scorecards at Joint Operating Committees in addition to annual audits is used to assess provider compliance, performance, monitor encounter submissions and allows for continuous process improvement. We are on the leading edge of VRM and we have not identified any other health plan with similar operational oversight.
- ***Conduct Face-to-Face Visits and Confirm Compliance:*** Provider Relations Advocates are assigned a specific territory and are responsible for regularly meeting with providers. These meetings determine contractual compliance, including but not limited to medical records, appointment availability, physical environment, appointment wait times, advance directives and service delivery documentation. Staff from other departments may accompany the Provider Relations Team on site visits in order to provide specific information and education to the provider. They also help address any issues or concerns providers may have about billing or authorizations.
- ***Health Information Exchange& eMR:*** Our **Regional President, Bill Hagan** has been a driving force in the implementation of Health Information Exchange (HIE) via **our leadership** with the Health Information Network of Arizona (HINAz) in its formation and venture funding. We also funded and implemented the use of statewide electronic medical record (eMR) system for the CRS program in each MSIC and facilitated their connection with HINAz, the statewide HIE. The eMR provides the capability for a **c**entralized, integrated medical record by allowing providers to import a Continuity of Care Document (CCD) from HINAz into the MSICs' respective eMR system.

Sustaining an Adequate Network

UnitedHealthcare Community Plan initiated network changes are planned, implemented and evaluated to ensure continuous improvement. We have developed and will maintain a provider network compliant with and meeting AHCCCS standards in all seven GSAs. To support and sustain an adequate network we have undertaken initiatives to assist providers in addressing claims issues, resolve complaints, and offer enhanced reimbursement models resulting in improved provider retention:

- ***Enhanced Provider Service Model ("3/30"):*** We use the "3/30" call resolution process to ensure claims issues are handled in a timely manner, reducing the need for escalation through the claims dispute process. Our Provider Services Center (PSC) Team acknowledges all calls no later than three business days and notifies providers of resolution no later than 30 business days via email, written communication, web-enabled process or call back. Recent 3/30 reporting results demonstrate that 100 percent of issues are acknowledged within three days; 45.1 percent are resolved within the first contact and 96.6 percent of issues are resolved within 10 days.
- ***Provider Claims Resolution Process (PCRS) Model:*** The PCRS team was created to drive service, affordability and quality in health care by treating every provider service interaction as an opportunity to reduce administrative complexity and to offer a clear, consistent experience for providers. The model focuses on improving claims accuracy and resolving claim issues. Some transactions, such as PCP assignments and claim adjustments are handled over the phone, while the provider is on the line. Others may require additional follow-up. This model differs from the standard provider service model in that the PCRS team maintains ownership of the provider issue until they can either process the adjustment to meet the provider's expectation or educate the provider via an outbound phone call, ensuring a closed loop process. This enhanced service model has achieved strong results such as a **30 percent reduction in claims disputes**. Satisfaction survey scores average 5-10 points higher than with the standard provider service model. Additionally, a focus on addressing root cause has resulted in **nearly a 20 percent drop in the number of calls from providers about claims issues**. These actions keep our retention high.
- ***Provider Complaint Reduction:*** Our Provider Relations Team collaborates with other departments to gather, evaluate and trend provider call center input and develop effective intervention strategies to address identified issues. Our call center model is based upon analysis and bi-weekly trending of provider issues as well as effective resolution. As mentioned above, the PCRS model has been especially successful in reducing complaints as a result of internal/external partnerships which create shared investment in satisfactory issue resolution and real-time communication between the provider and the adjustor working the provider's claim. The Provider Relations staff reaches out providers and educates/retrains their staff as needed.
- ***Enhanced Reimbursement Models:*** UnitedHealthcare Community Plan is a national thought leader when it comes to value-based payment methodologies. Across UnitedHealthcare nationally, **more than $18 billion dollars in annual payments** are made through value-based contracts that span our Medicaid, Medicare and Commercial programs. These contracts include performance-based and bundled payments and involve Accountable Care Communities, Patient-Centered Medical Homes, Accountable Care Organizations and capitation arrangements. We continue to develop payment models that incentivize providers, are easy to implement and make it simpler for providers to execute. This includes 'tool kits' that providers can use to help them succeed under these new models, including timely data and user-friendly feedback on their performance. We are the only company to partner with Tucson Medical Center and Arizona Connected Care in a value-based ACO contract. We have a multiplicity of Accountable Care incentive arrangements offering embedded care management and transformation consultants. We were the first to launch PCMH in AZ, winning a recognized national award and achieving NCQA certification for the practices.

Performance – 2012 AZ Satisfaction Survey Results

Member:
CRS: Increased 1.2% to 87%
Adult: Remained the same at 76%
Provider: Increased 17% to 74%
In addition, nearly **9 out of 10 PCPs likely to renew** contract.

The result of these initiatives has been increased provider satisfaction by 17 percent in 2012 and **a provider retention rate of 99.9 percent.**

Program

3. AHCCCS supports efforts to reward desired care outcomes attained through care coordination and the…

UnitedHealthcare, under the direction of our **Chief Medical Officer (CMO), Dr. Stephen Chakmakian**, D.O., a family physician with more than 15 years' clinical and 10 years' AHCCCS administrative experience, uses data and evidence-based decision support tools to maximize care coordination for our members, resulting in improved outcomes and cost efficiencies. We use system-wide, integrated processes to systematically gather, analyze and share data, along with evidence-based decision support tools that enable internal staff and external providers to identify care opportunities by member and provider. Data review leads to care coordination initiatives and activities including direct interventions and actions with members and providers to address the care opportunities, resulting in improved outcomes and costs. For example, using our tools to track and analyze inpatient (IP) data, **we reduced IP admits/1000 by 25.1 percent, and IP days/1000 by 22.6 percent** over the life of the existing contract (excluding new AHCCCS bed day limits).

Data and Evidence-Based Decision Support Tools Used in Care Delivery

We have created specialized, clinically-integrated, interdisciplinary care teams that take a comprehensive approach to care delivery across the continuum, supported by the tools in our **Decision Support "Tool Box,"** including:

Reporting and Data Analysis Tool. Strategic Management Analytic Reporting Tool (SMART) data warehouse collects, stores and reports quality measures, prior authorizations and claims data. We produce reports and conduct clinical, quality and utilization management/care management (UM/CM) analyses used by our staff to drive our initiatives. We develop and share scorecards with practices to help them identify opportunities for improvement.

Risk Stratification and Predictive Modeling. Impact Pro population health risk ID/stratification tool (with evidence-based medicine (EBM) care gaps) guides/drives our clinical model's population and member-level clinical priorities. The tool provides robust data that we share with practices through our web-based Population Registry.

Accountable Care Population Registry (Population Registry). Secure, web-based tool allows us to share real-time data with practices on their patients. It provides real-time hospital ER and inpatient discharge lists for tracking follow-up. They can view lab results, Rx scripts and 3 years of encounter data by member. We risk stratify their members and provide visibility to high-risk members in their population along with prioritized EBM opportunities. Practices send us appointment data, allowing assessment of access to care, same day appointment availability and No-Show rates.

Clinical Data Management. CareOne, our comprehensive clinical data management system, provides a holistic view of our members' care management information, including utilization of services authorized, prescription history, health risk assessments, care plans, and care and disease management programs which we share via the portal with providers.

Health Risk Assessment (HRA). Provides early identification and stratification of member needs and acts as one component in the UM/CM care plan development and care coordination process.

Adverse Events Reporting Tool. Subsequent Events of Cluster Activity (SECA) report summarizes ER and IP adverse events via hospital ADT data files or claims activity and adds member Impact Pro risk score to identify members at highest risk who will benefit from our focused high-risk care management interventions.

Clinical Care Guidelines. Nationally recognized, best-practice level-of-care Milliman Care Guidelines (MCG) along with UnitedHealthcare Clinical Guidelines (which compliment MCG), provide additional EBM clinical guidelines and allow for a consistent, EBM approach for clinical reviews.

Inpatient UM/CM Census. Blended Census Report tool (BCRT) provides timely identification/tracking of members in facilities and allows our UM/CM team to conduct effective end-to-end UM/CM, discharge and care transitions.

Readmission Risk Assessment (RRA). UM nurses use this tool to assess the risk of readmission. The assessment dictates the level of discharge and transition care management (TCM) the member receives prior to discharge, allowing us to develop care plans that reduce readmissions (RA) and to prioritize post-discharge follow-up care.

UM/CM Scorecard. Provides our UM/CM team with weekly authorization-based UM/CM metrics reporting and continuous tracking/ trending of key UM statistics.

Maternal Child Health Scorecard. Web-based scorecard provides information such as ante partum admissions, UM data, neonatal intensive care (NICU) data, average gestation, deliveries, rate of premature deliveries, C-section rate, admits/1000, ER visits/1000 and case management enrollment. We use this information to develop and run clinical initiatives that improve prenatal and post-partum management and reduce NICU admissions.

Comprehensive UM/CM Report. Provides our UM/CM team with year to date claims and current authorization-based UM metrics reporting and additional tracking/trending of key UM/CM measures, targets and long-term goals.

Hospital Benchmarking. Our clinical leaders review data **with hospital leadership** from the Variant Day Analysis (VDA) tool, which provides detailed benchmark analysis of overutilization days by hospital by APR-DRG at the state or national level. It allows us to work with hospital partners to identify opportunities for improvement and develop annual and ongoing collaborative clinical initiatives to improve performance.

ER Escalation Report. Allows us to show hospitals the propensity to admit members from their Emergency Department to either observation or IP level of care compared to peer hospitals in Arizona, the region and nationally. We share this data with hospital partners to discuss opportunities to reduce unnecessary costly care.

Provider Portal. Secure portal gives providers access to critical member information through a single source, facilitating better and more responsive care. Provides access to a variety of comprehensive plan- and member-specific information, such as HEDIS, CMS Core Measure and STAR data. Providers can also view the member's HRA and care plan and add comments to the care plan. The case manager can review and respond to the provider's inquiry.

Performance Measures/HEDIS. MedMeasures and View360 provide HEDIS, CMS Core Measure and STAR data to providers through our secure Provider Portal. We use the data to guide and drive quality initiatives and outreach.

Provider Profiles. Contains preventive care, access to care and utilization management measures. Profiles providers and benchmarks them across all of our health plans, looking for providers that fall outside the expected range for service delivery. The PAC reviews the data and works with providers to address issues.

Using Data and Evidence-Based Decision Support Tools (DST)

As the largest provider of special needs services in Arizona, we provide integrated, high-quality and timely care for individuals living with chronic illnesses, frailties and disabilities and we continue to advance care coordination models. Throughout this section, we describe, in several settings/environments, how we use and share with providers using data-driven, evidence-based care tools that identify members most likely to benefit from interventions and apply programs tailored to meet their needs, improving care delivery to the total population.

First Key Contacts – *Health Risk Assessments*

Care coordination starts when our multilingual outreach team makes member engagement calls to conduct the initial **HRA**, which triggers issuance of disease-specific materials or referral to our care management team. We identify and support any special needs, offer referrals to qualified clinicians and promote appropriate preventive care services.

Accountable Care Communities (ACC) – *An Innovative Model of Care (MOC) Since 2008*

When members chose a PCP, they may select a provider at one of our 12 ACC practice partnerships, currently representing 64 physical health clinic sites and six integrated physical/behavioral health sites in three counties, caring for approximately *75,000 members*. We use **SMART** and **Impact Pro** analyses to select practices whose population health risk will benefit most from our ACC model. We share our vision, mission and values; provide access to DSTs, such as our **Population Registry;** establish data exchange; and set defined care coordination processes with clear accountability.

In our ACC partnerships, a team comprising our CMO, ACC practice consultant and an embedded RN care advocate (CA) collaborate to advance patient care needs. Our CMO is the primary clinical liaison to the practice physician leader. The ACC consultant builds the relationship, is responsible for data exchange, communications, training/technical support and analysis and monthly reporting to drive rapid cycle improvement. The RN CA is our employee, from the community, located in the ACC practice to focus on the high-risk membership cohorts.

Data and Evidenced-Based DST: We provide practices with our **Population Registry** to share clinical information, clinical outcomes measurement and care coordination management and support, based on data from tools, such as

Impact Pro. Practices work with us to achieve shared goals, including: (1) improving access to care; (2) reducing avoidable ER visits; (3) reducing inappropriate utilization; and (4) addressing care opportunities for high-risk patients.

Through the **Population Registry**, practices provide us weekly eMR appointment feeds by site, including 'No-Show' data, which we analyze and share to identify ways to improve same-day access to care. We have established **ADT file exchange** with 28 AZ partner hospitals to provide practices critical, timely data, delivered through our **Population Registry**, to develop 'best-practice' transitions of care and outreach to members by the practice after ER visits. The practice provides member appointment completion data and post-ER events outreach/follow-up and works with our UM RNs prior to discharge to schedule 7-day follow up appointments. **Results:** In our Pima ACC practices (29,516 members) the YTD average No Show rate is <12 percent vs. industry and practice reports >20 percent for our population. 7-day kept post-discharge appointments kept range now from 60 to 70 percent.

Relationships

"The PCMH Pilot Program has driven sustainable change within our organization. Prior to our partnership, we were hesitant to implement change due to fear and anxiety… What we did not realize is that by improving access to care using real-time data obtained from the Population Registry, we were able to shift care from the high cost inpatient and ER care to a lower cost primary care model."

– David Rogers, CEO Sunset Community Health Center

Using **Impact Pro**, we analyze the practice population, tier highest risk members by diagnoses or total risk of an adverse event (ER/IP) and share open EBM/HEDIS care opportunities. Using these tools, our team decides which members will benefit most from enhanced care coordination focus, load these members into high-risk (HR) **Population Registry** cohorts and outline specific program goals, processes and actions to engage members and close EBM opportunities. We support the practice to address unmet care needs and reduce adverse events.

Our geographically diverse ACC relationships support other *'value-added'* quality initiatives that improve care outcomes. For example, in 2012, Dr. Chakmakian worked with our QM Department and the ACC practice physicians on EPSDT services for children 0-2 years of age. Using **MedMeasures,** we identified incomplete age-appropriate HEDIS services and, through the **Population Registry** and **Provider Portal**, shared the data with ACC practices**.** The practices then took steps to verify missing services and to contact the member's parent or guardian for appointments. **Results:** 57.7 percent of 3,257 identified children with EPSDT gaps in care received services within 90 days after ACC partner collaboration.

Relationships

"The Accountable Care partnership between UnitedHealthcare Community Plan and Phoenix Pediatrics has been a flexible, dynamic transformation that was made possible by a shared vision of patient centered excellence."

- Kevin Berger, MD, Phoenix Pediatrics

Disease and Care Management – *Focused Approach*

We have tremendous care coordination success with our ACC practices, but it is not practical to deploy the ACC MOC to all providers. Therefore, our integrated clinical team and non-clinical support staff conduct disease & chronic care management and care coordination with non-ACC providers. We have focused on: hospital-to-home care transitions to reduce readmissions and reduce non-emergent ER; high-risk CM (HRCM); HIV/AIDS; narcotic abuse/overuse; behavioral health; and AHCCCS/ provider/ UM/CM team referrals. **Data and Evidenced-Based DST**: We proactively identify and assign HRCM using **HRAs** in **CareOne**, **Impact Pro** risk analysis, **Adverse Events Reporting Tool** analysis, **ADT data** and pharmacy DUR reports. **HRAs** and **CareOne** care plans are available to providers through our **Provider Portal**. We pursue goals similar to those in ACC practices, such as reduced avoidable admissions/readmissions and ER visits. For example:

- UM RNs perform a **RRA** and make best efforts to set post-discharge follow-up appointments for all members prior to discharge. A coordinated hand-off occurs to the Transitional CM who follows-up in 48 hours and ensures the appointment is kept. The TCM provides ongoing care coordination for up to 30 additional days. If needs continue, we continue to support and address members longer term needs.

- Our Care Management team 'health coach' uses the nightly **ADT data** and an auto-dialer system to make live contacts the day after an ER visit. Much like ACC practices, the member is connected with our health coach who provides education, direction and assistance regarding appropriate ER use and how to better access their PCP.

Healthy First Steps (HFS) – *Our New Mothers and their Newborns*

For our pregnant members and newborns, HFS provides a multi-faceted approach to improve prenatal and post-partum management and foster a physician/member partnership throughout pregnancy. Our team of Arizona licensed OB RNs and OB/GYN physicians promote ACOG, MCG and other standard of care guidelines, working with providers and hospitals to promote local and national best practices.

Performance - HFS Outcomes Tracked by the Maternal Child Health Scorecard

For 7,048 births tracked from 10/01/11 to 09/20/12:

- Low birth weight rate = 6.33% (targeted goal of < 8%)
- Preterm delivery rate = 9.66% (target goal < 10%)
- C-section rates = 26.65% (targeted reduction goal 28%)
- Average gestational age at time of delivery is 38.5 weeks
- Average birth weight is currently 3239 grams
- Average gestational age at HFS enrollment = 15.4 weeks

We have partnered with **Nurse-Family Partnership® (NFP)** to provide no cost services for first-time pregnant Medicaid members. NFP is a community health program where we partner mothers with a RN who conducts home visits until delivery and through her child's second birthday. Independent research shows better outcomes (earlier prenatal care; full term; higher birth weight; increased breast feeding; and reduced tobacco use) and proves a 5:1 ROI when NFP is engaged. Maricopa County experienced the following outcomes: (1) 74 percent of members receiving prenatal care during their first trimester; (2) 90 percent of babies were born full term and 91 percent were born at a healthy weight - at or above 2500g; (3) 92 percent of mothers initiated breastfeeding and 38 percent continue to breastfeed at child age six months; and (4) 39 percent decrease in smoking in pregnancy.

The HFS **Neonatal Resource Services (NRS)** program provides IP UM for infants in NICU and post discharge care coordination. Neonatologists work with our CMO to promote high quality, cost effective NICU care. Selected babies are followed for up to one year and, when possible, NRS pairs NICU graduates with Peds Tool-trained AHCCCS physicians upon discharge. **Data and evidenced-based DST**: HFS uses State eligibility files, OB Risk Assessment Forms and **HRAs** to identify and risk-stratify program candidates and reviews quarterly the **Maternal Child Health Scorecard** to identify utilization trends and guide initiatives. **Results:** Through the NRS program, we r**educed authorized NICU admits/1000 by 24.8 percent and authorized NICU days/1000 by 11.5 percent.**

Interdisciplinary Care Coordination Team – *UM/CM Evolution*

Despite robust care coordination efforts, there are times our members will be admitted. Whether reimbursement is a per diem basis or a DRG, we coordinate care collaboratively with stakeholders. We have a defined IP notification process where data is entered into **CareOne**, we produce a **Blended Census Report** (which tells the RN where the patients are) and a team verifies member info, TPL and COB. The case is tasked electronically to the ICCT RN care manager assigned to the facility. The IP team uses a daily **Inpatient UM/CM Census** to identify which members are admitted where allowing us to conduct effective end-to-end UM/CM, discharge and transitions of care plans. UM/CM begins within 24 business hours of notification by skilled RNs, discharge planners and medical directors who round daily on every member. During weekly and monthly team meetings all UM metrics against targets and goals are reviewed from the **UM/CM Scorecard**, which drives ongoing clinical initiates and updated actions plans.

Data and evidenced-based DST: Using **CareOne**, the ICCT RN and medical directors ensure admissions are medically necessary as guided by MCG, local/national practice standards, internal experts and peer-to-peer discussions. Discharge planning begins on day 1 and coordinating care sets a 7-day post-discharge follow-up. We conduct a **RRA** on all members and, when certain risk levels exist, refer them to TCM who will follow members and support all care needs post discharge. **Results:** As of November 2012, **67 percent of members seen by UM RNs have an appointment arranged prior to discharge and 55 percent of these appointments have been kept.**

We hold JOC meetings with hospital partners' leadership to review and share key data from our DSTs. Our **Hospital Benchmarking tool** identifies the top 15 APR DRGs, by admits, opportunity days and readmissions, and the top opportunity days by admitting physicians and top observation conversion opportunities. Our **ER Escalation report** shows, by hospital and admitting physician, the propensity to admit to either observation or IP level of care, by diagnosis, compared to peer hospitals in Arizona, regionally and nationally. This collaborative data sharing drives

discussion about the opportunities to reduce unnecessary costly care.

Value-Based Payment Models

We are a national thought leader when it comes to value-based payment methodologies. However, we believe that **incentive payment does not automatically equate to care delivery reform.** Practices that first share a commitment to implement mature structures and processes that will transform care delivery and lead to improved outcomes should be further incentivized. Across UnitedHealthcare, we make more than **$18 billion dollars in annual payments through value-based contracts** that span our Medicaid, Medicare and commercial lines of business. These contracts include performance-based and bundled payments and involve ACCs, PCMHs, Accountable Care Organizations and full capitation arrangements. We are continuing to develop payment models that are easy to implement and that make it simpler for providers to deliver high-quality care. This includes 'tool kits' that providers can use to help them succeed under these new models, including timely data and user-friendly feedback on their performance.

Using DSTs and Data to Implement Outcome- and Value-Based Payment Models

We understand that ER and IP care is costly and a reduction of ER and IP utilization has the most opportunity to reduce cost and improve care. Therefore, we have focused value-based payment models on reducing inappropriate ER and IP use along with high risk proactive patient care. Since a savings incentive is earned based on achieving key metrics, transparency in sharing clinical data and track key metrics is critical. We use the **Population Registry** and **Provider Portal** to share data with providers about their performance and achieving outcomes that can result in payment. These tools give providers the ability to track, trend and respond to practice performance. We conduct monthly JOCs with providers to review their performance using these tools and claims analysis from **SMART** data. These tools allow us to work with providers using a Plan-Do-Study-Act approach to develop ongoing clinical initiatives to improve performance and position them to benefit from value-based payments.

Value-Based Payment Models in Arizona

***ACC Shared Savings Program*.** We have initiated AHCCCS-approved innovative pilot contract amendments with two well-established ACC practices (Sunset CHC and San Luis Walk-in Clinic). A shared savings incentive may be earned if the practice is able to see at least 80 percent of patients after an IP stay within seven days of discharge, see at least 60 percent of patients with an ED visit are seen by PCP within seven days of discharge, and see that at least 80 percent of patients across all high risk cohorts in the **Population Registry** have completed EBM care opportunities as compared to a historical baseline. **Results:** With Sunset CHC, the results of the shared savings incentive to date are **reduction of admits/1000 by 13.3 percent, IP day/1000 by 11.1 percent and ER visits/1000 by 4.7 percent**.

ACC Care Coordination Incentive Payment Model. Since the inception of our Phoenix Pediatrics ACC, our contractual enhanced care coordination reimbursement program has achieved results in a special needs pediatric population. We track results using the **Population Registry** and claims data in **SMART**. **Results:** From 12/1/2011 to 10/31/2012: **reduction of admits/1000 by 19.2 percent and days/thousand by 36.6 percent as of 10/31/12.**

***OB P4P program*.** We have 70 OB physicians, totaling 3,826 births in 2011, engaged in this program. To qualify for the full supplemental payment, the OB must have a confirmed initial prenatal visit, submit a completed ACOG assessment and limit the number of low birth weight and C-section live births below an established threshold. We track results based on submissions to HFS and **SMART** claims data analysis. **Results**: 86 percent timeliness of prenatal care visits in 2011; 2012 C-section rate for participating OBs is 27.54 vs. 29.74 percent for non-participating; 2012 low birth weight rate for participating OBs is 5.85 vs. 7.08 percent for non-participating; and decreased incidence of preterm deliveries. The improved health outcomes of mothers and babies demonstrate savings and quality improvement.

In the past year, we were honored to support AHCCCS' efforts to gain CMS approval for a modified State Plan Amendment to transform the Medicaid reimbursement structure to encourage system reform that reimburses for improved health outcomes. This will allow the savings from bending the cost curve to be shared and accounted for as medical expense, helping us to expand our value-based payment models and experience more broadly across Arizona.

We are committed to our relationship and understand the AHCCCS goal to improve effectiveness, quality and health outcomes for Arizona. We are continuously looking for **innovative solutions** to implement outcome and value-orientated payment models which enhance and transform care delivery to members.

4. Mr. Andrews is a member in your plan. He is extremely overweight, and spends long periods in bed…

Overview

Mr. Andrews' primary care physician (PCP), Dr. Durden, requests that we provide chronic care management to support him in addressing multiple medical/behavioral health care needs. PCPs have 24/7 access to make such referrals through our Provider Customer Service Unit which forwards to the Care Management (CM) Unit where comprehensive care management begins. Based upon the initial physical and behavioral needs outlined by Dr. Durden, he qualifies for high-risk CM due to complex acute and chronic health care opportunities: inpatient (IP) and recent emergency room (ER) visits; obesity, chronic obstructive pulmonary disease (COPD), chronic cardiac condition (two myocardial infarctions (MI) secondary to coronary artery disease (CAD) and status post stent insertions); and anxiety.

Our systemic process to improve his health care outcomes includes integrating and coordinating services based on the six health home service elements essential to providing an effective integrated interdisciplinary care plan using team based strategies: (1) comprehensive care management; (2) care coordination and health promotion; (3) individual and family support; (4) referral to community and social support services; (5) comprehensive transitional care from inpatient to other settings; and (6) the use of health information technology to link services. Below we describe in detail the approach to Mr. Andrews, how we offer special assistance navigating his health care, and how we support his PCP and ensure an integrated interdisciplinary care plan that will address his comprehensive care needs.

Health Home Service Elements

(1) Comprehensive Care Management and (2) Care Coordination and Health Promotion

Assessment to Identify Individualized Care Needs for Mr. Andrews

Upon notification from Dr. Durden, the provider service representative builds a case in CareOne, an integrated clinical system that houses all member information and care interventions. The case is tasked to Joe on the high risk care manager (HRCM) triage support team who outreaches to Mr. Andrews to gather personal/social information, inventory his expressed needs/concerns. Joe then introduces him to our certified HRCM, Sandra, a licensed Arizona RN with 12 years of care management experience, who begins her assessment of Mr. Andrews using our integrated clinical management system, CareOne. Each HRCM receives training in cultural sensitivity, documentation guidelines and safety, ensuring all facets of effective member care interactions are used when working with a member. (e.g., all HRCMs are required to become certified case managers as soon as they become eligible to take the national exam).

Sandra initially assesses for any special language needs, physical disabilities and cultural or religious considerations. In the event that language or other barriers exist which may adversely impact a successful intervention, she will make accommodations for these before proceeding. Language Line interpreter services are available and provide access to more than 170 languages to meet communication needs. Sandra will address key points like explaining Mr. Andrews' enrollment, *Member Handbook*, membership cards, benefits/COB, his rights and responsibilities and providing hers and UnitedHealthcare's member services contact numbers. From the member level detail screens in CareOne, all team members who support Mr. Andrews can document interactions and interventions, keeping all members of the care team informed. Sandra has access to Mr. Andrews' initial health risk assessment (HRA) in CareOne and she will update it or develop a new one if needed; she has an Impact Pro global risk analysis based on claims in our Strategic Management Analytic Reporting Tool (SMART) data warehouse; and claims-based Significant Event Clusters of Activity (SECA) report (summary of ER and IP events), which complement her case notes. She collaborates with Mr. Andrews, Dr. Durden, and the high risk clinical health plan team (LPNs, MSW, pharmacists, a behavioral health coordinator and physicians) to solve access to care issues, psychosocial, disease education needs and more.

Individualized, Integrated Care Plan for Mr. Andrew's Chronic Illnesses

Using a patient-centered approach, motivational interviewing and skilled observations, Sandra builds a detailed CareOne care plan through a defined process:

- Assessing Mr. Andrews' health literacy about the conditions impacting his health and wellness
- Obtaining the names of his current and former treating physicians and past medical records
- Further assessing his functional abilities, care needs and community support network

- Engaging him to determine his personal vision of what he wants as his short, medium and long-term health outcomes while learning how much help he is willing to accept and his level of likely participation

1. COPD: Mr. Andrews becomes short of breath and is easily fatigued, limiting his activities of daily living (ADL) and generating anxiety sufficient enough to call for emergency medical services. **Discussion and Plan:** Sandra asks Mr. Andrews about his breathing difficulties and learns how he received a diagnosis of COPD. She asks when he has seen a pulmonologist and the provider's name. In addition to seeking affiliated records, she asks Mr. Andrews about any medications prescribed to help his breathing, the dosages and whether he is using them. Sandra will also look up claims medications, assess medication possession ratio and help fill or authorize PCP-ordered treatments. Sandra engages our Pharm-D, Sandy Brownstein, as needed; helps him understand what the medications are intended for and how he should take them; reviews side effects; and answers questions/concerns. Sandra asks Mr. Andrews about triggers that worsen his breathing and whether he smokes or is around other irritants and begins to address these. If he does smoke (the most common cause of COPD), she will ask him about his past efforts to stop smoking and encourage him to quit as part of his health wellness. If deemed safe by Dr. Durden, she will share that AHCCCS covers tobacco cessation products, including replacement therapy, tobacco cessation support medications and a tobacco cessation program offered by the Arizona Department of Health Services (ADHS). Sandra will help him enroll. Depending on information discovered and PCP orders, Sandra will help arrange a consult or follow-up visit with a pulmonologist to have pulmonary function testing, a medication review and assess blood oxygen saturation/oxygen needs and/or pulmonary rehabilitative services. Sandra will ensure that Mr. Andrews understands where he can call after-hours to help answer his questions, where urgent care centers are located and work with Dr. Durden on a plan to avert unnecessary ER visits. Sandra will provide easily understood COPD educational materials via mail or if he has access to the Internet, the link to the COPD guidelines available to our providers and members. **Self-Management and Health Promotion:** Advances in information technology have introduced new design approaches that support health care delivery and patient education and offer alternatives that some members may find much more engaging than traditional disease management approaches. Some of these advances have the potential to empower Mr. Andrews and support a transition from a passive to a more active role in which he is informed, has choices and is involved in the decision-making process. Our *MyJournE* Web-based journaling tool will be offered to Mr. Andrews and is used in journaling recovery efforts that can be shared. Key *MyJournE* themes include: building recovery and resiliency through offering secure online journaling that can be kept private or allows sharing entries or messaging with trusted peers, friends, family, and potentially care managers; the difference between being ill and well is often having social connections; and compelling member engagement: *MyJournE* provides Mr. Andrews a forum for mood tracking and insight regarding his COPD. **Desired Goal/Outcome:** Mr. Andrews will establish care with an expert who can update his COPD treatment plan and have linked support from Sandra and team members, immediately reducing his primary driver for high-cost: less effective care in the ER. He will begin the process of improved self-management of his COPD condition through training, support and guidance.

2. Chronic cardiac condition: Mr. Andrews is not steady on his feet and ambulates only a short distance, after which he develops shortness of breath (SOB). **Discussion and Plan:** Sandra realizes this could be due to Mr. Andrews' COPD, but that SOB can be an anginal equivalent and an impending sign of worsening CAD and/or stent failure. She inquires whether/when he has seen a cardiologist and seeks records and checks for encounters. She also asks if he was asked to use any medications to treat his heart and whether he is using them as ordered. Recognizing the clinical urgency, Sandra reaches out to Dr. Durden to share her findings and collaborate on a reassessment. She will support the PCP/specialist regarding any of Mr. Andrews' medical care needs, such as monitoring his blood pressure, medications, weight and associated medical directives until he is better prepared to self-direct. **Desired Goal/Outcome:** Mr. Andrews establishes care with experts who can reevaluate his heart condition, the most urgent medical matter impacting both morbidity and mortality. Sandra, Dr. Durden and he jointly redefine the treatment course and whether new testing or interventions are needed, with linked support from Sandra and other members of the care team as needed.

3. Morbid obesity, excessive fatigue and limited ambulation: Discussion and Plan: Mr. Andrews has several comorbidities and associated medical treatments that may contribute to weight gain. It can be a clinical challenge to assess whether existing conditions or his treatments are causing fatigue and limitations in ADLs, or whether there are additional medical evaluations to be discussed with his physicians. To help evaluate options, Sandra asks details related to his weight and these symptoms, such as when Mr. Andrews recalls them beginning, whether there have been

recent or progressive changes and if he has shared this information with his physicians. Depending upon his feedback, she then coordinates with the PCP/specialist regarding next steps, which may include an updated visit/testing (e.g., thyroid/hormone imbalances), sleep disturbances or other etiologies often linked with obesity, COPD, CAD/MI and fatigue. Sandra gets agreement from Dr. Durden to order a home health nurse visit to evaluate his housing condition, mobility in his surroundings, safety issues and obtain more information about support systems he may have. Sandra may also discuss with Dr. Durden whether to dispatch a community health worker (to visit Mr. Andrews at his home to follow up on the care plan being developed, more personally and directly support his chronic conditions and help promote healthy decisions). Sandra and Dr. Durden agree to trigger an evaluation with a physical therapist to address Mr. Andrews' maneuverability and progressive strengthening to rehabilitate his current diminished physical state. While doing so, particularly given his propensity to remain in bed as a consequence of the symptoms, she will explore options in coordination with Dr. Durden like: bariatric evaluation; durable medical equipment needs to help him get around more easily (e.g., walker or wheelchair); or enhanced transportation needs (e.g., medical stretcher van). Sandra will determine if coordination with a registered dietician is possible to better address obesity and nutrition and discuss how Mr. Andrews can start to gain gradual self-control over his weight. **Desired Goal/Outcome:** Collaboratively ensure that necessary medical evaluations have or will occur to make certain Mr. Andrews has been properly diagnosed, supporting the best course of action. We take steps to better ensure his safety and independence, giving him the tools needed to comply with upcoming medical appointments and meet ADLs. Mr. Andrews will better understand the interdependencies of his symptoms and appreciate the importance of compliance with a diet that works for him. Sandra helps him remain ambulatory, increasing time out of bed, in order to prevent greater debilitation and potential complications such as pressure sores and growing depressive symptoms. More knowledge of his conditions will help to empower him so that he can be more self-sufficient and satisfied with his situation.

4. ER overuse: Mr. Andrews' over use of the ER may be caused by the lack of understanding his medical conditions, a lack of adequate evaluation and management and underlying psychosomatic and social issues. **Discussion and Plan:** Sandra will follow the line of questioning used when we conduct next-day ER outreach based upon nightly facility ADT data (e.g., do you know who your PCP is and how to reach them or did you call your PCP before going to the ER?). She will review the appropriate times to consider using the ER and discuss what alternative resource (urgent care locations close to him or a peer Mr. Andrews could use when he feels the need to go to the ER). She will coordinate with Dr. Durden, asking her to discuss his symptoms which trigger frequent ER use. Sandra may also ask her teammate and Health Coach, Jackie, to speak to Mr. Andrews about how he feels when he goes to the ER and promote techniques to reduce anxiety and ER overuse. Our Behavioral Health Coordinator (BHC), Stacey Hochstadter, LCSW, will speak with Mr. Andrews about the feelings he has connected to his breathing troubles which trigger ER use. **Desired Goal/ Outcome:** Sandra will use all her available resources to address the root cause of why Mr. Andrews chooses the ER over other available resources and influence positive alternatives.

5. Additional behavioral health support needs: Anxiety. **Discussion and Plan:** Sandra works with Stacey to assist with referrals to the Regional Behavioral Health Association (RBHA) system for evaluation, assessment and treatment needs. From the conversations with Mr. Andrews, he becomes anxious when not knowing how to manage his medical conditions. A self-management program will be implemented. Since Mr. Andrews is spending much time in bed, he is at higher risk for developing feelings of isolation and depression. A referral to a local support group and/or the RBHA through Dr. Durden may provide Mr. Andrews with the social interaction his is missing and will provide him with coping skills he does not currently possess. **Plan:** Behavioral health (BH) services for a medical condition (under acute services) or BH assessment/RBHA service referral and coordination. **Desired Goal/Outcome:** Improve Mr. Andrews' ability to cope with his medical conditions and provide community, patient and family support, training and resources.

6. Disease management support needs: Mr. Andrews is diagnosed with several chronic health conditions for which we offer written disease management (DM) educational materials in easily understood (4th to 6th grade) language for both COPD and CAD. Sandra believes these written materials will help promote Mr. Andrews' understanding of his chronic conditions and how to manage them. **Discussion and Plan:** Sandra believes these written materials may help him understand what is happening with his health. Once he receives these materials, Sandra will review them and ask him questions to validate his comprehension. If Mr. Andrews understands his conditions better, he can have input into his treatment modalities. The additional evaluation and management with Dr. Durden and specialists will include requesting that they engage Mr. Andrews in clear conversations about his conditions. She will point out the areas where she sees he needs the greatest level of health information to support the education process. As their relationship

is established, Sandra will also try to discuss end of life wishes and make sure he has advanced directives in place. **Desired Goal/Outcome:** Mr. Andrews will develop an increased understanding of his disease processes, interdependencies, his role in self-management of his care and his shared responsibility with his physicians.

(3) Individual and Family Support and (4) Referral to Community and Social Support Services

Mr. Andrews has the right to choose to live in the least restrictive, most appropriate setting to meet his extensive needs and our assistance in coordinating his Medicaid benefits to help him maintain and improve his independence. **Discussion and Plan:** Sandra finds he has no clear family/social support system. Depending upon how much immediate medical need and risk presents, Sandra may discuss with Dr. Durden and ancillary support therapies/services whether a temporary skilled placement is needed. She will determine if he is Medicare eligible and discuss support/education regarding Dual Special Needs Program (D-SNP) options with supplemental services. She can determine if ALTCS may be a viable alternative benefit in order to meet more of his ADLs through enhanced benefits. Sandra will investigate with Mr. Andrews other supports available to him, such as community-based resources (e.g., friends, faith-based involvement and low-cost community centers), using *UnitedHealthcare Community Services Connect,* an innovative web-based tool with a resource library of community support agency information. The Arizona database includes community resources and services grouped into nine categories: clothing; financial assistance; food; housing; job placement; language; legal services; transportation; and youth service. Organizations included in the database are vetted through web-based research, phone calls and input from the local outreach team and the database is reviewed and updated regularly. Additional low-cost suggestions include: Arizona Bridge to Independent Living; the Virginia G. Piper Sports & Fitness Center offering assessment, information, support and training on use of equipment; parks and recreation or one of the community college fitness programs, both of which can provide recreation assessments that address adapted needs; and several local hospital heart support groups that have a focus on mental health. **Desired Goal/Outcome:** For Mr. Andrews to reside in the least restrictive, most appropriate setting to ensure all his care needs are met in accordance with his wishes and to identify and/or develop a support system which allows him enhanced socialization, peer support and meaningful activities outside of the home.

(5) Comprehensive Transitional Care from Inpatient to Other Settings

Prior to his discharge, he is referred to a RN transitional care manager (TCM), Kelly, who connects and welcomes him to the care management program, explains the benefits, provides RN contact information and schedules a time to speak with him within 48 hours of discharge to make sure all needs of his discharge plan have been met. Kelly serves on the same team as Sandra and Jackie. She completes a post hospitalization assessment with Mr. Andrews and confirms that he has a post-discharge physician appointment. If he was not scheduled an appointment, she helps him make one and:

- Completes a medication reconciliation to make sure Mr. Andrews has obtained and been informed about his current prescribed medications. She collaborates with Sandy Brownstein, when needed.
- Confirms that Mr. Andrews attends his 7-day post follow-up appointment with Dr. Durden or specialist.
- Educates on ‘red flag’ symptoms regarding diagnoses/conditions and appropriate levels of care to access.
- Confirms referrals to BH and community resources if Mr. Andrews is assessed to have these needs.
- Continues to monitor Mr. Andrews for up to 30 days. If she identifies that Mr. Andrews has additional medical or behavioral health coordination of care needs past 30 days, they will refer him to Sandra for ongoing services.

(6) Use of Health Information Technology to Link Services

CareOne provides all those participating with Mr. Andrews and his providers an integrated data system so team members can document interactions and interventions, keeping all members of the care team informed. The care plan may be accessed by Dr. Durden via our secure Provider Portal, where he may ask questions which are reviewed and responded to or addressed by Sandra as part of the comprehensive process. Sandra also uses *UnitedHealthcare Community Services Connect* to link members with complex needs to community resources.

Systemic Processes to Improve Care Outcomes

Identification of High-Risk Members with One or More Chronic Illnesses

We learn of Mr. Andrews from Dr. Durden's referral. Given our systems and processes to identify patients like Mr. Andrews, such as the ER and IP monitoring tools discussed below, it is unlikely that we would have waited to initiate care management for Mr. Andrews based on referral from his PCP. Since Mr. Andrews was already with our plan, it may be that we attempted to complete a HRA several times, but were unsuccessful, so a High Risk Case Manager (HRCM) could not be assigned. In the absence of an HRA or other points of entry like the DM referral from his PCP, we use the following **systemic processes** to bring Mr. Andrews to our attention much sooner:

- ***Proactive identification and HRCM program assignment:*** Proactive identification resources that help us systematically identify members for HRCM are: (1) HRAs; (2) SECA report seeking members with two or more IP admits or four or more ER visits in the previous 6-month period. The report includes the raw number of unique adverse episodes (ER and IP); (3) health risk score from Impact Pro, our predictive modeling software tool; (4) reporting that shows if the member is engaged in case management services; and (5) Risk of Readmission Assessments (RRA) conducted on members prior to discharge. Each month members are preemptively referred for HRCM outreach and assessment when they are triggered through this combination of data.
- ***Monitoring ER visits:*** Beginning in 2009, we receive nightly ADT files from many hospitals in Pima, Maricopa and Yuma counties. We are engaged in ongoing efforts to expand reporting hospitals statewide. Currently there 28 facilities that report ADT data, indicating which of our members has been discharged from the IP or ER setting the day prior, the reported diagnoses, time of visit and disposition at the time of discharge. This IP and ER discharge data is transferred each morning to our Accountable Care Communities (ACC) practice Accountable Care Population Registries. We have 12 ACC practices, encompassing 64 physical health clinic sites and six integrated physical/behavioral health sites in three counties caring for approximately 75,000 members. Our community-based clinical partnerships provide quick, local and accountable care outreach activities. The ACC practices use our Population Registry daily to see every instance of members in the ER and outreach to these members engaging them to schedule a follow-up care visit within seven days. For all members receiving their primary care at non-ACC practice sites today, this ADT data is sent to our health coach CM staff that, using an auto dialer system, makes outreach calls to help re-engage members with their physicians. Whether Mr. Andrews' PCP belongs to one of our ACC program practices or not, there is a strong likelihood we would have actively engaged him into care and HRCM in a 'real-time' manner after his first ER visit and any subsequent ER visits he may have had.
- ***Monitoring IP events:*** It is likely that Mr. Andrews has been admitted to an acute IP facility when he suffered from one of two acute MIs and required stent placement. Our utilization management (UM) RNs perform IP utilization of members admitted to an acute care facility. During the concurrent review process, the UM RN completes a RRA to determine the acuity score and provide insight into the members with the highest risk for IP readmission or ER admission post discharge. Based upon the RRA score, Mr. Andrews is referred to discharge care managers (DCM) to provide additional support while in the acute care facility while making sure the discharge plan is in place for Mr. Andrews at the time he is ready to be discharged. One specific goal for all admitted members is to have an appointment scheduled with their PCP prior to leaving the hospital, which will take place within seven days of discharge, and the UM RN/DCM team follows-up to ensure that visits occur. Home health service needs are assessed, durable medical supplies and discharge treatment settings are reviewed to make sure he has the most comprehensive discharge plan in place. The UM RN and the DCM contact Mr. Andrews' treating provider to make a post discharge appointment for him pre discharge. The date and time of the follow-up appointment with the provider is given to him prior to discharge.

Summary

We recognize that Mr. Andrews has a complex set of health conditions and anticipate that our comprehensive interventions and provider engagement will stabilize them, allowing him to thrive independently and begin the steady process of improving his overall quality of life. Our consistent and robust process of identification of at-risk members and effective comprehensive member engagement and needs assessment, complemented by these advanced programs, ensures we employ a holistic approach to improve health care outcomes for Mr. Andrews and other members like him.

5. George Robertson, a 29 year old AHCCCS member, was involved in a motor vehicle accident on…

Overview

Mr. Robertson, a 29-yr old Acute AHCCCS member for the past five years and a UnitedHealthcare member, was unfortunately in a motor vehicle accident (MVA) on March 1, 2012. Mr. Robertson was treated for 21 days and discharged to home; however he was subsequently readmitted. This entire episode of care resulted in, or contributed to, the following acute and post-acute health care issues:

- Traumatic femur fracture and sternum injury, status-post open reduction internal fixation (ORIF)
- General mental health/substance abuse (GMSA) with partial treatment and potential active relapse
- Socioeconomic challenges that place his short and long-term health recovery goals at increased risk
- Recurrent sustained injury from a fall, resulting in fractured ribs and traumatic brain injury (TBI)
- Potential legal consequences connected to suspected illicit drug possession and use
- Challenges navigating the health care delivery system due to his unique special needs which bridge the behavioral and physical health systems under AHCCCS and the Arizona Department of Health Services

To fully address complex care needs like Mr. Robertson's, our interdisciplinary clinical care coordination team takes a consistent and comprehensive evidenced-based approach to care delivery. We base care coordination on actionable data, active communications and defined responsibilities. **Our systemic process to improve his health care outcomes is based on the six health home service elements essential to providing an effective, integrated, interdisciplinary care plan using team based strategies, including:** (1) comprehensive care management; (2) care coordination and health promotion; (5) comprehensive transitional care from inpatient to other settings; (3) individual and family support; (4) referral to community and social support services; and (6) the use of health information technology to link services. Below, we will describe his coordinated care across the continuum.

Health Home Service Elements

(1) Comprehensive Care Management and (2) Care Coordination and Health Promotion – While Hospitalized

"Acute" Assessment of Individualized Care Issues for Mr. Robertson

Mr. Robertson enters our care coordination delivery model as result of an MVA, where the influence of illicit substances and unmet treatment/recovery needs are contributing factors. Arizona General Hospital (AGH) notifies our intake department 24/7 via a singular phone/fax or web-portal. The ease of our systems and long-standing hospital relationships across our health plans (Acute, DD, CRS, D-SNP, Commercial, Medicare) enables timely notification of Mr. Robertson's admission, allowing for clinical coordination to begin within 24 business hours. Our intake department builds a case in CareOne, our integrated clinical management system, and quickly issues AGH a notification number. CareOne provides all those who ultimately engage in Mr. Robertson's care full access to complete information regarding his care. A specialized unit verifies his member and insurance information (AHCCCS eligibility, coordination of benefits (COB) and third-party liability (TPL)) for accuracy and completeness, ensuring that we and the hospital have correct data. This unit will initiate a possible TPL case due to possible accident insurance. The case is then electronically tasked to Mary Renee Prendergast, who has more than 33 years of RN and 19 years of UM/CM experience, the assigned hospital utilization management nurse (UM RN) on our Integrated Care Coordination Team (ICCT) for AGH.

Mary receives a daily census from our Blended Census Reporting Tool where she can monitor and track Mr. Robertson's admission and initiate concurrent review within one business day. Mary, like all our UM staff, is an Arizona-licensed RN with extensive clinical experience, who undergoes regular training and inter-rater reliability testing. She meets Mr. Robertson at AGH, completes a clinical assessment, begins to engage support from team members (e.g., discharge planner; Behavioral Health Coordinator (BHC), Stacey Hochstadter, LCSW; and Medical Director, Dr. Guy O'Conner) and reviews his case during ICCT daily rounds. As soon as it is appropriate during his 21-day admission, Mary will complete a Readmission Risk Assessment (RRA) and actively plan for his discharge, minimizing length of stay while establishing an effective outpatient care plan. These steps are critical to uncover

information that will impact Mr. Robertson's safe and timely discharge to the right level of care following stabilization and acute IP treatment.

Prior to discharge, Mary and the ICCT assesses his needs, including reviewing the most appropriate level of care (e.g., skilled nursing facility (SNF) vs. home with support services). During interdisciplinary rounds, Mary collaborates with the ICCT Discharge Care Manager (DCM), Sindey James and Stacey. Stacey, who has established relationships with the Regional Behavioral Health Associations (RBHA), contacts the Maricopa County RBHA liaison to confirm whether Mr. Robertson is currently receiving services, identifies the assigned SA behavioral health provider, *Community Bridges*, and contacts the clinic to involve appropriate staff in conjunction with our RN and Sindey. For members like Mr. Robertson, who are already engaged in services through the RBHA, we discuss options, such as a pre-discharge psychiatric consultation, medication review and a predefined follow-up after his discharge. As the initial discharge date approaches, Sindey works directly with our BHC/RBHA, specialists, his assigned PCP, Dr. Paulson, and the facility to ensure the following needs are securely addressed: (1) Arrange appointments with Dr. Paulson and specialist(s) within 7-days; (2) reestablish an RBHA appointment, agreed to by Mr. Robertson and the RBHA; (3) review discharge instructions/medications and arrange transportation, home health, DME or other needs; and (4) based on his RRA score, assign a post-acute Transition Care Manger (TCM), Cindy Cunningham, to follow-up in less than 48 hours to complete a medication reconciliation and ensure post-discharge appointments are kept. Cindy follows Mr. Robertson for two weeks and meets his transition care needs, but recognizing that he has long-term high risk needs, she does a warm transition of care to our RN high-risk care manager (HRCM), Colleen Laffey. Colleen becomes Mr. Robertson's lead HRCM to address his ongoing care management needs.

(5) Comprehensive Transitional from Inpatient to Other Settings – Hospital to Home

These coordinated steps will fully assess and meet Mr. Robertson's immediate acute transitional care needs, but this is only the beginning. The information indicates to our clinical staff that Mr. Robertson is at high risk for readmission and other needs/concerns remain. We support his care transition, like that of other similar members, by close hospital engagements and a member-centered approach that assesses longer term needs related to functional abilities, medical conditions, behavioral health and existing support systems, including:

- Mr. Robertson will not only have set 7-day post-discharge appointments, but we make efforts for records to be provided in a timely fashion so that follow-up care will be effective and that appointments are kept.
- Our BHC, Stacey, will follow up with Mr. Robertson to confirm that his follow-up appointment with the outpatient behavioral health provider or intake appointment is kept. She will help him identify a substance abuse support group he may benefit from participating in. She will also help make sure medical records (as permitted by law) are transferred between behavioral/physical providers.
- If Mr. Robertson is not established with a PCP, Cindy will help him to become established with a PCP who can best meet his needs. Our TCMs work closely with our Accountable Care Community (ACC) practice consultants and RN care advocates to link him with a high-engaged ACC practice (with whom we have begun establishing integrated physical and behavioral centers of excellence).
- Cindy will address transportation and ensures that Mr. Robertson is released to a safe and secure environment by questions prior to discharge about his home environment (and if told would assess as unsafe).
- Given the high risk, Cindy ensures our Home Health agency comes to see Mr. Robertson to assess his safety and fall risk (which is high), equipment needs, provide any home-based therapies ordered for recovery and addresses any needed authorizations or alternative placements (e.g., a SNF if the home environment presents too great a risk which would be the case given his injury and the 2 flights of stairs).
- Cindy will conduct medication reconciliation, enlisting support from our Pharm-D, Sandy Brownstein, when needed.
- Our leadership teams meet for quarterly Joint Operating Committee (JOC) meetings with key stakeholders, like hospitals and those who provide Home Health or Transportation, holding us all to higher accountability standards and collaboratively addressing opportunities to improve care delivery.

Potentially Avoidable Adverse Event: Readmission for Mr. Robertson

Four weeks after his initial discharge, Mr. Robertson was unfortunately found at his Phoenix area apartment in possession of illicit substances. We believe that the processes our team put into place and described above, such as both a hospital prior discharge functional assessment and a post discharge face-to-face function assessment, will help avoid this adverse event and avoid paramedics having to be called to rush him back to the ER. However, upon notification of the readmission, all clinical staff assigned, including his previously-established HRCM, Colleen, to Mr. Robertson's case within the past 60 days are notified via the CareOne system so the care team may begin assessing, planning and implementing a new strategy. Mr. Robertson, who already faced a challenging recovery, is re-hospitalized for four days and diagnosed with a new head injury, later classified as a TBI. He also sustains broken ribs from the fall down a flight of stairs, putting him at risk for a longer recovery period and for new post-acute comorbidities, such as pneumonia or any complications related to the ingestion of illicit drugs.

In addition to supporting his care, we train the UM RNs to report readmissions that may have been avoided. If the Dr. O'Conner and the RN agree that Mr. Robertson's readmit was avoidable they refer the case to the quality management (QM) department to investigate whether the discharge placement process fell short or missed key risk factors, making home discharge unsafe. From a QM perspective, our processes self-monitor/self-regulate discharge and placement processes for members, but an independent QM RN analysis will be triggered based upon the QM referral. Ultimately the circumstances will be summarized and discussed with our Chief Medical Officer (CMO), Dr. Stephen Chakmakian, D.O. We use defined tracking and trending policies, procedures and systems to document all such QM investigations, as well as leveling. Any case which exceeds level (level 0-1) quality of care (QOC) concern will be presented to the plan Provider Advisory Committee (PAC). The PAC is a robust peer-review committee with community and hospital-based clinicians that ultimately supports all efforts to improve QOC across the continuum.

It is not immediately clear that Mr. Robertson is readmitted to the same hospital, therefore the need for data sharing and integrated care teams may carry additional significance. We believe that Mr. Robertson and others like him will be treated with greater specificity at lower cost if his records of care are available to treating physicians. For this reason, much like our data sharing technology with practices through the Accountable Care Population Registry, we have invested in the upcoming health information exchange (HIE) in Arizona, the electronic movement of health information among organizations. As the Health Information Network of Arizona (HINAz) implements the statewide HIE network based upon the HIE platform from UnitedHealth Group, it will enable the sharing and exchange of clinical data from all available sources across the State though a web-based virtual health record. When Mr. Robertson's physicians conclude he has a new diagnosis of TBI, despite his recent MVA and underlying SA, they will have greater diagnostic confidence and consider the additional value of neuropsychiatric and behavioral health service involvement.

With our ICCT actively reengaged, they identify from Care One data that Mr. Robertson already has 21 paid IP days this year and as a courtesy, verbally notify hospital CM staff that his annual bed day limit is approaching. Mr. Robertson is fully reassessed during his readmission, additional steps not initially considered or taken will be developed and pursued, and an alternative LOC is discussed using Milliman Care Guidelines (MCG). This would be a long-term acute care hospital or high-level SNF capable of meeting his new needs. Ann, our Post-Acute Team (PAT) RN, who supports the ICCT in SNF reviews and placements, requests an interdisciplinary meeting with his treating physician(s) and therapists (physical/speech/occupational; facility nursing; social services; nutritional representative; Pharm-D; Sandy Brownstein; and BHC, Stacey) to discuss/develop short-and long-term goals and a revised treatment plan. Mary will also speak with Phyllis, our internal Long-Term Care (LTC) Coordinator, to begin the process to see if he may qualify and benefit from ALTCS enrollment. Phyllis assesses and helps fill out a LTC application during the readmission. Based upon Dr. O'Conner's review and recommendations from his treating physicians, Mr. Robertson is deemed a good candidate for a non-PAR SNF that specializes in TBI or specializes in treating members with behavioral and substance abuse conditions needing specialized care.

Non-Participating Skilled Nursing Facility: Chosen for TBI Expertise

We have a large network of facilities and Cindy has knowledge about contracted SNFs willing, able and capable of providing the specialized services required for Mr. Robertson. In the unlikely event a non-PAR SNF is needed, an authorization to cover payment for services will be generated by the RN, assuming the SNF accepts default AHCCCS rates. If the non-PAR SNF will not accept an authorization, our clinical and network staff has a well-defined process to

develop either a Single Case Agreement (SCA) or quickly initiate full contract discussions. Mr. Robertson's care will never be compromised while an agreement is made.

Once in the SNF setting, care coordination follow-up is conducted by Ann, who will continue to follow-up with Mr. Robertson as he progresses and meets milestones during his skilled placement. Our RNs and medical directors will follow-up to confirm his needs are continually reassessed and met, and that the SNF length of stay is of appropriate duration. The team will preemptively plan for a safe discharge in the same fashion as our ICCT will when members discharge from hospital to home. Cindy will again support all the key elements to establish a safe discharge, as defined by our clinical PAT team, the SNF and any treating providers. Given the sequence of events leading up to this point in care for Mr. Robertson, additional considerations will be developed prior to and post-discharge, based upon his unique individual needs.

Health Home Service Elements

(1) Comprehensive Care Management and (2) Care Coordination and Health Promotion – Community-Based

"Post-Acute" Assessment of Individualized Care Issues for Mr. Robertson:

Greatest setback risks/challenges and proactively addressing these concerns

Having become familiar with Mr. Robertson from admissions and input from RBHA staff, he is currently characterized as resourceful and has knowledge of health care system services and benefits available to him. Mr. Robertson is of average intelligence and completed high school with one year of community college, demonstrating that he can complete challenges and set goals, responding well to 1:1 supervision. However, he has also demonstrated a higher than average risk to incur serious physical trauma and readmission, influenced by his overlying behavioral health/SA struggles. In addition to these facts, he now faces greater long-term recovery challenges as a result of the TBI, coupled with what appears to be an unsafe living environment, poor social support system and a risk of legal action due to possession of illegal substances. These physical and behavioral health needs must be met by collaborating across the AHCCCS and RBHA delivery systems.

***1. Incomplete participation in outpatient SA treatment in the past - Discussion and Plan*:** Left untreated, SA puts him at higher risk of readmission, as evidenced by recent events. Stacey will remain partnered in care coordination with RBHA staff to ensure Mr. Robertson engages in outpatient SA services while identifying and eliminating barriers or obstacles. She will work with the RBHA and Mr. Robertson to find out what may have worked best in the past and what did not (related to his obtaining treatment), providing him with the understanding and resources to better develop a relapse prevention plan that incorporates the names and phone contacts of individuals and agencies to contact in a crisis. She collaborates with Dr. Paulson and RBHA to help ensure co-morbid behavioral conditions are considered and assessed as part of a whole-person approach. If he declines SA treatment or referrals, she will work with Dr. Paulson and behavioral health prescriber on other interventions to minimize as much as possible his obtaining controlled medications at multiple prescribers or the ER. She will request the RBHA assign a case worker to accompany him to behavioral health-associated appointments, as needed, and remain in contact with Dr. Paulson to help coordinate records between the physical and the behavioral clinicians. The team will work with Mr. Robertson to help him understand the impact of his drug use on his current medical condition and precautions that need to be taken going forward. **Desired Goal/ Outcome:** Keep Mr. Robertson on an outpatient path to recovery and reduced habitual risk of ongoing SA. Simultaneously approach and address his physical health needs and GMH/SA risks, in one plan of care. Acknowledge that his bodily injuries may heal, but with new TBI pathology and a habitual risk of ongoing SA, an integrated wellness with compliance to GMH/SA recovery is critical to success.

***2. Short and long-term recovery challenges due to TBI − Discussion and Plan*:** Cindy can determine at any point in the first 30 days post discharge that Mr. Robertson needs ongoing high-risk case management and transitions care to our HRCM, Colleen. She will follow-up on potential new benefits (e.g., ALTCS and/or SSI) as a consequence of his TBI and promote a strong primary care relationship through Dr. Paulson or by guidance to a specialized and highly engaged accountable care practice. Colleen collaboratively partners with all care givers, including Dr. Paulson, to develop achievable medium and longer-term care plans, until his care needs are sufficiently met as defined by Mr. Robertson, the RBHA and Dr. Paulson. Colleen will ensure that he receives the right type of care, at the right time and

in the right location, including non-PAR placement and payment coordination. A referral for Mr. Robertson will be made to the Brain Injury Alliance of Arizona which is a non-profit, State-wide organization dedicated to enhancing the quality of life for people with brain injuries and their families by providing community support to members with TBI. Cindy will follow up to make sure an appointment is scheduled at the location closest to his home. **Desired Goal/ Outcome:** Help Mr. Robertson at this stage in his life to maximize his recovery potential by providing the greatest opportunity and the tools to do so. Help Mr. Robertson to make choices for a healthier life-style by focusing in on his strengths and achievements and providing him with the knowledge, tools and support necessary.

***3. Physical health care follow-up: Discussion and Plan*:** Generally, there are increased risks for compliant and full follow-up care regarding acute and chronic injuries or illness. Mr. Robertson has been identified at higher than average risk, compounded now by cognitive impairments. Colleen will help him coordinate with home health, transportation services, ancillary clinicians (e.g., physical therapy), Dr. Paulson and specialists to better ensure follow-up care required for his core physical ailments, the ORIF, sternum injury and fracture ribs and internal bleeding.

(3) Individual and Family Support and (4) Referral to Community and Social Support Services

***4. Safe living environment, limited family and social support networks and potential legal consequences stemming from possession of an illicit substance − Discussion and Plan*:** Due to Mr. Robertson's TBI, Ann will ensure an assessment is conducted to determine if he is able to return to an independent setting. She will identify any support systems Mr. Robertson may have in place and include them in the discharge planning process. Upon Mr. Robertson's consent, community care givers, such as friends, neighbors and family who may be caring for him, are included in the treatment plan and care coordination efforts. If he is deemed capable of returning home with support services, we will pursue a ground floor living request and initiate a home safety evaluation**.** Stacey can also coordinate with the RBHA who may be able to assist with housing needs if necessary. Colleen will provide Mr. Robertson with up-to-date direction to community-based resources using our proprietary *UnitedHealthcare Community Services Connect*, an innovative web-based tool with a resource library of community support agency information. The Arizona database includes community resources and services grouped into nine categories: clothing; financial assistance; food; housing; job placement; language; legal services; transportation; and youth service. Organizations included in the database will be vetted through web-based research, phone calls, and input from the local marketing team and the database will be reviewed and updated on a regular basis. **Desired Goal/Outcome:** Empower Mr. Robertson to achieve the highest level of functioning, providing him with safe living alternatives, helping him to develop a social support network, ensure he understands his medical status and consequences if left untreated and provide legal resources and support to address possible drug charges.

(6) Use of Health Information Technology to Link Services

In addition to CareOne supporting a centralized care plan, available to Dr. Paulson via our Provider Portal; our reporting capabilities between the health plan and hospitals; the Accountable Care Population Registry; HIE Virtual Health Record viewer which supports clinical record sharing with providers; and the many decision support tools used by the care coordination team, we also have an internally-developed secure application for smart phones called **LifeLens**. This technology is being piloted for LTC in Tucson. It allows our field staff to film, store and forward video of a member's physical and psychological behavior and/or living conditions for a higher level review. A UnitedHealth Group patient portal is used as a repository for collected videos. The application and patient portal are both IRB approved, secure and HIPAA-compliant for privacy. The clinical team uses the video to observe and assess the member in their living environment. The clinical team reviews the video to identify barriers and develop potential solutions to reduce member risks in their home.

Summary

Our integrated care team represented by Cindy, successfully coordinates the complex care needs for Mr. Robertson, and members like him, as they move through the continuum of care where optimal care transitions are critical to our success. Our member-centric coordinated approach with Mr. Robertson proactively assesses his health and behavioral status and individual needs regardless of disability, condition, age, functional and cognitive ability, race/ethnicity or gender, cultural background or eligibility category. We help Mr. Robertson achieve the best possible outcomes and reduce the risk of future adverse events with support from established community partnerships.

6. Describe the Offeror's experience in Medicare Advantage and/or Medicare Special Needs Plans…

UnitedHealthcare Community Plan has been supporting AHCCCS programs for 30 years, including providing D-SNP services since 2006. More of Arizona's D-SNP members choose us than any other health plan. We have been the ***choice*** of **more than 29,000 D-SNP members (43 percent of Arizona's D-SNP members)** and more than 200,000 in other Medicare products/programs Statewide. Today, we provide multiple state-funded health care programs for Acute, CRS, ALTCS and Medicare-Medicaid D-SNP eligible populations and we intend to participate in the Dual Eligible Demonstration should AHCCCS choose to pursue that route. Led by our CEO, Kent Monical, our local team has demonstrated experience and responsibility to perform the requirements associated with this Solicitation (YH14-0001).

Performance – Serving the Needs of Arizona

We serve more than one million members, including 154,000 MA and SNP, 29,000 D-SNP and 8,200 LTC members.

Our Arizona experience is backed by an extensive national footprint serving populations similar to those in the AHCCCS program. We have **provided Medicare services for 25 years** and **serve 2.75 million Medicare members in 49 states (we serve one in five Medicare beneficiaries),** including **241,727 D-SNP members in 29 states; 138,305 Institutional and Chronic/Disabling Condition members in 25 states; and 2,367,000 MA members.** Our national policy and program relationships, depth and breadth of experience and geographic and demographic diversity of populations served provide us with significant national relationships that we can successfully leverage to assist Arizona in influencing the future direction of state and federally funded health care improvements.

We will **seamlessly manage all transitions** resulting from this solicitation and stand ready to work with AHCCCS to ensure the changes are understood by our member and provider communities. We believe this transition represents an opportunity to bend the cost curve and improve outcomes for members, health plans, providers, AHCCCS, the federal government and taxpayers., Our ability to successfully serve dual eligible or MME members is dependent on the following key UnitedHealthcare processes and member and provider benefits:

- ***Full program alignment availability for D-SNP members*** provides the greatest potential for effective coordination of care, improving health outcomes, controlling cost and avoiding unnecessary duplication of services. CMS has approved our D-SNP to accept D-SNP enrollment in 14 of Arizona's 15 counties. We have submitted a Notice of Intent to CMS to expand to Gila County for January 2014 enrollment.
- ***Community partnerships*** include Accountable Care Communities (ACC) and FQHC partner providers. We have worked to expand the AHCCCS Acute program relationship with these providers including the D-SNP program. Our long-term partnerships with ACCs and FQHCs Statewide (25 percent of D-SNP members paneled to ACC and FQHC partners) have contributed to improvements in quality and care coordination. We are in active discussions with ACCs to reward positive outcomes and health status improvement making sure the provider network is established and meets the needs of the D-SNP members under both their Medicare and Medicaid benefits.
- ***Successfully identifying those members that are D-SNP eligible*** and making efforts to maintain a high level of alignment within UnitedHealthcare. Upon enrollment we identify those members that are D-SNP eligible and appropriate cost share rules and care flags are registered in our enrollment, claims and care coordination systems.
- ***Coordinating care internally*** (fully aligned D-SNP members) or with their Medicaid plans and providers if not fully aligned. Once enrolled, our D-SNP members receive a risk assessment from which we determine health and case/disease management needs and development of appropriate care plans.
- ***Accurately administering benefits according to the members' alignment*,** including claims payment. Upon incurring services, we adjudicate claims based on cost share rules and enrollment alignment status (only one claim from the provider is necessary when a member is fully aligned and communication of the Medicare primary claim status is supplied to the provider when the member is not fully aligned).
- In both care and claims coordination, **systems and processes are in place to make sure appropriate communication occurs with the providers involved in the care of the member** as well as the other health plans in which the members are enrolled with the intent of minimizing duplication of, and disruption in, care.
- Supplemental Benefits play an integral role in motivating dual eligible beneficiaries to choose to move from Medicare FFS and our carefully chosen Supplemental Benefits have played a key role in our ability to continue our growth and are a primary reason that Arizona D-SNP enrollment leads the nation.

As the state and national leader in Medicare Advantage and Medicare Special Needs Plans, we are prepared to help Arizona improve its national leadership role in coordinated management of the dual eligible population. Throughout this section we present our innovative, coordinated and integrated network management, member services/satisfaction and medical management/coordination processes and strategies that provide person-centered approaches to better coordinate care for D-SNP eligible individuals and improve member experience. They include: providing evidenced-based quality of care; successfully managing the multiple AHCCCS program alignments resulting from this procurement; sensitively handling members with special needs with our comprehensive coverage; commitment to member choice with assistance to navigate complex multiple systems; and educating and credentialing providers.

Processes to Enhance and Maximize Care Coordination

CMS establishes Model of Care (MOC) elements and standards from which health plans develop their MOCs that identify how they will be met. Through collaborative work with CMS and based on our expertise meeting the medical/behavioral health care needs of the Medicare-Medicaid population, we have developed industry-leading MOCs that have regularly exceeded CMS requirements. If AHCCCS elects to proceed with the Demonstration, we understand that our MOC will change. We continue to refine our D-SNP MOC and our Medicare-Medicaid Demonstration MOC recently received a **full 3-year CMS approval and a score of 95 percent** in meeting the 11 CMS elements in the State of Ohio Demonstration submission, where we were successful in winning a bid for its 2013 Financial Alignment Demonstration program.

Innovation – Concierge Unit

Dedicated, Arizona-based staff conducts risk assessments, updates member information and assists members with questions about benefits and providers. They receive geographically aligned calls, providing "local" expertise. The staff conducts 500-600 risk assessments and handles 5,800 calls monthly and has an average tenure of 3.8years.

Our D-SNP and Demonstration MOCs use a **holistic, consumer-centered, continuous care model with a focus on care coordination** for those most vulnerable. The MOC drives case management and is the basis on which we build each member's care direction. Recognition of and integration/coordination of behavioral health needs has long been and remains a critical component of care coordination efforts. The D-SNP MOC process begins at enrollment via the completion of a telephonic Health Risk Assessment (HRA). We enter HRA findings into our CareOne centralized care management system and use them to assess members' needs, develop the interdisciplinary plan of care and provide the determination of appropriate evidence-based interventions (e.g., health promotion and wellness activities, health risk management and care coordination advocacy through disease and case management) and corresponding member self-care education. Throughout the year we monitor gaps in preventive care and disease management and resources/interventions deployed based on gaps determined, (e.g., breast exams and annual primary care physician (PCP) visits).

We use multiple contact points to help members access necessary services, including: clinically oriented calls (High Touch Call Team); in-home assessments for members with multiple gaps in care and more intensive diagnoses; case management referrals and stratification (devoting resources as determined by case management determined needs); mail and telephonic contact with members offering assistance in obtaining/scheduling services; personal care assistants available to all of our D-SNP members (Concierge Unit) to help them understand their benefits, find participating providers, schedule appointments and ensure each member has their needs met.

Through our MOCs and our care coordination activities and programs, we have improved outcomes for members. Our 2013 STAR scores show we incur the **lowest rate of readmissions of all full D-SNPs in Arizona**. We clinically review prior authorization for elective services from a Medicare benefits perspective and direct approval/denial decisions to a Medicaid review/notification process if the beneficiary is fully aligned or to the requesting provider for pursuit of the beneficiary's Medicaid plan if not fully aligned. Throughout all these processes, members' PCPs receive input advising them of their members' gaps and results of interventions. **Integrating and coordinating care for the dual population is driven by the MOC but is enhanced by other activities within the organization, including**:

Member Services: we have centralized the customer service function with calls routed to appropriate staff based on the member's needs, including differentiation between Medicare- and Medicaid-related issues. We cross-train customer service staff in both sides of the D-SNP member's coverage. **Grievance System:** we have structured the grievance process to receive grievances and route them, based on the primary payer, to specialized staff based on the

grievance type (e.g., Medicare-related grievances are routed to grievance staff fully trained to process Medicare-related grievances). **Quality Management:** we have fully integrated quality management functions for Medicaid and Medicare. Our Quality Management Committee and board will monitor and report on all CMS-required actions and reporting for quality functions, including functions associated with credentialing, quality of care investigations, health plan employer data and information set reporting and interventions, chronic care improvement programs, quality improvement programs, MOCs and Medicare Consumer Assessment of Health Plans Study. We have detailed plans to continue to improve our current 3.0 STAR rating. **Corporate Compliance:** these activities are centralized in UnitedHealthcare wherein all AHCCCS-related and CMS-related compliance requirements are monitored and reported from a single resource, on a local, Arizona-basis, as well as nationally. This allows us to maximize attention to compliance requirements and ensures ongoing adherence to program (Arizona and CMS) compliance requirements. **Medical Management:** Functions related to the approval, review and ongoing administration of health benefits is consolidated within UnitedHealthcare ensuring maximum coordination between Medicaid and Medicare benefits. Prior authorization and concurrent inpatient review programs are managed from a primary payer perspective and coordination of benefits rules are utilized in managing ongoing health services usage for those Medicare-eligible members that are enrolled with UnitedHealthcare for only their Medicaid benefits. **Provider Network:** A key to our success is establishing and maintaining long-term, diverse and positive relationships with our provider network. We monitor our network to make sure our PCP and specialty providers are available and accessible to members regardless of their location. Our network includes more than 14,000 providers that participate in one or both of the Medicaid and Medicare products. **More than 99 percent of our D-SNP physician providers also participate in our Medicaid programs** and more than **90 percent of Medicaid physician providers also participate in our D-SNP program** (contracting efforts are underway to fully align the remainder of the network).

We are a proven leader in satisfying our members as evidenced by our low (0.79 percent per month) voluntary disenrollment and year-over-year voluntary retention of more than 90 percent. We recognize the need to accommodate new members through this contract and our provider network is positioned to support double our current enrollment in Arizona.

Relationship – High Member Satisfaction

Experience and flexibility results in high member satisfaction and a low voluntary disenrollment rate (0.79%/month).

D-SNP and Demonstration Benefits for Providers

Whether under a D-SNP or the Demonstration approach, providers face challenges and confusion navigating a historically fragmented system. Our D-SNP program has established several processes to help providers navigate the unique needs of the dual eligible population, including: **(1)** Members select their PCP on enrollment and may change PCPs at any time. During the HRA we confirm the member's PCP, ensure the member knows how to contact their PCP (noted on the D-SNP member ID card) and help the member schedule an initial appointment with the PCP; **(2)** Providing continuous PCP communication, in addition to referral and claims services, in an effort to make sure PCPs are aware of the care needs of the members. For example, we provide multiple notices to PCPS of the need for various health screenings, such as breast and colorectal exams. Using our Provider Portal, PCPs can determine the status and outstanding gaps in care for their members; **(3)** Providing PCPs with a Patient Assessment Form that helps them determine their members' screening and diagnostic needs based on the member's clinical and claims history. Our incentive program motivates providers to submit the forms and, in 2012, PCPs submitted nearly 5,000 forms; **(4)** Conducting chart audits and providing PCPs with results/recommendations on care gaps cited for ongoing care needs; and **(5)** Establishing an In Home Assessment program for members with multiple gaps in care to ensure timely access to needed screening and diagnostic services. We serviced more than 100 members in the last two months of 2012.

Promoting efficiencies and alleviating administrative burdens for providers is critical to maintaining adequate networks and access to care. In the integrated system under this Demonstration, plans will administer a single, fully integrated benefit plan and structure. As with fully aligned D-SNP enrollment, providers will not submit cost share claims to a second Medicaid plan. Providers will work with a single plan to secure prior authorizations, manage hospitalizations and establish an appropriate medication regimen, reducing the potential for service duplication and lack of coordination potentially present under the current bifurcated approach to separate enrollment and plan selection.

Members Served by Medicaid Only

Our approach to care management and coordination does not differ with this population and we have established systems to coordinate our Medicaid-only members' benefits, services and claims with their PCP. For example, through our Provider Portal, PCPs can view and add comments to the member's CareOne care plan. The member's case manager can review and respond to the PCP's inquiry. We have developed our systems and processes, including enrollment, benefit management and claims, with the ability to maintain line of sight to the presence of members' primary payer (Medicare FFS, another MA Plan or D-SNP or our own D-SNP) and communicate with the provider community and the various plans on matters of coordination of benefits and benefit authorizations.

Improving Member Experience for both Medicare and Medicaid Services

Improving the D-SNP member experience starts with our focused sales efforts recruiting qualified dual eligible beneficiaries. It continues as our Concierge Unit guides members through enrollment, multiple programs and benefit structures, HRA, accessing and coordinating services and case management/disease management referral, regardless if they are fully aligned for Medicare and Medicaid services through us or only accessing our D-SNP Medicare program.

Overall member satisfaction is evidenced by nearly 23 percent of our dual membership being located in GSAs in which we are not a Medicaid option for members. These 6,300 D-SNP-eligible Medicare members made a conscious decision to select us despite not currently having access to an AHCCCS Medicaid plan in their county. To support integration, preserve our members' choice and minimize member disruption, we are adding Gila to our 14 existing counties. Continuous improvement of the member experience in all of our programs plays a significant role in our success. D-SNP eligible members that lose their AHCCCS eligibility are permitted to remain enrolled in the Medicare program for up to six months, providing them the time to determine an appropriate direction to meet their health needs.

Based on a comprehensive member engagement approach to help members manage their medical and behavioral needs, our MOC focuses on fully aligning the member's coverage (Medicare and Medicaid) with fully aligned assessment of their needs and full alignment of the health services required by them. We have developed an enhancement to our MOC for the Demonstration that establishes a ***health system navigator*** assigned to each Demonstration member early in their onboarding. Utilizing Concierge Unit's approach to assigning a personal care specialist to each D-SNP member, introduced more than five years ago, the Demonstration MOC uses the ***navigator*** functioning as the hub of member's care coordination – a holistic, person-centered and directed continuum of care focus and a refinement to the front end of the care management process.

The ***navigator*** will navigate the member's direction through the often complicated health system. For example, if the member needs to participate in a disease management program, it is the member's navigator who contacts them to discuss the benefits of the program. The ***navigator*** assists the member in securing vital health screenings and services throughout the year. The ***navigator*** assists in maintaining the member's current contact information (the dual eligible population tends to change addresses or phone numbers at a rate much higher than a typical Medicare population). The level of care coordination is based on the member's needs. Members with low to moderate needs have fewer contacts/touches than members who are high users of services who have more frequent touches. The enhancement to our care coordination process will also include the member's expressed wishes about who should participate in their care team (e.g., family members, PCP and care givers). Community partnerships will be leveraged in an effort to meet the members' medical, behavioral and community needs.

Strategies to Increase/Maintain Aligned Medicaid/Medicare Enrollment

We begin efforts to increase and maintain full alignment of members prior to enrollment at the recruitment and sales process through onboarding activities and throughout the members' enrollment with us, including:

- ***Integrated Medicaid/Medicare Sales*:** Through more than 700 independent, Arizona-licensed agents, we offer our Medicare products to dual-eligible members by contacting age-in Medicaid members and providing educational events. We use quarterly mailings to advise eligible members of the opportunity to enroll in our D-SNP Medicare plan. On those occasions when aligned members lose Medicaid eligibility, we maintain membership in the Medicare plan for up to six months. If members continue to be ineligible for Medicaid, we offer them the opportunity to enroll in the MA program that meets their needs.

- ***Supplemental Benefits complement Medicare and Medicaid*:** Supplemental benefits provide a mix of benefits and services that fill that gap between Medicare and Medicaid benefits, including vision, hearing, dental and the health products catalog program. We review the benefit mix annually to confirm it continues to meet the needs of our members while providing opportunities for members to improve their overall state of health. Historically, higher-demand benefits have been catalog, vision and dental. The supplemental benefit structure under the Medicare-Medicaid Demonstration is largely driven by the adequacy of funding of the combined revenue stream.
- ***Aligned provider network*:** As a standard practice we include all products (Medicare/Medicaid) in our agreements. In addition, our existing network is cross-contracted to maximize the benefits of fully aligned provider networks offered to fully aligned membership. To date, our statewide network is over 90 percent aligned and meets or exceeds CMS access requirements in every county we are approved to offer our D-SNP.
- ***Dual Eligible Demonstration preparation*:** We have amended agreements with our D-SNP network to facilitate MME's goal of full program alignment and serve as the single point of contact for MME members, such as member handbook, claims/health service administration, provider directory, customer service and benefit structure.

Performance – Membership and Full Alignment

Increased membership by 12,000 since 2007, 43% of D-SNP enrolled members are enrolled with us and 70% full Medicare-Medicaid alignment in Medicaid GSA counties.

- ***Claims coordination*:** We identify Medicaid plan affiliation upon enrollment and have established review processes to make sure incorrect coordination of benefits (COB) is minimized. A recent AHCCCS audit has indicated that more than 99 percent of COB claims were adjudicated correctly.
- ***Concierge Unit*:** We maintain a locally operated team of personal care specialists available to D-SNP members for assistance. The Concierge Unit is the precursor and model on which the ***health system navigator*** was built.

As a result of these and other efforts, we currently maintain a 70 percent full Medicare-Medicaid membership alignment rate in our Medicaid GSA counties (Maricopa, Pima, Yuma and La Paz). We are positioned to be fully aligned and grow market share. Our strategies to increase and maintain aligned enrollment include:

- ***Our comprehensive network*** – Our provider network is approaching full alignment with 99.3 percent of our Medicare providers participating in our Medicaid program. We are amending provider agreements and will be complete at the time HSD tables are submitted in February 2013 (agreements are amended to secure participation in the Demonstration with a second phase of agreements to participate once reimbursement rates are known).
- ***Our Demonstration MOC*** – building on the value provided by our Concierge Unit concept, our **Health System Navigator** develops a personal relationship with the member and serves as the single point of contact for all care coordination; our member-centered interdisciplinary care team that is driven by our assessment of the member's needs and the member's expressed wishes about the parties who should participate in her/his care team.
- ***SMI coordination in areas of the state outside of Maricopa County*** – We have developed a statewide behavioral provider network and our MOC will ensure maximum coordination between medical and behavioral needs and the RBHAs and Tribal RBHAs. Often with serious behavioral/ physical health problems, active coordination with the RBHAs ensures the member's behavioral health providers and PCP are in close communication and participate in the member's care and medication regimen.

UnitedHealthcare National Product Branding

To improve member and provider participation we have standardized our national Medicaid-related product identity as UnitedHealthcare Community Plan and the D-SNP identity as **UnitedHealthcare – Dual Complete**. Should Arizona proceed with the Demonstration, we are prepared to participate. ***UnitedHealthcare Connected*** is our national product brand for our integrated care program for the Medicare-Medicaid Financial Alignment Demonstration.

Summary

We recognize the benefits of alignment of Medicaid and Medicare enrollment that the coordination of a member's care is improved, duplication of medical services is virtually eliminated, efficiencies of communication of care needs with members as well as providers is enhanced, and the potential for making sure improved health outcomes and overall health status is increased.

Organization

7. The health care system in the United States is currently on an unsustainable path. The projected…

As a leader in the Arizona health care market, UnitedHealthcare Community Plan is acutely aware of the pressures that rising health care costs place on the people, providers, and state and federal governments. Through our experience over the past 30 years and through communication and collaboration with stakeholders across the state, we know that better outcomes at lower costs can be achieved through care transformation initiatives that yield improved outcomes and lower costs. As demand for high-value health care builds, we face the near-term imperative to transform the way we deliver health care services. We firmly believe the potential for improvement exists. The amount of waste in the health care system provides both the opportunity and the mandate for transformation.

We believe that the **greatest opportunity to reduce waste** in Arizona involves **reducing adverse events (e.g., re-admissions, unnecessary ER visits, etc.), improving access and care coordination for the highest cost members, reducing redundancy in the healthcare system utilization, and assuring that the site of care is appropriate** for member acuity. While we continue to see savings opportunities in provider and member fraud and have outlined those opportunities below, this area does not appear to offer the same savings return potential for the state of Arizona as care model transformation. Additionally, while administrative simplification does present savings opportunities and improved stakeholder convenience, the most significant impact is that it will allow providers more time providing direct patient care in systems aligned with improved integrated care models.

Outlined below are four critical initiatives that have the potential to materially reduce waste within the current healthcare system. The initiatives we have developed are not, of course, of the "one and done" variety. Rather, the initiatives we present here are elements of the overall systemic change required to improve quality and reduce costs. These initiatives are transformational with various components of each initiative already completed or in the process of being implemented. We initially developed these initiatives recognizing the multifaceted and integrative nature of the health care system as well as the fact that dramatic improvements needed will require coordinated and system-wide change. We also recognized the distinct need for collaboration between and among stakeholders to produce effective and sustainable change. Each stakeholder brings different strengths, skills, needs, and expertise to the task of improving the system, faces unique challenges and is accountable for different aspects of the system's success.

The specific initiatives we are pursuing to improve quality outcomes and enhance cost containment are: (1) Continuing evolution of **Integrated Care Models** (consistent with CMS July 10/12 memo to State Medicaid Directors) across multiple communities; (2) **Expanding Access to Scarce Specialty services** in rural markets; (3) **EPSDT member engagement and modernization;** and (4) Moving from **Reactive to Proactive Fraud Management.** What follows is an item-by-item review of the initiatives, a description of the core improvement aim of the initiative, stakeholders whose engagement is necessary for each initiative and specific strategies undertaken to implement each initiative. The strategies are grouped into three categories: foundational strategies (enabling technology), care improvement strategies (processes) and policy strategies (policy, regulations, community alignment) in the tables presented for each initiative outlined below:

1. Continuing Evolution of Integrated Care Models

***Goal Statement*:** Expand our Integrated Care models across multiple communities in the state, with one-third of our membership engaged in an Integrated Care Model by 2016.

Description: Mature **Integrated Care Models** have demonstrated the ability to: (a) accurately identify members at the greatest future risk for an adverse event based on advanced **predictive models** and enroll those members into more comprehensive care management; (b) improve **member engagement and accountability** for their health by combining education with more accessible PCP scheduling; (c) reduce re-admissions and ER utilization through **transitions in care** that reconnect members with their primary care physician within 7-days of an adverse event by coordinating our utilization management processes and each practice's outreach engagement, (d) reduce system redundancy (e.g., duplicative tests and prescriptions) through real-time **provider data sharing**, (e) improve the quality of care for our most vulnerable members by sharing with providers identified **evidenced based care opportunities** that should be addressed as part of the members treatment plan, (f) lower the cost per service of care by **opening**

access to care at the site of services best aligned to the members specific needs/acuity, (g) improve the **integration of services** by connecting the various system stakeholders with common information (e.g., behavioral health intervention when over-utilization is due to behavioral, not medical issues), (h) improve **accountability** of all stakeholders through **continuous monitoring of outcomes against measurable goals**, and (i) demonstrate **sustained improvements** by **better aligning incentives** to the cost and quality outcomes of a population served. Several Integrated Care Models exist (e.g., Patient-Centered Medical Home, Accountable Care Community, Health Homes, etc.) with two common features: (1) a commitment from the stakeholders to ongoing process changes and rapid cycle improvement; and (2) a digital infrastructure and data utilities that support the exchange of actionable information in ways that improve, not disrupt the existing care processes. These foundational elements (enabling technology) for changing existing medical processes are significant. We've listed in the table below the core strategies/foundational requirements that must be deployed, then adopted, and subsequently evolved to maturity. We are deploying and/or adopting, and/or advancing these tools to ultimately **improve access to care, lower avoidable re-admissions, decrease emergency room visits and improve care** for the highest cost members. Concurrent with the deployment, adoption, and maturation of these foundational strategies (care improvement enabling technology), we assure continued full compliance with privacy policies, value based contracting approvals, community support and related AHCCCS policies.

***Timeframes*:** Digital infrastructure deployment (for selective components) has already started, with the Community Care Coordination System and Referral Management integration to follow in 2014. Adoption and maturation of this digital infrastructure will continue throughout the contract period. The Data Utility and Care Improvement implementation timeframes are appropriately aligned (i.e., early deployment has occurred in various components, with additional deployment occurring in 2014 and adoption/maturation occurring through the life of the contract).

***Stakeholders*:** Stakeholders involved in this process include providers, members, community-based organizations, HINAz, AHCCCS and advocacy groups.

Outcomes: The Integrated Medical Model Initiative is a proven means to lower adverse events, (unnecessary ER visits and admissions), reduce re-admissions, reduce redundant system utilization, and improve access to care. We will continue to monitor, measure and report findings from this initiative to all stakeholders involved

Continuing Evolution of Integrated Care Models		
Foundational Strategies	***Care Improvement Strategies***	***Policy Strategies***
1. Digital Infrastructure - Development and Adoption a. Promote eMR adoption b. Population Registry Expansion c. Implement an Automated Comprehensive Care Transitions Tool d. Deploy a Community-Based Care Coordination Cloud application e. Deploy a Community-Based Referral management cloud application 2. Data Utility Development a. Clinical & Claims Repository b. HINAz expansion and adoption	1. Integrated Care Models / Accountable Care Processes a. Risk stratification and evidence-based medicine delivery for the practice b. Comprehensive Care Transition Process c. Provider Data Sharing Processes d. Community Health Worker education and expansion e. Delivery Model Deployments i. Health Homes ii. Medical Homes iii. Accountable Care Communities iv. ACO	1. Value based contracting and reimbursement 2. Privacy and Consent deployment 3. Transparency – provision of practice based scorecards for integrated care 4. Broad leadership engagement with community leaders engaged in Accountable Care Communities 5. Program and metric evaluation 6. Plan-Do-Study-Act Approach

2. Expanding Access to Scarce Specialty Services in Rural Markets

Goal Statement: Improve access to scarce specialty services in rural markets by leveraging newly developed, low cost cloud-based and mobile technologies for telemedicine, telemonitoring and teleconferencing.

***Description*:** Expanding timely access to clinical services using technology closes service delivery gaps in rural areas where specialty provider services are difficult to obtain. These technologies not only improve members' access to services, they also reduce costs by maintaining services in a lower acuity environment. Studies have shown and our first-hand experience confirms that telemedicine dramatically increases access to specialists for members residing in rural and remote areas of the state, resulting in more timely treatment interventions and reducing adverse events. Telemonitoring enables the sharing of diagnostic information, alerting the care team to changes in high cost members' conditions. These early alerts allow the care team to outreach and implement interventions to address the changes in condition before they result in high cost emergency admissions and readmissions. Teleconferencing such as Project ECHO (a Robert Wood Johnson Foundation funded program developed by the University of New Mexico Health Sciences Center School of Medicine), is a transformative model of health care delivery that brings high-quality care to high risk/high costs members wherever they live. Through teleconferencing, a secure virtual environment is created where community-based providers are able to consult with specialists residing in distant, urban areas. Through real-time virtual grand rounds, providers are able to share medical knowledge to expand treatment capacity. This environment allows the providers to create a holistic treatment plan with direct input for all applicable specialists and subspecialists. Through these technologies, we are able to enhance access to services, resulting in improved outcomes and avoiding costly emergency admissions and readmissions. Foundational technologies required to expand access to specialty services include secure conferencing, cloud-based connectivity, mobile applications, and a community-based care coordination system. The adoption of these technologies is dependent on the alignment of appropriate reimbursement for these services.

***Stakeholders*:** We will work with all appropriate stakeholders including AHCCCS, providers and technology vendors to address the adoption of these technologies and the reimbursement issues. We already have had preliminary discussions with the University of Arizona for specialist participation.

***Timeframes*:** We are in the process of deploying cloud-based technology in various areas in the state and will expand the areas based upon contract award. We are also currently piloting the capabilities of mobile technology through our *LifeLens* program and anticipate a more broad scale deployment in 2013/2014. In addition, the deployment of the Community Care Coordination System will occur in 2014, with subsequent adoption and maturation in 2015/2016.

***Desired Outcomes*:** This initiative will drive operational efficiencies by providing specialty services to members where they reside, resulting in more timely treatment interventions and reducing emergency admissions and readmissions. In addition, monitoring alerts through telemonitoring will enable care teams to intervene and implement appropriate care in a timely manner, avoiding costly admissions and readmissions as well as improved care outcomes. The teleconferencing technology will enhance communications among providers, enabling the development and implementation of treatment plans in a timelier manner, resulting in improved outcomes and lower costs.

Expanding Access to Scarce Specialty Services in Rural Markets		
Foundational Strategies	***Care Improvement Strategies***	***Policy Strategies***
1. Broaden access to cloud-based telemedicine infrastructure 2. PCP/Specialist conferencing (i.e., grand rounding) tool 3. Deploy telemonitoring for selected conditions 4. Mobile technology deployment 5. Community Care Coordination System	1. Telemedicine Network and Protocol Deployment 2. Telemonitoring (similar to pilot in Yuma for congestive health failure) 3. Teleconferencing (similar to Project ECHO-Extension for Community Healthcare Outcomes) – we are seeing success in other markets	1. Reimbursement policies related to telemedicine payments

3. EPSDT Member Engagement & Modernization

***Goal Statement*:** Through the deployment of advanced technologies, we will increase member engagement in EPSDT services and reduce administrative burdens and inefficiencies for providers (as well as the health plan and AHCCCS) of the paper-based EPSDT tracking system through electronic data exchange.

***Description*:** EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. The purpose of the EPSDT program has been to discover, as early as possible, the potential impediments that may impact our children and to provide continuing follow up and treatment so these issues do not go neglected. Since one in three U.S. children under age six is eligible for Medicaid, EPSDT offers a very important way to ensure that young children receive appropriate health, mental health, and developmental services. A substantial, robust body of epidemiological and clinical evidence regarding pediatric health risk and treatment standards underscores EPSDT's continuing importance. The EPSDT system has improved our capacity to detect, treat, manage and reduce the impact of chronic physical and mental health conditions that may affect development, resulting in improved health and lower health care costs. Our ability to accelerate improvement in the EPSDT system requires (1) engaging members differently through interactive tools to participate, refer and track their or their children's care; (2) providing more real time monitoring of service to allow for more timely and less costly interventions; and (3) distributing enhanced educational materials to our members with easier to understand explanations. The EPSDT tools are threefold: 1) use of eMR to capture EPSDT data; 2) use an automated referral management tool to generate and track referral recommendations from EPSDTs with notifications to referred service providers; 3) member reward programs using on-line/mobile tools similar to those used in our Baby Blocks™ program. The members enrolled in the program receive rewards for scheduling and attending appointments.

***Stakeholders*:** Various stakeholders involved in the adoption of these initiatives and technologies include members, providers, AHCCCS, HINAz, technology and application vendors.

***Timeframes*:** The digital infrastructure (eMRs, HIE, HINAz, etc.) connectivity is currently being deployed including the use of Direct. We will focus on the accelerated adoption of these technologies during 2013 to 2015. We anticipate rolling out the digital EPSDT tools during 2014 with engagement tools and improved health literacy materials available concurrently.

***Desired Outcomes*:** Current interventions in the EPSDT program are not as targeted and member-specific as they can be with real time data exchanges and referrals are very manual. The current process for completing and tracking EPSDT forms is a manual, labor-intensive process with delays in recognizing opportunities for interventions. With the adoption of eMRs and utilizing the digital interface technologies available through the HIE, EPSDT data can be shared in a more real-time manner, resulting in more efficient and effective EPSDT follow up services and lower overall health care costs. In addition, members with low health literacy have trouble navigating the health care system and following their treatment recommendations. As a result, they are at greater risk for medical complications, experience lower quality of life, and cost the health system significantly more than those with higher health literacy. We are focusing on addressing low health literacy and working to empower members to more easily access, understand and act upon important health information. We are creating EPSDT materials that make it easier for members to better understand their health, navigate their health benefits and adhere to treatment recommendations. Collectively, enhancing the health literacy of our members will assist in eliminating waste of unnecessary services, inefficient care and preventive failures. The modernization of EPSDT tracking will also reduce administrative expenses, increase care outcomes and reduce overall costs.

EPSDT Member Engagement & Modernization		
Foundational Strategies	***Care Improvement Strategies***	***Policy Strategies***
1. eMR 2. EPSDT patient activation tool (like Baby Blocks) 3. Digital Infrastructure (e.g., HINAz & Direct) 4. Referral Management	1. Member Engagement Activities 2. Health Literacy deployment 3. Refined population and patient-specific interventions 4. Referral Management tracking	1. Migration of EPSDT paper forms to digital environment 2. Approval of Member Rewards Program

4. Moving from Reactive to Proactive Fraud Management

***Goal Statement*:** Further enhance our fraud management program to detect and prevent fraud and waste using more real time identification and analysis tools linked with eMR clinical data.

***Description*:** UnitedHealthcare Community Plan currently uses a variety of state-of-the-art data analytic tools to detect fraud, waste and abuse. These processes include prospective data mining for outlier claims to detect aberrant patterns or trends, and rules based algorithms based on national coding standards. Through these current programs, we have identified a significant share of fraud and waste. With the adoption of eMRs and use of the data sharing technologies such as the HINAz, we have the opportunity to advance fraud detection to the next level. We are deploying a more real time assessment and analysis of potentially suspect services, moving fraud detection from a reactive to a more proactive approach. Under our current process, when claims are identified as probable outliers, they are denied and medical records are requested from the providers. With real time clinical information available, both potential and probable outliers can be reviewed prior to claim adjudication being completed. This both decreases unnecessary claim denials and identifies potentially fraudulent activity without alerting potential suspect providers. To enhance this process, we will further enhance our Prospective 2.0 software to identify elements of the eMR to assist in the analysis process. The critical element of this fraud detection process is the accessibility of real time clinical information.

***Stakeholders*:** We will work with all appropriate stakeholders including AHCCCS OIG, providers, HINAz and our technology vendors to address the implementation and adoption of these analytic tools.

***Timeframes*:** Full adoption of our proactive fraud management program is dependent on the availability of real time clinical information. We are anticipating the deployment of HINAz in 2012/2013 with accelerated adoption of the digital infrastructure from 2013 through 2015. Our proactive fraud management program will be fully aligned to these timeframes.

***Desired Outcomes*:** Enhancement to these processes and capabilities will result in the reduction in unnecessary services and fraud. The expansion of our current prospective processes will enable us to detect and identify fraud and waste in a more proactive manner. Our technologies will be continuously expanded and will address any changes in national or state specific coding changes.

Moving from Reactive to Proactive Fraud Management		
Foundational Strategies	***Care Improvement Strategies***	***Policy Strategies***
1. Prospective 2.0 2. Clinical Repository 3. Digital infrastructure (e.g., HIE/HINAz)	1. Fraud reviews with Clinical Repository information	1. Fraud databases transparency 2. Provider transparency 3. Consent to access records for Fraud reviews

Summary

The initiatives we have presented are elements of an overall systemic change which is required to improve quality and reduce costs in the health care system. These initiatives are transformational in nature with various components of each initiative already completed or in the process of being implemented throughout the next contract period. Our initiatives are focused on what we believe are the greatest opportunities to reduce waste – reducing adverse events, improving access and care coordination for our highest cost members, reducing redundancy in utilization and assuring members receive the right care at the right time in the right place. With the support and collaboration of identified stakeholders, we can produce effective and sustainable change in the Arizona health care system.

8. The Offeror is required to develop a compliance program designed to guard against fraud and abuse…

Compliance Program

UnitedHealthcare Community Plan is dedicated to the highest standards of integrity. Our compliance and ethics program is the vehicle through which we develop, implement, maintain, compile and monitor compliance with contractual and regulatory requirements governing our business in order to achieve effective fraud, waste and abuse (FWA) results. We operate with the highest ethical standards and build integrity in our work, furthering a culture of compliance. In addition, our compliance and ethics program governs all of our officers, employees, providers and sub-contractors and serves as a blueprint for ethical and compliant business practices.

Providing services to many programs (Acute, Children's Rehabilitative Services, DD, D-SNP and LTC) allows us to track and trend FWA activities across program lines. This allows us to share information when we see trends in one area that has not yet appeared in another and reduce the potential for FWA.

Integrity – Code of Conduct

Our Code of Conduct provides guidelines to help us sustain the highest possible standards of ethical behavior in our work every day. Our shared values of integrity, compassion, relationships, innovation and performance summarize what we hold highest as a company and describe the behaviors each of us must work toward every day. Integrity purposefully leads the list. It is fundamental to each of the four other values and to everything we do.

UnitedHealthcare Community Plan's **Compliance Officer, Kimulet Winzer, J.D., Contract Compliance Manager, Jennifer Palumbo, and our Compliance Committee** are responsible for oversight of the compliance program. Ms. Winzer and Ms. Palumbo have 31 cumulative years of experience in health care with the Arizona Health Care Cost Containment System (AHCCCS) and six years of experience with UnitedHealthcare Community Plan. Ms. Winzer, who is accountable to our CEO, is involved with our quality improvement programs and serves on the Quality Management Committee, the Service Quality Improvement Subcommittee and others, as needed. This participation provides essential feedback to assure collaborative effort and input from compliance to leaders as may be required. Our Compliance Committee includes representation from cross-functional areas and executives with fiscal authority to require immediate redress of issues as needed.

Ms. Winzer is onsite in Arizona and available to all employees. She also contributes to the employee newsletter and ensures compliance through face-to-face, computer-based and virtual trainings and all-employee emails periodically sent throughout the year to foster a culture of compliance. Employees have access to the most current policies and materials through SharePoint which allows immediate access to policies from all departments. All employees, including senior executives, are responsible for fostering a culture of compliance. As a means of making compliance part of our everyday culture we have adopted the slogan, "Compliance: it's our Rock" and "Compliance is Everyone's Job". Continuous awareness activities ensure parties at all levels understand their responsibilities to help identify and report suspected FWA.

Our compliance plan is based upon the seven essential elements of a compliance program as articulated in the Federal Sentencing Guidelines. As part of the program, we retrospectively and prospectively mine clinical and claims information to detect suspicious activity. The core elements of our compliance program include:

- Written Policies and Procedures
  - Clearly delineated expectations regarding structure, process, and outcomes that tie to regulatory expectations.
- Effective Oversight
  - Ongoing business and board oversight of our compliance program. Designation of a Compliance Officer.
- Conducting Effective Training and Education
  - General and specific information provided to employees to facilitate compliant activities.
- Developing Effective Lines of Communication
  - Dissemination of relevant information for employees to understand compliance structure/process, and ensuring open lines of communication to elevate issues/concerns.

- Enforcing Standards through well Established Disciplinary Procedures
  - Address problems as they arise and respond appropriately with progressive discipline as may be appropriate.
- Auditing and Monitoring
  - Engage in ongoing assessments of all operational functions.
- Reporting Detected Offenses and Developing Correction Action Plans
  - Ensuring appropriate consequences attach to identified compliance issues or unlawful activities.

Additional Ways We Limit Fraud and Abuse

We monitor all business operations, in part through the monitoring of activity through our departments, for the purpose of identifying and reporting suspected FWA to state and federal agencies, as appropriate and taking steps to quickly resolve internal issues to prevent ongoing risk. All of our departments monitor FWA in the event such activity is suspected. New employees are trained on FWA, how to identify it and their responsibility for reporting potential cases and the process for reporting cases. Employees receive ongoing training and other reminders about their responsibilities regarding the detection and reporting of potential cases of fraud and abuse on at least an annual basis. We have a multi-faceted compliance and ethics program. Tools and programs used to prevent fraud and abuse include:

- ***A Claims Cost Management (CCM) Team*:** The CCMs oversee cost avoidance efforts to ensure payments which may represent fraudulent, wasteful or abusive charges are stopped pre-payment, reducing the need for post-payment recovery. Our executive team monitors CCM findings and shares or approves new models to detect FWA before they are implemented.
- ***Provider Education*:** To reduce the possibility of provider fraud, providers are made aware of policies and procedures and contract requirements through language in our contracts, provider manuals, our website and provider newsletters. They are educated on appropriate billing through provider forums and individual outreach as needed to help avoid possible fraud.
- ***Fraud, Waste and Abuse Workgroup*:** This workgroup is chaired by Deb Alix, Director of Claims and Encounters with membership consisting of: Kimulet Winzer, Compliance Officer and other members of our executive team: Kent Monical, CEO; Garell Jordan, CFO; Sheila Shapiro, COO; Dr. Steve Chakmakian, CMO; Wendella Howell-Bell, Director of Network Strategy and Provider Relations; and Glenn Thomas, In-house Counsel. They monitor the results from all of our fraud detection, investigation and recovery activities. This team is closely involved in FWA operations to ensure optimal and compliant results. Outcomes from our cross-functional claims/clinical/contract workgroup include:
  - ***Provider Satisfaction:*** Through our review of providers with aberrant billing concerns and our claims/clinical management/network contract management workgroup, we've been able to address specific provider concerns and provide specific feedback, thereby minimizing provider disruption and claim disputes.
  - ***New Algorithms:*** The workgroup reviews new algorithms for consideration and compares with AHCCCS guidelines to ensure the algorithm meets or exceeds regulatory expectations.
- ***The UnitedHealthcare Government Programs Audit Management Team*:** We leverage tools and resources available through this team, which manages, reports and tracks audits and corrective actions for regulatory compliance audits or studies conducted by federal agencies including, but not limited to: the Centers for Medicare and Medicaid Services (CMS), Office of Inspector General (OIG), General Accountability Office. Audit Management also tracks, reports and provides support to UnitedHealthcare Community Plan during regulatory compliance audits conducted by state regulatory agencies. Additionally, internal audits or CAP validation audits are conducted to ensure the business and associated contracted entities are meeting expectations, requirements of state and federal regulations and other regulatory commitments made by UnitedHealthcare Government Programs to both internal and external stakeholders and regulators.
- ***UnitedHealthcare Community Plan Employees*:** All employees are responsible for conducting business in an honest and ethical way, fostering a climate of ethical behavior that does not tolerate FWA and remaining alert to instances of possible FWA.

- ***Sanction Check Process*:** Our sanction check process monitors sanctions from state and federal agencies to ensure payment is denied for providers excluded or terminated from participation in Medicare or Medicaid programs. To ensure denial, the claims processing system will flag an identified provider (both contracted and non-contracted). We receive sanction information monthly, for all providers with active federal or state issued sanctions. Once received, this information is passed to all UnitedHealthcare entities, ensuring providers with active federal or state-issued sanctions are identified across all programs and contracts.
- ***Verification of Services*:** We have a quarterly process to randomly contact members to validate services were actually provided. Any matters confirming services were not provided are referred to the Compliance Department for review and submission to AHCCCS, if appropriate.

Additional Ways We Identify Fraud and Abuse

The goal of our FWA Program is to ensure AHCCCS funds are used effectively, efficiently and in compliance with applicable state and federal laws and policies. Our Program Integrity Policy defines the planning, prevention, detection and reporting activities undertaken to minimize or prevent overpayments due to Medicaid FWA. We have a "prevent and save" philosophy while other health plans have "pay and chase" philosophies. Every dollar lost to the misuse of AHCCCS benefits is one less dollar available to fund programs which provide essential medical services for Arizona residents. In coordination and communication with the AHCCCS OIG, we have assisted the AHCCCS program in recovering overpayments on cases referred for suspected fraud for criminal prosecution.

Prospective Review and Investigation

The focal point of our FWA program is our cost avoidance analytical tool used to identify FWA by providers and members. We overlay our FWA services with a powerful software detection tool, **Comprehensive Prospective Review 2.0 (P2),** which allows us to **identify and scrutinize questionable claims before payments** are actually made and to conduct detailed post payment reviews.

Performance – Cost Savings

In 2011, we began a new cost avoidance program that resulted in savings of approximately **$1,223,170 ($0.81/PMPM) in 2011** and **$4,324,527 ($1.29/PMPM) in 2012.**

P2 identifies suspect claims to pend because of one or a combination of factors such as unlikely diagnosis and procedure code combinations. P2 incorporates two complementary components that evaluate claims that assume most providers are billing correctly and look for claims that are outliers. This is accomplished by creating data driven peer groups to identify outliers. To do this, providers whose service mix is similar (based upon billed CPT codes) are grouped together. When claims are identified as an outlier they are denied for review. We then send the provider a request for medical records to support the review process. Both analytics use only UnitedHealthcare Community Plan data as part of the evaluation process.

Part of the process includes our Prospective Investigations Team which performs various tasks within each case including, but not limited to: validating whether the claim meets suspect criteria/allegation; provider research on Internet; claim history research where applicable; clinical review of the medical records; and clinical recommendation to allow or deny the claim.

Our prospective FWA service has proven highly successful on two key indicators:

- ***Minimizing Provider Disruption:*** To reduce administrative costs of managed care programs, our FWA program detects aberrant billing protocols to allow for education of providers where necessary and ensures reporting of those who engage in inappropriate billing practices. Minimizing provider disruption prior to paying a claim allows for the opportunity to engage with a provider to determine if provider education or further analysis is warranted.
- ***Generating Savings:*** The prospective tool is highly successful at generating cost savings for managed care programs for which it is employed. This is due in part to preventing overpayments and correcting provider behavior to reduce associated administrative costs.

Retrospective Review and Recovery

Retrospective reviews of paid claims are performed based upon tips or referrals received internally or externally. The reviews include but are not limited to: trend analysis, medical record audits, financial effect and loss quantification and resolution recommendations.

Evaluation of the case helps determine the recovery approach. For cases progressing to the recovery stage the following tasks are performed: contact with the provider for review and education, review of medical documentation, collection of recoverable dollars and review of any system adjustments to prevent future occurrences.

Internal Fraud, Waste and Abuse Teams

We receive FWA information from several sources including electronic data mining; tips from law enforcement; internal staff; subcontractors; providers; members; state and federal regulators and agencies; our other businesses/plans and other health insurers/organizations. Additionally, we employ a range of fraud detection methods to detect provider FWA including:

- ***Data Analytics*:** We detect fraud by developing state-specific algorithms to identify patterns that might indicate inappropriate use of services or billing. These are used to facilitate review of select claims before payment (prospective) or review of claims and provider practices post payment (retrospective).
- ***Grievances and Appeals (G&A)*:** G&A are reviewed for possible abuse of members by a provider and for patterns of inappropriate utilization, referrals or other inappropriate practices. G&A are referred to appropriate personnel/departments for any necessary follow-up.
- ***Credentialing*:** We use the credentialing process in part to prevent the fraudulent use of the Medicaid system by disbarred, unlicensed, unqualified, and otherwise inappropriate providers.
- ***Editing and Reporting Tools*:** Our state-specific algorithms are implemented in our claims editing tools and reporting to facilitate review of suspect claims.
- ***Claim Payment Review*:** Prospective reviews will screen all incoming professional and facility claims with a payment amount greater than zero. The predicative modeling detection tool invokes an advanced scoring model to reflect the mathematical probability (or risk) of fraud or abuse associated with each claim. Deb Alix, our Claims Administrator, will review and take further action if necessary.
- ***Claims Data Analysis*:** Claims data analysis identifies suspect patterns and practices and may lead to an audit. Audits uncover instances of inappropriate billing and clinical quality of care deficiencies. The preliminary information is presented to the provider, who is able to respond, before being sent to the Peer Review Committee. The primary purpose of the audit process is to improve the accuracy of claims submission and to improve overall quality of care.
- ***Medical Review*:** Our clinical staff and management, including utilization management and care coordination staff, are trained to detect potential FWA.
- ***Tip Reporting*:** Provider Manuals, Member Handbooks and communications include our mailing address and toll-free hotline numbers as methods for reporting suspected FWA. All of our employees are informed to use our internal online tip referral tool, the toll-free number or to contact the local compliance team.
- ***Gap Analysis*:** Through the internal monitoring and auditing process, we may identify opportunities to improve our FWA detection process.
- ***Best Practices/Industry Standards*:** We monitor and develop best practices and industry standards on health care FWA detection.

Relationships – Working with Other Health Plans to Improve Processes (CONG)

We participate actively in the Compliance Officer Network Group (CONG) to discuss and share information on program fraud waste and abuse activity. CONG brings together health plans in Arizona to further develop a systemic compliance system that incorporates the experience and skill of all parties. Working together to share information on compliance standards allows us to continuously improve compliance knowledge, skill and expertise around training, identification of fraud or abuse through open discussion and sharing of information. Through this collaboration, we can work together to bolster the foundation of compliance understanding across the State.

- ***Member Services Center and Care Coordination Team Interaction*:** The interaction between members and providers with our member services center and care coordination teams is a source for potential FWA tips. These tips are transferred to our compliance team for documentation and submission of suspected matters to the State as required.

Additional Ways We Address Fraud and Abuse

We require the prompt reporting of suspected FWA and report it to the State within 10 calendar days of discovering instances. When we report instances of suspected Medicaid fraud and abuse to AHCCCS' OIG, we include the results of analysis or other available information, such as questionable billing practices by providers (e.g., unusual billing patterns, services not rendered as billed and same services billed differently or separately). Examples of allegations of FWA include billing for services that were not ordered, duplicate billing, falsifying or altering documents and misrepresentation of services or diagnosis.

When aberrant activity from a provider, person or entity is identified, we conduct preliminary research in which investigative analytics are applied to claims data for the last three years (if available). We are aware and include as part of the FWA training to inform staff not to contact the person or entity who is the subject of the investigation about any matters related to the investigation or enter into or attempt to negotiate any settlement or agreement or accept any monetary or other thing of valuable consideration offered by the provider who is the subject of the investigation. We may find no evidence of fraud and abuse, but instead identify a need for and conduct education and training for the provider, person or entity in question. We maintain documentation of the education and training provided.

Compliance Scorecards

Our compliance scorecard is organized to focus program activities on the structures and processes necessary to drive improved compliance outcomes. Activities include, but are not limited to: engaged and effective oversight structures, monitoring of identified key compliance indicators, outcomes of audit or regulator notices, privacy disclosures and our culture. Results of those activities are tracked, trended and reported as part of the overall compliance program.

Collaboration within UnitedHealthcare Community & State

As part of a national company, UnitedHealthcare Community Plan is in the unique position to leverage resources and experience from other markets to identify best practices within the FWA program. We are part of a multi-state workgroup focused on program integrity working to identify methods to continuously improve detection and remediation of program integrity requirements.

Future Innovation

We are working with the Health Information of Arizona (HINAz) to gather a variety of data, such as membership, demographic and clinical data, that can be viewed via a Virtual Health Record by any provider participating with HINAz and responsible for member care. As HINAz becomes widely used, we believe it can be used to obtain complete and secure health information in real-time, helping identify FWA scenarios such as requests for duplicate services, member abuse of the program through redundant or inappropriate services and continued focus on potential misuse of prescription medications.

9. Describe in detail the ongoing processes and strategies the Offeror will implement to minimize the…

Our **Member Appeals and Claims Disputes Manager, Martha Fuentes**, is responsible for the overall management of our claims disputes and appeals activities. She has 19 years of experience with UnitedHealthcare Community Plan and six years in her current role administering our claims disputes process. Ms. Fuentes and our Claims Disputes Department are based in Arizona.

Our philosophy of continuous learning and improvement extends to our local Claims Disputes Department, as evidenced by our metrics. We have increased the automation of our member appeals and claims disputes, which improved our processing time and minimized opportunities for errors. We have demonstrated a significant decrease in claims disputes receipts for the past three years. Our goal is to resolve disputes quickly and not wait 30 days, per regulatory rules**. Claims disputes receipts for our Acute program decreased 17 percent from 2010 to 2011 and decreased 21 percent between January and November of 2012**. From October 1, 2011 to September 30, 2012 the average days to close an Acute claims dispute was 17 days with 99.99 percent closed within 30 days. The extension volume has also shown a considerable decrease with only one extension request for the Acute Care Program in a two-year time period. The continuing collaboration with internal departments, provider education and early claim trending identification has led to less disputes filed. As a self-corrective initiative, we implemented a state fair hearing inventory reduction plan of closing 2,500 matters, which was exceeded by 886, for total actual closures of 3,386 matters in 2012 resulting in significant cost avoidance in the state fair hearing process.

Ongoing Processes and Strategies to Minimize Claims Dispute Process

We have a number of processes and strategies to minimize the inventory of claims disputes, thereby reducing the number of state fair hearings. We feel the best way to minimize claims disputes is to resolve any claims issue before it gets to the dispute stage and understand the importance of improving our claims process in order to reduce the number of claims disputes and fair hearings. To this end, we have implemented a number of policies to ensure proper submission of claims. These policies and strategies include:

- Initial process of claim resolution
- Inpatient versus Observation reimbursement
- Trend analysis
- Provider claim educators
- Coordination between our internal departments and quality committees
- Ombudsman resolution
- Provider educational tools

Initial Process for Claim Resolution

Our providers have a number of options in place to help them before resorting to the claims disputes process. One way is to call into the provider call center. Our Provider Services Team handles phone inquiries from providers through a centralized toll-free number and completes claims research projects. Our provider service representatives help providers understand information in their remittance advice and may review the claim with the provider to determine if it is appropriate to file written claims disputes. The provider claims disputes policy accompanies all remittances and includes specific information on how and where to file the dispute with documentation of relevant timelines in accordance with ARS 36-2903.01(4).

Providers can view their provider profiles, check member eligibility, submit claims, check claims status, request claim adjustments and view summary data available online via our provider portal. Staff logs all inquiries in first-in and first-out (FIFO) order. If claims cannot be processed for additional payment, letters are sent to providers informing them the claims were processed correctly and no additional payment will be made. The letter also contains notice of the providers' claims disputes rights. Underpaid claims, if any, are reprocessed and providers are notified via a remittance that also includes a notice of claims disputes rights. If a provider calls to check the status of a claim, they are offered reconciliation reports, which reflect a history of their claim payment.

Provider Claims Resolution Process

Our Provider Claims Resolution Process (PCRS) model is designed to address provider issues before they become claims disputes. The PCRS Team was created to drive service, affordability and quality in health care by treating every provider service interaction as an opportunity to reduce administrative complexity and to offer a clear, consistent experience for providers. The model focuses on improving claims accuracy and resolving claim issues. This enhanced

service model has achieved strong results as evidenced by improved provider experience. In Arizona, we have seen a **30 percent reduction in claims disputes** since implementation. Satisfaction survey scores average 5-10 points higher than the standard provider service model. Additionally, a focus on addressing root cause has resulted in nearly a 20 percent drop in the number of calls from care providers about claims issues.

Provider 3/30

Our provider call center is our providers' point of contact for making inquiries, registering complaints or requesting information. We meet the requirements of the 3/30 process; we acknowledge all calls within three business days and notify providers of resolution via email, written communication, web-enabled process or call back, referring to the case number within 30 business days. This process ensures claims issues are handled in a timely manner, reducing the need for escalation to the claims dispute process. But for this program, we would have had 7,500 open issues, resulting in a much higher volume of claims disputes. Results from our October 2012 3/30 report demonstrate: 100 percent of issues are acknowledged within three days, 45 percent are resolved at first contact; *96.6 percent are resolved within 10 days* and 99.4 percent are resolved in 30 days. Results from our recent 3/30 report demonstrate excellent results and above anticipated resolution time frames. We have a reduction in repeat phone calls and reduction in the volume of repeat adjustment requests. Our model is built on the foundation of honoring our commitments to providers.

Provider Ombudsman Resolution

Our provider ombudsman position was created in late 2011 to offer additional assistance to providers. Our Provider Ombudsman, Monica Husband, has more than 25 years of experience specific to Arizona Health Care Cost Containment System (AHCCCS) health care and has been our provider ombudsman for one and a half years. She works with providers and appropriate health plan staff to resolve provider issues and serves as an additional resource to providers who are unaware of the usual channels of communication or who need a critical escalation point. It provides our Claims Management Team with the opportunity for self-correction/self-reporting of claims issues as well as open communication with AHCCCS.

Performance – Inpatient vs. Observation

We became aware of a trend of denying hospital claims that could meet alternate bed criteria. Starting in 2012, we put a process in place to remediate claims issues by reviewing claims to see if they meet a level of care. This process has decreased hospital claims disputes.

Trend Analysis

We gather information at all key provider touch points (e.g., provider calls, claims disputes, service visits) to determine root cause of issues and resolve those issues. We contact the provider by phone, email or letter depending upon the provider's preference. We use the following methods to identify and trend deficiencies:

- ***Retrospective review:*** Used to detect patterns in provider issues logged through calls or claims disputes
- ***Post processing review of claims data:*** Examination of claims denials or payment pattern trending to determine changes in patterns
- ***Operational meetings:*** Held with claims, call center and authorization staff
- ***An analysis of identified issues:*** Determination of solutions or changes to existing processes; if required, we test for accuracy before implementation and monitor post-implementation for resolution

Deficiencies are tracked and escalated for resolution after a thoroughly documented analysis of the issue. Deficiencies tend to be categorized into provider education, system issues, and manual processing issues. Possible resolutions include:

- ***Provider Education:*** Providers are made aware of education and communication mechanisms, including our Provider manual, bulletins, billing guidelines, provider mailings, provider newsletters (offer tips on claims submission; updates on upcoming process changes), the provider call center and the provider portal. Also, our provider claims educator enhances our claims billing communications with providers. **All of the above mechanisms are designed to: help the provider submit claims, understand reimbursement policies and how to correct and resubmit claims accurately**.

- ***System Issues:*** All system deficiencies are logged into an IT tracker database for analysis of impact and evaluation of resolutions. Changes follow standard software implementation work flows for analysis, design testing, and quality verifications.
- ***Manual Processing Issues:*** These issues are primarily caused by manual processing instructions not being complete or not well understood by staff using them. The resolution is most often training and focused audits post-training.
- ***Corrective Action and Monitoring:*** May be established if claims payment deficiencies are identified and not corrected. We would monitor the corrective action through additional reporting.

Claim Educators

Our Provider Claims Educator, Deidra Yslas, is a Certified Professional Coder (CPC) and an AAPC certified coder and has more than seven years of experience with billing and coding. She is fully integrated with our grievance, claims processing and provider relations' systems and facilitates the exchange of information between these processes and providers. Her primary functions are to: educate contracted and non-contracted providers (i.e. professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available resources such as provider manuals, website, fee schedules, etc.; interface with our call center to compile, analyze, and disseminate information from provider calls; identify trends and guide the development and implementation of strategies to improve provider satisfaction; and frequently communicate (i.e.: telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.

In addition to our provider claims educator, we have other educator staff, including: our **Claim Administrator, Deb Alix,** CPC, CPC-P, CPC-H, also an AAPC certified coder with UnitedHealthcare Community Plan for 13 years and Director of Claims and Encounters for five years; **Jodi Chavez, Sr. Business Claims Analyst and Carol Williams, Encounter Data Analyst.**

Coordination between Internal Departments

In order to proactively identify and resolve claims disputes, we have created a process by which we track and trend dispute causes. Our claims dispute analyst tracks and trends claims disputes; once causes of claims disputes are identified, we escalate and route them to the appropriate area or person. We hold a weekly meeting attended by Craig Newton, Director of Quality Management and Performance, Wendella Howell-Bell, Provider Services Manager; Deidra Yslas; Jodie Chavez; Deb Alix and other departments as needed to identify resolutions. These resolutions can take the form of education of providers or claims staff, issuance of bulletins, training sessions, etc. We trend and report claims disputes and member appeals through the **Quality Management Committee and Service Quality Improvement Committee.**

In addition, our Joint Operating Committee (JOC) holds meetings with hospitals, providers or practices to discuss issues they have – anything from claims disputes and payments to implementing new processes. This opportunity is another way by which we identify any potential claims issues.

Provider Education

To ensure providers submit clean claims after transitioning to the managed care processes, we provide them with education and on-going training for billing, claims submission and connectivity. We reach out to providers with face-to-face meetings, town forums and community events to ensure we are available for communication and discussion of information for claims submission and transition to managed care processes. We offer specialized training to all community providers who deliver critical services to our members. This training includes but is not limited to:

- Explaining benefits covered under UnitedHealthcare Community Plan and how this may be different than current benefits under the state or existing program
- Explaining how we can quickly pay claims if we have the following:
  - Accurate claim submission – including explanation of forms and appropriate coding for services provided
  - Obtaining appropriate authorizations and using the information on claims submission
  - Assist the providers in submitting the appropriate paper work to receive electronic payment

- Discussing provider documentation requirements for the program such as W-9, credentialing and contracting requirements
- Partnering with providers when abuse and neglect is detected
- Fraud, waste and abuse initiatives

In preparation for county expansion, we have several outreach projects that we initiate at the launch, including face-to-face appointments, telephonic outreach and letters. We also ask providers to attend a conference where we provide initial orientation. We schedule the orientation on multiple days/times for their convenience. We also coordinate with other managed care organizations and provider trade associations to perform orientations and trainings jointly.

End-to-End Process (ETE)

Our ETE is a quality process through which we evaluate the accuracy of the full population of claims based upon a random sample from the entire population of claims, including physician, facility, and ancillary. ETE determines claims accuracy based upon a review of "source of truth" documents for upstream processes (eligibility, provider contracts and benefits) in addition to accuracy of system and manual adjudication.

Relationships

In 2011, our senior leadership met with Tucson provider groups and individual offices. Each concern they had, including eliminating unnecessary prior authorizations and common credentialing were addressed and remediated through education, updated contracts, claims projects or AHCCCS program improvements. In a satisfaction survey conducted five months later, 92% were satisfied to extremely satisfied. We continue to meet with the Tucson provider group to discuss overall ideas and improvements in health care. The number of claims disputes at the high point was approximately 105 and 21 in Nov of 2012. That is a reduction of 80%.

Interventions and Strategies Employed to Resolve Claims Disputes without Resorting to the Hearing Process

As mentioned in detail above, we have a number of strategies in place to act rather than react in order to reduce the number of claims disputes. In addition to these strategies, our Appeals and Claims Disputes Department has implemented a process to ensure state fair hearings are handled in a timely manner and all efforts are made in resolving a matter prior to the hearing scheduled. We've ***implemented a number of these efforts in 2012, resulting in a 74 percent reduction in state fair hearings in 2012.*** These strategies include:

- ***Efficiency improvements:*** Scanned all incoming state fair hearing requests within two business days and assigned them to an appeals analyst for appropriate research, provider discussion, resolution and possible withdrawal prior to the issue of a Notice of Hearing.
- ***Trending improvements:*** Produced a monthly trend report to identify root cause analysis for both claim disputes and state fair hearing requests. Our appeals analysts enter trends as identified into the Root Cause SharePoint for proper tracking, routing and resolution to ensure any future claim issues are resolved to eliminate the submission of a dispute or hearing. The state fair hearing backlog has reduced substantially based upon scanning, trending and upfront discussions with providers upon the receipt of a hearing request.
- ***Established an action plan with the goal to reduce the inventory of state fair hearings:*** The action plan consisted of outlier reviews, medical review of hospital cases and discussions with network managers. Wendella Howell-Bell and Dr. Steve Chakmakian, Chief Medical Officer were tasked with improving this process and handling review of these cases upon receipt. Agenda items were added and discussed at the Provider's JOC meetings, letters were created indicating payment information to assist providers in submitting withdrawals without the provider creating additional forms and inventory update meetings were held with executives and managers informing them of the progress made. The state fair hearing inventory reduction plan targeted a closure of 2,500 matters which was exceeded by 886, for total closures of 3,386 matters in 10 months.

Future Innovation

We are leading efforts to deploy Health Information Exchange (HIE) with the Health Information Network of Arizona (HINAz) to processes in-bound and out-bound patient data transactions. Through this process a variety of data flows into HINAz such as membership data from payers and clinical data from hospitals, clinics, labs and pharmacy via SureScripts. This data can be viewed via a Virtual Health Record (VHR) by any provider participating HINAz and

responsible for patient care. One goal of HINAz is to provide us with complete medical records, which would help reduce the number of claims questions and issues; decrease provider, AHCCCS, health plan and administrative judges' time; and eliminate many of the timeliness and record completeness issues. In addition to HINAz, some other initiatives we will put in place to further reduce claims disputes:

- ***Denial management process:*** Once a week, we will conduct a real-time review of the top five providers that have had high claims denials submission and reach out to them within five days to research the root cause and ascertain remediation. This effort should reduce claims disputes and improve the cash flow to the provider by providing guidance on claim submissions.
- ***Improve case file sharing with AHCCCS and Office of Administrative Hearings:*** (Currently done today through couriered paper copies) Send over case files via a secure ftp folder on the state system for immediate review and handling. This will eliminate courier costs, paper costs and provide better case file organization for current and future reference.
- ***Scalability:*** We have a scalable member appeal and claim dispute model, whereby an increase in membership can be easily handled by our staff currently serving other programs, who are specifically cross-trained on AHCCCS, DD and CRS rules, regulations, policies and processes without negative impact to compliance timelines.

Performance – Partnership with HINAz

We project with availability of VHR/medical records from HINAz we would have avoided:
21% of member appeals
38% of claims disputes
42% of state fair hearings

In conclusion, our ongoing process to review root causes and develop strategies, such as our Provider Claims Resolution Process and our participation with HINAz, minimizes the need for providers to use the claims dispute process and allows us to resolve claims disputes well before 30 days and minimizes the need for state fair hearings. UnitedHealthcare Community Plan's continued commitment, local presence and extensive experience are evident in our proven results.

10. Information Technology (IT) Systems Demonstration

UnitedHealthcare Community Plan's managed care information system and data exchange interfaces are currently implemented and supporting Arizona Health Care Cost Containment System (AHCCCS) programs. Led by Chief Information Officer (CIO) Mohan Basavapatna, PhD., under the direction of CEO Kent Monical, our information technology team brings 30 years of critical experience developing and implementing the interfaces required to exchange data with AHCCCS. We have worked in partnership with AHCCCS to continually refine our managed care information system to meet new requirements and enhance the support of services delivered to our members. These technology initiatives include:

- Implementing a functional statewide health information exchange in collaboration with Health Information Network of Arizona (HINAz).
- Implementing new data exchange requirements, such as 5010, national provider ID (NPI) and National Drug Code (NDC) codes.
- Piloting a telemedicine initiative for the CRS program that gives providers access to secure video conferencing tools allowing them to provide services to approximately 24,000 special needs children in the State.
- Deploying our proprietary Accountable Care Patient Registry that provides practice clinical teams with access to real-time and profile clinical information on an assigned patient population.
- As the enrollment broker for the CRS program, developing tools to automate enrollment, such as the Service Activity Manager (SAM) tool. SAM received applications and verified applicants' eligibility for the plan, created Member Service Plans that helped determine the members' plan of care and maintained all documentation to support the application and plan of care.
- Implementing a multi-channel 3/30 process that, for provider inquiries, ensures that we respond to providers within three days and close the inquiry within 30 days. We customized provider tools that provide inquiry status through our provider portal and provider management tools to track and report status on provider inquiries that support the operations process to meet the 3/30 goals.

Processing Data and Administering Actions

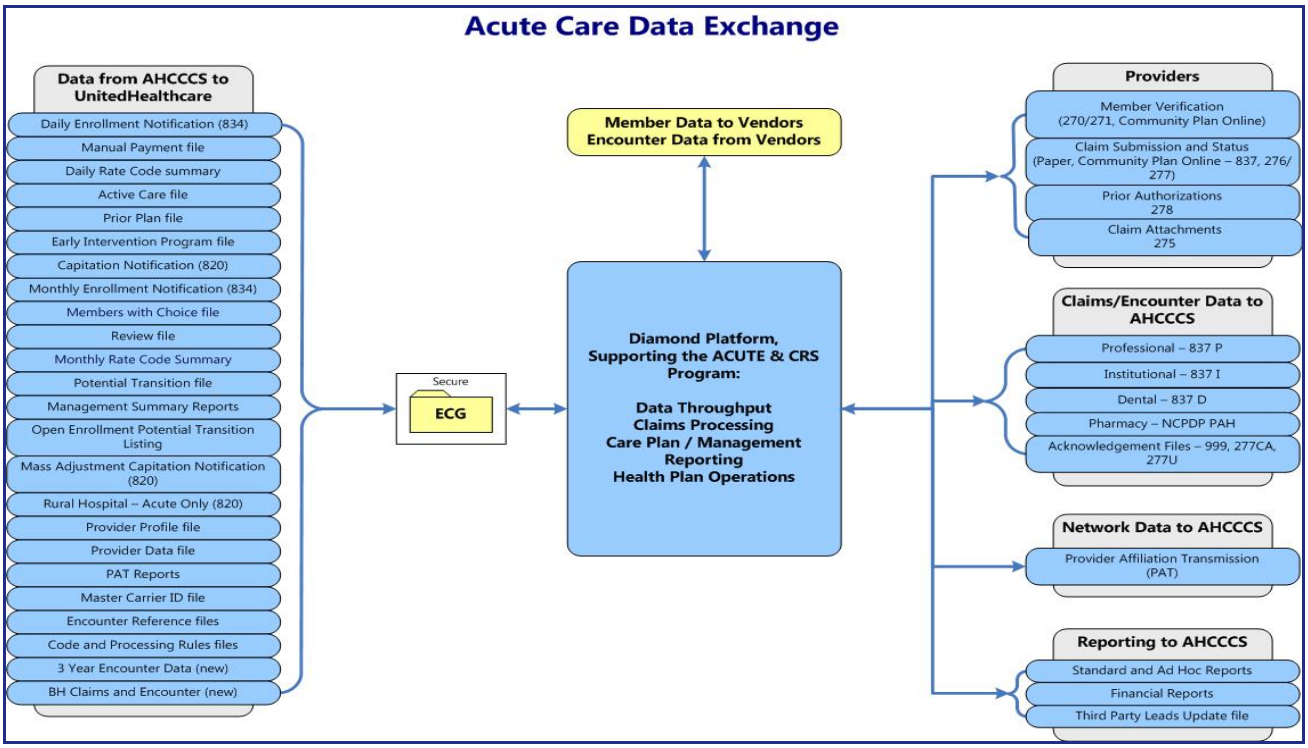
As presented below, **we have in place all of the technical interfaces required to successfully exchange data with AHCCCS.** We have designed our systems with an open services based interface architecture that allows for fast, easy integration with AHCCCS systems, and other State and federal IT systems and data sources. We can reconfigure this flexible interface architecture to support changing file formats and data elements with little or no change needed on the part of the sending systems.

Building on our flexible architecture, we have we worked with AHCCCS to implement new data exchange requirements. For example, in 2011 we modified our systems to ensure they were producing 5010-compliant transactions and tested those transactions with the State and other vendors. We made these changes within the State's timelines. We also implemented NPI requirements. We implemented data elements (e.g., codes, units of measure and values) to our encounter data reporting so the State could provide reporting to the federal government using standard National Drug Code (NDC) codes for physician-administered drugs, enabling the federal government to reimburse the State for these drugs.

Performance – Supporting the AHCCCS Interface Requirements

As a current AHCCCS contractor, we have in place all of the technical interfaces required to successfully exchange data with AHCCCS for the Acute Care and CRS programs.

Our information systems are fully compliant with the requirements associated with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191, as amended or modified. We comply with HIPAA Electronic Data Interchange (EDI) requirements, including the HIPAA-compliant format version. Our systems are fully compliant with HIPAA privacy and transaction and code set standards. We use standard HIPAA 820, 834, 835, 837D, 837I, 837P, 270/271U, NCPDP Post Adjudication History (PAH), 275 claim attachments, 276/277 and 278 file formats for electronic transactions. We are in compliance with the new x12 5010 EDI standards.



As demonstrated through our participation in the AHCCCS program, we are capable of supporting numerous types and levels of information processing and data exchange, including:

Providers. Our Diamond core transaction processing system allows for setup of physician and hospital networks and acute and long-term care provider demographics, and the storage of unique state provider identifiers (e.g., AHCCCS IDs) using the weekly provider files from the AHCCCS FTP site. 270/271 files allow providers to inquire about the health care benefits associated with a member (270) and allow us to respond to the provider's request (271). 275 transactions allow providers to submit claim attachments. 276/277 files allow providers to request the status of a claim (276) and allow us to respond to the provider's request (277). 278 files allows us to transmit to providers health care service information, such as member, patient, demographic, diagnosis or treatment data for the purpose of request for review, certification, notification or reporting the outcome of a health care services review.

Claims/Encounters. We create and submit encounter files in the requisite formats: 837P (professional), 837I (institutional), 837D (dental), NCPDP PAH (pharmacy) using our National Encounter Management Information System (NEMIS) encounter data submission and reporting system. Encounter data, based on extracts from our claims system, is collected, validated and submitted regularly through established interfaces with AHCCCS. We process acknowledgement files (999, 277CA, TA1 and pend/denied files (277CA, 277U) twice monthly. AHCCCS uses the data provided to support reinsurance calculations. We reconcile payments to the AHCCCS capitation file.

Reporting. We produce more than 70 standard reports from various systems, such as our Diamond claims processing system, Strategic Management Analytic Reporting Tool (SMART) Medicaid data warehouse for reporting and data analytics and CareOne medical management platform. Our management information systems enable us to be fully prepared to meet the data element and format requirements to produce all AHCCCS-required management reports.

Member/Enrollment. We process daily 834 enrollment and monthly 834 reconciliation data. Our automated enrollment processing requires minimal manual intervention. We process this data through our core processing platform's interface engine and load it into our Diamond core processing system to support claims processing.

Finance. Our preprocessing system accepts AHCCCS capitation files through HIPAA-compliant 820 transactions.

Reference Files. We process and use all other reference files, including Provider Records/Profiles, Procedure Tables, and Fee Schedules. We accept Provider and Profile Reference Files and load them to our provider subsystem used by our claims platform for editing and resolving provider data discrepancies. We also generate Monthly Provider Network Files as required.

Securely Exchanging Data

We securely exchange data with the State using our Electronic Customer Gateway (ECG). ECG provides a secure electronic transport mechanism for internal entities and external business customers to exchange data files on-demand or scheduled using job automation and control services, including transmission validation. It uses SFTP, HTTPS and FTP (file encryption required) transport methods.

Innovation – Supporting Ongoing Interface Requirements

Our systems have an open services based interface architecture that allows for fast, easy integration with AHCCCS, State and federal IT systems and data sources. We can quickly reconfigure our flexible interface architecture to support changing file formats and data elements.

Ability to Support Future Requirements (AHCCCS Technical Interface Document, p.88)

We continually monitor CMS regulations to comply with regulatory mandates. We respond quickly to regulatory changes, evidenced by the fact we were one of the first to receive 5010 certification—far in advance of most vendor supported systems. Our systems are adaptable to updates in order to support future AHCCCS and federal requirements, such as:

ICD-10. We are preparing for the transition from ICD-9 diagnosis and procedure codes to the ICD-10 code sets. Due to the scope and critical nature of the project, UnitedHealth Group has allocated significant resources to ensure a smooth and successful transition to ICD-10. Thousands of UnitedHealth Group and UnitedHealthcare Community Plan employees are working to be code-ready in 2013 to allow for business process changes, training, contract renewals and trading partner testing prior to the mandatory transition date, October 1, 2014. In preparation, we are conducting testing, including inbound and outbound transactions, to validate ICD-10 claims payment (neutrality), such as performance testing, operations testing, encounters testing and HIPAA transaction testing and testing with vendors and customers throughout 2014.

Committee on Operating Rules for Information Exchange (CORE). The CORE operating rules streamline administrative information exchanges and improve provider access to patient benefits coverage and financial information at the point-of-care. CORE is a multi-phase, collaborative health care industry initiative aimed at improving access to electronic patient administrative and payer information for care providers before or at the time of service, using any technology. Each phase expands the available data criteria and augments the functional requirements for electronic data exchange. We have completed the CORE Phase I and II testing process, certifying that we can deliver more efficient and predictable patient-eligibility and claims-verification information to doctors, hospitals, physician offices and other care providers, according to operating rules developed by CORE. We are the first health care organization to complete certification using the updated platform, which builds on non-mandated aspects of the HIPAA version 5010 requirements.

APR-DRG Implementation. All Patient Refined-Diagnosis Related Groups (APR-DRG) organizes approximately 20,000 clinical diagnoses and procedures into approximately 300 groups that each includes a measurement for severity of illness and risk of mortality. This grouping provides a common measurement across disparate patient types that allows for the comparison of hospital services, individual physician performance and patient outcomes through the use of severity adjustment. We have implemented a solution in several states to support APR-DRG grouping using our WebStrat tool, which stores state rate information and prices claims appropriately.

National Health Plan Identifier (NHPI). A health plan enumeration system, coupled with the implementation of the X12 5010 standards, will make it possible to automate third-party payment systems. We are preparing for the NHPI implementation by assigning a UnitedHealth Group enterprise business owner responsible for the implementation and creating a workgroup that meets weekly to analyze the impact of the NHPI on our systems and the changes we will need to make to our technology. Mr. Basavapatna is addressing health plan-specific NHPI requirements and will interface with the national team to ensure local NHPI requirements are aligned with the national effort.

Systems and Data Exchange Requirements (RFP Sections D1/D2, Section 64)

We have in place all of the technical interfaces required to successfully exchange data in the formats prescribed by AHCCCS, including the required HIPAA formats, and to provide the required data elements to AHCCCS.

Performance – Supporting the AHCCCS Interface Requirements

We currently meet the systems and data exchange requirements defined in RFP Sections D1 and D2, Section 64.

Electronic Transactions. We exchange data with providers using HIPAA-compliant electronic transactions, including 270/271U, 276/277, 278, 837 (claims) and 835 (provider remittance advice) file formats. We can make claims payments via electronic funds transfer and accept electronic claims attachments.

Contractor Data Exchange. As an incumbent contractor, we have completed and submitted the EDI Trading Partner Agreement and have a Transmission Submitter Number (TSN) for encounter submissions.

Contractor Responsibilities. We understand that we are responsible for any delayed submission or payment or penalty due to our submission of incorrect data and that AHCCCS will not accept data that does not meet its standards. We agree to indemnify and hold harmless the State of Arizona and AHCCCS from any and all claims or liabilities incurred as a consequence of any incorrect data submission. We understand that neither the State of Arizona nor AHCCCS shall be responsible for any incorrect or delayed payment to our providers resulting from our incorrect data submission. We understand that we are responsible for identifying any inconsistencies in data files received from AHCCCS and that we will correct any unreported inconsistencies at our expense. We have mature systems that programmatically identify and resolve most data file inconsistencies. Our mature processes resolve most file inconsistencies that are not resolved programmatically. When there are inconsistencies in these files that cannot be corrected using our systems or processes, we bring the inconsistency to the State's attention and work with the AHCCCS to remediate the issue.

Member Data. We accept from AHCCCS original evidence of eligibility and enrollment in the daily 834 enrollment data file and the monthly 834 reconciliation data file. We understand these data files are the source of truth for enrollment and eligibility. Upon request, we will submit PCP assignments to AHCCCS and will work with the State to determine an appropriate format for this data submission.

Claims Data. Our Diamond claims processing and payment system is HIPAA-compliant and processes, cost-avoids and pays claims in accordance with ARS 36-2903, 2904 and AHCCCS Rules R9-28 Article 7. We have designed our systems with an open services based interface architecture. We can quickly reconfigure this flexible interface architecture to support future AHCCCS claims-related policy requirements as needed.

System Changes and Upgrades. We understand the costs of software changes are included in administrative costs paid to us. We will continue to work with the State's PMMIS systems contact and to evaluate ongoing Electronic Data Interchange options. When system changes are contemplated we provide a high level of engagement with AHCCCS beginning locally as a partnership between our local team and AHCCCS. As externally driven and internally driven changes are identified, we use the full support of our local and national resources to remain proactive and responsive to AHCCCS. Emerging requests are worked through the change management process. Throughout this process we continue a high level of engagement with AHCCCS, including: agreement and documentation of the requirements; development of a project plan with a timeline and milestones; joint test planning, go live planning and coordination; cross platform test execution, test case review, and testing approval; and go-live coordination and post go live monitoring. We will notify and provide the system change plan to AHCCCS for review and comment and, during implementation of system changes, conduct frequent, agenda-driven, technology-focused meetings including AHCCCS, AHCCCS contractors, UnitedHealthcare Community Plan and other managed care organizations as needed.

HIPAA. We are in compliance with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all federal regulations implementing that Subpart that are applicable to our operations.

HIPAA Privacy and Security Audit. We understand this requirement is under review by AHCCCS and that AHCCCS will provide detailed guidance. Once we have received guidance from AHCCCS, our Compliance Officer, Kimulet Winzer, will ensure the audit is performed in accordance with AHCCCS requirements.

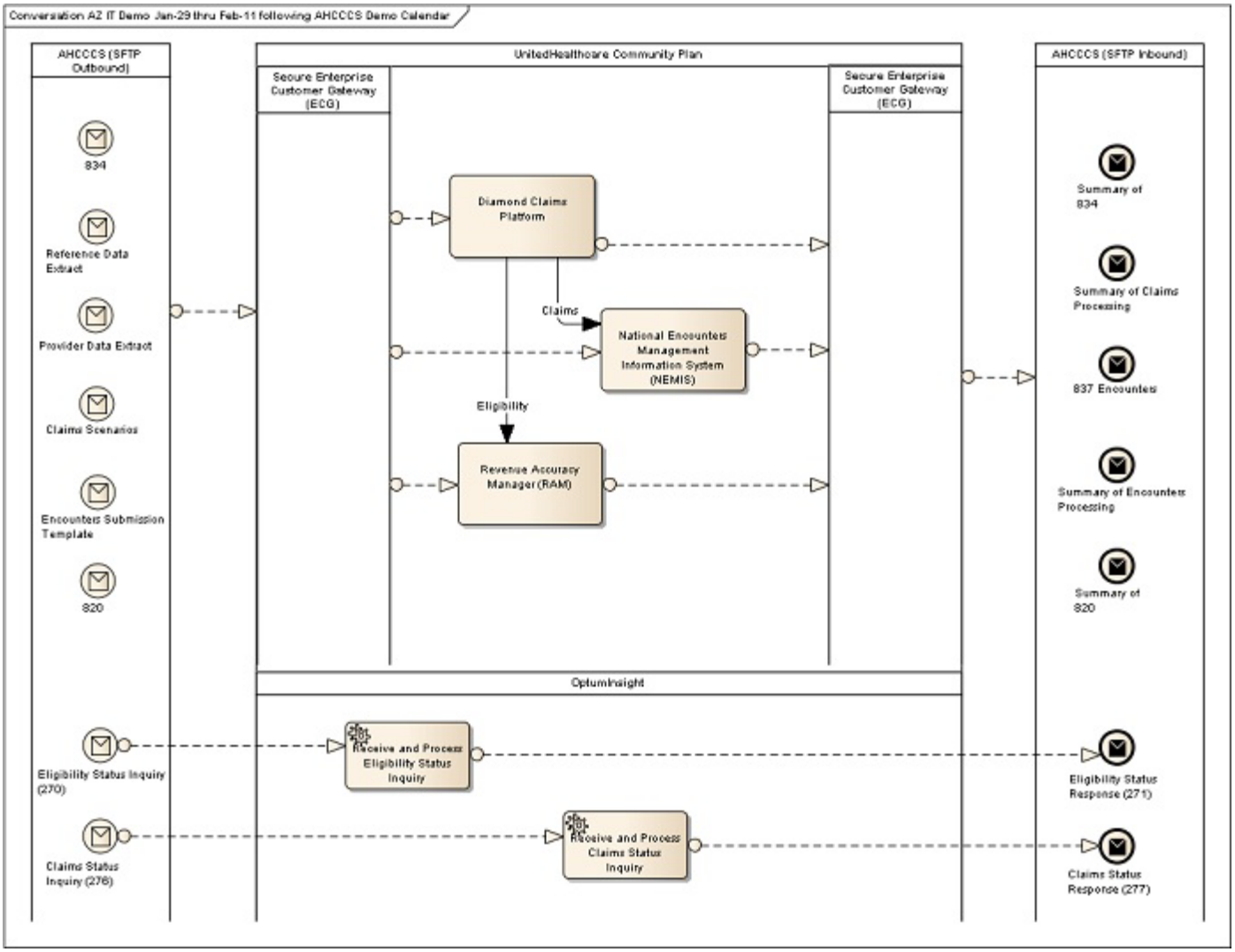
Health Information Exchange. We are contracted as a data user and currently exchange eligibility data with HINAz.

Information Technology Systems Demonstration Acknowledgement

We acknowledge that our participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No.10; that we will comply with the stated guidelines and calendar for this process; and that the IT Systems Demonstration will be scored as part of our proposal.

Our IT system demonstration project management team is led by Gabe Moreno, Implementation Services Project Manager. Mr. Moreno is a member of our corporate IT team and will coordinate our efforts to participate in the demonstration. He will be supported by Jeff Greenspan, Arizona Health Plan Operations Manager, who will manage the local functional teams (e.g., enrollment, claims, encounters and finance) that will assist with user testing and problem solving. Mr. Basavapatna will provide oversight of our efforts to participate in the demonstration.

Our corporate and Arizona health plan IT teams are currently preparing for the IT system demonstration, including assigning local health plan and corporate IT project managers to manage our efforts, developing a project plan, allocating appropriate local and corporate IT resources, planning to receive reference data from AHCCCS, setup of a test environment so that we can load the State's test data and respond appropriately and developing scripts and checklists to ensure we provide accurate and timely demonstration data to the State. The following diagram presents our receipt of AHCCCS test data, the flow of that data through our systems and the submission of successfully processed test data back to AHCCCS.



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F. CRS Narrative Submissions

Access to Care/Network

11. Describe the steps that the Offeror will take to ensure that individuals with a qualifying CRS…

Overview

Through the experience we have gained, we understand the complexity of the CRS program and deliver the best possible care for children and young adults who have chronic, complex and often rare conditions. In our efforts to support CRS families, many of whom are in a vulnerable state, we have successfully developed and implemented an **integrated, family-centered, culturally competent**, multi-specialty, interdisciplinary CRS service plan process. This process is accessible to the four CRS multi-specialty interdisciplinary clinics (MSICs) and other providers, assisting members in navigating the care delivery system and making sure members receive necessary services timely. We work continuously to maintain and expand a network of pediatric sub-specialists and experienced service providers. While sustaining the MSIC model, we have expanded our network by adding additional primary care physicians (PCPs) and behavioral health (BH) providers in the community allowing greater choice in the CRS providers. The CRS program and our network are designed to provide specialty care utilizing the MSIC as the member's health home from which services are provided both within the MSIC and the broader community.

In order to broaden the network and yet maintain a "fully the integrated medical record" requirement, we funded and implemented the use of electronic medical record (eMR) systems with each MSIC and facilitated their connection with the Health Information Network of Arizona (HINAz), our **statewide Health Information Exchange (HIE)**. eMR systems have been initiated for Tucson, Yuma, Flagstaff and Phoenix, to meet the critical need of a CRS **integrated medical record** by importing a Continuity of Care Document (CCD) from HINAz or HISP/Direct into the MSICs' respective eMRs. The CCDs that will be imported will contain clinical data that is available from other eMRs (e.g., hospitalizations, lab results, PCP progress notes). These systems will provide us, along with the MSICs and the community providers, an integrated Virtual Health Record of the CRS care, allowing an **"open"** network.

The delivery of CRS clinical care is difficult to manage because of very limited rural sub-specialists. Moreover, not all sub-specialists are willing or able to work with this fragile population. We are responsible for establishing, monitoring and maintaining a **statewide provider network** that **delivers well-coordinated, family-centered, culturally and linguistically appropriate, multi-specialty and interdisciplinary primary, specialty, dental and BH care**. We currently meet or exceed AHCCCS's required network standards for PCPs, dentists, pharmacies, specialists, ancillary providers and facilities across the state. As part of an **expanded network and member choice**, primary care and BH services will also be offered and have been contracted at the MSICs and surrounding communities.

Accountable Care – Improving Outcomes through Access to Care

Access to Care is a fundamental principle of the program we have developed – an Accountable Care Population Registry (Population Registry) to share key information regarding CRS patients. This year, the Tucson MSIC implemented the tool, focusing on the approximately 378 members who are dually enrolled with CRS and our acute care plan. When comparing Tucson's January 2012 to October 2012 measures, we attained the following improvements:

- Reduced admissions/readmissions/1000 by **79 percent;** increased discharges that were seen by their PCP within seven days by **186 percent**
- Reduced non-emergent ER visits/1000 by **28 percent;** increased ER visits seen by their PCP with seven days by **150 percent**
- Improved **access to care** by increasing kept appointments by **5.9 percent;** decreased 'no show' incidents by **33.3 percent**
- Improved care of high-risk (HR) patients who completed their PCP visit in the last 60 days by **57 percent**

This model is being deployed at the other three MSICs. Through use of the Population Registry and CRS program delivery, we are achieving improved collaboration with Arizona's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to more effectively improve access to care, identify potential risks and provide treatment

of serious and chronic health conditions in order to minimize long-term delays and costly medical consequences in the future.

Measuring Access to Care

For CRS, there is an AHCCCS Quality Management (QM) performance measure that states 75 percent of new members must have their first CRS visit within 45 days or by the date on the member's Initial Service Plan (ISP). We monitor this measure daily and report monthly performance measures to the MSICs. Two of the four MSICs are exceeding the minimum target with 80 percent of new members receiving their first CRS visit within 45 days. We will make sure a new member's initial CRS visit occurs within 30 days and an appointment for initial BH services within seven days of referral, as appropriate, meeting the requirements of this RFP. Additionally, we meet AHCCCS's required network standards. In 2012, we received recognition for our CRS health plan, as a best practice from the Medicaid Health Plans of America (MHPA).

Steps to Ensure CRS Qualified Members Access Needed Care

Network Foundation – Step 1

Since being awarded the CRS contract, we have learned that not all physicians can, or even desire to, care for children with special health care needs (CSHCN). As the only payor in the state with CRS statewide experience, we have a single, **statewide CRS provider network** which includes the four regional MSICs, hospitals, pharmacies, medical, dental and BH providers, durable medical equipment (DME) providers, labs and physical, occupational and speech therapists. Prior to our award in 2008, access was limited to services (Lab, Rad, Rx, DME, specialists, etc.) only in the physical MSICs or adjacent hospitals in Flagstaff, Phoenix, Yuma and Tucson. Through expansion efforts, we created open access to 94 hospitals and statewide labs, radiology, DME and pharmacy. We deployed rare pediatric sub-specialists beyond the Phoenix and Tucson metro areas in field clinics and expanded telemedicine. This open access increased **member choice and service** as they were no longer limited to selected services available at their MSIC or related hospitals. We understand the importance of convenience and **member choice** and continue to expand and improve our provider network where it is possible and supports the MSIC model. Major network enhancements are:

Year	*2008 (Pre-Award)*	*2013 (Current)*
Hospitals	6 regionally based	94 statewide
Therapists (OT/PT/ST)	4 MSIC-based therapists	262 statewide
Durable Medical Equipment	4 MSIC-based locations	Statewide w/field clinics & telemedicine
Pharmacy	4 MSIC-based pharmacies (no mail order)	1,047 Statewide and border communities – on 10/1/13 mail order will be made available to all CRS members
Specialty Pharmacy	St. Joe's discontinued supplemental metabolic formula	**We teamed with ADHS to continue to provide life-saving metabolic formula**
Primary Care Physicians	0	**8,365**
Behavioral Health	0	16 provider organizations with 68 sites 33 facilities statewide

The CRS Network Development and Management Plan demonstrates our capacity to serve the expected and growing enrollment in each service area, in accordance with CRS contract requirements and sound business principles. The network plan is used by the network department, in **collaboration** with other cross-functional teams, as the basis for ongoing monitoring and development of the provider network. The plan is reviewed, updated and submitted to AHCCCS for approval annually.

With such a limited number of specialists within the state who have the expertise or willingness to see CRS members due to their complexity, we have many processes in place to secure needed care that may not be available. We have arrangements with key centers of excellence, such as Children's Hospital in Massachusetts, and Stanford to provide services when needed.

CRS Network Enhancement – Step 2

In 2012, we expanded our CRS network for specialty care, primary care and BH services. Specialty care was expanded through our contract with the CRS Medical/Dental Staff IPA, Inc. (CRS IPA). We added PCPs for CRS through contract amendments to all of our existing PCPs. We also expanded our BH outpatient and inpatient network for CRS services encompassing the scope of AHCCCS-covered services. These expansions **increased member choice and access** to experienced pediatric sub-specialists and included:

- In April 2012, we entered into an agreement with the CRS IPA to provide covered CRS medical services. The CRS IPA is a non-profit physician group who formed more than 20 years ago to serve the specialized and often rare CRS eligible conditions seen in our membership. Mainly serving the Phoenix MSIC, participating CRS IPA physicians also provide critical telemedicine services and travel to other MSIC locations for CRS field clinics across the state to provide pediatric sub-specialty care not available in those locations.
- Also in April 2012, we executed a contract with District Medical Group (DMG) for the management of the CRS Phoenix MSIC. As of October 1, 2012, a new 55,000 square foot state-of-the art facility was opened with no member disruption and for the first time Phoenix members records are electronically stored. Starting January 2013, the Phoenix MSIC will be offering primary care and co-located BH services. We supported the opening of this clinic with financial backing from UnitedHealthcare.

Performance – Center of Excellence

The Barrow's Cleft and Cranial Facial Center has been recognized as a **Center of Excellence**

- An advantage of having contracted with DMG as the new Phoenix MSIC is that we are able to capitalize upon their partnership with the U of A residency program. The residency program is a recruiting tool and a critical component to training future specialists who are knowledgeable, experienced and desire to care for children with CRS conditions. As many of these specialists begin to retire, the residency program benefits the state by ensuring the sustainability of these providers in the CRS program.
- The Tucson MSIC has doubled their capacity for primary care; all of the PCPs in our network are experienced at providing primary care to CRS members with special needs. In addition, BH care is coordinated on site. University residents also do rotations at the clinic as a means of gaining experience in managing fragile children.
- Phoenix Pediatrics, a primary care practice with more than 35 years of experience in CSHCN, is a strong partner of ours. We recently transitioned 300 new complex members due to the termination of Mercy Care plan's contract. Because Phoenix Pediatrics was already in our network, **these new members retained access to the Phoenix Pediatric provider** they had an established relationship with, and we made sure a seamless transition ensued. We continue to contract with the best pediatricians to provide exceptional care and service to our members.
- Dr. David Hirsch, MD, MBA, FAAP, is our Pediatric UM medical director, and was a founding partner in the Phoenix Pediatrics practice. He is a national expert and former committee member of the American Academy of Pediatrics, CSHCN. Dr. Hirsch works in concert with Dr. Leslie Paulus, MD, PhD, FACP, CRS Medical Director to identify recruitment needs and ensure the best outcomes for our CRS members. **They are highly respected.**

Behavioral Health Expansion

Currently, CRS members are limited to four BH visits related to their CRS condition, with many services being provided by the RHBA. Through integration of acute care, BH and CRS benefits, BH services will be expanded. We are prepared with a statewide network of pediatric BH specialists, which will minimize the need for members to change providers.

We developed and will use an **integrated care plan, including BH and primary care services, along with enhancing current family involvement and community support systems leveraging new cloud-enabled community-based health home technology**. Our care coordination teams are ready and prepared to smoothly transition CRS members from their RBHA care provider to our **CRS integrated network** with minimal disruption through our approach to integrating and coordinating BH services (described in question 13). Additionally, we will further enhance the program by ensuring that necessary data will be received and included in our **community-based care coordination system** (CCCS), a cloud-enabled tool, so that regardless of where members receive their specialty, primary or BH care, their physicians will have access to the integrated care plan and will be a formal part of the care team structure for each given member.

The Phoenix and Tucson MSICs and their pediatric psychology experts have been our partners in developing our CRS **model for BH integration**. We expanded our BH network to cover the scope of AHCCCS BH benefits, increasing **member choice** and access to experienced pediatric specialists.

Non-Traditional Services Expansion - Step 3

Expanded Field Clinics

Since 2008, our sub-specialty providers travel to locations closer to the homes of members who are not conveniently located near an MSIC, **providing families with the choice** of remaining in the community and seeing their MSIC provider or going to a field clinic. In the last year, a total of 930 CRS members were scheduled for field clinics across the state. Specifically, there were 35 clinics in southern Arizona, 21 outside the Phoenix area and 22 in Northern Arizona. We are working to expand access and the network on the Navajo Nation through an agreement with Tuba City Comprehensive Care Management Plan (CCMP) for CRS services – our first 638 facility contract.

We also will seek opportunities to expand field clinic options for CRS members. We expanded field clinics in the Phoenix metropolitan area in 2011 through an agreement with Banner Desert - Cardon's Medical Center to provide single-condition urology and gastroenterology services to patients in the East Valley.

Pharmacy

Prior to 2008, the pharmacy network was limited to the four MSICs. Today, it consists of more than 1,100 retail pharmacies statewide and includes popular locations like Walgreens, CVS, Wal-Mart, Target, and community-based food stores like Fry's, Basha's and Safeway. Our network greatly expanded options to offer after-hours, weekends and 24-hour access, allowing families to use the same pharmacy for their CRS and non-CRS children. Families have gained the convenience of using the drive-up window when picking up prescriptions previously called in by the provider. We are in current discussions with Walgreens to have a pick-up location with the Tucson and Phoenix MSICs for increased member convenience. In addition, many CRS members require specialty and metabolic pharmacy services which we continue to provide through the OptumRx network. At the start of the contract, we will offer a 90-day mail order option for maintenance drugs - adding value, choice and convenience to CRS members.

Telemedicine

Our use of telemedicine technology closes service delivery gaps in rural areas where specialty provider services are difficult to obtain. We expanded **telemedicine visits** in the last contract year by 10 percent, **offering post-discharge telemedicine follow-up services, reducing readmission rates** and improving medical outcomes among high-risk patients. In addition, by **extending the reach of specialty provider services** by and offering telemedicine services in Yuma, Flagstaff, Tucson and Tuba City, CRS members and their families no longer have to travel long distances, significantly improving satisfaction. Similarly, by reducing travel to remote locations for field clinic visits, providers are more efficient with their time, reporting satisfaction and expressing interest in expanding services. To meet this objective, we are **working to expand telemedicine services** to field clinic locations in Northern, Eastern and Southern Arizona.

Innovation – Telemedicine Ranks High with Members

In a 2011 satisfaction survey, 94% of members would use telemedicine again.

Telemedicine Innovations

Our commitment to health care modernization and reform includes improving access and leveraging newly developed, low-cost, **cloud-based** technology; in 2012, we **funded** the implementation of this technology. High-speed Internet connections provide an easily accessible, low-cost, secure and scalable answer to a long-standing telemedicine barrier. This technology easily connects with traditional telemedicine equipment using personal computers, tablets and smart phones. Another innovation currently being piloted is a data capture tool called **LifeLens. LifeLens** allows video capture/store and forward capability in the field via iPhones that would allow for higher level review of physical settings as well as member interactions.

Leveraging and Balancing Providers in the MSIC versus the Broader Community

The benefit of the MSIC is a local physical community organization that supports the **health home principles** listed in Section 2703 of the Affordable Care Act (ACA), which include: to provide our members with **comprehensive** care management; **care coordination** and health promotion; **comprehensive transitional care** from inpatient to other settings**; individual and family support**; referrals to community and social services; and the use of health information technology to link services and facilitate the exchange and **coordination of the member's medical records.**

Families of children with complex and chronic conditions face multiple challenges. By offering **comprehensive services** in one location, families benefit from **collaborative, coordinated care**, resulting in **cost effective**, quality outcomes that meet family needs without having to go from specialist to specialist in multiple locations with multiple appointments. **We contract with the four MSICs** who provide the required **34 specialty clinics** and required multi-specialty interdisciplinary teams (MSITs). This includes the requirement to operate specific multi-disciplinary field-based clinics in the community with specific frequencies. Our integration and **coordination of specialists inside the MSIC offers** families a central hub with supportive resources like the child life specialist and mechanisms, such as eMR/EBM that help support their involvement in decisions regarding their child's health care.

Performance – Tucson's MSIC Member Satisfaction

Tucson's most recent Patient Satisfaction Data indicated that **97% felt they received Excellent or Very Good care** from their provider; 94% felt their Overall Experience was Excellent or Very Good.

Each member may choose their PCPs from our expansive network and we will continue to encourage all PCPs to join our CRS network. However, for convenience, we've arranged for primary care services at the MSIC. Currently, the Tucson MSIC provides primary care onsite; the Phoenix MSIC will provide primary care starting January 2013 and the Flagstaff MSIC will offer primary care beginning May 2013. Whether **community-based** or at the MSIC, the CRS member's PCP is a key participant in their shared **integrated care plan**. We will identify a listing of those PCPs who are accustomed to a special needs population, and encourage selection of a board-certified pediatrician for members 12 years and younger. We will incent all CRS PCPs to use HISP/Direct or to connect directly with HINAz so that Progress Notes and Care Continuity Documents can be shared with the multi-disciplinary team. This requirement will be added to our contracts.

We balance services and providers both inside and outside of the MSIC. Viability of the critical MSICs requires sufficient volume to keep them operational. As a managed care program, covered services must be ordered and provided by CRS contracted providers. One way we balance the use of providers in the MSIC versus those in the broader community is through prior authorization. Our general approach is to have services that require the intervention of several sub-specialists occur at the MSIC but those that require only one specialty, such as club foot, to occur in the community. Some services such as therapies are approved outside the MSIC, closer to a member's home. With the use of the Community-Based Care Coordination tool and HIE all primary care services can occur outside of the MSIC. Secondly, we balance the use of providers through coordination with the MSIC. For example, Casa de los Ninos is a BH provider working **collaboratively** with the Tucson MSIC. Joint planning and care conferences may occur at the MSIC, but BH services are delivered in the community, generally at the member's home. In the future, expanded BH services with the **integrated plan** will be offered both on-site and in the community. We will employ **value-based** payment methodologies with the CRS IPA to encourage a balance of MSIC and in-office visits. Using our **Community-Based Care Coordination System**, the tool that supports referral management and care coordination, we have the necessary capabilities to ensure there are no barriers for CRS members to choose a community-based PCP or BH provider and still achieve the need for integrated multi-specialty inter-disciplinary CRS care. Paramount in this care delivery are both a fully integrated medical record and an fully integrated care plan available to the member's multi-disciplinary team of sub-specialists, primary care, behavioral health, life-care specialists and the member's caregiver. Through virtual rounds using secure collaborative video conferencing we can enable joint care plan reviews.

As we have expanded and improved our network over the last five years we have gained vast experience, allowing us to create a vision with measurable success, greatly improving AHCCCS's EPSDT program and the exceptional care we provide to our CRS members.

Program

12. A 13-year old foster child diagnosed with Spina Bifida, Intermittent Explosive Disorder, history of…

Overview

Jana is a 13-year-old foster child newly enrolled in the Children's Rehabilitative Services (CRS) program as of January 10, 2013. Jana's current guardian is her foster family, overseen by Child Protective Services (CPS), who is involved in all of Jana's care decisions. Jana is enrolled in the CRS Partially Integrated Behavioral Health (BH) coverage type and her acute care is with Comprehensive Medical Dental Program (CMDP). The CRS Partially Integrated BH coverage type benefits include both services for all CRS-related conditions and all BH services. Jana will receive her CRS-related medical and BH coordination of care from specialists in the multi-specialty interdisciplinary clinic (MSIC) or in the community in a manner which promotes care continuity and acknowledges the need for a holistic, culturally sensitive, multi-specialty, interdisciplinary **team-based approach** to complex care.

If Jana is an American Indian (AI), CPS coordinates with her tribe regarding custody and guardianship. Depending on the tribe's and CPS's decisions, Jana's acute care may be with CMDP or through Arizona Health Care Cost Containment System (AHCCCS) fee-for-service (FFS). Her BH coverage might be with the Tribal/Regional Behavioral Health Authority (T/RBHA). If she receives T/RBHA services, she would have CRS-Only coverage type benefits, which includes all CRS condition related services.

Below we describe Jana's integrated CRS care plan. This approach centers on six **essential health home service elements:** (1) comprehensive care management; (2) care coordination and health promotion; (3) comprehensive transitional care from inpatient to other settings; (4) individual and family support; (5) referral to community and social support services; and (6) the use of health information technology to link services.

We have created the following care plan, based on a common clinical picture seen with members we currently serve who have spina bifida (SB), in conjunction with the identified high risk concerns of intermittent explosive disorder, poly-substance abuse, and post-traumatic stress disorder (PTSD), which collectively may be related to sexual abuse as well as other types of trauma. Additionally, complex social challenges including placement in foster care with CPS (possibly Tribal) involvement are noted. For the purposes of a refined care plan, we have noted Jana has several acute and chronic care physical needs including: L3-L4 level SB with partial paralysis from her hips down; hydrocephalus requiring a VP (ventricular peritoneal) shunt; a neurogenic bladder and bowel, scoliosis; and a pressure wound.

Health Home Service Elements

(1) Care Management and (2) Care Coordination and Health Promotion

Initial Interactions and CRS Assessments for Jana

Upon receipt of enrollment information from AHCCCS on January 12, 2013, Jana's records are evaluated by our enrollment care coordinator Nancy, a registered nurse with five years' experience developing Individual Service Plans (ISPs) and extensive training in CRS benefits and conditions. She develops the ISP in collaboration with Dr. Leslie Paulus MD, PhD, FACP, CRS Medical Director. Dr. Paulus has 23 years of complex pediatric care experience and nine years' experience specific to the CRS program. Jana's ISP is a precursor to the care plan. It summarizes enrollment information and prioritizes her needs for CRS eligible services. The ISP lists specialty appointments assigned for each CRS diagnoses and BH needs. It also assigns the preliminary care team and health home MSIC.

On January 15, 2013, a member services representative, Arlene informs CMDP via a SharePoint log and the CPS care manager (CM), Stacey, by phone of Jana's acceptance into the CRS program. Arlene provides them Jana's enrolling diagnoses, the multispecialty interdisciplinary clinic (MSIC) assignment and the contact information for Jenniffer, the MSIC clinical coordinator. Arlene apprises Jana's BH providers via a cloud-based community-based care coordination system (CCCS) and requests the required transition information. Jana's primary care physician (PCP), Dr. Pamela Murphy, is also notified of her enrollment, with requests for additional information. She is informed how she will be able to participate in the care plan development and also given Jenniffer's contact information at the MSIC. Dr. Murphy's involvement will allow for coordination of services such as early and periodic screening, diagnostic and

treatment (EPSDT), vaccines, sexuality education and pregnancy prevention to be identified and included in the care plan.

CRS network providers are assigned as the specialists at the MSIC. If the specialists who have previously treated Jana are MSIC participating, Jana is assigned to their clinics; this process supports **care continuity and member choice.** On January 16, 2013, Arlene makes a welcome call to Jana and her foster family to introduce them to the CRS program, and explain the services provided by CRS and those obtained from CMDP, her acute care plan (or if she is AI with T/RBHA, the CRS Only coverage type). A warm transfer is then made to the **Phoenix MSIC** to schedule Jana's first appointments to meet her care needs and ensure scheduling occurs within the appropriate time frame. This assistance is also provided to make sure that her foster family is aware of the care recommended in the ISP. We receive input from the foster family for immediate needs including language translation/cultural concerns and preferences on entry into the program. Jana and her foster family are informed of the CRS *Member Handbook*, available on the CRS program website and in hard copy, which explains the details of the CRS program. They are given the name and phone number of Kari, registered nurse, a CRS coordinator at the MSIC, to assist as needed. In addition, they are told that upon referral a screening BH assessment will be set up by January 16, 2013 to address Jana's BH needs, meeting the seven-day requirement (if Jana is AI and receiving T/RBHA services, her BH services will be coordinated with the T/RBHA).

(3) Comprehensive Transitional Care and Follow-Up

Transition to the Multi-Specialty Interdisciplinary Clinic

Jana is assigned to the Phoenix MSIC based upon geographical location and her ISP is submitted to the MSIC for review. The CRS process for transition includes a risk assessment (CASII -The Child and Adolescent Service Intensity Instrument), which occurs on January 16, 2013 at the first BH visit. The CASII is used to triage to appropriate care management. Jana's identified health care needs drive assignment of a high risk CM named Sally. Sally is a CM with five years of BH care management experience and CRS program training. Jana will be given Sally's contact information at her first BH visit. If Jana receives T/RBHA services, the T/RBHA CM is notified and a request for results of previous assessments is made at enrollment by member services. If no assessments have been completed, one will occur to allow identification of risk for need of care management. For members with high risk assessments scores and T/RBHA involvement, a registered nurse CM, named Pamela, will be assigned. Pamela has five years of experience with the CRS program and 20 years' experience as a pediatric registered nurse. Jana's ongoing services (e.g., prescriptions, durable medical equipment (DME), provider visits) through CMDP, her CRS-related conditions and her BH needs are reviewed by her assigned case manager (Pamela if T/RBHA is involved) after the initial assessment. We **collaborate with Jana and her foster family** to facilitate a smooth transition or continuation of services through current providers for a period of 90 days.

Jana's first clinic visit on February 5, 2013 (within 23 days of the first BH visit and initial consultation) occurs at the MSIC with Dr. Cara Wright, a pediatrician (nine years of CRS experience). The appointment is scheduled back-to-back with Dr. Carolynne Garrison, the MSIC psychologist (20 years CRS experience). This scheduling allows an in-person conference about her SB-related conditions and BH needs, commencing the development of the integrated care plan. The care plan is located on a cloud-based CCCS that is accessible by any of Jana's providers in the MSIC and in the community. Stacey works with other multispecialty interdisciplinary team members (MSIT) present at each visit which includes the nurse, social worker, child life specialist and BH specialist. The clinic composition is specific to the CRS program requirement in which **the clinics are composed of key MSIT members and adjunctive interdisciplinary team members** on an as-needed basis. The MSIC makes a reminder phone call on the day prior to Jana's first appointment(s) and mails pre-visit appointment notices.

Care Plan and Desired Outcomes

Shortly after the first visit, an initial transition care plan is developed by Dr. Wright, Dr. Garrison and Jana's case manager, creating the core care team. The care team recommends transition or continuity of BH providers based upon the provider expertise and therapeutic relationships previously formed, and whether Jana receives T/RBHA services, if she is AI. The care plan is a living document which is updated as identified needs change. The moral or religious belief system of Jana and Helen, her foster mother, are identified. Jana's specific goal to participate in an after-school art club and to increase her social circle is acknowledged. Jana and her foster family are actively engaged in developing the

care plan, including their vision, goals and treatment preferences. All CRS diagnoses with ongoing treatment needs are identified and verified at the MSIC visit on February 5, 2013, allowing appropriate treatment decisions and assignment of appropriate providers. Her care plan encompasses optimal health and wellness goals, and includes psychosocial and cultural needs with input from Jana's community providers, including Dr. Pamela Smith. We reach out for input for elements for the care plan from Jana's CPS case manager, Stacey and CMDP; and the Tribal case manager and T/RBHA if she is AI. **Collaboration with individuals, groups, providers, community organizations and agencies** charged with the administration, support and delivery of services to Jana occurs. The care team monitors completion of the recommended services in the care plan, supporting Jana and her foster family to improve self-management. The MSIC also follows the CRS Clinical Practice Guidelines (CPG) for SB, which is reviewed by Dr. Paulus and subject matter experts annually. The CPG includes requirement for an annual multi-specialty interdisciplinary myelomeningocele (MM) team assessment. After stabilization of Jana's acute transitional needs, she is scheduled for her MM planning interdisciplinary clinic appointment. The appointment is scheduled on a Friday, coinciding with the Phoenix MSIC's **Spinal Bifida Association of Arizona (SBAAZ)** monthly luncheon for members and their families, which is held in the MSIC setting. Our relationship with community partners, like the SBAAZ, strengthens our ability to provide resources to members and families for peer support and coordination of educational needs.

***VP Shunt due to hydrocephalus - Discussion and Plan*:** Jana has complaints of intermittent vision changes and headaches, but no current symptoms. These symptoms are likely related to her CRS conditions; thus, they are added to her care plan for evaluation and management. A neurosurgery appointment is scheduled on March 5, 2013 at the MSIC to evaluate the symptoms. Jana and her foster family are taught the signs and symptoms of shunt malfunction, and an ophthalmology consult is scheduled to evaluate her vision changes. **Desired Goal/ Outcome:** Prevention of death or secondary visual and cognitive complications related to hydrocephalus from unrecognized shunt malfunction.

Relationships – Peer Support and Socialization

The **SBAAZ CRS weekly lunch** is the most celebrated part of an MM Planning Day at CRS. Held at the Phoenix MSIC, this weekly socialization opportunity is enjoyed by all SB members.

***Neurogenic Bladder - Discussion and Plan*:** Jana has frequent bladder infections associated with a neurogenic bladder. She performs clean intermittent catheterization (CIC) for her neurogenic bladder management. There have been no recent renal function testing or urine cultures. VCUG (Voiding Cysto-urethrogram), renal ultrasound, blood and urine tests are ordered to make sure her kidneys are not being harmed. A child life team member plans to be present for any urological exams or tests to assist Jana, based upon recommendations from the psychologist. Kate, the urology nurse for six years, will speak to the psychologist, Dr. Garrison, for the best approach to use when instructing Jana on the proper technique for CIC. It is important to verify her current CIC technique is not contributing to her infections. A bowel program will be reviewed as constipation may increase the risk of urinary tract infections (UTIs) and fecal incontinence. The bowel and bladder program will help Jana with **improved social integration, independence and comfort**, but also prevent gluteal pressure wound worsening. **Desired Goal/ Outcome:** Identify the root cause of the frequent UTIs and prevent renal function problems. Consider Jana's psychological needs related to PTSD, which impact bladder and bowel care, while teaching Jana self-management of her neurogenic bladder and bowel. Improve social integration, independence and comfort.

***Orthopedic needs - Discussion and Plan*:** Jana has several needs, including scoliosis, lower extremity paralysis and an associated buttocks pressure wound. The physical therapy (PT) seating specialist is called to see Jana during the first MSIC visit to assess the positioning and wheelchair needs in relationship to her wound to eliminate pressure. A wound specialist appointment is scheduled and initial treatment prescribed. Jana is scheduled into the MM Orthopedic Clinic in approximately a month, March 5, 2013, to address the worsening scoliosis and its impact on the pressure wound. An MRI is ordered to assess for possible tethering or syrinx, and for any need for bracing or surgical intervention of the scoliosis. A formal PT/OT assessment for ambulatory assistive equipment needs, braces and functional needs is set up for the same day as the MM Orthopedic Clinic.

The impact of Jana being overweight is addressed after obtaining an accurate weight on a wheelchair scale and a BMI calculation (one of the many advantages of the MSIC). Education and written materials are given to Jana and Helen, her foster mother, to help ensure a healthy diet is provided; a nutrition evaluation is scheduled for March 5, 2013 to coordinate with the scheduled MM Orthopedic Clinic appointment. Jana and Helen are provided information on the

AZ Special Olympics (SOAZ**), an integrated school sports and health athletics programs, designed by and for people with disabilities and special health needs. The SOAZ Healthy Athletes program empowers persons with a disability to reduce BMI and lower blood sugar and cholesterol levels**. Jana is excited about being part of the Special Olympics and agrees to work on better nutrition. The BH team will also review the potential that BH issues can cause overeating and may be a contributing factor to Jana's elevated weight. **Desired Goal/ Outcome:** An integrated treatment plan of Jana's orthopedic needs based upon CRS CPGs and the identification of factors that may worsen co-morbidity, Jana's mobility/function and overall quality of life.

***Behavioral Health - Discussion and Plan*:** Jana has been diagnosed with intermittent explosive disorder, poly-substance abuse, history of sexual abuse and PTSD. Jana is also likely displaying associated problems in areas of cognitive function and learning, academic adjustment, attention, mobility, medical compliance, socialization, self-esteem, mood and behavior related to her SB. Enrollment in the foster care system also raises the question of attachment concerns and risk of prenatal exposures, complicating the clinical presentation. Jana's complex needs require assessments to be conducted by a highly skilled BH team who specializes in working with chronically ill children and their families; therefore, Jana will be assigned a higher risk CM.

On February 5, 2013 the MSIC psychologist, Dr. Garrison, evaluates Jana for correct BH diagnoses at her first visit, clarifies current treatments with community providers and formulates plans for the transition of Jana's services or coordination of her services outside the MSIC. An evaluation for the root causes of Jana's PTSD, occurs during the first visit with planned continuation of her assessment at follow-up visits. She assesses Jana's cognitive, educational and vocational goals once acute BH needs are addressed. She works on behavioral approaches to assist in managing the SB condition of neurogenic bladder and bowel, given the potential for PTSD exacerbation with usual treatments. Treatment for the PTSD with counseling is scheduled to occur at the MSIC or community provider based on the care team recommendations. The care team will take into account Jana and her foster family's relationship with the therapist (or T/RBHA if Jana receives services) before a decision is made.

The MSIC child specialty psychiatrist, Dr. Klaehn has extensive expertise with CRS conditions, and knowledge of medication management related to these conditions. He will provide ongoing psychiatric intervention to monitor Jana's mood regulation, impulse control and attention, including all BH medication management, and provide recommendations, when there is T/RBHA involvement. Dr. Klaehn suggests avoidance of antipsychotics, instead using medications to reduce anxiety and manage PTSD-associated hyper arousal. He works with Jana's neurologist to rule out neurological causes for the aggressive behavior. He assists Dr. Mackie, the psychologist in the community who is treating Jana's sexual abuse and poly-substance abuse, in further developing the behavioral treatment plan. Dr. Klaehn continues to monitor the learning, attention and impulse control issues often associated with SB, which sets the stage for problems with mood regulation. Jana's high-risk case manager works with her and her foster family to build further community supports for development of a sober lifestyle, which includes access to 12-step groups, peer support and other individualized approaches to help Jana develop a non-substance abuse peer group, which is essential for treatment. **Coordination of MSIC BH recommendations with the community providers, CPS CM and CMDP (Tribe CM/TRBHA for AI ethnicity) occurs by direct team-to-community-provider interaction, electronic medical record (eMR) access, telemedicine and consultation reports**. **Desired Goal/ Outcome:** Improving Jana's function and independence and addressing all her BH needs using the care plan, which includes the **member/family centered BH team plans.** Jana's complex BH needs related to SB need to be integrated with her other BH needs of PTSD, sexual abuse and substance abuse. Collaborating with all involved providers, while maintaining HIPAA compliance, we will ensure care coordination that uses Jana's natural supports and a trauma informed delivery system service to offer the most appropriate care for Jana.

Pediatric to Adult Transition-Discussion and Plan

We will develop a pediatric-to-adult transition plan for Jana by age 20, but this is actually an ongoing process from adolescence forward. All teens, including those with cognitive disabilities like Jana, are included in planning for adulthood in a way that is meaningful to them. The plan will include developmentally appropriate discussions related to work, education, recreation, guardianship options and social needs. The transition planning reviews Jana's options to opt in if she chooses to remain with the CRS program past age 21. Choices to be explored may be alternate AHCCCS, Medicare or private health plans if she ages out. The transition plan will be age-appropriate and periodically updated to address Jana's current needs. It will include strategies to address barriers to transitioning from a pediatric-

to an adult-oriented system of care and identify an adult-care PCP experienced in her needs. The transition plan will be developed with Jana, her family and her providers. We will adhere to all AHCCCS policies including the AMPM, Chapter 520, regarding Pediatric-to-Adult Transition Plans**. Desired Goal/ Outcome:** Successful transition to adulthood for best outcomes in function and provision of health care needs using an adult transition plan.

(4) Individual and Family Support and (5) Referral to Community and Social Support Services

Our outreach and involvement with community partners enriches member and family networks of peer support, self-advocacy, education and self-management of conditions. Upon Jana's enrollment in the CRS program, she and her foster family are consulted during every step, verifying Jana and her foster family understands and agrees with her health care needs and treatment plan. For example, Sally the CM notes existing social supports and individual/family strengths. She will coordinate with CPS and their identified goals for Jana's return to her custodial family. Jana's power of attorney (POA) and legal guardian information are documented. Sally obtains Jana's records for current medications to allow appropriate psycho-pharmacological evaluation of the causes of her behaviors by February 5, 2013, within the first 30 days of enrollment. Sally plans a meeting with Jana's school to coordinate **her integrated physical and BH needs** for her IEP/504 plan and enrollment in available community youth programs or after-school activities. Coordination with CPS, CMDP is ongoing. If Jana is AI and receives T/RBHA services, the Tribe CM and T/RBHA CM also receive updated care plans. Additional referrals to the community might include: park and recreation programs, Boys & Girls Clubs and Passages, as well as activities with the SBAAZ. The need for respite for Helen, the foster mother, is reviewed. Referrals to the community would align with the identified strengths, needs and culture of Jana as determined jointly with Jana, her foster family and her interdisciplinary team.

(6) Use of Health Information Technology

In 2008, we designed and implemented a process for using an **integrated medical record** that is accessible to the four regional MSICs. This system allows implementing a care plan and making sure information is available to statewide CRS specialists and interdisciplinary teams. We also designed and rolled out the Accountable Care Population Registry (Population Registry) in 2009, allowing the MSIC more timely insight into Jana's emergency room visits and hospitalizations, assisting them in timely follow-up evaluations and **decreasing admissions/readmissions**. The registry also provides information such as medications filled and open evidenced-based medicine (EBM) care opportunities, Health Effectiveness and Data Information Set (HEDIS) care gaps and dates of provider encounters. Additionally, another advancement that will be implemented to further enhance care coordination with our program is CCCS, a cloud-enabled Community-Based Care Coordination System that will allow for any of a CRS member's providers in the MSIC or community to have access to and participate in the development and maintenance of the integrated care plan.

Our innovative Impact Pro™ risk and EBM tool shows the severity of both Jana's medical and BH care needs at any point in her care. Jana's medical and BH risk can be assessed at a variety of points such as PCP or specialist referral, as a result of reports such as an emergency room report, inpatient reports and Impact Pro or Population Registry reports. Jana's risk is identified upon her entry into the CRS program based upon her clinical information and CASII results. We have facilitated the eMR connection with the Health Information Network of Arizona (HINAz), our statewide health information exchange (HIE) from which a Continuity of Care Document (CCD) can be imported into the MSICs' respective eMR systems. For providers not connected to HINAz, we will incentivize use of HISP/Direct through Health-e Connections to share clinical records. The CCDs will contain clinical data that is available from eMRs (e.g., hospitalizations, lab results, PCP progress notes), so we and the MSICs will have an integrated, global view of the CRS total care in order to improve access and health outcomes. The use of an eMR and connection to HINAz is consistent with federal and state privacy laws and enables us to operate the HP in a manner that is **efficient and effective for health care** and **provides improved, well-coordinated, interdisciplinary care**.

Summary

Our integrated CRS care model will provide **innovative care coordination** processes to address Jana's complex physical, behavioral and social needs. She and her family are fully involved as services are facilitated and coordinated. As a result, Jana will achieve greater independence; reduce her risks and complications and gain insight and personal growth along the way, allowing for improved function and health outcomes.

13. Describe the Offeror's approach to integrating and coordinating behavioral health services for CRS…

Overview

Kristen Challacombe, MSW, Vice President Children's Rehabilitative Services (CRS) and **Dr. Leslie Paulus, MD, PhD, FACP, CRS Medical Director** are directly responsible for implementing our approach to integrating and coordinating behavioral health services for CRS members. Ms. Challacombe has 12 years of Arizona Medicaid experience with five specific to the CRS program. Dr. Paulus began her medical career as a resident with the CRS program. She has 23 years of complex pediatric care experience and nine years of experience specific to CRS. Together, with our numerous committed provider partners, MSICs, community stakeholders and employees, we have plans in place to achieve successful CRS benefit integration and care coordination with minimal member disruption.

In collaboration with the member, family and others, we will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Behavioral health services will be tailored to the member and family and will be provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the member's/family's cultural heritage. Increasing and promoting the availability of integrated, holistic care for members with CRS and behavioral health conditions will help these members achieve better overall health and an improved quality of life. In developing our integrated care service delivery model, we utilize the Arizona Vision for children principles including: (1) Respect for and active collaboration with the member and parents is the cornerstone to achieving positive behavioral health outcomes; (2) Implementation of the behavioral health services must lead to functional outcomes, stabilizing the member's condition and minimizing safety risks; (3) Collaborate with all providers/specialties when conducting assessments and developing, monitoring and adjusting service plans; (4) Access to a comprehensive array of behavioral health services, sufficient to ensure members receive the treatment they need; (5) Evidence-based best practices guide the delivery of services; (6) Services are provided to member in the most appropriate setting; (7) Members identified as needing behavioral health services are assessed and served promptly; (8) The unique strengths and needs of members and their families dictate the type, mix and intensity of behavioral health service provided; (9) Behavioral health services support the stability of the member, minimizing multiple placements, helping a member remain at home; (10) Services are provided in a manner that respects the cultural tradition and heritage of the member and family; (11) Independence is supported by services that include support and training for parents in meeting their child's behavioral health needs, and support and training for members in self-management; and (12) Connections to natural supports available to the member and parents' own network of associates, including friends, neighbors and community organizations are utilized.

Integrating Behavioral Health Services for CRS Members

In developing our integrated approach to behavioral health (BH) services for CRS members, we recognize the significant need for collaboration with members, families, providers and other agencies. We view members and their parents as our partners throughout the care delivery process. This includes their active participation and expressed preferences in the assessment process, the planning, delivery and evaluation of behavioral health services.

Our approach to the delivery of BH services includes (1) providing each member with a BH assessment; (2) assigning a BH professional to each member receiving BH services; (3) developing and revising, as needed, each members' individual service plan; (4) making referrals to services providers, as needed; (5) coordinating all behavioral, physical and CRS services ; (6) developing and implementing transitions, discharges and aftercare plans for each member; and (7) actively engaging members, families, and peers in service planning and service delivery. All of these services are integrated with CRS and physical health care services, resulting in a holistic manner.

Integrated Care Model

In our CRS integrated care model, the member is the center of all care activities and the MSIC is the member's health home. The member's PCP, providers, physicians, advocates and community stakeholders are their **partners in care.** The member and family are afforded the **highest quality and most cost-effective care through appropriate care coordination** and benefit delivery. Based upon the results of risk stratification tools and of health and BH assessments, highly complex members are paired with a high-risk care manager who is accountable for monitoring and ensuring the **member's integrated care plan** is followed and goals are achieved. The care manager is an integral part of the

member's care team. Pamela Ray, registered nurse, leads our pediatric, high-risk care management program and brings 20 years of nursing experience with five years care managing complex pediatric members.

All currently enrolled CRS members have an initial service plan (ISP). In the last contract year, we achieved **100 percent** timely service plan development every month. AHCCCS's minimum standard for this quality metric is 95 percent. Our vision is to improve **care coordination** for children with special health care needs by transforming how care is delivered across the full continuum of physical, BH and **community-based services**. Upon CRS enrollment, an ISP is developed, summarizing a member's demographic information and prioritization of services. This is the first step in assessing a member's health needs and precedes development of a program enhancement, i.e., a member specific **integrated care plan**, which encompasses a treatment plan for specific physical and BH diagnoses. We coordinate with the MSIC, providing records obtained from the initial eligibility determination. Member Services makes a welcome call to the member and family to introduce them to the CRS program. Member Services then transfers the call to the MSIC to schedule the member's initial appointments making sure the member is scheduled within the required timeframe (30 days or less for a CRS visit and seven days for a BH referral). An appointment with the PCP may be made depending on health care concerns and follow-up needs identified in clinical documents. The **care management team includes community partners,** e.g., Raising Special Kids, Mentally Ill Kids in Distress (MiKid) or school nurses. These partners strengthen our ability to provide resources to members and families for peer support and **coordination** of educational needs. BH Screening is a standard element of the ISP with further actions dependent on that initial screening. All screening results become part of the care plan.

Network

UnitedHealthcare Community Plan is committed to assisting members and families in achieving recovery and resiliency. Our approach to BH service delivery is to continuously evaluate and improve the service delivery system. We recognize the children's BH system of care is well established in Arizona. We believe in using the strengths of the existing children's BH system, while focusing on further developing areas of identified need or concern in partnership with the Children's Provider Network Organizations (CPNOs) and current BH providers, ensuring continuity of care and ease of transition. In addition, some of the MSICs have expanded and now include BH providers onsite (therefore co-located) Members and their families now have a choice of receiving BH services in the MSIC or in the community, including in the member's home. The CPNO, QCN, has become part of our contracted network for CRS.

In 2008, we successfully transitioned CRS members from a closed network, limited to four regional MSICs, to a single statewide CRS network that both increased members' access to care and improved members' choice of hospitals, pharmacies, durable medical equipment providers, and physical, occupational and speech therapists. We understand the importance of member choice and have expanded our statewide CRS network in preparation for an integrated CRS plan. In 2012, we expanded our primary care physician (PCP) network for CRS through contract amendments to all of our existing PCPs (over 8,300). We also expanded our BH network to cover the scope of AHCCCS BH benefits (16 provider organizations with 68 sites and 33 facilities statewide). This expansion increases member choice and access to experienced pediatric specialists. Our members will have access to a comprehensive array of BH services through our BH network, enabling us to smoothly transition CRS members from their RBHA care provider to our CRS integrated BH network with minimal disruption.

Comprehensive Care Plan

Upon enrollment or referral for BH evaluation, each member will receive an initial BH assessment by a qualified BH professional to identify specific member strengths, goals and needs related to BH services. The results of the BH assessment and identified care needs will be incorporated in the member's comprehensive care plan. The member's unique strengths and needs which dictate the type, mix and intensity of BH services. The assigned BH provider becomes an active participant in the member's integrated care team. The comprehensive care plan includes all behavioral, physical, CRS and social care needs of the member and is unique to the strengths and needs of the member

Care Coordination and Referral Management

Based upon the comprehensive care plan, the assigned BH provider will delivery or make referrals to address the member's care needs. Referrals are made to appropriate BH providers and community supports for both the member and the family, including community peer support services. Peers may be used to assist members and families make

and attend appointments as well as with care transitions. Care coordination activities include at a minimum, engaging the member and family in service planning, communicating among the behavioral, physical and CRS service providers regarding the member's progress and health status, test results, lab reports and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services and/or errors. The care team will ensure periodic re-assessments occur at least annually or more frequently when the member's psychiatric and/or medical status change**.** The care team will monitor adherence to treatment goals including medication adherence and individual health status and service utilization to determine use of evidence-based care and adherence to the ISP.

Technology Used in Care Management Services:

Community-Based Care Coordination System (CCCS)

Key to our approach to integrating BH for CRS members is our cloud-enabled Community-Based Care Coordination System (CCCS). This web-based tool will be available to CRS network providers (within and outside of the MSIC) and supports referral management with electronic capabilities, including a secure messaging application that enables the multi-specialty interdisciplinary team (MSIT) to make service referrals to community-based providers and to coordinate with our BH partner to ensure identification of BH issues. CCCS supports secure exchange of member information, e.g., a comprehensive member summary with diagnoses, progress notes and care conference notes.

Health Information Network of Arizona

We work with Health Information Network of Arizona (HINAz) in continuing to deploy a statewide health information exchange (HIE) that processes in-bound and out-bound member data transactions (demographic and clinical) via HL7 and CCD formats. Data can be viewed via a Virtual Health Record by any provider responsible for member care and participating with HINAz, providing MSICs and **community-based providers** with ready access to CRS members' medical records.

The current functionality of HINAz allows membership data to flow into HINAz from payors along with demographic and clinical data to flow into HINAz from ambulatory clinics, radiology clinics, labs and SureScripts (pharmacy). The data is downloaded from HINAz and then imported into the provider's electronic medical record (eMR) system. Community PCPs not connected to HINAz and participating in CRS will be asked to share clinical information with CRS through HISP/Direct offered by Health-e Connections. HINAz stores member demographics, scheduling information and clinical data, and it is **member centric and fully electronic**, with the information viewable and reportable. MSICs currently send data to the HIE from their eMR systems. They have access to the HIE and the capability to import clinical data for members into their respective eMR systems, creating **a community-based clinical record**. This sharing of information allows MSICs to holistically treat the member and **coordinate care**. Any health care provider that becomes a participant in the HIE has access to member data, if authorized.

In Q1 2013, HINAz will send clinical data to payors who can use the data for analysis to improve both population health and reduce health care costs. The data will be sent directly to participating providers' eMR systems once they are fully operational, creating an **integrated medical record** from all community participants. Notifications of health care events will be sent real-time to participating providers so they can make appropriate care decisions. Notifications and alerts will also be provided to BH providers.

OptumRx Psychotropic Pharmacy Solutions eLERT

An innovation that assists us in formulating treatment plans and coordinating care is the OptumRx Psychotropic Pharmacy Solutions eLERT, which is a program that identifies over-medication and use of drugs that have potentially harmful interactions. This is vitally important because children and youth with CRS-eligible conditions and BH care needs are often over-medicated, leading to higher risk and poorer health outcomes.

eMR and HIE enable an Integrated Medical Record, including all Medications

At the MSICs, we use an **integrated medical record**, which feeds and receives information via HINAz. An example of its use is in the area of pharmacy services, notification occurs when there is suspicion of over-medication occurrence or use of drugs that have potentially harmful interactions. The program is integrated; therefore all of the member's medications are noted and evaluated on an ongoing basis. This includes both BH and PH medications. The MSIC's use of an eMR and connection to HINAz enables us to **operate the health plan in a manner that is efficient and effective** for health care and to provide improved, **well-coordinated, interdisciplinary care**.

Quality and Performance Measures

Based upon the information in the integrated care plan, we will ensure initial assessments for BH services are conducted within seven (7) days of referral and routine appointments for ongoing services are conducted within 23 days of initial BH assessment. In addition, the eMRs will be monitored for referral follow-ups, information sharing through progress notes and completion of all appropriate screenings, including their scores.

Coordinating Behavioral Health Services for CRS Members

Care coordination will be enhanced for CRS members through use of our **CCCS** cloud-based tool, resulting in shared BH information and actionable care opportunities among service providers and the MSIT. A high-risk care manager is accountable for managing the member's CRS **integrated care plan**. On October 1, 2013, AHCCCS will determine CRS eligibility and enroll individuals into one of the CRS coverage types depending upon which primary program the member is enrolled in for acute care services and the choices made by American Indian Health (AIH) members regarding where to receive their acute care and BH services, including:

- ***CRS Fully Integrated*:** BH services provided by the CRS contractor
- ***CRS Partially Integrated – Acute*:** BH services provided by a Tribal RBHA
- ***CRS – Partially Integrated BH*:** BH services provided by the CRS contractor for Comprehensive Medical Dental Program (CMDP) and developmentally disabled (DD) members
- ***CRS Only*:** BH services provided by a Tribal RBHA for CMDP, DD AI and AIH program members

Upon receiving AHCCCS notification of individuals who are enrolled in CRS, we will assign the new member to a MSIT and provide the appropriate member notifications. Care coordination staff will provide the six pre-defined health home services. We will make sure a new member's initial CRS visit occurs within 30 days and an appointment for initial BH services within seven days of referral, as appropriate, meeting RFP requirements. We will provide health information technology infrastructure to link services, facilitate communication among the MSIT and community-based providers, the CRS member and their family. Our **CCCS** will support efficient ongoing member management and support. This comprehensive, cloud-based tool will be available to the entire care team and will facilitate a focus on the member through features, (e.g., the ability to share a dynamic, integrated care plan) to ensure comprehensive services and supports related to medical, behavioral and social services.

The CRS integrated care plan documents mutually agreed upon goals and the action plan to achieve those goals. It includes evidence-based/informed interventions, which recognize and are tailored for the medical, social, behavioral health, functional impairment, cultural and environmental factors that children with special health care needs and their families face daily. In addition to targeted clinical outcomes, the health action plan will document how progress toward outcomes will be measured.

All efforts are made to involve the member, family, natural supports, service providers, specialists, schools, PCPs and community partners to provide compressive care by continually evaluating, planning and implementing an **integrated care plan** that allows for the member to reach their full potential. Our **CCCS** tool will facilitate the exchange and analysis of CRS fully integrated and partially integrated member information and supports **our approach to integrating and coordinating BH services for CRS members, as outlined by the following steps:**

1. Tracking and Sharing Member Information

- ***Notifications and Alerts:*** Leveraging HINAz hospital ADTs, we will use CCCS to send automatic, real-time alerts to care team members to notify them of any hospital-related member events, including emergency room and inpatient admissions or discharges. **CCCS** will be the source of communications about provider visits, progress notes, diagnoses, lab results, gaps in care, medication adherence and updates to the care plan. **CCCS** supports configurable access protocols to member information, e.g., customized roles, levels of access, member event triggers/alerts and auditing/reporting of access to member data.
- ***Integration with eMR and HIE:*** **CCCS** supports integration of eMR and HIEs to secure and consolidate lab results, medications prescribed and progress notes. We will work with HINAz to assess connectivity.
- ***Secure Messaging:*** Service providers and the MSIT can also communicate with one another through **CCCS** and securely transmit protected health information, e.g., care plans. **CCCS** uses Direct.

- ***Report Generation:*** **CCCS** generates reports on a wide variety of subjects relevant to CRS member needs, including enrollment, specialist assignment, member outreach attempts, access to member data and other metrics.

2. Monitoring Processes of Care and Outcomes

Our **CCCS** tool houses the CRS integrated care plan, enabling comprehensive monitoring by the member's high risk care manager as well as the MSIT. The care plan includes:

- A clinical documentation suite with customizable interdisciplinary care plans; individual, group and case conference progress notes; and a integrative workflow that focuses on the member
- A member's full clinical history, health action goals, interventions, assessment results, progress notes from all providers, member and provider-defined priorities and an audit log highlighting updates and changes to the CRS integrated care plan
- The ability to review, update and create member interventions
- An outreach journal, documenting all attempts to contact the member via phone, mail, email, home visit, hospital visit and community visit

3. Initiating Changes in Care

Changes in care can be initiated in response to alerts and **CCCS** messages resulting from customizable triggers to a wide variety of events, including emergency room and inpatient admissions or discharges, provider visits, diagnoses, abnormal lab results, gaps in care and medication adherence issues.

4. Addressing Member Needs and Preferences

We can leverage **CCCS** to address the needs and preferences of our member, including:

- ***CRS Enrollment:*** **CCCS** supports efficient management of enrollment by enabling modification and updating of member enrollment and eligibility status, which can be configured according to the specialized program.
- ***MSIT Assignment:*** A care team designed to meet the unique needs of each member will be assigned through **CCCS**. Multi-specialty interdisciplinary teams will include CRS-required specialists, PCPs, physical and behavioral health specialists, care coordinators, community-based service providers, and the member/family.
- ***Consent and Permission Management:*** **CCCS** enables documentation of member privacy consent and management of stakeholder access levels to variety of available member information.
- ***Member Input into Coordinated Care Plan:*** **CCCS** includes options for recording member preferences, e.g., prioritization of health goals.

5. Care Transition Management and Notifications

Our **CCCS** tool is an effective and efficient transition-of-care engine, beginning with the assignment of a new provider to the MSIT. New PCPs are able to access a member's integrated care plan and use the **CCCS** to share continuity of care documents from other providers' eMR systems. Care team members update the coordinated care plan based upon the discharge summary for a member. Through the Messages Application, care team members communicate and securely transmit member documents, including attachments (e.g., discharge summaries, referrals and care plans) and leverage custom templates for specific transitions of care.

- ***Over-Utilization:*** We will provide the four MSICs with timely and actionable information regarding incidents of over-utilization (e.g., non-emergent emergency room use, one-day stays and readmissions) through HINAz alerts. Real-time notifications will be logged by care coordinators in **CCCS**, which can be programmed to identify possible intervention strategies.
- ***Under-Utilization:*** We currently provide under-utilization reports to the MSICs. We will use CCCS as an additional tool to analyze a meaningful number of claims over a set period of time in order to accurately identify gaps in care and actionable opportunities using evidence-based guidelines. Also, **CCCS** has a catalogue of more than 120 different assessment tools, which can be customized to identify gaps in care.
- ***Need for Preventive Care:*** The **CCCS**'s integrated CRS care plan will notify all care team members of gaps in care and post prompts to initiate an intervention or update the care plan. Gaps in care will be identified based upon diversions from care pathways based upon identified medical, behavioral and social issues and established in accordance with evidence-based guidelines.

14. Describe the mechanisms that the Offeror will use to ensure that all providers, including those…

Overview

CRS provides medical care, rehabilitation, and related support services statewide to 24,600 AHCCCS-enrolled children and young adults diagnosed with one or more qualifying CRS chronic and disabling conditions. In October 2008, we began serving as the enrollment and health plan contractor for the CRS Program. For our CRS members, health care involves multiple clinicians, **covering the entire continuum of care**. This includes primary care physicians (PCPs), multiple specialists and other providers who may be involved such as: tribal/regional behavioral health (T/RBHA) providers, specialty pharmacy, durable medical equipment (DME), physical, occupational and speech therapists, diagnostic services, including telemedicine and field clinic coordinators.

CRS care is driven by a **multi-specialty interdisciplinary team** (MSIT) consisting of physicians and providers both inside and outside the multi-specialty interdisciplinary clinic (MSIC). Over time, a CRS member may transition to several lead specialists as their treatment needs change. Because of the complexity of the needs of these members requiring multiple surgeries, hospitalization, physical and BH care, it is imperative that there is an accessible **integrated electronic medical record (eMR)** for each member. Prior to 2008, when we became the contractor, this was accomplished by limiting access to a single location so the medical records and the care provided could be more readily coordinated. Surgeries, hospitalizations, and clinics were only allowed to occur in a very limited number of locations and the majority of clinics relied upon on-site pharmacies.

Since 2008, we have been contracted with the four regional MSICs: Yuma MSIC (Yuma Regional Medical Center), Phoenix MSIC (District Medical Group), Flagstaff MSIC (Flagstaff Medical Center), and Tucson MSIC (Tucson Children's Clinic). From the beginning of our CRS contract, we have worked tirelessly to fund, develop and **implement an electronic, integrated medical record** for CRS. In addition, since 2011, UnitedHealthcare Community Plan has contributed significantly to the development and facilitation of the Health Information Network of Arizona (HINAz), the statewide health information exchange (HIE), ensuring connection for us as a payor and for each of the MSICs.

Through the use and expansion of various technologies, we ensure all providers, both those within the MSIC setting as well as those outside of the MSICs have access to the data required to appropriately coordinate care for our members.

Mechanisms Used to Ensure Access to Data

Enrollment Mechanisms

When we became the CRS contractor, the Arizona Department of Health Services (ADHS) had several Performance Improvement Plans (PIPs) with Arizona Health Care Cost Containment System (AHCCCS) for timeliness of CRS eligibility, both for the percent of AHCCCS members for whom a positive and negative determination was made, as well as for timeliness of an initial service plan (ISP) and first visits. As part of our contract, we developed a new technology system, the Service Activity Manager (SAM) that enables CRS applications to be processed within the required 14-day time frame.

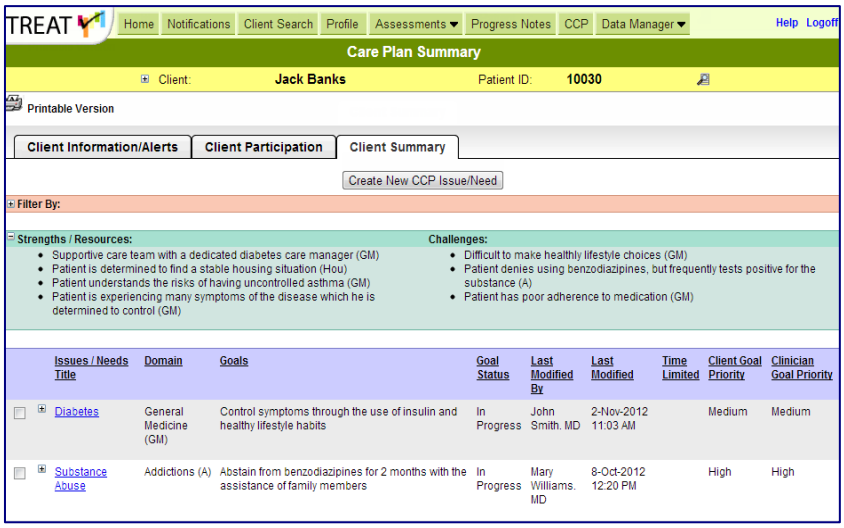
Excellent Performance Results in High Standards

In January 2011, AHCCCS increased the metric from 75% to 90% for timely notification. To date, we exceeded the standard for every single month.

SAM is an intranet-based database application that allows CRS enrollment staff to enter all the elements of a CRS application. In addition, all related medical documents necessary to make a decision about an applicant's enrollment can be uploaded. SAM is, however, much more than an enrollment tool. It also enables us to document important health information about an applicant that is used to develop the ISP along with the member's continued **comprehensive care plan**. Our prior authorization, clinical liaisons and **MSIC partners** all have access to SAM via a secured network. This is extremely helpful for **care coordination**, and is fully compliant with AHCCCS Contractor Operations Manual (ACOM) 409 requirements for coordination with AHCCCS health plans. Due in large part to SAM's implementation, we helped ADHS close their timeliness of CRS eligibility PIPs. Today, we consistently **exceed the performance standards** for timely eligibility notification and ISP development. Upon award of this contract, we will work to provide AHCCCS the right of entry to SAM to verify continued timely coordination of enrollment.

Cloud-Enabled Community-Based Care Coordination System

Effective with the new contract aware we will implement another enhancement to the program, **Community-Based Care Coordination System** (CCCS), a secure cloud-based tool. CCCS enhances care coordination for fully and partially integrated CRS members, providing access to an interactive care plan that is accessible to everyone on the member's care team, including providers within the MSIC, those in the community as well as those in the tribal communities. CCCS makes it possible for the MSIT to coordinate care by managing, analyzing and engaging members in real time as they move through the delivery system. The comprehensive care plan along with all additional services, are documented in CCCS and are available to all members of the care team. Each member of the care team, whether an MSIC specialist or a community-based PCP, can view and document care interventions or plan for a member's particular issue. CCCS also provides evidence based guidelines and care pathways based upon the member's identified medical, behavioral and social issues.



Accountable Care Population Registry

As the health home for the CRS members, the MSICs have been equipped with our Accountable Care Population Registry (Population Registry), enabling the MSICs to access clinical information on their assigned member population. The Population Registry is a secure web-based tool that provides clinical teams with the health information for all 24,600 CRS members. The Population Registry provides users with three distinct yet complimentary views of critical data: (1) Population View which provides access to lists of members in the population who need specific follow-up action and integrates processes and scripts for follow up steps including discharge management, emergency visit management and preventive care; (2) Patient View which provides access to three years of clinical history, one member at a time; and (3) Performance View with enables access to reports on performance trends and outcomes.

Today, nearly 30 hospitals provide us nightly with an electronic data of all admissions, discharges and transfers (ADTs) for our members, via a file transfer protocol (FTP) site. Each morning, we upload the notifications of emergency visits and inpatient discharges from the day before into the Population Registry and match to the member's clinical team for follow up and care coordination. Evidence-based care opportunities alert care coordinators to gaps in treatment of clinically complex members. This system will be made available to other care team participants.

Electronic Medical Records (eMR)

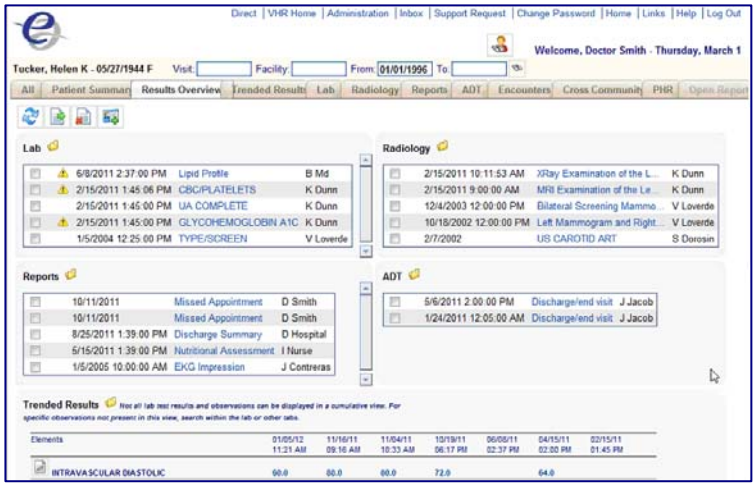
An eMR system captures and houses the member's demographic, scheduling and clinical data which is fully electronic, viewable and reportable. The eMR is vital to member **care coordination and accessing integrated health information**. It provides clinicians with timely access to members' clinical history and facilitates shared access to health information. Use of an eMR for the CRS population is expected to increase the clinician's ability to **manage complex conditions efficiently and effectively**. An eMR also **promotes reduction of redundant services** and **reduces medical errors and drug interactions**. For example, electronically stored results of tests such as laboratory tests, an MRI or a CT scan can be readily accessible to a wider range of providers, reducing the need for a repeated procedure. In order to have a more comprehensive view of the patient's outside the clinic encounters, we have begun work on importing a Continuity of Care Document (CCD) from HINAz into each of the MSICs' eMR systems. The CCDs that are imported contain clinical data that is available within the HIE (e.g., hospitalizations, lab results,

prescriptions filled) so the MSICs and the health plan, and other providers, have an **integrated, global view** of the CRS members.

Behavioral Health Mechanisms

With the new CRS contract starting October 1, 2013, the CRS program will **integrate primary and BH care**. Key to our approach for integrating and coordinating BH services for CRS members is our **CCCS** tool, which is available to our network providers and supports referral management through a number of electronic capabilities, including a message application that enables the MSIT to make service referrals to community based providers and coordinate with our BH partner to ensure identification of BH issues. **CCCS** also supports the secure exchange of member information and documentation, including a comprehensive member summary that includes diagnoses, progress notes and care conference notes. As a member of the care team, BH professionals will be able to view and document care interventions or plan for a member's particular issue or condition.

Health Information Exchange Virtual Health Record Mechanism



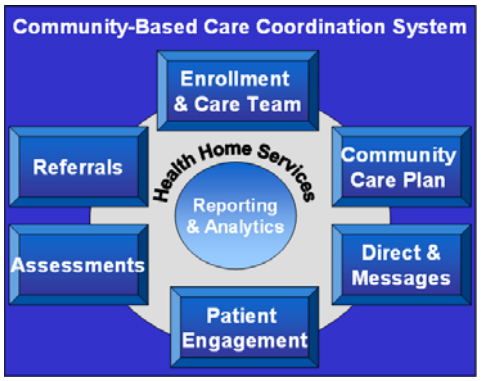
We continue to work with HINAz to create a functional statewide HIE that processes in-bound and out-bound patient data transactions (demographic and clinical) via HL7 and CCD formats. Data can be viewed via a **Virtual Health Record** (VHR) by any provider responsible for member care and participating with HINAz. This allows both hospitals and ambulatory settings to see a patient's clinical record. We continue to work with providers to expand the number of hospitals and clinics sharing data in HINAz. We have secured participation from Banner, CHW, TMC, UMC, Flagstaff and YRMC – all key players in the CRS program. We are working with PCH to have them join as well. In Q1 2013 AXOLOTL will launch the first phase of our integrated CRS clinical repository with hospital and ambulatory data from HINAz.

Consolidated Clinical Repository

In order to improve our analytic and measurement capabilities using clinical information we also plan on collecting HL/7, CCD, lab and pharmacy data from HINAz to build a consolidated **Clinical Repository**. Using real-time clinical data from the repository, we will apply our evidence-based rules engine to identify alerts on potential gaps in care for the populations we serve. Using episode treatment group (ETG) and episode risk group (ERG) tools, we will also apply episode of care analytics to help clinicians identify elements of the episode of care, which may be driving higher costs. We will share the interventions stemming from this analysis back with providers for care management opportunities with their patients. This repository will help us develop new program quality measures such as BMI, depression screenings, AOD screenings, the number of care transition records sent to PCPs and referral tracking.

Accessing Data for Appropriate Care Coordination

Each of the above mentioned mechanisms describe how we ensure all providers have access to the data needed to provide appropriate and timely care coordination. These mechanisms collectively come together in our **Community-Based Care Coordination System (CCCS)**, which facilitates the exchange and analysis of data and member information for CRS fully integrated and partially integrated members. CCCS also supports our approach to **integrating specialty, primary care and BH services** for CRS members. CCCS is a comprehensive, cloud-based system that is available to the entire care team and facilitates a focus on the member through numerous features, including the ability to share a dynamic, coordinated health action plan used to integrate services and



support related medical, behavioral and social services.

In our CRS integrated care model, the member is the center of our care coordination activities and the MSIC functions as the member's health home. The member and their family are afforded the **highest quality and most cost-effective care through appropriate care coordination** and benefit delivery. Based on the results of our risk stratification process and tools, and health and BH assessments, highly complex members are paired with a high risk care manager who is accountable for monitoring and ensuring the CRS **member's integrated care plan** is followed and goals are achieved. The care manager is an important of the member's care team. This model ensures the best outcomes for the CRS member by putting the right information into the hands of those who need it, when they need it.

Our CRS integrated model and CCCS support providers accessing data for appropriate care coordination. The member's MSIT coordinates care by managing, analyzing and engaging members and other providers in real-time as members require CRS covered benefit initiation, care planning and transitions of care. Care coordination activities include:

- Establishing rapport with the member, involving him or her and their family as decision-makers, in their care.
- Recognizing and applying cultural norms.
- Completing assessments and developing a member-centered integrated care plan.
- On an ongoing basis, the assigned care team may make contact via telephone, email and text, as appropriate.
- Asking questions and listening to a member's responses to gain insight into medical, BH and social problems.
- Performing BH screenings and health action planning using standardized and approved screening tools and health action plan templates.
- Using our comprehensive assessment tool as part of the goal-setting process. This assessment tool identifies problems or barriers to care and provides knowledge and insight necessary for goal-setting, action-planning and problem-solving strategies to overcome these barriers.
- Identifying root causes for inappropriate health care utilization or gaps in care.
- Reviewing cross-system health and social service utilization for care opportunities.
- Assessing the member's specific medical, behavioral health and long-term service needs.
- Identifying and providing referrals to resources (e.g., transportation to medically necessary services or therapy groups) that support the member in attaining the highest level of health and functioning.

CCCS is a collaborative platform, which creates connection points for partners in care to unify around data and tools that support real **care coordination**. It is distinctive in both the use of HISP/Direct connections for PCPs and community based providers. CCCS establishes a dedicated care coordination environment, managed by a high risk care manager, who will share actionable, evidence-based care opportunities at the point of care through proprietary risk and assessment software; alerting the MSIT of adverse events through secure messaging.

This will reduce systemic quality challenges often associated with providing complex care for children and youth with special health care needs, as well as, identify individual open care opportunities and decrease service duplication. Equally important, it provides **a sustainable environment for data that will enhance and streamline CRS complex care delivery** – *simply put*; it creates a **sustainable technology solution that enables the transformation of care**.

Transition Plans

Using CCCS, we have developed an implementation plan to ensure that all members transitioning from other health plans or a Regional Behavioral Health Authority (RBHA) have a documented transition plan within the first 90 days. This plan will ensure that there is minimal member disruption and allows for all providers involved in the care of the CRS member to view the care plan.

Pediatric to Adult Transition

We currently monitor and audit the MSICs to ensure that the MSIT has engaged the member in developing a pediatric to adult transition plan starting no later than age 16 and by age 20. The plan is **developed with members, families and their providers**. The transition plan includes strategies to address barriers to transitioning from a pediatric- to an adult-oriented system of care.

The plan is age-appropriate and periodically updated to address the member's current needs. It also identifies an adult-care PCP, for care received outside the CRS program, if the member decides not to opt in prior to their 21st birthday. In addition to health care, developmentally appropriate discussions related to work, education, recreation and social needs, are a part of the planning for adulthood. All youths, including those with cognitive disabilities, are included in planning for adulthood in a way that is meaningful to them. We will continue to adhere to these policies and all policies in the AMPM, Chapter 520, regarding Pediatric to Adult Transition Plans. Additionally, if a member chooses to transition out of the CRS program at age 21, their physicians will have access to their transition plan via CCCS.

Change of Contractor

When we receive members from a relinquishing health plan as a result of a contract award, we are responsible for **coordinating their care** so that services are not interrupted. A recent example of our ability to quickly and seamlessly transition members is when DDD ended the Capstone developmentally disabled (DD) health plan contract in 2012, and we were asked to assume Capstone's 1,700 members. We used our stakeholder relationships with the local Special Olympics of Arizona and the CRS Flagstaff MSIC to assure and inform DD members and families regarding this transition. Judy Smith, LCSW, our Flagstaff clinical liaison, made calls to and answered member questions from families, many of whom were familiar with Judy from their CRS relationship.

With the new CRS integrated contract, we will continue to ensure smooth transitions for members by maintaining their current providers and service authorizations at the time of enrollment for a period of up to 90 days, unless mutually agreed to by the member or member's representative. When relinquishing members, we are responsible for timely notification to the new health plan regarding pertinent information related to any special needs of transitioning members.

Summary

We have gained vast experience, learned hard lessons and invested substantially in our employees, infrastructure training, provider network, and our proprietary systems to ensure that providers both in and outside the MSIC have access to the data needed to improve health outcomes for CRS members through enhanced coordination of care. We are committed to our vision of CRS integrated care. This vision will be realized through **a sustainable information exchange environment that will streamline** the complex systems of care delivery that exist today for some of the most vulnerable Arizonans – ***children with special health care needs***.

Organization

15. Describe the role that stakeholder input will play in all facets of the CRS Program. Provide a written…

Overview

We understand that the Children's Rehabilitative Services (CRS) program can be challenging to navigate so we have implemented proven strategies to ensure ombudsman/client advocacy for our client advocacy program, **what we refer to as member advocacy and member advocacy program.** Ms. Judie Walker is our Member Advocate and it is under her direction and leadership that we established a member advocacy program that provides accessible, **effective, person- and family-centered, culturally** and linguistically appropriate care, delivered in a manner consistent with evidence based practice guidelines and best practices throughout Arizona. Ms. Walker is a partner in care, helping the member to advocate for themselves or their child, to better navigate the multitude of health and social service systems and to access care. She breaks down barriers on an individual level, and identifies systematic issues within our own processes. Ms. Walker is a key collaborator and works closely with the Division of Development Disabilities (DDD) and Indian Health Services (IHS) for their dual CRS membership issues.

Giving and caring about the communities and people where we live and serve is evident at all levels of our company, from the top executive at UnitedHealthcare through our front line employees. In Arizona, our COO, Sheila Shapiro, is a board member of the March of Dimes and has helped to secure funding for the March of Dimes Pertussis Awareness Program. In the past year, Arizona employees have volunteered more than 2,700 hours to community-based organization (e.g., Special Olympics of Arizona, St. Vincent de Paul), including 251 hours to the March of Dimes. In the last three years, Arizona employees have donated more than $1,250,000 in time and cash contributions.

Through our CRS stakeholders such as: multi-specialty interdisciplinary clinics (MSICs), medical and behavioral health (BH) providers, clinic-like settings (e.g., field clinics, virtual clinics, telemedicine) community-based advocacy groups, primary care physicians (PCPs), pharmacies, therapies, labs and diagnostic services, we preserve continuity of care, existing member/provider relationships and member/family choice.

Stakeholders' Input into All Facets of the CRS Program

The role of our stakeholders is to provide input for operational change and improvement and to influence the design and benefit mechanisms of CRS in order to provide quality, holistic care to Arizona's special needs population. We enlist their input through regularly standing meetings, member surveys, grievance investigations, participation of family members on various MSIC boards and community partner meetings, as a few examples. We recognize the importance of **collaborating** with stakeholders and addressing the changing mix of services needed by CRS members. The stakeholder role encompasses many facets, including, but not limited to: **integration** of an expanded service model, **care coordination**, network development, member service, reimbursement models, quality, medical management, community partnerships, **member/family involvement** and American Indian Health (AIH) care systems. These stakeholders provide expertise that contributes to the alignment of member needs with community resources, which overall enhances our CRS program delivery.

Relationships – Stakeholder Community Forum (Held June 13, 2012)

"As I was gathering my thoughts from yesterday's meeting, I realized I didn't get a chance to thank UnitedHealthcare's leadership about the meeting. I appreciate the health plan for making the process transparent and for providing updates to all involved parties." Son Yong Pak, CPHQ, CPC, Arizona Chapter of the AAP

Our stakeholders are too numerous to list individually, but some key stakeholders are: **state agencies** (Arizona Health Care Cost Containment System (AHCCCS)/Arizona Department of Human Services (ADHS)/Department of Economic Security (DES)), **national programs** (National Center on Financing Children with Special Health Care Needs/ Family Voices), **members, their families, family-driven advocacy groups** (Raising Special Kids/ Pilot Parents of Southern Arizona), **community organizations** (Arizona Association of Community Health Centers/March of Dimes/Special Olympics of Arizona/Arizona School Nurse Consortium), **medical and BH care providers** (EAR Foundation), **PCPs/physicians** (Phoenix Pediatrics), **therapists** (Arizona Physical Therapy Association) and the multi-specialty interdisciplinary clinics (MSICs). We value our

partner relationships and believe they enhance our ability to provide **member-centric** services, service evaluations, and member/family/provider education. Through our partner relationships, we are able to provide recommendations for **innovative ways** to improve and **integrate service delivery** that reflect best practices, as well as **effective, efficient** provision of care.

Stakeholders

We receive information and feedback from stakeholder groups such as: members and their families; providers, physicians and MSICs; and community/regulatory organizations. The information is either directly acted upon such as providing member materials or is used to improve the CRS program as detailed below.

Members and their Families

The most important stakeholder is the member and their family; they are the heart of what we do. All efforts are made to involve the member, family and their natural supports with other stakeholders, to provide comprehensive care by continually evaluating, planning and implementing a care plan that allows for the member to reach their full potential.

The **member advocacy program** promotes family involvement and supports families as key decision-makers in the care and services their child receives; one example of family involvement is through our Member Advocacy Committee (MAC). We **collaborate** with CRS graduates, families and community stakeholders in the development and review of recommendations for program improvements, training topics, websites and materials for the CRS program design and model. In addition, the ADHS, through their contract with Raising Special Kids, supports our **family and member volunteers** and allows them to partner with us through our member advocacy program.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS 4.0H) Child Medicaid survey that included the Children with Chronic Conditions (CCC) question set

This is the second year the CAHPS survey was conducted for CRS members using the additional children with chronic conditions protocol. 'Rating of Health Care' improved 7.5% from 2011 to 2012 and 'Obtaining Needed Care Right Away' was scored at 92%, a 6.2% improvement.

Providers, Physicians and MSICs

Our four MSICs touch members daily and are able to solicit member feedback through member satisfaction surveys, grievance investigations, participation of family members on various MSIC boards of directors and co-locating our staff at the MSIC, to provide information to and establish relationships with our CRS members and their families. We have embedded CRS clinical liaisons and enrollment representatives in the MSIC to help members **navigate and coordinate systems of care**, understand their **member rights and choices** and connect members to community resources. In addition to our employees being co-located within the MSICs, our Tucson clinic has multiple agencies including a parent-to-parent advocacy group, and our Flagstaff MSIC is a Safe Child Center (SCC) location (SSC is a program for evaluation of children who have been abused).

A key provider and stakeholder for CRS is IHS and 638 facilities. We are working to expand access and the network on the Navajo Nation through an agreement with the Tuba City Comprehensive Care Management Plan (CCMP) for CRS services – *our first 638 facility contract*. Additionally, we collaborate and obtain feedback from the AHCCCS American Indian Health Program (AIHP) through our quarterly CRS AHCCCS health plan meetings. Feedback is used from these meetings to improve CRS care coordination and benefit delivery.

Community/Regulatory Organizations

We have built **collaborative relationships** with community groups, health care and business coalitions, service providers and physician groups, educators, family and disability advocacy organizations and government entities, to develop a responsive network and promote the health and wellbeing of the CRS eligible population. These partnerships allow us to **coordinate efforts** and provide and disseminate up-to-the-minute, easily accessible information that impacts care and services available to CRS members. This is accomplished through regular informal and formal communications, including, but not limited to: newsletters, social media, provider forums, member events, our community webpage and a dedicated, published email account CRS_special_needs@uhc.com , which is monitored by our member advocate, Judie Walker.

Community agencies contact Ms. Walker directly when they have questions or hear that members have run into barriers; in turn, this information is used to correct any misinformation or identify and fix any care delivery or process issues both on an individual or systemic level. Many of these relationships have also resulted in invitations to participate in monthly/quarterly partner council and committee meetings, such as the Newborn Screening Partners, Children's Action Alliance and EAR Foundation meetings. Participation on these committees permits us to regularly receive real time feedback; thereby, allowing us to recognize what we do well, respond quickly and identify root causes when issues are identified and provide factual information.

Recently, DDD ended the Capstone developmentally disabled (DD) health plan contract, and we were asked to assume Capstone's 1,700 members. We used our stakeholder relationships with the local SOAZ and the CRS Flagstaff MSIC to assure and inform DD members and families regarding this transition. Judy Smith, LCSW, our Flagstaff clinical liaison, made calls to and answered member questions from families, many of whom were familiar with Judy from their CRS relationship.

Our stakeholder reporting structure consists of the MAC, which comprises members from all lines of business and represents diversity of ages, languages, disabilities, special needs, families, members and advocacy partners. The MAC meets quarterly and provides minutes/recommendations to the Service Quality Improvement Committee, who further reports to our Quality Management Committee (QMC). The QMC oversees and is responsible for implementation, **coordination and integration** of all quality improvement activities for the health plan. They, in turn, report to the health plan's board of directors. Joint Operating Committees of our MSICs, our CRS/AHCCCS health plan's quarterly meetings and CRS's medical directors' monthly meetings are standing meetings that help us manage CRS clinical operations and network, identifying any gaps and recommending network retention strategies.

Examples of How we Use Stakeholder Feedback

Social responsibility is part of our culture and how we do business. It is an evolving, strategic, cross-functional discipline that is made up of the common ground shared by our businesses, employees, communities and our mission as a company. Last year 79 percent of our employees and 97 percent of our executives spent time volunteering in the communities of people we serve. Arizona is a leading health plan within UnitedHealthcare which provides us leverage as we campaign for successful initiatives such as Community Partner Initiatives, United Mobilizing Communities' Research Innovation, Community Services Connection Innovation and United Community Grants Programs, as described below.

Community Partner Initiatives

The purpose of our Community Partner Initiative (CPI) is to bring our community partners together to leverage all of our community resources in offering an **integrated, community-based, coordinated system of care** for Arizona residents with disabilities and Children with Special Health Care Needs (CSHCN). We held an inaugural meeting in 2012, and due to the success and request of participants, four CPI meetings are now scheduled in 2013 (two in Maricopa County, one in Pima County and one in Northern Arizona). We believe the relationships we establish through CPI allow us to take advantage of future partnering opportunities, such as responding to community and national grants, and collectively leveraging our assets to deliver quality and **cost-effective** services for our members and their families.

Relationships – UnitedHealthcare is Best in Class

"The dedication and leadership exhibited by their staff in developing local collaborations with providers, patients and their families is inspirational… their vision for a fully integrated delivery model for children with special health care needs is truly best in class."

Kote R. Chundu, M.D.
Professor of Pediatrics, U of A College of Medicine Chair, Department of Pediatrics, Maricopa Medical Center
President and CEO, District Medical Group

United Mobilizing Communities' Research Innovation

We have funded a research project to redefine people's interactions with the health system by tapping the potential of communities "to help people live healthier lives" and manage their own care, despite rising costs and limited access to the health system. Working with community partners, meetings have been held at Adelante in Mesa where the focus of the study is being directed; the results of this study will be made available to all participants. The group is now working collectively to move the project forward. Ms. Walker is helping to maximize the use of stakeholders in the Arizona marketplace to identify appropriate social, political and community resources. She also continues to assess other community-related activities

ongoing within UnitedHealthcare to determine potential partnership opportunities. Our community partners also benefit from our Community Services Connection Innovation for needs such as maintaining updated materials.

Community Services Connection Innovation

Innovative solution is our Community Services Connection, which is a pilot program that allows us to connect the many organizations in the community who offer support to those in need including our partners and members. This involves the **development of a proprietary database of local community service organizations** that can be accessed through iPad web browsers to help connect people to services such as: information and requirements for those seeking housing, youth activities, senior programs, clothing, food, legal advice and more. This program is being evaluated and considered for future deployment. Our Community Grants program provides another opportunity to support and assist our partners.

United Community Grants Program

We have a UnitedHealthcare community grants program provided at no charge to our partners. We inform **community-based organizations** of this service and help to match our community partners with available grants. The consulting services available encompass: **grant funding**, which includes identifying organizational needs and available sources of funding to support them; researching summaries on funding organizations, population health needs, and gaps in existing services; and **skill-building/consulting services**, which incorporates program review to "tell your story" in the most compelling way possible; proposal editing and review. It is difficult for non-profits to identify and apply for needed funds so we created this community grants program. One such grant was awarded to the ***Arizona Special Olympics*** who, with the assistance of Ms. Walker, received a ***$240,000*** grant for a statewide program to integrate sports.

Expectations, Goals and Responsibilities for the Client Advocate as well as the Client Advocacy Program

National Standards for Children with Special Health Care Needs (CSHCN)

The Member Advocacy Program is founded upon the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) core outcomes. These include promoting the **community-based** system of services and breaking down barriers to community living for people with disabilities. To monitor progress towards these outcomes, we review, evaluate and update our CRS member advocacy program and work plan annually as we: regularly assess member and family satisfaction through care conferences, surveys and community meetings; provide ongoing, coordinated, comprehensive care, monitored by our CRS clinical liaisons, within our MSICs, our health homes; ensure sufficient insurance coverage and provide adequate and quality-covered benefits; provide ongoing screening for CRS members and coordination with BH, the Arizona Early Intervention Program (AzEIP), and DDD; make available community-based services for members providing uncomplicated access for families; and assist members with transitions to all aspects of adult life.

Member Advocacy Program

One vehicle of the advocacy program, overseen by Ms. Walker, is **our MAC**. As mentioned earlier, the MAC reports up through our QMC structure to our plan's board of directors. We understand the importance of obtaining input and feedback from Arizona members regarding the care provided by our plans, and embrace best practices for involving **members and their families as decision-makers** in helping design the CRS program. Our MAC is designed to make sure that we have a **comprehensive approach** to understanding and appreciating the unique aspects of special needs in all systems and programs. MAC will also provide input on BH services including policy development, planning of **integrated services**, service evaluation and Arizona member/family/provider education, and help develop recommendations for **innovative ways** to improve and **integrate service delivery**.

In addition to the MAC, our member advocacy program provides **opportunities for collaboration** with Arizona members, community representatives, advocacy groups and **community-based providers** to come together to share successes, bring issues and ideas from our Arizona members to us, jointly work on community outreach, identify common ground around legislative issues, provide input and feedback on new and future initiatives and review and evaluate how our programs fulfill our mission. Our member advocacy program also works to ensure member rights, family involvement, and continuous quality improvement through its policies, practices and decision-making

structures. We make sure that the CRS program supports families in their natural caregiving roles, promoting normal patterns of living and **family collaboration**.

Member Advocate Role

Our CRS Member Advocate, Judie Walker has a dedicated position which is responsible for overseeing our **member/parent advocacy program** which includes serving as an advocate within our health plan and within the community on behalf of CRS members and their families. This position works cross-functionally across our organization with our community outreach team, and other areas such as: member grievances and appeals, member services, provider services, compliance, CRS/DD, AIHP, LTC clinical teams and BH organizations. This role is to advocate, educate, inform and empower CRS members and their families.

Ms. Walker has 26 years of early childhood development knowledge, eight of which were serving the public at ADHS/OCSHCN overseeing the CRS program's Member and Provider Services, as well as cultural competency and family involvement areas. In 2010, the National MCHB presented Judie with the ***Champion in the Field of Maternal and Child Health in the States and Jurisdictions*** award for her outstanding contributions and excellence in improving systems of care for children and youth with special needs and their families. All of her experience was gained in Arizona serving Arizonians with special needs.

Compassion – Our Advocate Cares

Judie's name and direct phone number were printed on every member letter, stakeholder presentation and community email blast regarding the Phoenix MSIC transition of 16,000 CRS members - she helped inform and reassure members and community advocates.

Ms. Walker is an educator on best practices regarding care and support for families with children and youth with special needs. She delivers presentations on the CRS program and offers trainings on best practices. She is integral to our member services team. Through her personal experiences as a parent and her work, Ms. Walker has provided families with access to policy makers at all levels of government, bringing their voices into policy and program development. A tireless builder of partnerships, she is a member of the Institute of Human Development (IHD) and Newborn Screening Advisory Council and has championed numerous causes thorough her work with groups such as: Family Voices, Arizona Department of Education, Exceptional Student Services, Arizona Department of Health Services, Children's Action Alliance and Arizona Bridge to Independent Living and Raising Special Kids. She is known as a creative problem-solver at the federal, state and local levels, bringing together the resources of community players in **collaborative ways** to serve CSHCN.

Program Expectations, Goals and Responsibilities

The expectations, goals and responsibilities of our member advocate and member advocacy program are coordinating and disseminating communication regarding the advocacy for CRS members both inside the organization and outside in the community; overseeing the organization's member/parent advocacy program; and providing technical assistance in areas such as grievance cases and in the development of programs, systems, training, and resources that help meet the needs of our state's Medicaid populations (CRS, DD, Arizona Long-Term Care System (ALTCS), AzEIP, Duals, and the Elderly and Physical Disabled (EPD) program).

We recognize the importance of including all voices in the decisions and advancements of the CRS program. Engaging all stakeholders including: members, families, service providers, specialists, PCPs, including BH, and community partners, has provided us comprehensive feedback to drive change and improvement of our program, and fulfill a need for all parties to be heard. This **collaboration** has been successful for us for many years, helping us gain confidence and build trust within the community. We continue to **move forward innovatively and collaboratively** with all groups as we promote the health and wellbeing of our CRS members and provide them with our exceptional, **integrated, family-centered, culturally competent**, multi-specialty, interdisciplinary care.