

EXHIBIT A: OFFEROR'S CHECKLIST

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EXHIBIT A: OFFEROR'S CHECKLIST

The Offeror must complete the Offeror's Checklist. The Offeror's Checklist must be submitted with the Proposal and shall be the initial pages of the Proposal. The Offeror's Checklist includes all submission requirements for the Proposal. It is the Offeror's responsibility to ensure it has submitted all requirements in the RFP notwithstanding the items included in the Offeror's Checklist.

In the column titled "Offeror's Page No.," the Offeror must enter the appropriate page number(s) from its Proposal where AHCCCS may find the Offeror's response to the specified requirement. Refer also to the **Submission Requirements** outlined in RFP Section H: Instructions to Offerors.

OFFEROR'S CHECKLIST		
Submission Requirement	RFP Section	Offeror's Page No.
Offeror's Bid Choice Form	RFP Exhibit B Refer to Bidders' Library	3
Offeror's Completed and Signed RFP Solicitation Page	RFP Section A	5
Offeror's Signed Signature Page(s) for each Solicitation Amendment	Refer to Bidders' Library	6-A – 15
Capitation Bid Submission		
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Completed and Signed Attestation	RFP Exhibit F Refer to Bidders' Library	177

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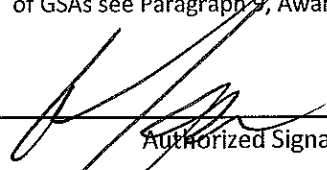
EXHIBIT B: OFFEROR'S BID CHOICE FORM

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SECTION I: EXHIBITS
EXHIBIT B: OFFEROR'S BID CHOICE FORM

Contract/RFP No. YH18-0001

EXHIBIT B: OFFEROR'S BID CHOICE FORM

ALTCS E/PD YH18-0001 BID CHOICE		
<p><u>Southwest Catholic Health Network Corporation dba Mercy Care Plan</u> Offeror's Name</p> <p>GSA North: Mohave, Coconino, Apache, Navajo and Yavapai Counties GSA South: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties GSA Central: Maricopa, Gila, and Pinal Counties</p>	<p>is bidding on the ALTCS E/PD Program in the GSA(s) <u>checked</u> below:</p>	
PERMISSABLE BIDS BY GSA		
N/A	Central Only	No
N/A	Central and South Only	No
<input type="checkbox"/>	North Only	Yes
<input type="checkbox"/>	South Only	Yes
<input type="checkbox"/>	North and South Only	Yes
<input type="checkbox"/>	Central and North Only ¹	Yes
<input checked="" type="checkbox"/>	Central and North and South ²	Yes
<p>¹In order to be considered for award in the Central GSA, the Offeror <u>must</u> submit a competitive bid in the North GSA as well. A submission for the Central GSA that does not include a proposal for the North GSA will not be considered. However, AHCCCS may choose not to award a contract for both GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.</p> <p>²AHCCCS does not intend to award contracts for all GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.</p>		
<p style="text-align: center;"> _____ Authorized Signature</p>	<p style="text-align: center;">January 13, 2017 _____ Date</p>	
<p style="text-align: center;">Mark Fisher _____ Print Name</p>	<p style="text-align: center;">President and Chief Executive Officer _____ Title</p>	

SOLICITATION # YH18-0001 ALTCS E/PD

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OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final Proposal revisions (if any). Signature also certifies Small Business Status.

Arizona Transaction (Sales) Privilege Tax License No.:

86-0527381

Federal Employer Identification No.:

For clarification of this offer, contact:

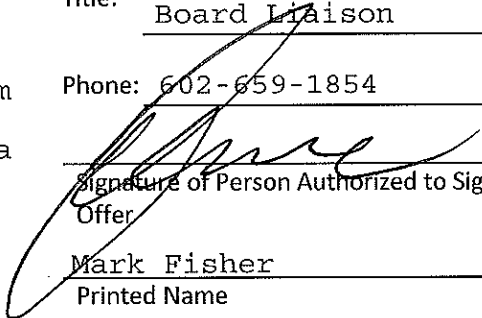
Name: Sharee' Perry

Title: Board Liaison

E-Mail Address: perrys@mercyareplan.com

Phone: 602-659-1854

Southwest Catholic Health Network dba
Company Name Mercy Care Plan


Signature of Person Authorized to Sign Offer

4350 E. Cotton Center Blvd
Address

Mark Fisher
Printed Name

Phoenix Arizona 85040
City State Zip

President & CEO
Title

CERTIFICATION

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

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror 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.
4. The Offeror certifies that the above referenced organization _____ is / 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, amendments and final Proposal revisions (if any), 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. The Contractor is cautioned not to commence any billable work or to provide any material or service under this Contract until Contractor receives written notice to proceed.

This Contract shall henceforth be referred to as Contract No. YH18-0001

Award Date: _____

MEGGAN HARLEY, AHCCCS Chief Procurement Officer

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SOLICITATION AMENDMENTS

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SOLICITATION AMENDMENT #6

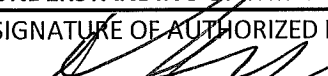
<p>YH18-0001 ALTCS E/PD RFP</p>	<p>Solicitation Due Date: January 23, 2017 3:00 pm Arizona Time</p>	<p>Chief Procurement Officer: Meggan Harley</p> <p>Email: EPDYH18_QuestionstoRFP@azahcccs.gov</p>
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A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

Section D: Program Requirements, Paragraph 80 – Value- Based Purchasing

Value-Based Purchasing Initiative: The purpose of the VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 318 CYE 16 and CYE 17 and as specified in Attachment F3, Contractor Chart of Deliverables. Quality distributions to Contractors will be funded by assessing 1 percent of Prospective Gross Capitation (Quality Contribution) exclusive of Acute Care Only payments. One hundred percent (100%) of the Quality Contribution will be distributed to one or more Contractors according to the Contractors’ performance on selected Quality Management Performance Measures relative to minimum performance standards established by CQM and the Contractors’ ranking on QMPMs. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a Contract Year basis. It is the intent of AHCCCS to require that the Contractor move to the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 effective October 1, 2017. Additionally, AHCCCS intends to update ACOM Policy 318 CYE 16 and CYE 17 requirements regarding the percentage of payments that must be governed by VBP strategies. That language shall require that both the ALTCS E/PD Contract, and the MA-DSNP Contract for ALTCS E/PD Duals, each reach 35% and 50% of total payments governed by VBP strategies for CYE 18 and CYE 19 respectively. Inclusion of payments for Room and Board for members residing in Nursing Facilities (which are included in per diem payments and not separately identifiable) are permissible when computing the percentage of total payments that are governed by VBP strategies.

<p>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</p>	<p>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</p>
<p>SIGNATURE OF AUTHORIZED INDIVIDUAL: </p>	<p>SIGNATURE: SIGNATURE ON FILE</p>
<p>TYPED NAME: Mark Fisher</p>	<p>TYPED NAME: Meggan Harley, CPPO, MSW</p>
<p>TITLE: President & Chief Executive Officer</p>	<p>TITLE: Chief Procurement Officer</p>
<p>DATE: January 18, 2017</p>	<p>DATE: 01-17-2017</p>

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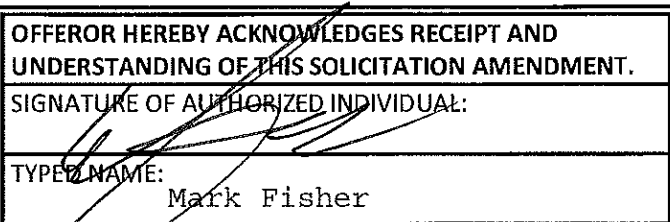
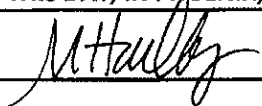
SOLICITATION AMENDMENT #5

<p align="center">YH18-0001 ALTCS E/PD RFP</p>	<p align="center">Solicitation Due Date: January 23, 2017 3:00 pm Arizona Time</p>	<p>Chief Procurement Officer: Meggan Harley</p> <p>Email: EPDYH18_QuestionstoRFP@azahcccs.gov</p>
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A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

1. The attached IT Demo Calendar revisions are incorporated as part of this solicitation amendment.

<p>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</p>	<p>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</p>
<p>SIGNATURE OF AUTHORIZED INDIVIDUAL:</p> 	<p>SIGNATURE:</p> 
<p>TYPED NAME: Mark Fisher</p>	<p>TYPED NAME: Meggan Harley, CPPO, MSW</p>
<p>TITLE: President & Chief Executive Officer</p>	<p>TITLE: Chief Procurement Officer</p>
<p>DATE: January 13, 2017</p>	<p>DATE: 01-11-2017</p>

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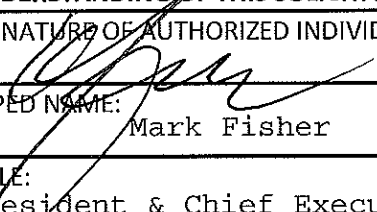
Douglas A. Ducey, Governor
 Thomas J. Belach, Director

SOLICITATION AMENDMENT #4		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: January 23, 2017 3:00 pm Arizona Time	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

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 ON THIS DAY, IN PHOENIX, AZ.
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: Mark Fisher	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President & Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: January 13, 2017	DATE: 01/06/2017

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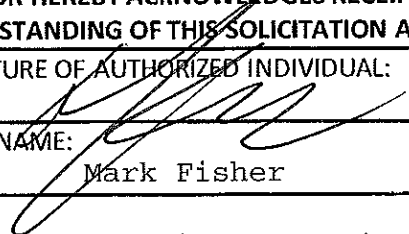
Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #3		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: January 23, 2017 3:00 pm Arizona Time	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

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 ON THIS DAY, IN PHOENIX, AZ.
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: Mark Fisher	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President & Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: January 13, 2017	DATE: 01/06/2017

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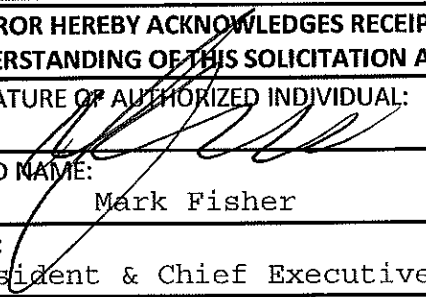
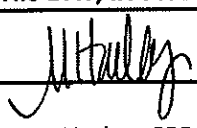
Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #2		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: January 23, 2017 3:00 pm Arizona Time	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

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 ON THIS DAY, IN PHOENIX, AZ.
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: 
TYPED NAME: Mark Fisher	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President & Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: January 13, 2017	DATE: 11/21/2016

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SOLICITATION AMENDMENT #1		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: January 23, 2017 3:00 pm Arizona Time	Chief Procurement Officer: Meggan Harley Email: <u>EPDYH18_QuestionstoRFP@azahcccs.gov</u>

A signed copy of this amendment must be submitted with your solicitation response.

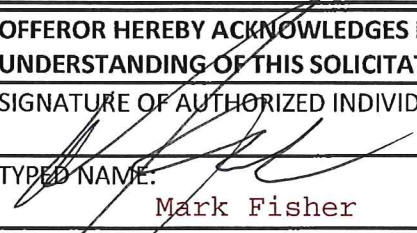
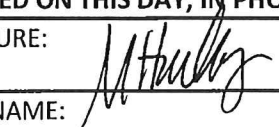
This Solicitation is amended as follows:

RFP Section I: Exhibits, Exhibit E: Medicare Requirements:
Participation as a Medicare Advantage Special Needs Plan

All ALTCS E/PD Contractors will be required to provide Medicare benefits to dual eligible members as a D-SNP in all awarded counties. Contractors will be required to implement Medicare business on **January 1, 2018** and thus all Offerors are required to submit a non-binding Notice of Intent to Apply (NOIA) as a D-SNP to CMS no later than ~~November 10, 2016~~ November 14, 2016. Additional information and exact submission dates for 2017 can be found here:

<https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/>.

To comply with the statute A.R.S. §36-2906.01, the NOIA must be submitted under the Medicare entity name. D-SNPs must have a contract with AHCCCS to enroll ALTCS E/PD full benefit dual eligible members and must have a D-SNP subset that matches this Contract. All Offerors must also submit D-SNP applications to CMS by ~~February 2017~~ February 15, 2017. Additional information on D-SNPs can be found at: <http://www.cms.gov/SpecialNeedsPlans>.

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: 
TYPED NAME: Mark Fisher	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President & Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: January 9, 2017	DATE: 11/7/2016

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CAPTATION BID SUBMISSION

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ALTCS/EPD RFP Bid Template -

Scored Rate Components by Risk Group and GSA

Dual	North	South	Central
Medical Component	\$2,552.82	\$2,782.09	\$2,848.74
Case Management Component	\$128.46	\$131.71	\$134.17
Administrative Component	\$34.00	\$45.34	\$47.13
Sub-Total of Scored Components	\$2,715.28	\$2,959.14	\$3,030.04

Non-Dual	North	South	Central
Medical Component	\$5,084.31	\$5,628.30	\$6,227.87
Case Management Component	\$138.57	\$137.48	\$138.66
Administrative Component	\$184.93	\$220.67	\$257.68
Sub-Total of Scored Components	\$5,407.81	\$5,986.45	\$6,624.21

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**CAPITATION ACTUARIAL
CERTIFICATION**

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Actuarial Certification
Mercy Care Plan
AHCCCS ALTCS Cost Proposal Bids: GSAs Central, North and South
October 1, 2017 – September 30, 2018
January 19, 2017

I, Jason Strandquist, am an employee of Aetna Life Insurance Company, the administrator for Mercy Care Plan. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

The purpose of this capitation rate certification is to comply with the Instructions to Offerors contained in the Arizona Long-Term Care Services (ALTCS) Request for Proposal YH18-0001 issued by AHCCCS. This certification is intended solely for use in the evaluation of Mercy Care Plan’s Cost Proposal and may not be appropriate for other purposes.

The scored rate components by risk group and GSA to which this certification applies are attached in AHCCCS’ required Bid Template sheets and shown in the table below. The rate components apply to the period October 1, 2017 through September 30, 2018.

Scored Rate Components by Risk Group and GSA

Dual	North	South	Central
Medical Component	\$2,552.82	\$2,782.09	\$2,848.74
Case Management Component	\$128.46	\$131.71	\$134.17
Administrative Component	\$34.00	\$45.34	\$47.13
Sub-Total of Scored Components	\$2,715.28	\$2,959.14	\$3,030.04

Non-Dual	North	South	Central
Medical Component	\$5,084.31	\$5,628.30	\$6,227.87
Case Management Component	\$138.57	\$137.48	\$138.66
Administrative Component	\$184.93	\$220.67	\$257.68
Sub-Total of Scored Components	\$5,407.81	\$5,986.45	\$6,624.21

I have examined the encounter data, financial records, assumptions and methods used to develop the gross medical expense, case management and administrative expense components proposed by Mercy Care Plan for the ALTCS Program contract.

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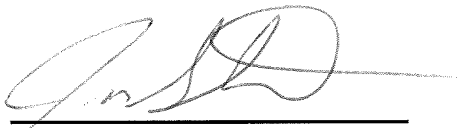
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In developing the assessment, I relied upon the encounter data and financial records provided by AHCCCS. I have accepted the data without audit and have relied upon AHCCCS for the accuracy of the data. I have also relied upon the historical expenses specifically for Mercy Care Plan to ensure each of the components proposed by Mercy Care Plan would be sufficient to cover their specific current and future projected expenses based on all known costs as of this certification.

In my opinion, the rate components are adequate to fund the medical, case management and administrative expenses for an average ALTCS population for each risk group and GSA.

My assessment of the proposed rate components is based on a projection of future events. Actual experience can and will vary from the experience assumed in the rates. Differences between the projection of future events and actual results depend on the extent to which future experience conforms to the assumptions made during the evaluation. It should be recognized that future events frequently do not occur exactly as expected; there are usually differences between projected and actual results. The projections were developed based on a best estimate of future events and should be viewed as such.

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



Jason Strandquist, FSA, MAAA
January 19, 2017

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SECTION I: EXHIBITS

EXECUTIVE SUMMARY

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 RFP Section I, Exhibit E, 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.



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Executive Summary

Southwest Catholic Health Network Corporation, dba Mercy Care Plan (MCP), a not-for-profit, locally owned and operated company, has strong roots in Arizona. One of the first AHCCCS health plans, MCP was formed in 1985 by two Arizona-based provider organizations - Ascension Arizona (a ministry of Ascension Health) and St. Joseph's Hospital and Medical Center (a Dignity Health member) - as a mission-based entity to serve Medicaid members in Arizona. Today, we work closely with providers and AHCCCS, as we have throughout our 30-year history, to develop and deliver programs and services that improve clinical outcomes and member satisfaction while bending the cost curve.

MCP is a locally-owned and operated health plan that maintains all operations within Arizona. We are embedded in the fabric of the communities we serve, employing over 2,000 individuals dedicated to serving Arizona Medicaid members. Further, MCP invests in local communities and in 2016, we sponsored over 130 events to promote healthier communities and engage with community-based organizations.

MCP is the only Arizona health plan with experience and expertise administering services for all AHCCCS programs serving Medicaid members. As a quality leader recognized by AHCCCS, CMS, and NCQA, we bring unparalleled experience in developing high-quality service delivery systems. For example, we achieved 97 percent compliance on our most recent Operational Review for the ALTCS program.

MCP Offers Superior Value and Supports AHCCCS' Goals

As a mission-driven, not-for-profit organization, MCP's number one priority is our members. As described below, our model of care adds value to the service delivery system and support AHCCCS' goals.

AHCCCS' Goal: Pursue Continuous Quality Improvement

MCP takes pride in forging innovations for collaborative, integrated, outcomes-based care. We were recently recognized by NCQA for our approach to promoting quality care for ALTCS members when we were selected by as 1 of 9 participants to provide input on accreditation standards for long term care programs. We think creatively to help members live independently in the setting of their choice while meeting and exceeding AHCCCS performance measures and national benchmarks. As a result of our programs, **75 percent of MCP ALTCS members are able to live in and remain in community-based settings.**

- In-home PCP services, which brings primary care to the member's residence, **meeting the member's needs and resulting in a 39 percent decrease in readmissions.**
- In-home diabetic retinal eye exams, which have helped us **achieve a 76 percent rate of compliance with retinal eye exams for members with diabetes, far exceeding the AHCCCS MPS of 49 percent.**
- The Exclusive Provider Program (designed to improve medication management for all MCP members), which has resulted in **participants experiencing decreases in the number of prescribers and prescriptions, reducing costs by 68 percent and saving more than \$4,000 per member in emergency department visit reductions.**
- Collaboration with the Tucson Fire Department to reduce unnecessary ambulance rides and preventable emergency department visits, **reducing emergency calls from MCP members by 64.5 percent.**

We continue to develop new strategies to address member needs, such our in-home Medication Therapy Management Program, which goes beyond other programs to include an in-home visit by an MCP pharmacist



and Case Manager to address medication-related issues. These programs will be available to all members, as well as region-specific initiatives, to improve the health and wellness of the communities we serve.

AHCCCS' Goal: Bending the Cost Curve while Improving Members' Health Outcomes

Since we first introduced value-based contracting to providers in 2010, MCP has remained a leader in promoting Value-Based Purchasing (VBP) across Arizona. Leveraging our extensive experience, we support providers in creating financially viable and sustainable VBP models. We assist providers in adopting systems and processes to collect and report on quality metrics, improve member and family engagement, and help members choose high quality, high value providers and centers of excellence. We evaluate our network to understand provider readiness and *meet each provider where they are*, providing the level and types of support needed to adopt VBP. ***MCP has 16 VBP arrangements in place, representing as much as 78 percent of our ALTCS spend in regions we serve and resulting in the following positive outcomes:***

- 28 percent improvement in Comprehensive Diabetes Care (A1C >9)
- 7 percent increase in A1C testing (MCP's overall rates (94%) far exceed the AHCCCS MPS)
- 89 percent of attributed members received flu shots
- 8.5 percent decrease in emergency department visits
- 16.3 percent reduction in readmissions
- 1.7 percent year-over-year cost savings (\$4.6 million) in shared savings arrangements

As a provider-sponsored, local, non-profit health plan that supports system transformation efforts, we use the savings accrued by helping members remain in the least restrictive setting. As we currently do in the regions we serve, we will distribute shared savings across providers and use this strategy to further incentivize quality, access and improved member outcomes across all awarded GSAs.

To further support AHCCCS's VBP goals, MCP brings a unique contribution: The Practice Innovation Institute (Pii), which is helping transform more than 2,500 clinical practices across Arizona to participate in CMS's Merit-based Incentive Payment System (MIPS) and alternative payment models. Pii stems from a collaborative effort between MCP and Arizona Health-e Connection to secure a \$14.6 million grant from CMS's Transforming Clinical Practice Initiative—the only one awarded to an Arizona entity and one of only 29 grants across the country. We will apply our Pii experience to participate in a Delivery System Reform Incentive Payment Program that achieves sustainable improvements in health care delivery.

AHCCCS' Goal: Reduce Fragmentation In Health Care Delivery to Develop An Integrated System Of Care

MCP is shaping delivery system transformation by implementing integrated care models to create high value health care. We are leading the integrated care effort via strategies such as "three-way" contracts that align incentives across behavioral and physical health providers. Further, we are connecting members to high quality, high value providers, including patient-centered medical homes, clinically integrated organizations that function as accountable care organizations, and high-touch provider organizations that meet members where they live in homes, groups and facilities. We stand ready to provide a fully integrated system that aligns incentives across all providers and maximizes the quality of care as we expand to additional regions.

We are adept at serving members with the most complex needs, who are involved in multiple systems. Our member-centric approach is collaborative, responsive to member needs, and focused on connecting members with high quality care and community resources to help them achieve their wellness goals. We have designated staff resources and implemented best practices to support care coordination. For example, we designated a Tribal Liaison to collaborate with American Indian tribes in the regions we serve to foster and leverage these relationships to achieve the best outcome for members. Additionally, we are adopting collaborative protocols



traditionally used by the behavioral health system to facilitate care coordination with the Veteran's Administration and Vocational Rehabilitation. In our experience, devoting resources and establishing consistent processes is crucial for establishing relationships between systems, leading to improved coordination and better member outcomes.

MCP Meets Medicare Requirements

Since 2006, MCP has provided high-quality, responsive, cost-effective, and culturally competent care to dual eligible members in our Mercy Care Advantage (MCA) D-SNP, which serves over 18,300 dual eligible members in Pima and Maricopa Counties. In accordance with RFP requirements, MCP submitted a Notice of Intent to Apply (NOIA) as a D-SNP to CMS on November 14, 2016 that covers all 15 Arizona counties. We will submit our D-SNP application for these counties to CMS by February 2017. MCA has an overall 3.5 star rating and specific measures show excellent results, including:

- 5 stars for Reducing the Risk of Falling
- 4 Stars for Care for Older Adults Medication Review
- 4 Stars for Care for Older Adults Functional Status Assessment

Our MCA Part D ratings also show excellent results, achieving 4 stars on measures related to Medication Adherence for Diabetes Medications, Hypertension and Cholesterol. We will leverage our existing processes to expand MCA to other regions of the State and demonstrate the same positive results, as described below.

Improving Member Alignment - 93 percent of the dual eligible individuals we serve are fully aligned with MCA.

This is due to our commitment to high quality member care and our extensive network of providers. In May 2016, we received approval from CMS to process Seamless Conversion Enrollments, which allows us to automatically enroll MCP members who will be Medicare eligible after turning 65 or after their 24-month Medicare disability-waiting period. As a CMS-approved plan, this initiative enables us to streamline and align Medicare and Medicaid requirements and policies to promote seamless, high quality, and cost-effective care.

Care Coordination - MCA's Model of Care applies best-in-class processes to maximize care coordination and member experience. Recently, CMS performed an onsite policy, procedure and outcome review. The CMS reviewers commented that our model was in the "superior" category and among the most highly ranked and sophisticated they had ever reviewed. During a 2014 CMS audit, **MCA received a perfect score on this model.** MCA was also designated as a Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) by CMS. MCA is the only plan in Arizona with this CMS designation, which promotes the full integration and coordination of Medicare and Medicaid benefits for dual eligible beneficiaries by a single managed care organization.

Medicare Data - MCA currently submits Medicare encounter data to AHCCCS and will continue to do so.

Member Transition - MCA has effective processes in place for supporting members during times of transition. For example, when we began operations in Pima County, we successfully transitioned 2,000 members to our plan. Additionally, we expanded the community-based options for members with behavioral health needs to include behavioral health residential facilities and assisted living homes, **increasing the number of members residing in HCBS by five percent.**

MCP brings exceptional value and a true commitment to serving Arizona. We are invested in transforming the Arizona Medicaid system and in keeping it at the forefront of innovation, and we demonstrate this commitment time and again. We look forward to continuing our partnership with AHCCCS, other health plans, stakeholders and providers to implement best-in-class tools and innovative approaches to deliver excellent services to members, create administrative efficiencies, and improve member outcomes.



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**MORAL OR RELIGIOUS
OBJECTIONS**

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SECTION I: EXHIBITS

MORAL OR RELIGIOUS OBJECTIONS

The Contractor shall 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 submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the Contractor's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.



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Moral or Religious Objections

Southwest Catholic Health Network Corporation dba Mercy Care Plan (MCP) was formed as an Arizona nonprofit corporation in 1985, after representatives of the state's Medicaid agency (the Arizona Health Care Cost Containment System, AHCCCS) invited Catholic hospitals to participate in the state's Medicaid program.

MCP was formed in 1985 by two Arizona-based provider organizations - Ascension Arizona (a ministry of Ascension Health, formerly known as Carondelet Health Network) and St. Joseph's Hospital and Medical Center (a Dignity Health member) - as a mission-based entity to serve Medicaid members in Arizona. The sponsors strongly believed that the formation of MCP was an important extension of the Catholic mission to serve the poor and persons with special needs.

Federal law mandates that state Medicaid agencies provide coverage for family planning services. Some of these services conflict with the Ethical and Religious Directives for Catholic Health Facilities, as adopted by the United States Conference of Catholic Bishops (the "Directives"), which prevent MCP and its Catholic members from providing certain family planning services listed in the AMPM Section 420. In the early years of Arizona's Medicaid program, AHCCCS contracted directly with providers for family planning services. However, AHCCCS discontinued this direct contracting in 1997 and moved responsibility for family planning benefits to the health plans contracted with AHCCCS to administer Medicaid benefits.

In 1997, MCP presented a plan to engage a third-party administrator to remove responsibility for family planning services from MCP and its Catholic members to Arizona Catholic leaders and AHCCCS. A third-party administrator was engaged in April 1997, and began providing services without direct involvement of MCP and its Catholic members on Oct. 1, 1997. However, further review of the arrangement by ecclesiastical authorities required a change in MCP's corporate structure to eliminate possible indirect involvement with or potential benefit from such family planning services. MCP added a non-Catholic, non-voting member, El Rio Santa Cruz Neighborhood Health Center, Inc. ("El Rio"), which under the MCP Articles of Incorporation has sole responsibility for, and derives any possible benefit from, required family planning services and which contracts with the third-party administrator directly for those services.

El Rio holds a separate contract with Aetna Medicaid Administrators LLC (Aetna Medicaid) to administer all family planning services that do not comply with the Directives. This structure continues the arrangement implemented in 2003 that was approved by AHCCCS. Therefore, all covered and medically necessary services will be available to AHCCCS members by MCP or its subcontractor Aetna Medicaid, through El Rio, to meet the covered services requirement. Any payments due to Aetna Medicaid for the activities defined in their contract will be the responsibility of MCP generally, or El Rio for services not allowed under the Directives.

In accordance with A.R.S. 36-2907(A)(8), MCP's election does not disqualify MCP from delivering all other covered health and medical services and MCP, acting through its non-voting member El Rio without involvement of its Catholic members bound by the Directives, selects Aetna Medicaid for administrative family planning and certain OB/GYN services. Therefore, all covered and medically necessary services will be available to AHCCCS members.



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**EXHIBIT C: NARRATIVE
SUBMISSION REQUIREMENTS**

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SECTION I: EXHIBITS

EXHIBIT C: NARRATIVE SUBMISSION REQUIREMENTS

Program 1

An 85 year old American Indian member currently enrolled with the Offeror, with Medicare Part A and Part B, and unknown tribal affiliation resides alone in Parker. The member has had several transitions in the last three years between Tribal ALTCS and the Offeror's ALTCS E/PD Health Plan. The member has received services from multiple IHS and 638 facilities as well as providers in the Offeror's network and through Medicare's network. Her diagnoses include Unspecified Depressive Disorder, Panic Disorder with agoraphobia, Transient Ischemic Attacks and history of CVA. Her vision has also been impaired by cataracts. This member also has demonstrated difficulty remembering conversations and confusion over her prescribed medications, resulting in inconsistencies in taking medications. Describe how the Offeror will manage care to achieve the best outcome for the member.




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Program 1

In serving American Indian members, Mercy Care Plan (MCP) recognizes the complexities and opportunities that exist in coordinating with systems of care, such as Indian Health Services (IHS) and 638 facilities. Our leaders have met with the Inter-Tribal Council of Arizona to improve coordination, and we continue to identify strategies to prevent fragmentation and improve outcomes for these members. To further these goals, we will designate a Tribal Liaison to continue to collaborate with and foster strong ties with American Indian tribes.

MCP is aware of the member’s status via communication between her Case Manager (CM), the member and family, and information received from the tribal facility (which is facilitated through our Tribal Liaison). Since we hire from the local community, the member’s CM has a similar cultural background and/or has received training about cultural norms and needs. The CM builds rapport with this member and her family, beginning with introductions about each other’s backgrounds, including tribal affiliations, relationships and preferences. During these interactions, the member asked that we call her by her first name, “Valerie.” As shown in the figure below, our processes align with AHCCCS’ goals and include culturally relevant solutions for helping Valerie achieve improved health and continue to live in the community setting of her choice.

MCP Coordinates Care to Ensure Members Access Services and Supports to Achieve Improved Health

Member-Centered Case Management	
MCP incorporates Valerie’s cultural preferences in the care plan and uses interpreters if she prefers to communicate in her native language.	
Member-Directed Care Options	
The CM helps Valerie make choices about her health care provider, services, living situation and end-of-life planning.	
Person-Centered Care Planning	
Valerie’s care plan includes goals for increasing her well-being and managing her independence.	
Consistency of Services	
The CM connects Valerie to Westernized and Native American healing services based on her choices.	
Most Integrated Setting	
The CM provides supports and services for Valerie to remain in her home.	
Network Accessibility	
MCP will authorize and coordinate services that Valerie chooses, including attendant care provided by a tribal agency.	
Collaboration with Stakeholders	
The CM collaborates with Indian Health Services and 638 Facilities with the assistance of our designated Tribal Liaison.	

Key Facts and Innovations

- Over **99%** of surveyed members who participate in the focused assessment reported that CMs answered their questions, explained services and understood their needs, and members found the visit helpful.
- MCP will designate a Tribal Liaison to foster collaboration with Native American communities in the regions we serve.

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PROGRAM 1



Although she can speak and understand English, Valerie’s preferred language is a tribal dialect. Thus, when visiting or contacting Valerie, the CM communicates through a contracted, certified interpreter. When delivering culturally relevant services, including interpretation and translation, we adhere to state and federal requirements, including National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care and Rule 1557 of the Affordable Care Act. By building a strong relationship, the CM can connect Valerie to needed services and benefits, provide ongoing support, remove barriers to care and confirm the services for Valerie are appropriate and effective in helping her live independently.

Assessing the Member’s Strengths, Needs and Goals

During the 90-day reassessment, we identify Valerie’s decreased vision, difficulty remembering conversations and confusion over her prescribed medications. The CM completes an in-person reassessment to determine changes in Valerie’s strengths, needs, available supports and goals that may impact her care plan. During the reassessment, the CM asks Valerie to explain how she feels and what she thinks is working for her, along with any areas of concern. The CM updates the MCP assessment, Skin and Fall Evaluation (SAFE) tool and AHCCCS’ Uniform Assessment Tool to identify Valerie’s current medical, functional and psychosocial strengths and needs; culture and beliefs; and formal and informal supports. The outcomes of our member-centered assessment provide the information required to develop Valerie’s person-centered care plan.

Using MCP’s assessment tool, and information gathered from PCP and tribal entities, the CM learns about: 1) potential triggers for the agoraphobia and panic attacks Valerie is experiencing, 2) reasons why she is accessing care in multiple locations through various providers, 3) the extent to which the cataracts are impacting her vision, 4) the extent of her memory loss, 5) medications Valerie is taking and why, 6) her capacity to perform Activities of Daily Living and Instrumental Activities of Daily Living, 7) formal and informal support systems, 8) Valerie’s preferences for living situation, providers and services, and 9) barriers to care that she is experiencing.

The CM also uses the SAFE tool to assess Valerie’s risk and current status related to skin condition and falls. Once the CM identifies Valerie’s risks, the CM explains the risk score to Valerie and her family/natural supports and discusses strategies to reduce future risks.

Throughout the reassessment, the CM listens to Valerie’s story and asks clarifying questions to fully understand her strengths, needs, supports and goals. This includes questions on whether Valerie uses traditional healing practices, the services and supports she has received and her service providers. For example, if Valerie is affiliated with the Colorado River Indian Tribe (CRIT), there are four tribal groups that comprise CRIT: Mohave, Chemehuevi, Hopi and Navajo. Valerie’s cultural identification could be any of these distinct cultures. In doing this, the CM gains a deeper understanding of the cultural and personal beliefs that impact how Valerie views and interacts with health care services.

Based on the assessments’ results, the CM learns that Valerie’s inability to see clearly impacts her significantly and makes it hard for her to read medications, take care of daily activities and manage her home. The CM asks about any recent episodes of depression or agoraphobia that Valerie has experienced and makes a referral for a full behavioral health evaluation to determine how to best address Valerie’s behavioral health needs. Valerie also reports that when she is feeling badly or needs medications, she goes to the most convenient provider (tribal facility or other), both in terms of appointment availability and her ability to access transportation.

In the future, once Valerie’s care and services are stable, the CM may complete the MCP-designed focused assessment tool to gather specific information about Valerie’s capacity and desire to self-manage her own personal health and development. The focused assessment includes member-centered questions that elicit deeper discussion between the member and the CM about Valerie’s specific needs and preferences. The tool is



specific to MCP's Case Management Program and enhances the rapport between the CM and the member to gain a deeper understanding of member needs across cultural lines. In a survey of MCP members, ***over 99 percent of respondents who participated in the focused assessment reported that CMs answered their questions, explained services and understood their needs, and that they found the visit helpful.***

Coordinating Benefits and Services to Reach Member Goals

Given that Native American members can participate in IHS, tribal and AHCCCS health systems at the same time, coordinating benefits and care is important in making sure Valerie receives all necessary services and supports in a manner that improves outcomes and prevents gaps in care. The CM may review claims data (such as blind spot data) and gather information from previous service providers, the Tribal ALTCS plan, IHS and 638 facilities, and the Medicare plan in which Valerie is enrolled.

The CM obtains assistance from the MCP Tribal Liaison to verify Valerie's tribal affiliation, gather information from IHS/tribal health centers that Valerie visited, and obtain records on services she received as well as any assessment information, recommendations, medications and lab results. The Tribal Liaison also requests information on the primary contacts for Valerie's care so she can maintain communication and invite them to participate in care planning. To assist in obtaining real-time data, the MCP Tribal Liaison makes sure we have a memorandum of understanding in place to facilitate information sharing and expedite problem resolution. As part of the care plan, the CM, Valerie and the appropriate providers identify actions for care coordination and communication that include phone and email contact to share progress updates and participate in joint meetings. The MCP Tribal Liaison is available to the CM to coordinate eligibility and service delivery and serve as a point of contact for IHS, tribes and tribal communities. On an ongoing basis, the CM uses information obtained from IHS to learn what she can about Valerie's needs, diagnoses and the effectiveness of the services provided.

Coordination with Medicare. If Valerie had not yet been enrolled in Medicare, the CM would assist her in completing the enrollment process. Since she has Medicare A and B, the CM assists Valerie in completing the process to enroll in Medicare Part D. The CM makes a referral to the MCA Team, who explains the supplemental benefits available through Mercy Care Advantage and value of aligning her Medicaid and Medicare benefits, and enroll her if she chooses. This improves the CM's ability to coordinate care so that Valerie has access to all services without barriers. If Valerie is enrolled in Medicare with a D-SNP other than MCA, the CM contacts the Plan to determine the services she is receiving and coordinate care. Our CM and the Medicare Advantage Case Manager agree to share information on Valerie's progress toward treatment goals, changes in status and identified needs.

Developing the Person-Centered Care Plan to Transition Care Seamlessly

Using the information gleaned from the assessment, the CM works with Valerie, her PCP, family member(s), extended family and clan relationships to update her person-centered care plan. During the care planning meeting, the CM uses motivational interviewing to identify Valerie's goals and interventions, placing her at the center of the service planning process. Based on Valerie's needs, strengths, goals and health literacy skills, the care plan addresses Valerie's integrated (physical and behavioral health) needs, in-home and community-based supports, and outlines her preferences and plans for advanced illness care including end-of-life care. When developing the care plan and throughout her care, the CM recognizes any choices that Valerie makes and coordinate care that respects her cultural beliefs and values. MCP offers a contract with any eligible provider, including tribal facilities in accordance with AHCCCS's regulations, who is willing and able to meet Valerie's needs and who meets our quality standards.

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Behavioral health services: To address the agoraphobia and depression Valerie is experiencing, the CM works with the MCP Behavioral Health Coordinator to identify treatment options such as cognitive behavior therapy, medication management and family psychoeducation. They also identify providers and service delivery methods such as telehealth, IHS or another local provider. Within two business days of Valerie's request for behavioral health services, the CM makes the referral and sends a notification letter to the PCP. If Valerie chooses telehealth services, the CM schedules her appointment at a time when she can bring a tablet computer and assist Valerie in connecting to services. The CM completes a quarterly behavioral health consult thereafter to discuss the effectiveness of the care plan and services in meeting Valerie's goals. Throughout Valerie's care, the CM makes sure that behavioral health services are delivered according to the *9 Guiding Principles for an Adult Service Delivery System*.

Ongoing medical and preventive care: Due to Valerie's agoraphobia, she is not always comfortable attending routine medical appointments so her CM offers to connect her to in-home PCP services. The in-home PCP team consists of advanced nurse practitioners and physicians who are fully credentialed by MCP and have the training and skills necessary to care for ALTCS members, such as Valerie, with complex conditions like diabetes, hypertension and hypercholesterolemia that may contribute to transient ischemic attacks and cerebrovascular disease. The team has full access to the specialists and subspecialists within the MCP network for neurology or other consultations as necessary. By increasing access to PCP services, this in-home PCP program helps to expedite solutions to medical issues and has resulted in a 3 percent decrease in emergency room use. The CM maintains contact with the in-home PCP to stay apprised of Valerie's needs and progress. In collaboration with the CM, transportation or remote consultation services are scheduled for Valerie. To help Valerie actively participate in her care, the CM educates her and her family support system on simple questions to ask providers to better understand their health conditions and what they need to do to stay healthy.

Vision services: To address Valerie's worsening cataracts, the CM coordinates an eye exam to determine if cataract surgery is warranted. Based on Valerie's preferences, her CM assists her in accessing these services through an MCP-contracted provider, Ft. Mohave Indian Health Center or the Parker Service Unit. If Valerie agrees to surgery, the CM coordinates with her PCP and provider who will complete the surgery. If Valerie enrolls with MCA and is not ready to consider surgery, she is eligible to receive eyeglasses through MCA's supplemental benefit. The CM explores finding a community volunteer (such as through the Ma-Chem-Ho-Na Senior Center) or caregiver that can read for Valerie and provides materials in large print to enhance readability.

Interdisciplinary team: If issues arise that prevent Valerie from meeting her goals, the CM may request additional input and direction from the MCP Interdisciplinary Team (IDT) to assist the care team's work with a member. IDT participants include a Medical Director, Pharmacist, Behavioral Health Coordinator, Valerie, her family/caregivers/natural supports, her CM and other members of her care team. Together, the IDT develops creative solutions to help Valerie meet her goals.

Advance Directives: When completing the re-assessment and through regular communication, the CM learns about Valerie's connection to tribal cultural norms, particularly when discussing matters of end of life. Valerie explains her religious preferences and cultural beliefs, and they discuss the impact on advanced illness care, including end of life planning. The CM and Valerie discuss options if Valerie is unable to remain at home, her wishes if she becomes incapacitated and the need for a medical power of attorney. The CM also gathers input from the PCP on treatment options and advance directives to assist Valerie in making informed choices. The CM guides Valerie through the process for completing advance directives, using tools such as Five Wishes, and documents her choices in the Mercy Life & Health Planning toolkit. The toolkit includes an easy-to-use organizer that helps Valerie (and other members) to keep important health information (advance directives, care plan, key



contacts) in a single location. The CM encourages Valerie to keep the toolkit in a primary location and tell family members, caregivers and natural supports where to find this information in an emergency.

Supporting Independence through Community-Based Supports

To support Valerie to live independently, the CM completes a home safety evaluation to determine if home modifications should be requested or any other services are needed to make sure Valerie's home is free of fall risks or other safety concerns. The CM asks Valerie about any friends, neighbors or family members that can assist her and they discuss concerns or needs Valerie has that may impact her ability to live independently. Together, they develop the following plan for in-home and community supports.

In-home supports: The CM and Valerie, with input from her PCP and IHS providers, determine that she can continue to live in her home with in-home supports. The CM completes the Home- and Community-Based Services (HCBS) Needs tool to determine how many hours of attendant care Valerie needs to have maximum independence and remain in the home. The CM secures a **personal emergency response system** and connects Valerie with **attendant care** to assist with personal care, housekeeping and cooking. If Valerie is most comfortable with individuals from the tribal community, the CM contacts tribal social services to seek out a personal care attendant who speaks Valerie's language and is familiar with the culture. The CM identifies options for **Community Health Workers** to promote wellness, provide coaching and help Valerie advocate for herself. The CM also contacts the Ma-Chem-Ho-Na Senior Center to identify a native language speaker to assist Valerie. Additionally, the CM works with the Parker Fire Department (with Valerie's consent) to develop a plan for coordination with MCP when she contacts 911. ***MCP has effectively worked with the Tucson Fire Department to reduce unnecessary ambulance rides and preventable emergency department visits for high utilizers, resulting in a 64.5 percent reduction in emergency calls from MCP members.*** We build on these strategies to coordinate with the Parker Fire Department. If Valerie needs nutrition support, the CM may arrange for **Meals on Wheels** through the Parker Senior Center as included in her care plan. To address Valerie's memory loss, the CM helps to develop strategies for medication and appointment reminders, such as creating a calendar, taking notes and setting reminder alarms.

Medication support: To help Valerie take her medications, the CM offers to authorize a home health nurse to fill a weekly pill organizer as well as to monitor vitals. To determine the cause(s) for Valerie's increased confusion, the CM consults with her PCP and schedules a medical appointment. The CM may also arrange for Valerie to participate in our Medication Therapy Management (MTM) Program, which helps increase Valerie's understanding of medications and decrease medication-related problems. The program goes beyond traditional MTM to include an in-home visit with the CM and an MCP pharmacist. The pharmacist evaluates Valerie's medications (prescriptions, over-the-counter and dietary supplements) to address poly-pharmacy and drug interactions. The pharmacist informs Valerie about the importance of medication compliance. If the pharmacist identifies a serious medication issue that needs to be addressed, he/she calls the prescribing provider during the home visit. The CM authorizes home health care for medication management and helps to schedule follow-up appointments.

MCP is adept at serving members with the most complex needs who are involved in multiple systems. Our person-centered approach to meeting members where they are, considering their cultural preferences, building upon their strengths, and respecting their choices makes us the plan of choice for ALTCS members with needs similar to Valerie's. Our processes are collaborative, responsive to members' needs, and focused on connecting members with high quality care and community resources to help them achieve their wellness goals.



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SECTION I: EXHIBITS

EXHIBIT C: NARRATIVE SUBMISSION REQUIREMENTS

Program 2

A 71 year old Hispanic member, residing in Kingman, diagnosed with schizophrenia, Opiate Use Disorder, diabetes and dementia was enrolled with the Regional Behavioral Health Authority with a Serious Mental Illness determination. He was residing in a Behavioral Health Residential Facility to stabilize his behaviors and to improve his independence with activities of daily living. The member was on court ordered treatment, was noncompliant with taking his medication, and began to exhibit suicidal ideation with a plan to commit suicide. He was subsequently transferred to a Psychiatric Level I Facility in Kingman. Since being admitted, the member's condition has stabilized and he is ready for discharge; however, his dementia has progressed such that he is ALTCS eligible and is now enrolled in the Offeror's health plan. His family would like him to be transferred to Flagstaff to be closer to them. Describe how the Offeror will initiate and manage care, including services, supports and treatment options to achieve the best outcome for the member.

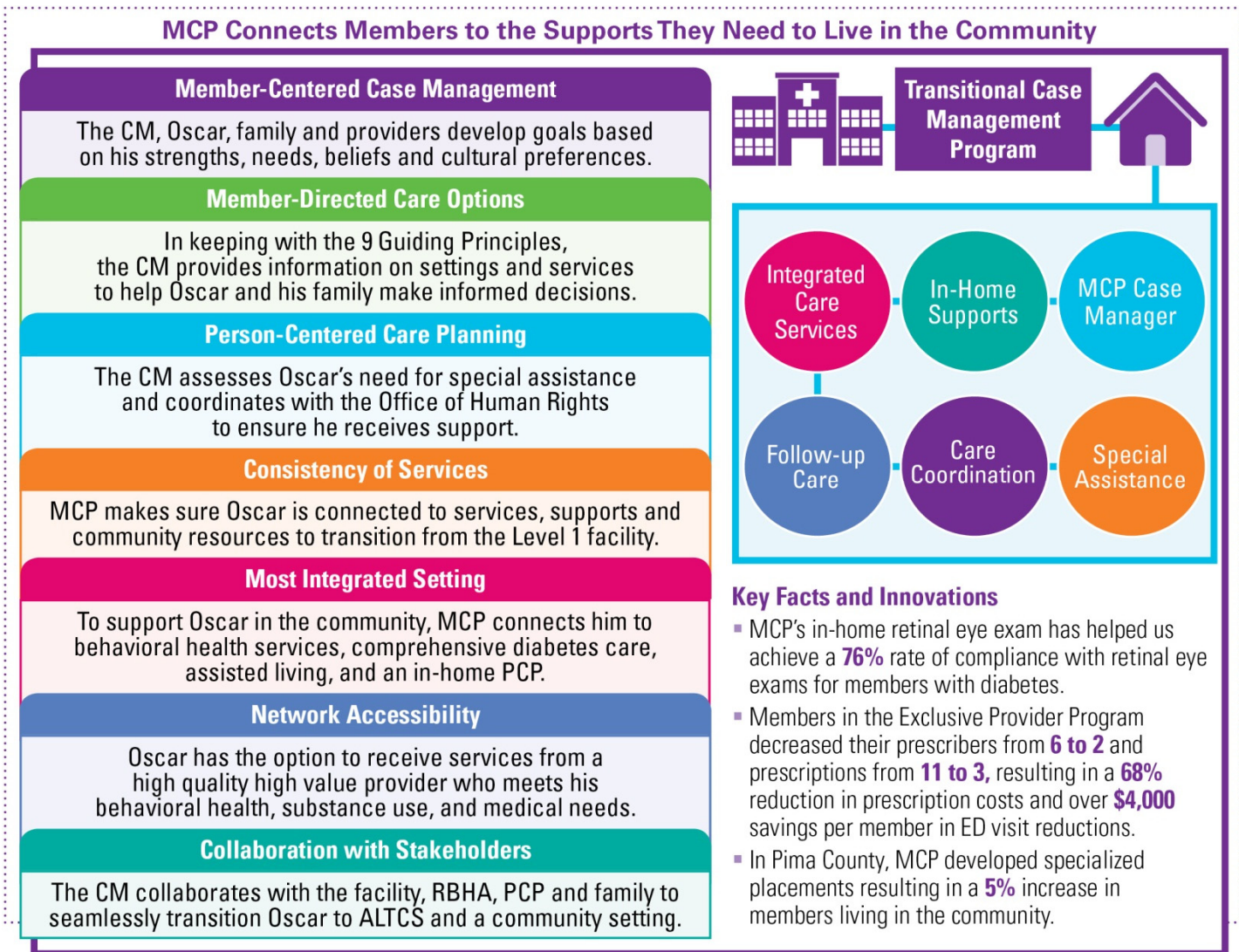


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Program 2

Mercy Care Plan (MCP) makes every effort to keep members in the community and close to their families and natural supports. We work with the member, family and local providers to develop care and placement options that promote wellness, recovery and independence. We do this by understanding each member’s needs and collaborating with members, providers and local community-based resources.

Our processes for engaging the member begin while he is in the Level 1 facility through our Transitional Case Management Program and continues through assessment, care planning and ongoing service delivery. Within one business day of notification of enrollment, MCP assigns the member to a Transitional Case Manager (CM), who is trained in long term care and hospital discharge processes. Our Transitional CM contacts the member to introduce him/herself and to explain the benefits and programs available through MCP. In this first meeting, the CM learns the member prefers to be called by his first name “Oscar” and he requests that we involve his family in all discussions about his care. As shown in the figure below, our systems align with ALTCS program goals and connect Oscar to supports to help him return to the community.





MCP's Transitional Case Management Program

MCP helps Oscar transition to an appropriate setting via our Transitional Case Management Program, which is based on the Coleman model and encourages individuals to take an active role in their care. The Transitional CM collaborates with facility staff to develop a discharge plan that meets Oscar's needs in an appropriate setting based on his and his family's choices and their cultural preferences. Throughout Oscar's stay, the Transitional CM coordinates with the facility to monitor his readiness for transition and verify that the discharge plan is appropriate. The Transitional CM regularly contacts Oscar and his family to answer questions and confirm their preferences, needs and choices. He/she also works with the Behavioral Health Coordinator and Regional Behavioral Health Authority to transition Oscar's behavioral health services and care plan to MCP.

As part of transition planning, we conduct a Readmission Intervention Assessment (RIA), an MCP-developed tool that promotes timely outreach and a successful transition back to the community for hospitalized members. The RIA helps us identify risk factors for readmission via a combination of nationally recognized, evidenced-based practices as well as our knowledge of the needs and challenges faced by ALTCS members in Arizona. The Transitional CM completes the RIA upon notification of a newly enrolled member in the hospital to identify the member's needs and any risks and barriers to transitioning successfully to the community. The Transitional CM uses this information to inform the discharge plan and follow-up services and supports. ***The RIA has contributed to a 50-percent reduction in readmissions among MCP ALTCS members over the past five years.*** In Oscar's case, the Transitional CM confirms that appointments for follow up behavioral health and medical services are scheduled, needed services and durable medical equipment are arranged, previously authorized surgeries and treatments are coordinated, and medication reconciliation is completed. The Transitional CM also collaborates with MCP's Utilization Management Team to complete prior authorizations and confirms that Oscar has authorization to continue using the same glucometer and diabetic supplies that he used while in the facility.

Based on our assessment and Oscar's preferences, we may use Peer Support Partners to provide care transition services once he is discharged. Peer Support Partners build upon their relationships with community providers to facilitate successful transitions of care. The Peer Support Partner collaborates with members and CMs to determine members' needs and level of services required to support them in achieving independence in home and/or community settings. In Oscar's situation, he and his family, CM, and facility staff agree that he should transition to a Skilled Nursing Facility (SNF) for a short-term stay with the goal of transitioning to a community-based setting near his family. The CM verifies a PASRR Level 1 is completed.

Assessing the Member's Strengths, Needs and Goals

Within one business day of Oscar's discharge from the hospital, the Transitional CM discusses Oscar's discharge plan, goals and status with the CM dedicated to the receiving SNF. Based on Oscar's language preference and his needs, Oscar receives assistance from a Spanish-speaking CM who is a licensed behavioral health professional.

The CM completes the comprehensive assessment within five business days of Oscar's admission into the SNF. During the assessment, the CM uses our standardized assessment tool to determine 1) Oscar's strengths, needs, interests and belief systems, 2) cultural and linguistic considerations, 3) capacity to perform Activities of Daily Living and Instrumental Activities of Daily Living, 4) Oscar's history with behavioral health services and needs for ongoing treatment, 5) formal and informal support system, 6) the need for durable medical equipment, 7) whether Oscar needs special assistance, 8) current medication and medical conditions, 9) need for a specialty diet, 10) family/caregiver resources, and 11) a safety assessment to determine the level of suicide risk. With Oscar's permission, the CM contacts Oscar's family to gain their input on his strengths and needs as well as their preferences for his ongoing care.



As part of the assessment, the CM works with our Behavioral Health Coordinator to complete an assessment using the American Society of Addiction Medicine (ASAM) tool, obtain Oscar's behavioral health records, including court-ordered treatment status, diagnoses, substance abuse history and treatment. He/she also contacts the Behavioral Health Residential Facility to gain further understanding of Oscar's needs, progress toward learning independent living skills, barriers to goal attainment and what prompted Oscar's admission to the Level 1 facility. Based on the CM's assessment of Oscar's ability to communicate his needs and participate in care planning, the CM notifies the AHCCCS Office of Human Rights within five days of determining that Oscar may benefit from special assistance.

The CM shares the results of the comprehensive assessment with the MCP interdisciplinary team (IDT), which includes Oscar, his family, PCP, our Medical Director, Pharmacy staff, Court-Ordered Treatment Specialist, Placement Specialist, medical power of attorney, and person providing special assistance. The team discusses Oscar's history, needs, preferences, strengths and what has worked and not worked. They identify options for placement, services and supports that help Oscar to achieve his goals.

Coordinating Benefits and Services to Reach Member Goals

If Oscar is not yet enrolled in Medicare Part B, the CM assists Oscar in completing the Medicare enrollment process. The CM makes a referral to the Medicare Mercy Care Advantage (MCA) Team, who explains the supplemental benefits available through Mercy Care Advantage, value of aligning his Medicaid and Medicare benefits and enrolls Oscar if he chooses. If Oscar is enrolled in Medicare with a D-SNP other than MCA, the CM contacts that plan to learn which services Oscar is receiving and coordinate care. In that case, the MCP CM and the Medicare Case Manager agrees to share information on Oscar's progress toward his treatment goals, changes in status and identified needs.

Developing the Person-Centered Care Plan

The AHCCCS Office of Human Rights, in concert with the CM, determines that Oscar's brother is willing and able to provide special assistance. The CM then facilitates the development of a person-centered care plan in a shared partnership with Oscar and his family based on the outcome of the comprehensive assessment, the Pre-Admission Screening and recommendations from the PASRR, the member's PCP and other providers. The CM encourages Oscar and his family to identify specific, achievable goals for recovery and the most integrated setting to meet his needs. To help them make informed choices, the CM educates them about ALTCS services, community resources and placement options. The CM synthesizes results of assessments, gathers input from the PCP and other providers, and considers Oscar's culture and values to develop the care plan.

Through the care plan, Oscar and his family begin to clearly understand their goals, agree on the services and supports that are most appropriate to meet their needs, and learn about Oscar's rights and responsibilities. Oscar and his family receive a copy of the care plan after the care planning meeting. The care plan serves as a valuable resource for Oscar and his family because it describes agreed upon services, the provider of care, and when the services are scheduled to occur (including scope, duration and intensity of each). All pertinent MCP staff and providers receive Oscar's care plan for use in decision making. This is a powerful tool for MCP personnel and providers to collaboratively support Oscar's goals for recovery and independence.

Together with Oscar and his family, and based on the results of the assessment and care planning processes, the CM identifies placement options to meet Oscar's needs and support him in a setting that is most integrated, least restrictive and allows him to be independent and healthy in the setting that most closely matches his choices and preferences. Based on the information provided, MCP anticipates that Oscar requires a short-term stay in a SNF with capacity to address members with behavioral health needs while we determine the status of his schizophrenia, extent of his dementia symptoms, capacity to complete Activities of Daily Living and manage

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his diabetes, reasons for and status of opioid abuse and behavioral health services, and the family's ability and willingness to care for his needs. If Oscar agrees to relocate, MCP's CM works with Contracting and/or Provider Relations to find a SNF provider in Flagstaff or work with an existing provider to meet Oscar's needs. When planning for Oscar's move, the CM may also contact the Area Agency on Aging Ombudsman to help identify recommended providers. Once the short term-goals have been met, we assist Oscar in successfully transitioning to the most integrated setting that meets his needs.

Stabilizing Oscar's Needs with Short-term Skilled Nursing Placement

While Oscar is in the SNF, the CM schedules a PCP visit and coordinates with the PCP to establish medical, behavioral and neurological evaluations to determine the extent of Oscar's dementia symptoms, the effect of opiate use on his health, and need for ongoing diabetes monitoring and management. The dietitian in the SNF completes a nutritional consult to inform Oscar and his family about appropriate food choices to help control his blood sugar levels. The CM also arranges for Oscar to receive a psychiatric assessment to evaluate suicide risk, his need for ongoing behavioral health services and supports, and the impact of symptoms on his ability to self-manage his diabetes. The CM also obtains release forms to coordinate the ongoing sharing of information.

Using the results of the medical and behavioral health evaluations, the CM collaborates with Oscar, his family, facility and providers to determine the community setting that meets Oscar's needs. The CM assesses the family's capacity to care for Oscar at home and together they determine the types and frequency of services and supports needed if he lives with them. If Oscar and his family want to pursue the option of going to their home, the CM may authorize therapeutic bed hold days for Oscar to have a trial home visit with the family.

Helping Oscar Successfully Transition to the Community – Assisted Living Facility

Oscar, his family, CM and PCP determine that an Assisted Living Facility (ALF) with a Global Cognitive Impairment Unit in Flagstaff is an appropriate placement. To support Oscar in this setting, they develop a plan for services and supports to help Oscar stay healthy and safe, including behavioral health services, diabetes care, assistance with Activities of Daily Living and medication adherence, coordination of benefits, and end of life planning.

Ongoing behavioral health services. The IDT discuss the most appropriate options to meet Oscar's behavioral health needs. This includes arranging for the Placement Preservation Team to educate the assisted living facility staff on ways to meet Oscar's behavioral health needs and determine other supports for Oscar to be successful in this placement. If Oscar prefers to receive services through his previous provider, we offer to continue those services via telehealth until he is comfortable transitioning to another provider. He can select a provider who visits him in the facility or another provider and we arrange for transportation. In collaboration with the behavioral health provider, Oscar and his family, the CM incorporates behavioral health goals and services into the person-centered care plan, including a crisis plan based on the safety assessment and risk factors (such as previous suicide attempts) in case Oscar's symptoms exacerbate or he expresses suicidal ideation. The crisis plan outlines steps to mitigate crisis situations and who to call if a crisis occurs. If Oscar is currently on court-ordered treatment, the CM monitors these services based on the training they received on the pre-petition screening and court-ordered evaluation processes.

Comprehensive diabetes care. Oscar has the choice to receive fully integrated services from a variety of our high-value providers, including one that provides comprehensive and individualized diabetic care. The CM coordinates with our Value-Based Operations Team and Member Services to help Oscar select providers that deliver the highest value. For example, as we do in our current GSAs, we develop programs that use Community Health Workers and local providers to provide tools and resources related to chronic disease self-management to help Oscar and his family manage the symptoms of his diabetes.

If Oscar is unable to leave the ALF to attend appointments, the CM identifies alternatives to meet his needs. For



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example, the CM may arrange for Oscar to receive an in-home diabetic retinal eye exam through MCP's relationship with Nationwide Vision. ***We have effectively used this strategy to help achieve a 76 percent rate of compliance with retinal eye exams for MCP ALTCS members with diabetes, far exceeding the AHCCCS MPS of 49 percent.*** The CM may also schedule in-home laboratory testing and in-home PCP care. The CM also connects Oscar and his family to community organizations for education on diabetes care, nutrition consults, the importance of exercise, training on how to use a glucometer and ongoing diabetes management.

Addressing opiate use. As part of the medical evaluation completed by the PCP during Oscar's SNF stay, the PCP may refer Oscar to specialists for pain management and/or substance abuse intervention. Based on his needs and choices, and using ASAM as a guide, we connect Oscar with services to reinforce proper use of opiates, such as substance abuse treatment (including Medication Assisted Therapy, individual and family therapy, pain management specialists, intensive outpatient therapy). He may also choose to receive services from the Integrated Pain and Substance Abuse Centers of Excellence, which we are currently piloting. Further, we can provide additional support through MCP's Exclusive Provider Program, which links members to a single prescriber. We may also employ quantity limits for controlled substances.

These programs have been effective in improving member care and are discussed with Oscar as part of his person-centered care plan. For example, the Integrated Pain and Substance Abuse Center of Excellence pilot has shown promising early results in helping people with complex issues to improve their functioning (as measured by evidence-based functional assessments) and reduce morphine equivalent daily dosing requirements to near zero. If appropriate, Oscar may be referred to the Exclusive Provider Program, designed to improve medication management. ***Program participants have experienced decreases in the number of prescribers and prescriptions, improving care and reducing costs by 68 percent.***

Advanced illness care and end of life planning. The CM, Oscar and the family discuss Oscar's future goals, and his brother agrees to serve as medical power of attorney or surrogate decision maker, when needed. The CM helps Oscar complete advance directives and informs the family on how they can support Oscar's wishes. The CM documents Oscar's wishes in the Mercy Life & Health Planning toolkit to help Oscar keep his important health information (advance directives, care plan, key contacts) in a single location.

MCP has adopted the National Quality Forum's framework for advanced illness care, which encompasses a broad range of services that bridges families and caregivers, communities and the health care system. Through the care team, we empower members to participate in their health care decisions to the extent possible and honor their preferences and decisions. This includes offering palliative care in various settings (including home, community, hospital, hospice, nursing homes and other long term care facilities) especially at the end of life, which may include hospice care. We have partnered with Arizona Palliative Care to support families of members with dementia, educating them to decrease caregiver burnout and enabling members to remain in the least restrictive setting. The program also helps prevent unnecessary SNF placements, minimizes the use of medications, encourages use of urgent care centers, increases direction for "no hospital" or "DNR" in advance directives, and improves collaboration with community agencies. ***Program participants have experienced decreases in hospitalizations resulting in improved quality of life and a cost savings of more than \$398 per member per month.***

MCP brings unparalleled experience and knowledge to serving members with a serious mental illness who have complicated physical health needs. We will leverage the experience we have gained through our work with Mercy Maricopa Integrated Care and our community relationships to implement an integrated service delivery system built on close care coordination, best practices and an unwavering commitment to improve the lives of the members we serve.



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Provide a description of the Offeror's past experience as a Medicare D-SNP Plan. The Offeror must include examples demonstrating its most effective initiatives (excluding CMS mandates and the provision of supplemental benefits) yielding improved health outcomes and experiences for dual members. Provide implementation dates of each initiative, the metrics and/or the measurement process utilized to support these outcomes, size of the Medicare D-SNP membership and the number of members participating in each initiative. Describe how the Offeror will replicate these initiatives in any and all awarded GSAs.



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Program 3

Since 2006, Mercy Care Plan (MCP) has provided high-quality, responsive, cost-effective and culturally competent care to members in our Mercy Care Advantage (MCA) Dual Eligible Special Needs Plan (D-SNP). Through MCA, we serve more than 18,300 dual eligible members, 89.2 percent of whom are fully aligned; and we are the aligned Medicare plan for Mercy Maricopa Integrated Care members. Over the years, we have increased and maintained aligned enrollment. Our experience includes passive enrollment to introduce SNPs to Arizona in 2006, a successful expansion and retention of largely dual eligible ALTCS members in Pima County, and implementation of seamless enrollment. We inform members and providers about benefits via our website, newsletters, the Member Handbook, and in-person events. Our local presence, member outreach and strong provider relationships are assets in increasing and maintaining alignment of dual-eligible members.

Best Practices for Promoting Alignment

We drive member choice by providing an unsurpassed member experience. We offer members services through a sustainable D-SNP Plan that goes above and beyond AHCCCS' requirements to include programs that deliver high quality care and enhance the member's experience. Our strategies result in a high number of dual- eligible members enrolling in our plan.

Seamless Enrollment

In May 2016, we received approval from the Centers for Medicare & Medicaid Services (CMS) to process Seamless Conversion Enrollments, which allows us to automatically enroll MCP members who will be Medicare eligible after turning 65 or after their 24-month Medicare disability-waiting period. In October 2016, we began notifying eligible MCP members about their automatic enrollment in MCA on their Medicare entitlement effective date. The written notice explains benefits of being an MCA member and how this plan will help coordinate with MCP coverage. While members can "opt-out" of MCA prior to their enrollment effective date, we help them make the most informed choice. We identify Mercy Care Long Term Care members who will be receiving the seamless enrollment information and notify their assigned Case Managers (CMs) so they are prepared to answer members' questions. As a CMS-approved plan, this initiative enables us to streamline and align Medicare and Medicaid rules, requirements and policies for seamless, high-quality, and cost-effective care.

MCA-Specific CAHPS Survey

Providing the best member experience for our MCA members is a priority. We are administering an MCA-specific CAHPS-like survey that includes more detailed questions. This survey focuses on the specific needs of the members we serve and helps us to develop specific interventions to improve our programs, enhance member experience and improve member engagement strategies.

Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)

Our MCA plan achieved FIDE designation from CMS for a D-SNP, which promotes the full integration and coordination of Medicare and Medicaid benefits for dual eligible beneficiaries by a single managed care organization. This enables us to continue operating our highly effective D-SNP through sustainable business practices that help us to retain our Medicare status. We can also offer more robust supplemental benefits, which encourages member alignment.

Best Practice Model of Care

Our MCA Model of Care applies best-in-class processes to maximize care coordination and members' experiences, resulting in a perfect score in our 2014 CMS audit review. Recently, CMS performed an onsite policy, procedure and outcome review comparable to an AHCCCS Operational Review. At the exit conference, CMS reviewers commented our model was in the "superior" category and among the most highly ranked and

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sophisticated they had ever reviewed. MCA received a three-year approval for our model, which is the fullest and longest approval period achievable.

National Experience/Support

In addition to our local knowledge and experience, we leverage the extensive resources and experience of our administrator, Aetna Inc. (Aetna). One of the country’s largest and most respected health care companies, Aetna began offering plan-sponsored Medicare Advantage HMO plans in 1986, Medicare Advantage PPO plans in 2003, and sponsored Medicare Advantage Prescription Drug (MAPD) Plans in 2006. For 2017, Aetna’s MAPD plans earned an overall weighted average of 4.0 stars, and 91 percent of Aetna’s Medicare members are enrolled in plans rated 4.0 stars or higher, a four percent increase from last year. We leverage the full range of Aetna’s national Medicare experience, internal audit support and claims payment methodology to support best practices for MCA.

Effective Initiatives Yield Improved Health Outcomes

We take pride in innovating and facilitating collaborative, integrated and outcomes-based care. The following describes initiatives across all of our plans that have improved member outcomes. We will continue to develop new and innovative initiatives for the next contract period.

ACTIVATE Model of Transitional Care Program

The ACTIVATE Program was developed in partnership with Foundation for Senior Living and Dignity Health to improve member health outcomes post discharge and decrease the risk of re-hospitalization. All of our Home- and Community-Based Services LTC members admitted to a Dignity hospital in Maricopa County are eligible for the program, regardless of primary payer source or diagnosis. The program uses evidenced-based practices from Coleman and other models. It includes an embedded nurse at the hospital who collaborates with hospital staff and has access to census and medical records. The nurse works with hospital staff to ensure that discharge planning starts on the day of admission, and the nurse works closely with the member/family, medical providers and the case manager for up to 30 days post discharge. Coordination with MCP’s CM confirms that services are in place upon discharge and that the CM is aware of issues that may require follow up. This process also helps confirm the member follows up with scheduled appointments, receives discharge medications and communicates medical needs to the PCP.

MCA's approach to coordinating care drives significant value for members and other stake holders:

- 3% higher access to preventive services
- 31% lower discharge rate
- 43% lower hospital days/1000
- 19% lower average length of stay
- 9% lower ED visit rate
- 21% lower readmission rate

—Avalere Health 2012, MCA versus FFS dual eligibles

Primary Outcomes: *Reduced readmission rates from 18 to 4 percent* for members in the intervention.

Implementation Date: December 18, 2011

Metrics: Percentage of members with readmission reductions; percentage who had PCP follow-up within 30 days of hospital discharge; percentage we were able to locate “red flags” information for during home visits

Process: A Transitional Care Nurse meets with the identified members in the hospital; provides them with an after hospital care plan; reviews their medication, disease and health information, home needs; and assists with follow-up medical appointments. The Transitional Care Nurse meets with the member and caregiver in the home within 72 hours of discharge to evaluate the transition and provide education and support. The nurse then follows up with phone calls and additional home visits when needed for a period of 30 days post discharge.

Medicare D-SNP members/participating: 401 enrolled; 297 have completed or are still in the program.



Replicating in Awarded GSAs: We will apply this program in other areas as it has proven beneficial to all members, including those with other payers. We will identify hospital partners in the South and North GSAs to work closely with the member/family, medical providers and the LTC CM for up to 30 days post discharge.

Behavioral Health (BH) Conditions Identification Initiative

Our BH Conditions Identification Initiative enables us to better coordinate members' medical and behavioral health care needs by identifying behavioral health conditions. Having this clinically important information enables medical management to direct appropriate behavioral health services and resources for those members who have co-morbid medical and behavioral health conditions. Since implementation, we have been successful in identifying more members with behavioral health conditions.

Primary Outcomes: **32 percent increase in the percentage of members with behavioral health needs being identified for services, and a 58 percent increase in the percentage of members with drug alcohol dependence being identified for services.** As a result, we were able to intervene more quickly to connect these members to services, improving engagement in care and outcomes.

Implementation Date: Fourth quarter 2013

Metrics: Increase in the identification of MCA members who may need behavioral health services

Process: If a clinician becomes aware of an ALTCS member's behavioral health need, the clinician immediately calls the member's CM. Within 72 hours, the CM refers the member to a behavioral health provider and encourages the member to see the provider within 30 days.

Medicare D-SNP members/participating: To date 4,991 members have participated in this initiative.

Replicating in Awarded GSAs: We plan to continue this initiative to determine our members' behavioral health needs throughout the awarded GSA membership.

High Quality/High Value Health Care Initiatives

Through these initiatives, we implement alternative payment models to incentivize excellent care for the members we serve through our network of high quality/high value providers, including ACOs, clinically-integrated organizations, Patient-Centered Medical Homes (PCMH), and in-home PCPs. This initiative helps us identify opportunities for improvement in certain primary care services as measured by HEDIS metrics. Our program goal is to meet or exceed the established targets for each of the metrics applicable to the high quality/high value practice.

Primary Outcomes:

- Member flu vaccination rate improved to 88 percent
- All three quality measures for comprehensive diabetes care for members with type 1 or 2 were met:
 - 28 percent improvement for members who had better A1c control
 - 7 percent improvement for members who completed A1c testing
 - 3.5 percent improvement for members completing LDL screening
- A nearly 2 percent year over year absolute reduction in member readmissions in the most recent performance period

Implementation Date: January 1, 2015

Metrics:

- The percentage of adults ages 18-64 who receive a flu vaccine during the measurement year
- The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with HbA1c poor control (>9.0 percent)

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- The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with HBA1C Testing
- The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with LDL-C Control (<100)
- Utilization of emergency department visits
- Percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days for members 18 and older in the following categories: 1) Count of Index Hospital Stays, 2) Count of 30-Day Readmission, 3) Average Adjusted Probability of Readmission

Process: Providers achieved or surpassed the targets by contacting the member by phone or onsite visit. This process enabled us to complete member-level reporting daily, monthly and quarterly.

Medicare D-SNP members/participating: 1,396 total members assigned to a high quality/high value provider

Replicating in Awarded GSAs: We will offer this program in our awarded GSAs, and work hand-in-hand with providers to identify opportunities for improvement in the delivery of primary care services. In addition, we continue to identify and share best practices to improve the health of our members.

Prevention and Wellness Initiatives

We base our prevention and wellness initiatives on assessments of the population, results of prior years' activities, our strategic plan, and goals for condition management and other special programs. We evaluate the effectiveness of prevention and wellness activities by benchmarking against previous internal performance and national standards (such as HEDIS® and the CMS Star rating system).

Primary Outcomes:

- 27 percent improvement in Colorectal Cancer Screening rates
- 45 percent improvement in Adult BMI Assessment rates
- Care for Older Adults:
 - 90 percent improvement in Advanced Care Planning
 - 25 percent improvement in Medication Review
 - 47 percent improvement in completed Functional Status Assessments
 - 39 percent improvement in completion of an annual Pain Assessment
- Management of Members with Diabetes:
 - 4 percent improvement in Hemoglobin A1c (HbA1c) Testing
 - 8 percent improvement in HbA1c control (≤9.0%)
 - 10 percent improvement in Medical Attention for Nephropathy

Implementation Date: January 1, 2012

Metrics:

- Improvement in the rate of colorectal cancer screenings
- Improvement in the rate of adult BMI assessments
- Improvement in the care for older adults
- Improvement in management of members with diabetes

Process:

- Coordination of care via three-way calls between member, provider, and MCP to schedule appointments
- Written reminders to members of appointments that were scheduled during outreach calls
- Automated telephonic reminders to members who may be due for services (well visits, mammograms)
- Written education information and reminders to members about preventive services
- Text messages to members



- Inclusion of information related to preventive services in the member newsletter
- Education to and coordination with providers regarding these services

Medicare D-SNP/participating: All SNP membership (over 18,300 members) are eligible

Replicating in Awarded GSAs: The prevention and wellness program has proven successful in improving the care and services provided to members, and we will replicate this program in awarded GSAs.

Additional MCP Initiatives for the new ALTCS Contract

Our initiatives go above and beyond the Medicare and/or supplemental benefits. We focus on meeting individuals' physical, behavioral and psychosocial needs and mitigating social determinants that impact their choices and health outcomes. We have developed the strategies below to address social determinants of health and will offer these programs to members served through this contract.

MCP's In-Home PCP Program to Improve Access to Care

This program provides in-home PCP services to improve member access to care, expedite solutions to medical issues and decrease unplanned hospitalizations and emergency room use. The program is currently available in most areas of Maricopa and Pima Counties, and has improved member access to primary care, helped to expedite solutions to medical issues and helped to decrease unplanned hospitalizations and emergency room use in lieu of a PCP visit.

Readmission Intervention That Helps Ensure a Successful Discharge to the Community

When members are hospitalized, CMs use the Readmission Intervention Assessment to coordinate a successful discharge to the community. CMs encourage members to see their PCP within seven days of discharge. The CM contacts members within 72 hours of discharge from the hospital, which reduces the chances of readmission from medication conflicts or lack of clear discharge orders.

Hospital Readmission Reduction Project to Improve Discharge Adherence

To reduce avoidable hospital admissions, MCP partnered with contracted attendant care agencies in Maricopa and Pima Counties to design and implement procedures for improving discharge adherence (medication adherence and attending seven-day appointments with PCP and applicable specialists) as well as improving care coordination following a member's hospitalization. The agencies track, monitor and trend compliance of their interventions and policies.

In-Home Medication Therapy Management (MTM) Program

MCP is implementing an in-home MTM for members in the community to increase member/caregiver understanding of medications and decrease medication-related issues. Our MTM program goes beyond traditional programs to include an in-home visit by the member's CM and a pharmacist to address polypharmacy, medications associated with a new diagnosis, drug interactions and the importance of medication compliance.

Care Transition Programs to Improve Outcomes

We are collaborating with the Area Agency on Aging's Care Transitions (Healing @ Home) Program to provide evidence-based transitional care for members discharged from acute and skilled nursing facilities in Maricopa County. This program has demonstrated a 16 percent reduction in 30 day readmissions nationally and we expect to see similar results. We will use our existing relationship with agencies such as the Pima Council on Aging/Carondelet Health Network and Northern Arizona Healthcare to develop similar programs in other GSAs.

MCA improves each member's experience by providing member-focused care that empowers and supports the member as they move through the health care system.



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Approximately 20% of the ALTCS E/PD population dies annually representing a significant percentage of the membership. This requires an increased emphasis on supporting members through life transitions such as declining health, aging and/or terminal illness. Describe the Offeror's experience in serving members during these life transitions. Describe new innovative strategies the Offeror will use to support members with decision-making and care needs throughout the term of the Contract.



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Program 4

Mercy Care Plan (MCP) recognizes that bringing appropriate services to members can help them achieve a better quality of life and health outcomes. As noted in numerous studies, such as the *New England Journal of Medicine*, palliative care is a rapidly growing medical specialty, and mounting evidence shows that Palliative Care Teams enhance quality of health care for persons living with serious illness and their families, while reducing medical expenditures. As conditions progress, hospice services can be beneficial. Of all Medicare beneficiaries who died in 2014, 46 percent used hospice – a rate that has more than doubled since 2000 (Kaiser Foundation). Hospice use in nursing homes has been associated with lower rates of invasive therapies and hospitalizations, improved management of pain/symptoms and higher family satisfaction with care.

Advanced illness care, including end-of-life care, represents a critical social and economic issue that continues to escalate due to an aging population and increased burden of chronic illness. The Kaiser Family Foundation reports that 90 percent of adults would prefer to receive end-of-life care in their home if they were terminally ill, yet data shows that **only about one-third of Medicare beneficiaries (age 65 and older) actually die at home**. With the growing aging population, advanced illness and end-of-life care planning is an important part of helping members express their preferences. To be part of the solution, we continue to develop and implement strategies that improve quality of life as members and their families face life transitions including difficult end-of-life care decisions.

Experience Serving Members During Life Transitions

MCP has been an ALTCS contractor since 2001. Our member-centered case management program effectively engages members and families throughout enrollment and during life transitions so they have needed services and supports they want as the member's condition evolves through advanced illness and end-of-life care.

Dedicated, Trained Case Managers Who Address Member Needs During Life Transitions

We assign all ALTCS members a Case Manager (CM). Most CMs are social workers with a minimum of a bachelor's degree and two years' case management experience. We assign members with high medical or behavioral needs to our specialized CMs who are behavioral health clinicians or registered nurses skilled and experienced in addressing members' more complex needs, high-risk behavioral issues and medically complex conditions. We also assign CMs by placement type (e.g., Skilled Nursing Facility), which means they are experts on educating the member and family on member rights and requirements related to that level of care. All CMs receive training on serving the ALTCS population during life transitions, such as end-of-life care, advance care planning, palliative care, supportive care and hospice; Mental Health First Aid; covered behavioral services; the Adult Service Delivery System-Nine Guiding Principles and the Arizona-Vision Twelve Principles for Children Service Delivery, cultural awareness of the member and family related to end-of-life care; and use of tools designed for members in specific settings.

The CM consults with the Interdisciplinary Team (IDT), composed of experts in both medical and behavioral health, to continually assess members' conditions as they transition through advanced illness and end-of-life care. The member and family are invited and encouraged to participate in IDT meetings. The IDT includes

Jeff: MCP Promotes Quality of Life through all Life Transitions

MCP assisted Jeff, who was enrolled after struggling to maintain his independence at home. He had previously been hospitalized and intubated for significant respiratory issues. Jeff's CM assisted him in transitioning to an assisted living facility, aided him in end-of-life care planning, and ensured his wishes were respected. At the time, he was expected to live only a few weeks. With the appropriate care at the facility, proper case management and the peace of mind that came from having his affairs in order, Jeff lived for another year. He passed peacefully and in accordance with his end-of-life choices. At his memorial service, his daughter specifically mentioned the compassionate care he received from his MCP CM.

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providers involved in the member's care, such as high quality, high value providers experienced in serving members needing advanced illness and end-of-life care. The IDT provides the forum for conversations with the doctors, nurses and pharmacists involved in the member's care to address palliative, curative and hospice care services, as well as pain management and pharmacy services. The IDT assures members and families have access to the right services at the right time as their needs evolve and that their preferences are voiced and understood by the care team.

Life transitions. The CM proactively, and at any time that they become aware that a member's condition has declined or they have been diagnosed with a terminal illness, conducts a thorough assessment that includes the member and member's family's preferences, interests, needs, culture, language and belief system (including spirituality) and modifies the member's care and service plans, as appropriate. Our goal is to keep members at home for as long as possible by providing in-home supports such as palliative and hospice care, in-home PCP services and other in-home alternatives. The CM may also recommend behavioral health services including counseling, family therapy and other resources such as support groups for the member and/or family to help deal with the life transition, a physical therapy evaluation for any new durable medical equipment or home modification needs due to the member's declining condition, or referrals for chronic care management.

Even when it is the best choice to transition a member into a Skilled Nursing Facility (SNF) or Assisted Living Facility (ALF), the member and family may still experience emotional and physical stresses. To support members and families through this transition, we assign CMs by facility type. These CMs receive additional training so they have the knowledge and tools to provide services and advocate for members in facilities. They provide support to the member and family as they deal with the member's transition from independence to a more dependent setting. These CMs receive additional training on the federal regulations that protect the rights of members in SNFs/ALFs and how to confirm that our members' rights are not violated. They are trained on the regulations for SNFs/ALFs as well as requirements for specialty units within these settings, the Residency Agreement and the provider's contract requirements so they can explain members' rights and verify that members receive the services to which they are entitled. All CMs receive training on the criteria for SNF/ALF placement and how to determine when a member may be ready to move to a more integrated setting that best meets the member's needs.

Advance directives. Completing an advance directive alone does not resolve all barriers to members and families getting the care they prefer. Additional barriers include lack of provider awareness that an advance directive exists, the inability to access advance directives timely, and lack of provider compliance with advance directives. We describe our strategies to overcome barriers in the *Innovative Strategies to Increase Members' Quality of Life* section, below.

We use multiple strategies to increase the number of members who can participate in and voice their wishes for their advanced care planning via an advance directive. These include automated reports identifying members in need of an advance directive so CMs can target their efforts, CM training on the cultural implications in completing an advance directive, regular review of advance directives as members experience a change in placement and/or decline in condition, and appointment of a public fiduciary as appropriate when a member lacks the capacity to make decisions and lacks family to make decisions on the member's behalf. We also provide members and families with referrals to organizations that can help with advance care planning, such as Arizona AARP, Area Agencies on Aging, Jackson White Elder Law and the National Institute on Aging.

MCP exceeds AHCCCS' benchmark of **55%** with a **77%** completion rate for ALTCS members with a completed advance directive or an identified power of attorney.



Advanced illness care and end-of-life care. Non-curative care focuses on comfort and quality of life for the member. Our CMs continually assess members as their needs change while they progress through advanced illness and end-of-life care, modifying the care and service plans and assisting the member and family as needed, and engaging the IDT to discuss the complex needs of the member regarding transitions of care. We maintain a network of both palliative care and hospice providers. We have streamlined prior authorization and referral requirements for palliative and hospice services while coordinating benefits with Medicare to make access to advanced illness and end-of-life care easy so that the right services are available at the right time based on the member's needs.

Innovative Strategies to Increase Members' Quality of Life

As a long-time ALTCS contractor, we recognize the increased demand for advanced illness and end-of-life care. We have developed and implemented innovative strategies that address barriers to enhancing member's quality of life and improve the ability of members to choose their own treatment plan, and will develop new innovative strategies as described below.

Information to Support Decision Making and End-of-Life Care

MCP will develop a *Mercy Life & Health Planning Toolkit* that will be provided to members and families to help organize critical information needed during life transitions. The toolkit will include materials to inform members and families about available resources regarding end-of-life care and tools to assist with decision making, such as:

- The National Institute on Aging's *End of Life: Helping with Comfort and Care* booklet, which provides an overview of issues faced by people caring for someone nearing the end of life
- *Aging with Dignity's Five Wishes Living Will*, the first Living Will that incorporates personal, emotional and spiritual needs in addition to medical wishes (available in English and Spanish)
- Hospice of the Valley's Living Will and Health Care Power of Attorney form
- Healthy Living messaging included in MCP's Member Newsletters
- *Innovative Strategies for Decision Making*, a Jackson White pamphlet sponsored by MCP that provides end-of-life planning resources

To address barriers associated with providers' awareness of a completed advance directive and timely access to it, the *Mercy Life & Health Planning Toolkit* will include completed advance directives that the member or family can present to providers, in addition to the PCP, at the time services are rendered (such as during an emergency).

Web-based resources. We will develop an "Advanced Illness and End-of-Life Care Planning" page on our website to provide members and families with resources and documents related to end-of-life planning. The page will include the option to submit a question to MCP regarding end-of-life planning resources.

Enhanced Case Manager training. We will develop and provide enhanced training for our CMs about having advanced illness care conversations with members and families regarding advance care planning. Training will focus on providing tools to guide difficult conversations with members and families about advance care planning and end-of-life care options. The goal is to increase productive conversations that result in a completed advance directive that represents the member's wishes.

Community partnerships to improve quality of life. To maintain awareness of available resources to appropriately refer members and families, our staff regularly collaborate with community organizations who also serve ALTCS members, such as local Area Agencies on Aging, Jackson White Elder Law, Arizona Health Care Association, The Bridge Group, Arizona Hospital Association (Thoughtful Life), ELDER Alliance, and Assurance and

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Arise. Each organization in some way supports the aging population to stay healthy, active and have quality of life through the aging process. We will continue our collaborations with these agencies to identify opportunities to improve quality of life for our members.

Community leadership through activities like the Thoughtful Life Conversations initiative. Studies have shown that fewer than 25 percent of advance directives are followed, especially in emergency situations, which presents a challenge regarding compliance with advance directives. MCP has been an active participant in the Arizona Hospital and Health Care Association’s Thoughtful Life Conversations (TLC) project, which is creating a cross-disciplinary, multi-stakeholder organization to improve health care for people with advanced illness. The TLC supports several pilots, including in Flagstaff, through implementation of a locally adapted version of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm. The POLST Paradigm emphasizes advance care planning conversations, informed shared decision-making between patient and health care professional about the treatment the patient would like to receive at the end of his/her life, and ensuring patient treatment wishes are honored. Our participation in the TLC project allows us to help providers in the community gain access to training and conferences that will help move the system forward in its ability to provide the highest levels of person-centered care.

Native American members. MCP collaborates with the Arizona Advisory Council on Indian Health Care and will focus efforts on recognizing the cultural considerations around end-of-life care for Native Americans. We will augment our training for CMs about cultural sensitivity when discussing advance directives with members and families who are Native American based on the information shared by the Council.

Support for LGBTQ members. Through our collaborations with community partners, such as the Alzheimer’s Association and Area Agencies on Aging, we will develop materials for LGBTQ members to assist them with the special circumstances they face with estate planning and end-of-life care. Additionally, we will make trainings such as the Project Visibility Training Program available to our providers. With the assistance of this program, seniors are ultimately able to make more informed decisions as to which senior providers are "LGBTQ friendly."

MCP Programs to Support Decision Making and End-of-Life Care

Mercy Paws. Mercy Paws is a new program developed by MCP to address a barrier that can happen when members do not have adequate care for their pets if they have to be hospitalized. The program supports HCBS members who lack informal supports by providing safe and secure pet care during stressful health-related emergencies. Members experiencing life transitions related to declining health, aging and/or terminal illness are likely to have times where they need to be away from the home to receive treatment. Mercy Paws helps to alleviate the stress of worrying about their pets while members get the care they need.

Arizona Palliative Care Dementia Program. MCP continues to work with Arizona Palliative Care to provide support to families of members with a diagnosis of dementia who live in the community. The program provides support and education to member’s families to decrease caregiver burnout and to allow members to remain in the least restrictive setting. Evidence-based data for the program shows cost savings for institutional care and medical care in general. The program also helps to avoid SNF placements when members are better suited to live at home or in a group home. Other benefits of the program include medication review and reduction, encouragement to use urgent care centers rather than hospitals, increased direction for “no hospital/DNR” in advance directives, improved collaboration with community agencies and education for behaviors associated with dementia. CMs refer

During the first year of the AZ Palliative Care Dementia Program, we improved member quality of life while saving **\$184,226**, or **\$398** per member/ per month due to decreased hospitalization and ED usage.



members diagnosed with dementia living in the community to this program to provide additional support for the member and family. While we understand that Alzheimer's is not the only advanced illness and end-of-life transition, statistics show it is the most prevalent and life altering event for members and families. We will continue to identify initiatives that enhance quality of life during advanced illness and end-of-life care.

Supporting Members in the Most Integrated, Least Restrictive Setting

We afford members and families the choice to remain in their own home or an alternative residential setting rather than entering an institution. Our member-centered case management approach helps maximize a member's level of functioning, health status and all around quality of life. If a member needs a placement not currently available in our network, we create capacity by initiating new contracts with existing providers and facilities or developing a creative solution to meet the member's needs. For example, when we were awarded a contract in Pima County, we identified members going through life changing experiences. The community did not have enough providers to offer alternative settings to meet members' needs in the lowest level of care possible, as well as link them to appropriate care and supports. We worked with the community to develop two Adult Foster Care Ventilator Homes that provide a family environment, a placement option that was previously unavailable. Below we describe additional strategies to help members remain in the most integrated, least restrictive setting as they go through life transitions.

Mercy Rewards. To address the unique needs of our members, MCP will incentivize providers to accept members for placement through our Mercy Rewards Program. Facilities that meet or exceed established thresholds will receive financial rewards.

Long Term Care Environments to Support Members through Transitions

Continuity of Care model. MCP developed a continuity of care model where members remain in the same community with the same providers as their needs evolve. Our *Immanuel Campus of Care* establishes an integrated, level of care model. The campus offers placement and supports for all levels of care. Medical and behavioral health professionals collaborate as a team while treating members on the campus. With this model, the whole member is treated (biopsychosocial). Care coordination meetings are held with the member and any formal/informal supports to discuss the member's development and potential to step up or step down within the same campus community and providers. This causes less disruption for our members and gives them a chance to gain more independence or access additional supports when their condition declines.

Global Cognitive Impairment (GCI) units. MCP is working with our contracted SNFs to provide options related to end-of-life planning, such as referrals to a GCI Unit in a SNF or ALF. These units will offer more robust services to members with cognitive impairments than the current Memory Care Units. Programs in GCI Units will include meaningful activities, a safe environment, staff who understand how global cognitive impairment impacts a person and how to interact with them. Many SNFs and ALFs will be seamlessly transitioned to this new program.

In-Home PCP program. MCP offers members who prefer to receive their medical care in their home setting to enroll in our In-Home PCP Program. Members do not need to be homebound to qualify, but do need to be either MCP Long Term Care only or enrolled in our Medicare Advantage Plan. The program has improved member access to primary care, helped expedite solutions to medical issues, and helped decrease unplanned hospitalizations and emergency room use in lieu of a PCP visit. This enhanced accessibility provides for better coordination of benefits and a greater opportunity to manage avoidable hospitalizations to more members. Members experiencing a life transition are considered for appropriateness of referral to the In-Home PCP Program. We identify PCPs with competencies in addressing advanced illness and end-of-life care, such as providers certified in palliative care, to improve members' quality of life during these life transitions.



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The Offeror has a newly-enrolled 32 year old male with a Traumatic Brain Injury who temporarily resides in a Skilled Nursing Facility. He has limited mobility and functioning due to morbid obesity with a weight of 390 pounds and has a newly developed Stage 3 pressure ulcer on his buttocks. The member reports being depressed due to his divorce, loss of his job and social life. He attributes the “run-of-bad luck” to his obesity. He is sure he could get his life back if he could lose weight and become active again. Describe how the Offeror will assist the member to ensure he receives the highest quality care, services and supports.



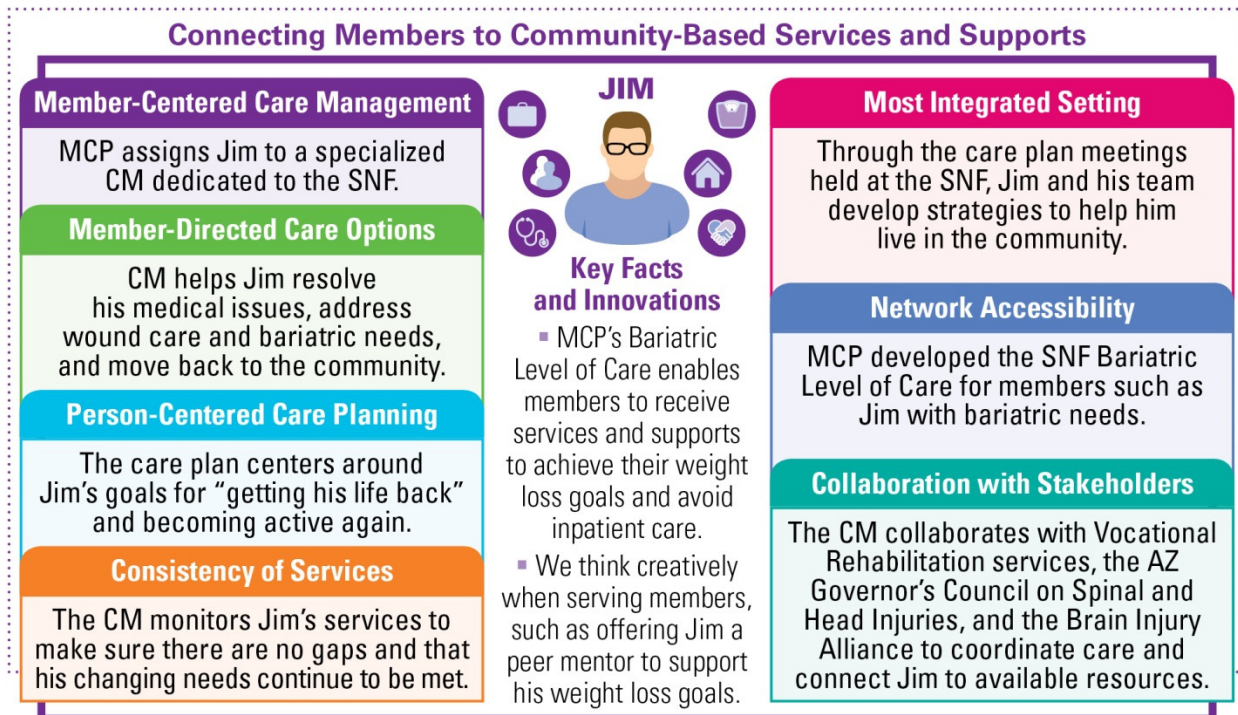
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Program 5

As a mission-driven, not-for-profit organization, Mercy Care Plan’s (MCP’s) number one priority is the members we serve. We go beyond simply administering health care benefits, making sure members and families stay informed about and connected to services, supports and resources that they choose and that improve their lives. MCP has systems in place to immediately support new members and families, develop a positive and trusting relationship with them, and complete the assessment and care plan within required timeframes.

Within one business day of notification of the member’s enrollment, MCP’s Intake Coordinator reviews the Pre-Admission Screening (PAS) and assigns a Case Manager (CM) dedicated to supporting members receiving services in a Skilled Nursing Facility (SNF). If the member was previously enrolled in an acute program, the CM works with our Transition Coordinator to obtain the member’s current authorizations for medications, treatments, specialty care and other services. The CM also contacts the Regional Behavioral Health Authority (if the member was previously enrolled) for information on the services provided and the member’s records.

The CM contacts the SNF to let them know they will be supporting the member and to find the best time to complete an initial visit. Because the CM is assigned to work with all MCP members in this SNF, he/she has a positive relationship with the staff and knows their processes. If the member’s family or other supports are involved in care, the CM schedules the visit at a time they can attend or arranges to gather their input prior to the visit, with the member’s permission. The CM completes an initial face-to-face meeting within a week of assignment. During this meeting, the CM introduces themselves, explains the ALTCS program, reviews the Member Handbook and how to file a grievance, learns about the member’s preferences, addresses urgent needs, answers questions and completes the comprehensive assessment and care plan. During this meeting, the member asks that the CM call him by his name, “Jim”. As shown in the figure below, our processes align with ALTCS program goals and include creative strategies to help Jim meet his goals.





Assessing the Member's Strengths, Needs and Goals

As a part of the comprehensive, holistic assessment, the CM reviews Jim's strengths, needs, interests, beliefs, cultural and linguistic preferences. The CM learns about Jim's goals and the full range of biopsychosocial issues impacting Jim's health. During the assessment, the CM listens to Jim and uses motivational interviewing to help engage Jim in identifying any underlying issues that may be roadblocks in meeting his goals for health and independence. The CM explains to Jim that the assessment helps us determine Jim's needs and develop a mutually agreed upon care plan.

The CM uses MCP's assessment tool along with AHCCCS' Uniform Assessment Tool to understand the level of assistance Jim needs to complete his Activities of Daily Living as well as potential behavioral health and social needs and the impact of the Traumatic Brain Injury on his health and functioning. When completing the assessment, the CM gathers information and input from Jim's PCP, the bariatric team and other specialists (wound care, neurologists). The CM reviews the SNF chart and talks to the staff about Jim's care to inform the assessment. During the face-to-face interview, the CM completes the depression screening portion of the assessment, which suggests that Jim needs a referral for behavioral health services. The CM also discusses Jim's strengths, past successes with self- management, problem solving, and family and informal supports. He/she asks about Jim's community involvement and interests in housing, employment, education and social supports.

To assess for common risk factors, MCP uses the Skin and Fall Evaluation tool to identify risk and current status related to skin condition and falls. We evaluate members in Home- and Community-Based Services and Assisted Living Facilities (ALF) settings using this tool at each assessment visit. Once the CM identifies Jim's risks, the CM explains the risk score to Jim and the SNF staff and discusses strategies to reduce future falls. The CM reviews the SNF plan for wound care and follows up at each contact to verify that Jim's wound is being properly treated.

Developing the Person-Centered Care Plan

Using the information gleaned from the assessment, the CM works with the MCP Interdisciplinary Team (IDT), which includes Jim, his PCP (a high quality, high value provider that employs a wound care specialist), CM SNF care team and any family member/natural support to develop a person-centered care plan. In accordance with the 9 Guiding Principles, the IDT encourages and assists Jim to choose his own goals and interventions, placing him at the center of the service planning process. The CM uses engagement strategies (such as motivational interviewing) to help Jim identify his highest priority issues, important goals and the agreed upon activities to reach those goals. The CM also provides a detailed description of available services, supports and community resources that can assist Jim in meeting his goals and educates Jim on how to be autonomous in these activities.

The CM attends the SNF Care Planning meeting and encourages Jim to attend so that the entire care team at the SNF can collaborate on his discharge plan. Since Jim's goal is to be discharged from the SNF, every time the CM visits the SNF (often weekly), he speaks with Jim to check on Jim's satisfaction with care and to determine if Jim needs an advocate with the SNF. The CM identifies the possibilities for Jim's discharge by identifying Jim's financial resources and ongoing income along with independent housing resources, living with family if appropriate, or assisted living facilities that would meet Jim's needs and be acceptable to him.

SNF Bariatric Level of Care. We developed a bariatric level of care in SNF settings to address the additional services and supports members who are morbidly obese may need. Jim, his CM and PCP determine that Jim is an ideal candidate for this. The CM manages approval for placement at this level of care and monitors for continued eligibility. Within this level of care, employees receive special training on how to meet the needs of members with obesity, including sensitivity training, proper movement of an individual with obesity, and symptoms that indicate risk of complications. In keeping with our whole-person approach, MCP considers the member's need for behavioral health and psychosocial supports when recommending placement in this setting.



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We incorporate those treatment goals and identify appropriate services and supports as part of Jim’s care plan. The facility focuses on helping Jim reduce his weight with support from the SNF dietician and increase his mobility and functioning. Jim also receives physical therapy, occupational therapy, wound care and durable medical equipment (such as a specialty mattress) to increase his readiness to live in the community. Jim has the option of being connected to a certified Peer Support Specialist, who helps to motivate Jim in meeting his weight loss goals, develop coping skills, identify natural supports and help him gain the skills to move into his own residence. With the CM’s support, Jim and the Peer Support Specialist establish milestones to meet and celebrate those successes as they occur. In collaboration with the PCP, and based on his interests, Jim has access to MCP’s network of physician and surgeon experts in bariatric treatments and surgeries.

Jim, his CM, PCP, the SNF and other providers/supports identified by Jim determine the following short- and long-term goals as well as the appropriate services and supports to help Jim achieve those goals. The table below provides the types of goals and interventions that may be appropriate for Jim to assist him in preparing to transition from the SNF back to the community.

Priority	Jim’s Goal	Example Interventions (based on Jim’s preferences and needs)
Traumatic Brain Injury (TBI)	Optimize ability to perform activities of daily living and to live an active social life	<ul style="list-style-type: none"> Review for appropriate consults (neurology and occupational therapy evaluations) Peer support to assist with re-engaging in social activities Refer to a high quality, high value provider with expertise in TBI, such as Barrow Neurological Institute Evaluate need for TBI group home
New Stage 3 buttock pressure ulcer	Improve pressure ulcer, leading to healing	<ul style="list-style-type: none"> Coordinate to obtain a specialized mattress Verify that high quality wound care is occurring
Limited mobility	Increase functioning to obtain maximum independence	<ul style="list-style-type: none"> Discuss physical and occupational therapy evaluation and treatment with the SNF staff
Obesity	Reduce weight	<ul style="list-style-type: none"> Arrange for nutritional consult in the facility Offer connection to a certified Peer Support Specialist who can serve as a mentor Refer to a bariatric physician to develop a medically sound and evidenced-based weight loss plan, including options for future bariatric surgery
Depression	Reduce symptoms of depression	<ul style="list-style-type: none"> CM to work with the MCP Behavioral Health Coordinator to identify program options including those addressing treatment and adjusting to life changes such as divorce and job loss Encourage participation in nursing facility activities or other TBI support groups Arrange for integrated services within the facility
Desire to return to the community	Assist member to live in the least restrictive setting possible	<ul style="list-style-type: none"> Work with facility and identified supports to transition to an alternate setting with needed services in the community. Create Transition Plan

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Through ongoing care planning meetings, the team discusses Jim's ultimate goal to live in the community. They discuss several options, including placement in an in-network ALF that is dedicated to meeting the needs of members with a TBI. They also discuss Jim's interest in and capacity to self-direct services as well as placement in an independent setting with comprehensive services and supports. If Jim elects to move into his own home, the CM completes the cost-effectiveness study to determine if that is an appropriate option and coordinates an on-site visit for Jim to tour potential residences so he can make an informed choice about where he would like to live. As part of Jim's transition plan, the CM completes and coordinates the following activities:

- Community Transition Program that provides funding if Jim needs any household items, security deposits or other items to move into his residence
- Home/Safety Evaluation including assessment of any needed home modifications prior to discharge
- Close follow-up from the CM after Jim transitions to the community setting
- Connection to community TBI programs and support groups
- Assessment of Jim's interest in obtaining meaningful and competitive employment, with authorization of employment support services and coordination with community employment resource programs
- Discussion of other social interests that Jim may have and assistance accessing those activities
- Coordinates with the behavioral health provider to transition services (medications, counseling) to a community-based provider to facilitate continuity of care

Based on Jim's choices, the CM also arranges for Jim to receive ongoing care through a high quality/high value provider that has demonstrated the ability to deliver integrated care services in an effective manner.

Employment and Vocational Supports that Help the Member Reach His Goals

Jim expressed an interest in going back to work and reported feeling depressed since the loss of his job, so the CM engages Jim about his most recent job and the type of work roles and environments he prefers. The CM works with MCP's designated Employment Specialist to provide Jim with information on the Vocational Rehabilitation (VR) Program, Disability Benefits 101 (DB101) and the AHCCCS Freedom to Work Program.

Supported employment. The CM talks with Jim about his employment preferences (work roles and environments) and the possibility of returning to his former place of employment. They discuss education and supported employment services that are available to help with the job search process. The CM gathers information from the MCP Employment Specialist on options to support Jim in obtaining and maintaining employment through the Supported Employment model. The Employment Specialist, trained on employment topics through the Work Incentive Information Network, educates the CM on how to incorporate the Arizona DB 101 tool into personal goal development and educate members on this resource.

Potential supported employment services include the VR Program through the Department of Economic Security. This program has staff trained to work specifically with individuals who have a TBI. Following the Collaborative Protocols in place with ADES/RSA Vocational Rehabilitation (VR), the CM uses the established Referral Coordination Form to refer Jim for VR services, including job training and employment supports. The VR Program application process includes interviewing Jim about his areas of interest, past employment and specific skills. The CM and Jim discuss options based on Jim's current status and develop short- and long-term goals following the review of all options. The CM also informs Jim about the Individual Development Account Program, which allows him to save for ongoing education while earning a dollar for dollar match for further education.

DB101 online benefits training. To make sure Jim is aware of how earned wages from employment may impact his benefit eligibility, the CM works with Jim to complete a planning session online using wage and hour



information from potential employment opportunities. The CM inputs several wage and hour scenarios to provide Jim with an overview of his earning potential, benefit changes, time lines, and Medicaid buy in option.

Supported Employment. The MCP Supported Employment provider receives the DB101 summary from the CM and provide ongoing benefits counseling while Jim is engaged in Supported Employment services. Jim has the option to receive Supported Employment while in the ALF as staff are equipped with WiFi-enabled tablet computers to facilitate community-based service delivery. Through Supported Employment services, Jim learns more about the AHCCCS Freedom to Work Program, how earned income will impact his disability benefits and work incentives to help plan for the future. Because we train our staff on work incentives, including DB 101, Jim’s CM answers Jim’s questions about the Freedom to Work Program and coordinate benefits so Jim can maintain medical benefits while he is returning to the workforce.

Supporting Seamless Transitions to the Community

During Jim’s transition to the community, his CM monitors all aspects of the transition process and take immediate action to address any barrier or issue that may arise. He/she visits Jim within 10 days of discharge to verify that the care plan is being followed and is meeting Jim’s transition needs. If Jim is transitioned to his own home with housing supports, the CM arranges for him to receive appropriate services, supports and connections to community resources based on his preferences and needs, such as transportation for members with bariatric needs. For example, Jim’s care plan may include the following:

Priorities	Goals	Interventions
Traumatic Brain Injury	Be an active participant in the community, optimize ability to perform activities of daily living and live an active social life	<ul style="list-style-type: none"> • Attendant care services to assist with Activities of Daily Living • Habilitation services • Employment support services • Peer support services • Connection to community resources • Linkage to information on other interest groups
Medical stability	Pressure ulcer will heal and skin will remain intact, Jim will receive needed medical care, and have no unplanned hospitalizations or emergency department visits	<ul style="list-style-type: none"> • Facilitate delivery of needed equipment and supplies - hospital bed, specialized mattress, briefs (if needed) • Refer to home health nursing for medication support, pill organizers, education, skin checks • Transition to PCP services, specialty care, and outpatient services - wound care, neurology, bariatric experts and rehabilitative therapies • Refer for other evaluations, as needed • Enroll in TBI Care Program
Obesity	Increase activities, receive nutritional meals and reduce weight	<ul style="list-style-type: none"> • Arrange for nutritional support in the community • Continue peer support • Continue weight loss plan such as options for future bariatric surgery • Home modifications to doors, bathroom and egress, as needed
Depression	Reduce symptoms of depression	<ul style="list-style-type: none"> • Refer for behavioral health services including medications, counseling, peer support

To support Jim in living independently, his CM continues to monitor his progress, identify and address barriers, connect him to appropriate services and supports, and follow up to verify they are effective in meeting his goals for independence, improved health and re-integration to the community.



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Program 6

A young male Veteran with a service connected spinal cord injury and Post Traumatic Stress Disorder (PTSD) is currently residing in an Assisted Living Facility. He would like to someday own his own home, but will require in-home care/supports indefinitely. He would like to pursue other career opportunities and, although he is very motivated to return to work, he is concerned about losing his health care and other benefits. His interests include outdoor recreational activities that he pursued prior to his deployment and injury. Explain how the Offeror would support this member.



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Program 6

MCP works closely with system partners and community organizations to make sure veterans receive the services and supports they need when they need them. For more than 30 years, we have served members in Arizona, developing specialty programs to meet their unique needs. For veterans, we offer specialized services and supports through the Project H3 Vets Program and Rally Point Arizona Military Navigator. Rally Point offers veterans a toll-free hotline 24 hours a day, 7 days a week for crisis triage, service referral and community resource connection. They also maintain a Crisis Mobile Team of behavioral health clinicians who are also veterans and who can be dispatched through the crisis hotline. This “vet to vet” connection has proven to be invaluable in working with veterans in acute crisis situations.

For veterans experiencing chronic homelessness, both Rally Point and Project H3 Vets help them find affordable housing and support on their path to recovery. The groups help with lease processing, managing tenant and landlord issues, and acquiring basic household goods. They also provide ongoing peer support services for veterans transitioning into permanent housing to help them with budgeting, housekeeping, nutrition and other independent living skills. Rally Point’s Navigator Program has served more than 1,000 vets since it began in the summer of 2014. **One veteran said this about the program: “The services they’ve provided are unprecedented and unheard of. I only wish every veteran knew of their existence. It would be nothing short of life saving.”** Project H3 Vets has found homes for 264 veterans who were chronically homeless, and 90 percent of veterans have successfully remained in their homes.


For this member, our efforts focus on helping him to achieve his goals for independence while coordinating closely with the U.S. Department of Veterans Affairs (VA) and all providers and organizations involved in his care. As part of our commitment to members, MCP hires a diverse workforce who bring a variety of life experiences, including veteran’s status. In fact, in 2016 and 2017, our administrator, Aetna, was recognized by Military Friendly as the number one employer for veterans. We are strong advocates for all members who are also veterans, making sure they are aware of, and can access all available benefits and services. MCP has also partnered with the Arizona Coalition for Military Families to train each of our CMs on using the Veterans Navigation Tool, which offers resources that assist veterans in achieving their recovery, independence and wellness goals.

Because this member is currently enrolled with MCP, he has a relationship with a CM who informs him of programs and services and assists him in living independently in the setting of his choice. The CM also supports him in identifying employment options and engaging in recreational activities he enjoys while working to improve his overall health. The CM assigned to this member may have a similar background, be a veteran and/or received training on veteran’s needs and available resources. In our experience, members who are veterans need a CM who can help navigate the VA system and are a strong advocate. During the course of the CM developing a relationship based on shared experiences and providing consistent support, the member asks the CM to call him by his first name, “Mark”. The CM’s experience and knowledge of veterans’ needs are critical in supporting Mark and in connecting him to all needed services and supports.

As shown in the figure below, our processes align with ALTCS program goals and build upon the collaborative relationships that MCP has developed with the VA, providers, and community resources to help Mark achieve his goals for independence, employment and recreation.



MCP's Member-Centered Services and Supports for Veterans

<p>Member-Centered Care Management</p> <p>Mark is assigned to a CM who may be a veteran and will be a strong advocate.</p>	<p>MARK</p> 	<p>Most Integrated Setting</p> <p>To help Mark live independently, the CM connects him to veteran's benefits and community resources such as Vocational Rehabilitation, the local Industrial Development Authority Home in Five Program.</p>
<p>Member-Directed Care Options</p> <p>The CM educates Mark on self-directed care options.</p>		<p>Network Accessibility</p> <p>The CM helps to connect Mark to programs such as Rally Point and Project H3 Vets to assist veterans in navigating the system, accessing benefits, and connecting with treatment.</p>
<p>Person-Centered Care Planning</p> <p>The care plan centers around Mark's goals for owning his own home, returning to work and engaging in recreational activities.</p>	<p>Key Facts and Innovations</p> <ul style="list-style-type: none"> ▪ MCP will establish a Collaborative Protocol with the VA to outline our processes for care coordination. ▪ Through the Coalition of Military Families, MCP staff are trained to use the Veteran's Navigation Tool. ▪ We contract with Project H3 Vets, which has found homes for 264 veterans who were chronically homeless and 90% of veterans have successfully remained in their homes. 	<p>Collaboration with Stakeholders</p> <p>MCP works with Veteran's Affairs, Freedom to Work, and Vocational Rehabilitation services to help Mark achieve his goals.</p>
<p>Consistency of Services</p> <p>The CM monitors Mark's services to address any gaps or duplication identified.</p>		

Assessing the Member's Strengths, Needs and Goals

The CM completes a face-to-face re-assessment at the Assisted Living Facility (ALF) every 90 days, or more often when there is a change in Mark's status or condition. The CM also communicates with Mark's PCP, specialty providers (neurologist), and the VA to gather information on his progress and status. With Mark's permission, the CM encourages Mark's family and informal supports to be involved in his care to help Mark achieve his goals for independence, improved health and community re-integration.

As part of the re-assessment, the CM conducts a focused assessment using a tool developed by MCP to identify opportunities for members to develop and increase self-management skills. It features questions that elicit deeper discussion and guides the CM in helping Mark talk about his needs and goals in his own words. This fosters an open and trusting rapport between Mark and the CM and provides a strong basis for meaningful care plan development. The results of assessments inform the development of a person-centered care plan.

Additionally, Mark's CM performs the Skin and Fall Evaluation (SAFE) tool to assess member risk and current status related to skin condition and falls. Members residing in Home- and Community-Based Services and ALF settings are assessed using the SAFE tool at each assessment visit. Once the CM identifies Mark's risks, the CM explains the risk score to Mark and the SNF staff and discusses strategies to reduce the risk of falls.

Developing the Person-Centered Care Plan

To coordinate all services and eliminate duplication or gaps, the first step in addressing Mark's whole health needs is understanding the services he is currently receiving through the VA and any other providers. During the assessment, the CM asks Mark about all the services he is receiving through the VA and obtains a release of information so that he can obtain Mark's medical records and communicate directly with VA providers. Mark can receive primary care services through the VA or through his MCP PCP. Via the assessment process and during regular contacts with Mark, the CM learns about Mark's individual goals, needs, preferences, interests, beliefs, culture, and language. We then connect Mark to services through our high quality/high value providers, or develop new programs as needed to meet Mark's needs.



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Integrated high quality/high value services. The CM explains options for Mark to receive integrated care through a high quality/high value provider with demonstrated ability to deliver high quality services including comprehensive primary care and integrated behavioral health services (when appropriate) that improve member outcomes. These providers have mature electronic health information sharing, coordinated appointment setting, care navigation assistance, preventive service monitoring, and increased access to diagnostic and therapeutic services. The provider also assists in coordinating services with the VA and across specialty providers that Mark sees for his spinal cord injury. MCP's network includes highly specialized providers, such as Barrow Neurological Institute, which has programs for individuals with spinal cord injury. Mark can choose this or another provider. We encourage Mark (and all members) to select high quality, high value providers by informing them of their options for accessible providers with the expertise to meet their needs.

Addressing PTSD symptoms. Mark can receive treatment for his symptoms related to Post Traumatic Stress Disorder (PTSD) through a high quality, high value provider who delivers services according to evidence-based practices such as Cognitive Behavior Therapy, psychotropic medications and family psychoeducation, which have proven effective treatment for PTSD. Mark can also receive peer support services or participate in support groups available through the VA, Mental Health Association, or other community organization. Mark's CM works closely with MCP's Behavioral Health Coordinator to identify providers to best meet his needs, encourages him to select the treatment that addresses preferences and needs, and makes sure he has ongoing access to care.

Coordinating with the VA. If Mark decides to continue receiving his primary care and behavioral health services through the VA, he and his CM develop a plan for coordinating care and ongoing communication so that the CM remains apprised of the services Mark receives, progress toward goals, and any needs not being addressed. ***MCP will establish a Collaborative Protocol with the VA to outline our processes for care coordination.***

Developing a crisis plan. As part of the care plan, Mark and his CM develop a crisis plan that includes steps to mitigate potential emergencies, available supports and contact information for the 24/7 crisis hotline. We have established processes for the crisis line to notify the CM if Mark experiences a crisis. The CM then follows up with a phone call or visit and assist with scheduling appointments, as needed. The CM shares the crisis plan with Mark's team (with his approval), his family and the ALF.

Ongoing case management. The CM meets with Mark in person every three months at a minimum, at the Assisted Living Center or a location Mark chooses. The CM confirms Mark is receiving services that meet his needs, identifies barriers and helps Mark move toward his recovery and wellness goals. During each visit, together the CM and Mark discuss Mark's accomplishments toward his goals and any changes in status, and they update his care plan, as needed.

David: MCP's Knowledge of Veteran's Issues Leads to Member Engagement

David, a Vietnam veteran with a complex medical diagnosis enrolled with our acute program, was admitted to a SNF. At the same time, his family was evicted from their HUD apartment and moved in with friends. David reported feeling hopeless and did not want to engage in services. Our CM, David and the entire MCP team worked together to determine all possible resources to prevent him and his family from being homeless, such as the Veteran's Crisis Line, Arizona Coalition for Military Families, and the Vietnam Veteran Homeless line. David was discharged from the SNF to the VA hospital. During his stay, MCP's CM worked with the VA Hospital Social Worker to complete an ALTCS application for David. He was approved, and recent benefit changes enabled his spouse to keep his monthly social security check. David had previously refused ALTCS benefits as he did not want his spouse to be without income.

The CM, VA hospital staff, and MCP worked together to make sure David was discharged to a community setting and reduce the frequency of his inpatient admissions and ED visits. **Since his transition to ALTCS, David has not been admitted to an inpatient setting and has had only two visits.** David is now safe, receiving needed services and supports, and engaged in his care.



Helping the Member Reach His Goal for Independence and Community Re-Integration

As Mark has expressed the desire to own a home, his care plan includes a component to support him in moving toward that goal. He and his CM begin by determining available financial resources. Due to his disability, Mark may be eligible for Social Security Disability and/or Medicare benefits. If he is not yet receiving these resources and benefits, his CM assists him in completing the application process.

Housing resources. The CM consults with MCP's Housing Specialist to determine potential resources for Mark. Our Housing Specialist has received comprehensive training on topics such as best practices, fair housing laws, and other housing regulations. The Housing Specialist helps the CM assesses Mark's housing needs using the VI-SPDAT and uses the Veteran Navigation Tool to determine if Mark is eligible for the Special Adaptive Housing Grant, which helps veterans with certain service-connected disabilities live independently in a barrier-free environment. Based on Mark's needs and choices, the CM connects him to supported housing services as well as the Community Resources and Referral Center. They identify affordable housing options he may qualify for, to assist him in completing benefit applications and to offer the services of a Peer Navigator. To support Mark in his goal of obtaining a home, the CM provides information on the Maricopa County Industrial Development Authority Home in Five Program, which offers six percent down payment assistance to qualified veterans. The CM also educates Mark on the Individual Development Account Program, which enables Mark to earn a dollar for dollar match to save for his own home.

Community supports. The CM and Mark discuss the type of in-home and community-based supports necessary to keep Mark safe while living independently. The CM arranges for Mark to visit the Foundation for Senior Living Caregiver Training Home so Mark can see what a modified home looks like, practice maneuvering through the home, help determine the types and frequency of supports he needs and identify necessary home modifications. As Mark requires significant daily assistance, he and his CM identify options for in-home care. The CM finds information on the Aid and Attendance Allowance that increases the monthly pension for veterans who require daily in-home personal assistance, which may be an option for Mark.

Self-directed attendant care. Since Mark wants to be independent and is fully engaged in his care, the CM educates him on self-directed care and they discuss potential caregivers. Additionally, they talk about whether Mark would benefit from having a service dog and discuss available options. This includes assistance with veterinary care and equipment available through the VA as well as MCP's Mercy Paws Program, which provides care for Mark's service animal if he needs inpatient or facility-based care and has no other supports.

Peer support. As Mark moves forward in his recovery, the CM talks to Mark about a certified Peer Support Specialist and the benefit of working with a person who shares a similar experience. The CM contacts peer and family support providers to identify a specialist to support Mark in his current living environment and through the transition to his own home.

Recreational activities. Mark wants to participate in outdoor recreational activities similar to those he participated in prior to his injury. He and his CM identify options for re-engaging in recreational activities he enjoys including discussion of adaptive equipment or other support needed for Mark to participate to the fullest degree. This involves working to link Mark to former groups he was connected with by identifying community programs, such as Daring Adventures, Wounded Warriors, recreational activities and support groups for veterans. Using the Arizona Coalition for Military Families Navigator Training, the CM identifies a list of resources in Mark's community, including outdoor recreation therapy available through the VA, the Veteran's Success Center (if he lives in Flagstaff) and Therapeutic Riding of Tucson, which offers a recreational riding program for injured vets living in the Tucson area. The CM also provides Mark with the Arizona Department of



Veterans' Services Information Directory, which includes detailed information on benefits, employment and services available to veterans in Arizona.

Mark may also choose to participate in the fitness and recreational activities available through an Independent Living Center located near his residence - Ability360 Sports & Fitness in Phoenix, support groups through the National Spinal Cord Injury Association or other community-based organizations in which he expresses an interest. MCP provides a bus pass or light rail pass so that Mark can go to recreational and educational activities. If needed and if he chooses, the CM arranges for Mark to participate in mobility training available through the local transit authority so that he is comfortable in using public transportation. The CM encourages Mark to select those activities he is most interested in and includes those in his care plan.

Incorporating Employment Supports to Achieve Independence

Since Mark has expressed interest in becoming employed, the CM works with MCP's employment expert to provide Mark with Disability Benefits 101 (DB101) training and information on vocational rehabilitation and supported employment. The CM and Mark discuss available options given Mark's needs and interests.

Benefits education. To address Mark's concerns about losing his health care and other benefits, his CM works with him to complete a DB101 session online by bringing a Wi-Fi connected tablet to the Assisted Living Center. By completing the DB101 session, Mark learns about the AHCCCS Freedom to Work Program and work incentives available to individuals receiving Social Security and how earned income impacts benefits. Mark gains an understanding of how veterans and Social Security benefit programs work together to support individuals with disabilities in returning to work and achieving self-sufficiency while making necessary medical benefits available. MCP's Employment Specialist trains our CMs on work incentives and DB101 so they can answer most questions Mark (and other members) may have about the Freedom to Work Program and assist with coordinating benefits to support members in maintaining medical benefits while returning to the workforce. The CM sets an appointment at the independent living center to review and confirm benefit information. The long-term goal is for Mark to be gainfully employed.

Supported employment. The CM contacts a supported employment provider to assist Mark in obtaining and maintaining employment. Together the CM, Mark and Employment Specialist outline the supportive services that assists Mark to reach his goal. Services include identifying job preferences and interviewing Mark about his areas of interest, past employment and specific skills. The Supported Employment provider discusses options for employment or pre-job and vocational training that meets Mark's interest.

Vocational rehabilitation. The CM provides Mark with an overview of the Vocational Rehabilitation (VR) Program and connects with the program staff to discuss Mark's interest in the program and specialized services that would assist Mark to meet his goals. Together with Mark and VR program staff, the CM establishes a time to meet to receive additional information about the program. Mark and the CM attend the VR information session at the local VR office. The CM also discusses the VA VR Program, which may be an option if Mark meets service requirements, and helps Mark apply for VA VR benefits online, if needed. If beneficial, Mark may be co-enrolled in both VR Programs. As Mark moves forward in supported employment services and obtains employment, MCP provides additional benefits planning using DB101 and reports employment outcomes to the Work Incentive Information Network (WIIN). If Mark is interested in receiving peer support services or becoming a certified Peer Support Specialist, MCP connects him with the necessary training.

The CM continues to maintain regular contact with Mark, serving as an advocate, partner and care coordinator who supports Mark in meeting his goals for independence, recovery and wellness.



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ACCESS TO
CARE/NETWORK #7

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It is estimated one in four Arizonans will be over the age of 60 by 2020. It is reported that this increase in the aging population will result in exponential job growth in the long term care paraprofessional workforce over the next eight years. Present the Offeror's perspective on Arizona's current paraprofessional labor market and describe the Offeror's anticipated labor needs to adequately serve its membership through the term of the Contract. Describe innovative strategies the Offeror will implement to ensure recruitment, hiring and retention of a paraprofessional workforce by providers sufficient to meet the needs of, and provide quality care, to members in any and all awarded GSAs throughout the term of the Contract.



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Access to Care/Network 7

Mercy Care Plan (MCP) recognizes that workforce development directly impacts the accessibility of Long Term Care (LTC) services delivered by paraprofessionals. These services (attendant care, personal care, homemaking, respite care, habilitation and behavioral health) are important to maintain consistent care for our members. Our experience and relationships with community leaders helps us evaluate and contribute to developing Arizona's paraprofessional labor market. For example, in collaboration with AHCCCS, our staff members participated with the ALTCS Direct Care Workers Committee from the beginning to implement the Direct Care Workforce training requirements for all Direct Care Worker (DCW) agencies. We amended all Attendant Care contracts to include language requiring that DCWs meet training and testing standards. Our Quality Management staff monitor that agencies provide employees with initial and ongoing training to deliver high quality care to MCP members. Provider agencies must enter staff information in an AHCCCS database, which houses training and testing standards.

MCP's Perspective on Current Paraprofessional Labor Market

We include workforce development as part of our Network Management and Development Plan, which details how we monitor critical services – such as attendant care, personal care, homemaker and in home respite – to identify, correct and track gaps in services. We work with stakeholders (care workers, consumers, employers, training agencies and concerned citizens) as part of the Arizona Direct Care Workforce Alliance to advocate for change in the LTC system statewide. In supporting this program, we encourage agencies to provide the required DCW training to keep the workforce stable and enable DCWs to carry their training with them when moving from one agency to another. We also collaborate with the Arizona In-home Care Association, which represents a coalition of businesses in and affiliated with the in-home care industry, whose focus is to establish and enhance the credibility of non-medical home care providers. MCP is also on the board of the Caregiver Consortium, which seeks to strengthen the continuum of care and encourage development of needed services for caregivers and older adults that complete the continuum.

Anticipated Labor Needs to Serve MCP Members

A recent study completed by Vitalyst Health Foundation and the City of Phoenix commissioned the University of California to survey hospitals, community health centers, long-term care facilities and home health agencies in Arizona. The *Survey of Health Care Employers in Arizona: Home Health Agencies, 2015*¹ anticipates a need for approximately 47,000 new jobs in the allied health professions between 2013 and 2020, with the greatest growth demand among personal care aides rising from 21,760 in 2013 to 43,967 in 2020. We also researched source data from the Maricopa Community College District (MMCD) for growth need among personal care aides. MMCD's *The Allied Health Needs Assessment* also shows that growth for personal care aides will be more than 22,000 in 2020. The Paraprofessional Health Care Institute's *U.S. Home Care Workers – Key Facts* shows growth of more than 35,000 among personal care aides. In addition, the US Bureau of Labor Statistics expects a 41 percent increase in home care and personal care jobs and increased demand (by 56 percent) for home health aides in the next 10 years².

MCP has experienced growth in members receiving Home- and Community-Based Services (HCBS) in Maricopa County by five percent from 2005 to 2016, and in Pima County by almost six percent from 2012 to 2016. The

¹ <http://vitalysthealth.org/wp-content/uploads/2016/08/Home-Health-Agencies-Report.pdf>

² <http://phinational.org/home-care-workers-key-facts>

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HCBS population represents between 70 and 75 percent of ALTCS members who need the types of services provided by paraprofessionals.

In addition, MCP is piloting a program in 2017, using non-licensed Community Health Workers (CHWs) to deliver education about preventive services in Arizona, which will decrease the demand for paraprofessional services through member engagement in their own care. CHWs will provide education and support for members with diabetes and high emergency department utilization to help them understand disease management and access to services so they can better self manage their care. Our efforts will help inform the State of the clinical benefits of using CHWs to support members with complex conditions. CHWs will also support developing the workforce with the Sunrise Application process and provider registration activities in the future.

Expanding Services in GSAs new to MCP

We keep members in their local communities where possible, so they do not have to travel to Phoenix or other cities to receive the services they need. We have used our experience for all areas (including rural), rather than focusing only on populous ZIP codes. For example, when we entered Pima County in 2011, we worked with Ability 360 to bring its services to the area and now it is one of our larger agencies in Pima County, employing 212 additional people.

MCP partnered with **Ability 360** to bring their high value programs and services to Pima County. This organization now employs over **200** attendant care workers in this region.

Our MCP Vice President of LTC and our LTC Manager conducted provider forums in Flagstaff, Yuma and Tucson over the last nine months and also visited 79 agencies in 14 counties. These discussions included the growing need for health care providers and paraprofessionals, and the providers appreciated our interest in listening to them and in finding solutions. We will continue to work with them to recruit and train paraprofessionals in their communities.

Innovative Strategies for Increasing Provider Paraprofessional Workforce

MCP anticipates serving 40 percent of the ALTCS membership and therefore will need 6,000 to 10,000 new paraprofessionals to serve these members. ***MCP will allocate a minimum of \$2 million plus value-based incentives over the next five years in addition to leveraging the workforce initiatives and investments of our affiliate, Mercy Maricopa integrated Care*** to help meet this need. This will help ensure appropriate sufficient number of paraprofessionals are available to serve ALTCS members. Using the workforce studies mentioned earlier as well as our own extensive experience, we have identified specific strategies for increasing the availability of paraprofessionals to meet the anticipated need. We describe our strategies in the Workforce Development Plan outlined in the following table.

As shown below, our strategies focus on engaging with untapped workforce populations, implementing value-based alternative payment models to incent direct care agencies, and offering community grants to providers and other stakeholders where funding can be most useful in developing the health care paraprofessional workforce, including enhanced training and career development.

MCP's Projected Workforce Development Plan				
Targeted Workforce Populations	Projected Workforce	Recruitment	Training	Retention/ Maintenance
Provider agency-identified	2,000 (over 600)	MCP will reward agencies for recruiting a specific number of workers each	Agencies will receive an incentive when workers complete enhanced	MCP will offer incentives to agencies that achieve



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MCP's Projected Workforce Development Plan				
Targeted Workforce Populations	Projected Workforce	Recruitment	Training	Retention/Maintenance
potential staff	per year from 2018 to 2020)	year, providing an incentive for achieving the annual goal.	training to help them develop their careers.	benchmarks for retention.
Individuals eligible for AHCCCS WORKS	3,000 (1000 per year from 2018 to 2020)	MCP will offer incentives to agencies who hire individuals as part of AHCCCS WORKS (<i>contingent upon implementation of AHCCCS Cares</i>). We will educate MCP Acute members who are eligible for the AHCCCS WORKS program on the availability of employment options as paraprofessionals.	MCP will provide quarterly incentive payments to agencies when individuals complete AHCCCS-required training. Incentive programs will include provisions for at least half of the payments to be paid to workers who complete training.	MCP will offer incentives to encourage agencies to develop a career path for their workers and provide bonuses when agencies achieve established benchmarks supporting these efforts.
Transition age youth	1,000 (250 in 2018, 350 in 2019, 400 in 2020)	MCP will assist transition age youth in finding paraprofessional workforce employment, including collaborating with DCS to identify young adults exiting the child welfare system. We will collaborate with the Children's System of Care team and Youth Leadership Council to refine recruitment strategies. We will offer financial incentives to agencies that hire transition age youth including those exiting the child welfare system.	MCP will provide quarterly incentive payments to agencies when individuals complete required training. Incentive programs will include provisions for at least half of the payments to be paid to workers who complete training.	MCP will offer incentives to encourage agencies to develop a career path for transition age youth and provide incentives when agencies achieve established benchmarks supporting these efforts.



MCP's Projected Workforce Development Plan				
Targeted Workforce Populations	Projected Workforce	Recruitment	Training	Retention/Maintenance
Individuals seeking general employment options	4,000 (1,000 per year from 2017 to 2020)	MCP will sponsor job fairs to assist provider recruitment efforts. MCP will offer up to \$50,000 in scholarships annually from 2018-2020 for individuals who want to pursue vocational training.	MCP-sponsored scholarships will pay for initial training and continuing education.	MCP will offer incentives to encourage agencies to develop a career path for individuals and provide incentives when agencies achieve established benchmarks supporting these efforts.
Tribal members	100	MCP's Tribal Liaison will facilitate communication to help agencies recruit staff through the tribal social service agencies.	Agencies will ensure any recruited staff attend mandatory training.	MCP will offer incentives to encourage agencies to develop a career path for tribal members and provide incentives when agencies achieve established benchmarks supporting these efforts.

Working with Local Communities to Develop Creative Workforce Development Solutions

Along with the strategies outlined in our Workforce Development Plan, MCP will leverage our relationships with provider agencies, associations and advocates to meet the workforce demand. In each GSA we serve, we will continue to seek out creative ways to increase the availability of paraprofessionals, such as:

- **Identifying potential new workforce members** – We will identify new workforce members through the Veterans' Administration, Aging 2.0, Silvernest, family members, Project Visibility, Inter-Tribal Council of Arizona, and member and provider advisory boards. We will increase outreach efforts and solicit help from current providers, such as federally qualified health centers, integrated clinics, and rural health clinics, to expand their satellite sites and with provider agencies that deliver services outside of Maricopa.
- **Collaborating with local organizations** – We have met with all of the Area Agencies on Aging (AAA) Directors to discuss service delivery and challenges including workforce development. We are working with the AAAs to identify Title 5 (Senior Community Services Employment Program) opportunities available in the area. We are developing solutions, such as participating in their expos throughout



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Arizona, to seek out individuals interested in paraprofessional work within their communities. These relationships provide a continued forum to discuss statewide paraprofessional solutions.

- **Partnering with community employment resources** – We will work with resources available through ARIZONA@WORK, a statewide workforce development network that helps employers of all sizes and types recruit, develop and retain the best employees. This program provides comprehensive, locally based workforce solutions through a statewide network, and serves communities across Arizona. We will develop relationships with the statewide program as well as local job boards to educate them on paraprofessional job opportunities and training available in the health care system. We will encourage provider agencies to advertise positions at these locations and participate in job fairs and informational sessions to inform job-seekers about the opportunities available in our system. We have broad, statewide expertise as well as specific, local focus to serve the needs of employers and job seekers.
- **Offering community grants** – In collaboration with the Arizona Department of Economic Security (DES)/ Division of Aging and Adult Services (Senior Community Services Employment Program), we will offer opportunities for low income seniors, 55 years or older, to become paraprofessional workers in 2018. We are offering community grants to non-profit organizations participating in the DES program to train these works and implement retention strategies.
- **Implementing alternative payment models** – MCP supports paraprofessional labor providers within our service areas by including them in alternate payment models that promote sustainability. To reduce avoidable hospital admissions and emergency department visits, we implemented a three-year pilot in partnership with contracted provider agencies in Maricopa and Pima Counties to develop phased-in approaches for improving access and quality. Each agency is responsible to design and implement non-clinical policies and procedures to improve members' discharge adherence (including medication adherence), attendance at seven day appointments with PCP/specialists, and care coordination following a hospitalization. Agencies are eligible to receive incentive payments for demonstrating their adherence to established processes.
- **Supporting agency recruitment and retention efforts** – Based on feedback from our current providers, we know that it can be challenging for them to devote significant effort to recruitment and retention due to cost and lack of resources. Our plan to address these issues includes sponsoring local job fairs and working with them to develop a retention program for the paraprofessional workforce that includes opportunities for job advancement, increased responsibility, and monetary incentives.
- **Working with Employment Networks** – Through Ticket to Work, we will work with Employment Networks to provide job training and employment services to individuals receiving TANF and public assistance. We will also work with DES/Rehabilitation Services Agency to help educate individuals on becoming paraprofessional workers and find employment.

As an organization that has delivered services to Arizonans for more than 30 years, MCP has seen changes in workforce drivers, which have been impacted by member need and system changes. To address these workforce challenges, we will do as we have always done – partner with local communities and stakeholders to develop and implement creative ways and innovative strategies to make sure members have the supports they need. We are embedded in the fabric of the communities we serve and are committed to furthering the system of care for ALTCS members.



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ACCESS TO
CARE/NETWORK #8

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Access to Care/Network 8

A 16 year old male who is paraplegic secondary to a gunshot wound to the spine is currently enrolled with the Offeror. The member is currently receiving treatment in a Behavioral Health Residential Facility for inappropriate sexual behaviors perpetrated against a sibling and previous exposure to drug and alcohol abuse in the family home. In recent months, he has met all of his treatment goals and is ready for discharge. Due to his history of inappropriate sexual behaviors, the Child and Family Team recommends he not return to the family home. The family has heard about and visited an out of state group home where they would like to see the member placed. Describe how the Offeror will address the appropriate placement and service needs for this member.



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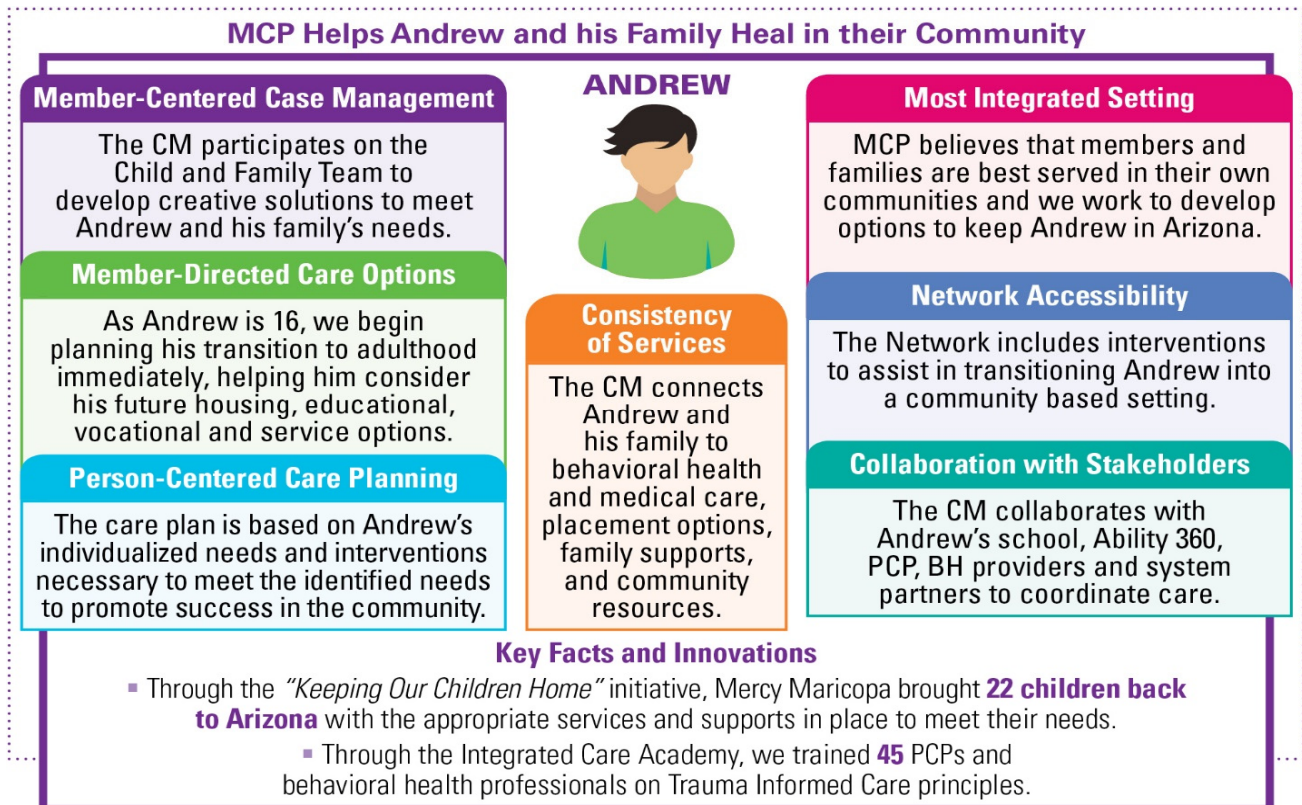
Access to Care/Network 8

Mercy Care Plan (MCP) makes every effort to keep members in the community and as close to their families and other natural supports as possible. We bring over 30 years’ experience managing comprehensive networks to serve members and families with complex biopsychosocial needs. We are the plan of choice because we have the expertise and systems to support members to live as independently as possible.

Member-Centered Case Management Program

MCP’s Long-Term Care (LTC) Program includes a member-centered case management approach to maximize members’ level of functioning, health status and quality of life. We train our Case Managers (CM) in motivational interviewing and a holistic approach to assessments to develop a person-centered care plan that meets member needs based on the member’s and family’s preferences, interests, strengths, culture and goals and that fosters motivation for change.

During the initial meeting with the member and his family, he asks us to call him “Andrew”. We assign a CM to Andrew selected from our specialty team of CMs (behavioral health clinicians and registered nurses) skilled and trained in addressing specific needs, such as pediatrics, high-risk behavioral health issues and medically complex conditions. CMs are trained to support the family in accordance with the Arizona Vision and 12 Principles for Children Service Delivery and with a Trauma Informed Care approach due to the trauma the family has experienced. In addition to being an integral part of the Child and Family Team (CFT), CMs have access to Medical Directors and our Interdisciplinary Team (experts in behavioral health, medical, pharmacy and senior ALTCS staff) for support in addressing member and family needs. The figure below shows the systems we have in place to support Andrew and his family in Arizona.





Assessing the Member's Strengths, Needs and Goals

Our holistic approach to the assessment addresses Andrew's medical, functional, social and behavioral health needs. During the assessment, the CM focuses on learning as much information as possible about Andrew's and his family's history, strengths, preferences, interests, needs, culture, language, belief systems and current functioning. He/she addresses Andrew's:

- Physical health needs regarding his paraplegia from his spinal cord injury; and also assuring his EPSDT needs and goals have been met and fully ameliorated
- Functional needs regarding his placement choice and any durable medical equipment needs
- Psychosocial needs regarding his sources of income and informal support network
- Family support needs regarding family/trusted adults that can provide placement options, the family's relationship goals with Andrew and strategies to achieve the goals, and supports needed for discharge
- Behavioral health needs regarding continued treatment interventions to address sexually inappropriate behaviors, previous trauma, progress attained at the Behavioral Health Residential Facility (BHRF), complex family dynamics (previous substance use), transition to adulthood, and services and supports for the entire family to move toward family reunification
- Educational and vocational needs regarding his education and social domains
- Coordination of care regarding any involvement with the justice system, or Department of Child Safety or other stakeholders

Developing the Member's Person-Centered Care Plan

The information learned in the holistic assessment, which includes Andrew's strengths, needs and goals, drives the development of the person-centered care plan to address Andrew's and his family's complex medical and behavioral needs. Andrew, his family and the CM mutually select services to help him attain his goals and support his highest level of self-sufficiency. The CM works with Andrew's CFT to identify the underlying needs and facilitate the brainstorming of interventions and strategies that can meet his needs. The CM provides Andrew and his family with tools to make informed decisions on setting goals, objectives and strategies to achieve those goals as well as the frequency of interventions selected and how the team will monitor progress. He/she advocates and encourages the CFT to meet Andrew's needs in the least restrictive setting to support self-sufficiency and independence. The person-centered care plan addresses Andrew's and the family's integrated care needs as follows.

Access to Care – Service Options

MCP strongly believes it is best practice to keep members, especially youth/adolescents, in Arizona, close to their families and in the least restrictive living environments. Based on our behavioral health expertise, we have learned that moving youth/adolescents out of state is often not the best option nor does it achieve the best outcomes. We support the CFT in identifying any possibility for reunification and in removing any barriers to this goal. We support the family in their choice to the fullest extent allowable and in accordance with the Arizona Vision and 12 Principles for Children Service Delivery. As part of the discussion of each placement option, the CM with the CFT and family consider all of Andrew's identified needs, such as his healthcare, incontinence issues, skin care needs, durable medical equipment and other needs related to his paraplegia.

The CM informs Andrew and his family about available in-state and out-of-state placement options appropriate for addressing medically and behaviorally complex conditions, as well as wraparound supports. The CM discussed with the CFT and family what it would take for the family to be comfortable having Andrew stay in Arizona, including the potential for 24-hour supports and developing a crisis and safety plan. If selected



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placement options are not in our network, we first identify any Letters of Agreement (LOAs) already in place that meet Andrew's needs. If not, we explore this possibility with the placement options.

As a matter of practice, we explore every possibility so members can live independently, and we have a history of creating innovative placement solutions for members with complex needs. For example, when MCP won the award to serve members in Pima County, we found there was a severe shortage of alternative placement options for the ALTCS population. Working with the community, we created additional capacity for BHRFs, assisted living centers and assisted living homes with behavioral health capabilities and, in collaboration with existing skilled nursing facilities, created new units specializing in serving the ALTCS population.

"Keeping Our Children Home". MCP and our affiliate, Mercy Maricopa Integrated Care, have experience with identifying in-state options for youth/adolescents with complex behavioral health needs. We are incorporating this experience into all our programs to support members in Arizona where they and their families can heal in local communities. In 2014, Mercy Maricopa Integrated Care facilitated discussions with its Arizona partners (AHCCCS, Arizona Department of Health Services, Arizona Department of Education, Division of Developmental Disabilities, Comprehensive Medical and Dental Program, a local children's provider and the Regional Behavioral Health Authorities) on the "Keeping Our Children Home" initiative. The group analyzed all youth/adolescents placed out of state to determine the reason for the placement, identify statewide strengths and gaps, and brainstorm options to fill gaps and create a network of placements and supports to bring the youth/adolescents back home. Through this initiative, we brought **22 youth/adolescents back to Arizona** with the appropriate services and supports in place to meet their needs.

CFT collaboration. The CM discusses the recommendation to move Andrew out of state with the CFT and the potential for him to remain in state closer to his family. If he does stay in the same area post discharge, he can keep the same CFT and providers for continuity of care. The CM and CFT also consider the BHRF therapists continuing to serve Andrew on an outpatient basis following discharge, if he remains in the area.

Specialized BHRF. If during the assessment process we identify additional needs indicative of BHRF level of care not yet addressed, we have established criteria for specialized BHRFs. If the criteria are met, we discuss with the CFT and BHRF staff potential placement in one of these specialized BHRFs as an option to further address Andrew's behavioral health needs.

Family placement. The CM also explores the possibility of placement with family members or trusted adults living in Arizona, such as grandparents or extended family who live close. Or, if necessary, we seek family members out of state who may be able to provide temporary placement that would keep Andrew connected with the family.

Out-of-state placement. After exploring all possible placement options in Arizona, if the family still chooses the out-of-state group home and Andrew meets medical necessity, we support Andrew and his family with the transition, following approval from AHCCCS. The CM with the CFT, educates the family about coordination of benefits with available payers, obtaining required prior authorizations for out-of-state services and the family's right to pay. We determine if an LOA exists with the out-of-state group home and, if not, explore the possibility of one. Qualified MCP staff will visit the out-of-state group home to assess the environment and share information from our assessment and person-centered care plan for continuity of care. We oversee Andrew's quality of care while he remains in this placement by monitoring that the services provided meet our quality standards. We will require that the group home notify us of any quality issues. Dependent upon the quality issue, a QM Nurse Consultant will investigate during an onsite visit as required by contract. The CM and the CFT begin transition planning to identify what is needed for Andrew to live successfully in the least restrictive environment back in Arizona with his family's support.

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Integrated Care Needs

The CM works with Andrew, his family and providers to develop goals for improved health outcomes and enhanced well-being. Together, they determine service and support options to meet the whole health needs of Andrew and his family. If Andrew is placed in the out-of-state group home, the CM works with the group home to identify providers and community resources nearby to meet Andrew's needs identified below and assist providers with registering with AHCCCS.

Physical health needs. Andrew has suffered a severe injury resulting in paraplegia. Depending on what we learn in the assessment, we will determine if physical rehabilitation and or habilitation is needed. Since he is under 21, we assure that he receives all EPSDT services. Thus, the CM consults with the PCP to determine if Andrews is due for any screenings or treatments and assists with making appointments. The PCP identifies high value high quality specialists, such as neurologists and Physical Medicine and Rehabilitation (PM&R) physicians to address Andrew's physical health needs. For an in-state placement, the CM coordinates with Ability 360, a community organization and partner, to conduct a physical therapy evaluation to determine Andrew's durable medical equipment and any home modification needs.

Behavioral health needs. When addressing behavioral health needs, we focus on both Andrew and his family. Wherever possible, we encourage reunification of the family. Thus, we will place Andrew as close to his family as possible. Based on the information obtained during the assessment, the CM along with the Behavioral Health Coordinator and Behavioral Health Placement Specialist (an additional position added by MCP to aid in identifying placement options for members with complex needs) determine if any additional evaluation is appropriate, such as neurological, psychosexual or cognitive testing.

The CM with the CFT recommends intensive behavior coaching designed to deliver intensive in-home and community-based support to families who have children that are at risk of being placed out of home. The goal is to help members increase competency and resiliency, as well as quality of life. He/she may also recommend family psycho-education. The family is encouraged to actively participate throughout treatment.

The CM with the CFT recommends individual and family therapy and supports to address sexually inappropriate behaviors, previous trauma, progress attained at the BHRF, complex family dynamics (previous substance use), transition to adulthood and services and supports for the entire family to move toward family reunification. He/she refers Andrew to providers who have been trained in trauma informed care principles. MCP LTC providers have access to evidence-based, trauma focused Cognitive Behavioral Therapy training through the MCP/Mercy Maricopa Integrated Care Academy. Through this Academy, we trained 45 PCPs and behavioral health professionals on trauma informed care principles in 2016.

The CM with the CFT, consults about Andrew's strengths and needs with the IDT. The IDT includes a Behavioral Health Manager, Behavioral Health Placement Specialist, Behavioral Health Supervisor, Spinal Cord Injury Specialist and Behavioral Health Coordinator as well as the Pharmacist, the CM, the BHRF provider, Housing Specialist and a Nurse Manager. Interventions may include discussion with the prescribing doctor, request for coordination between the PCP and the psychiatric prescriber, recommendations for placement or a change in

John: MCP Helps Members with Spinal Cord Injury to Achieve Amazing Successes

John was enrolled after a septic UTI. He suffered a spinal cord injury many years ago, and struggled to return to normalcy. Through the help and support of many agencies and dedicated people, including his MCP CM who made appropriate referrals and effectively coordinated his care, he now lives a true testimony. John plays power soccer at the ABILITY 360 center and travels with his team mates. He is involved in outreach with the Neuro Rehab Unit at Dignity Health and mentors new spinal cord injury patients by sharing his journey. He has also returned to construction work! He oversees work crews on local community projects and has had a huge impact. If it were not for key players in his care John would not be where he is today.



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placement, or a referral for additional behavioral health services to improve impulse control and self-regulation, coping strategies, and identification of boundaries. The IDT also recommends Andrew be seen by an adolescent psychiatrist prescriber, if he has not already, and verifies that the adolescent psychiatrist prescriber participates with the CFT. The IDT reviews Andrew's needs against medical necessity criteria to determine appropriate level of care needs.

Additionally, based on Andrew's strengths and interests, the IDT supports Andrew in programs where he can experience success and develop pro-social relationships with peers. The team discusses Andrew's history, needs, preferences, strengths and goals. The IDT identifies options for placement, reviewing the recommendation of the CFT for out-of-state placement as well as the services and supports to help Andrew achieve the goal of living independently in the setting of his choice.

Educational and vocational needs. The CM learns Andrew's status regarding school and his goals regarding his education and employment. As applicable, the CM contacts Andrew's school and participates in any Individualized Education Plan (IEP) meetings and makes recommendations in accordance with the IEP (and 504 if applicable). He/she assists with arranging necessary supports so Andrew can attend school, such as school-funded attendant care, attendant care outside of school, school-funded transportation and other support services. The CM coordinates supports so that MCP is the payer of last resort. If Andrew moves out of state, the CM encourages on-line schooling options so his education would not be disrupted if/when he returns to Arizona.

Individual and family support needs. Andrew and his family will need supports to make sure the chosen placement meets Andrew's needs and the family is progressing toward reunification. We train CMs to make sure services for children, youth/adolescents comply with the AHCCCS Clinical Guidance Documents specific to serving children and youth, the CFT model and the Arizona Vision 12 Principles for Children Service Delivery. The CM is local and knowledgeable about the resources in the community and informs the family about in-state supports available if Andrews remains in state. Although the same resources may not be available out-of-state, the CM works with the out-of-state group home to identify local supports. Upon agreement by Andrew and his family, the CM connects Andrew and his family to in-state community supports, which may include:

- *Ability 360* to provide recreational opportunities and activities for youth to participate
- *National Alliance on Mental Illness* to provide resource information on behavioral health and identify support groups specific to substance abuse and sexually inappropriate behaviors
- *Family Involvement Center* to provide family and parent education and support groups
- *Raising Special Kids* for the family to aid in acquiring skills and information beneficial to parenting children with disabilities or special health care needs

Transition age youth. When serving youth/adolescents, we address transition to adulthood and to consider the member's immediate needs as well as what his/her needs will be prior to and after turning 18. Since Andrew is at an age where planning for his transition to adulthood is critical, the CFT continues transition planning. The CM collaborates with our Transitional Youth Coordinator, Andrew and his family to incorporate the activities identified as part of transition planning into the person-centered care plan. The transition planning process follows the guidance in the DBHS Transition to Adulthood Protocol and addresses Andrew's social determinants of health. The CM works with the CFT to monitor transition planning goals and activities on an ongoing and consistent basis.

Regardless of the placement option chosen by the family, the CM will continue to monitor Andrew's and the family's progress toward reunification and connect them to services and supports as needed, as well as follow up to verify the placement is effective in meeting Andrew's needs.



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ACCESS TO
CARE/NETWORK #9

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Access to Care/Network 9

The Offeror holds an ALTCS E/PD Contract for both the Central and North GSAs and receives \$280 million per year in capitation revenue. Twenty-eight percent of the Offeror's members reside in nursing facilities; 72% of members reside in an HCBS setting. Of those members residing in HCBS, 18% live in Alternative HCBS Settings.

The Offeror's revenue under the D-SNP Contract for the same Counties which match the Central and North GSAs is approximately \$75 million. Annual expenses by category of service are as follows:

Inpatient Hospitalization	37%
Physician	22%
Pharmacy	22%
SNF and Home Health	7%
Emergency Room	3%
Outpatient Facility	4%
Other Medical	5%

The Offeror shall have at least the following percentage of contracts executed with health care providers under VBP arrangements in its second year of the Contract (CYE 19):

1. 50% of total ALTCS E/PD prospective payments, and
2. 50% of total DSNP payments

Describe how the Offeror will meet these requirements. The Offeror's response shall be limited to methods that meet the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) Framework for categories 2, 3 and 4, and address the following at a minimum:

- Similarities and differences regarding VBP contracting approaches in the Medicaid and Medicare lines of business, and
- The urban/rural dichotomy



The Offeror's response regarding ALTCS E/PD must include, but need not be limited to, contracting arrangements addressing integrated behavioral health and physical health service delivery, contracting arrangements for both HCBS and Nursing Facility settings, and relevant outcome measures of all VBP contracts.

The Offeror's response regarding the D-SNP must include, but need not be limited to, contracting arrangements addressing integrated behavioral health and physical health service delivery, inpatient readmissions and ED visits, and relevant outcome measures of all VBP contracts.

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Access to Care/Network 9

Since we introduced value-based contracting to providers in 2010, MCP has remained a leader in promoting Value-Based Purchasing (VBP) across Arizona. Leveraging our extensive experience, we support providers in creating financially viable and sustainable VBP models. We assist providers in adopting systems and processes to collect and report on quality metrics and improve member and family engagement. We then help members choose high quality, high value providers and centers of excellence. We evaluate our network to understand provider readiness and we *meet each provider where they are*, providing the supports needed to adopt VBP. We help providers progress towards increased accountability for the health of the populations they serve.

To underscore our commitment to VBP, we were the only AHCCCS contractor to participate in the Learning Action Network (LAN) baseline assessment of alternative payment models (APMs) used in the United States. Further, our sponsoring organization (Dignity) and management entity (Aetna) are LAN Committed Partners.

In our experience, the most effective VBP initiatives align Medicaid and Medicare interests, promote integrated physical and behavioral health (BH) care, consider both urban and rural delivery system needs, and incentivize improvements in critical areas of current system inefficiency (such as dependence on inpatient services, avoidable readmissions and unnecessary emergency department visits). Our VBP initiatives are responsive to and inclusive of acute medical providers, Home and Community-Based Services (HCBS) and nursing facility settings. Additionally, we consider how social determinants impact health outcomes and reward providers who positively influence the broader environments in which our members live and shape the choices they make.

In support of AHCCCS’s goals for VBP, MCP brings a unique contribution: The Practice Innovation Institute (Pii), which is helping transform more than 2,500 clinical practices across Arizona to prepare them for CMS’s Merit-based Incentive Payment System and APMs. Pii stems from a collaborative effort between MCP and Arizona Health-e Connection (AzHeC), which secured a \$14.6 million grant from CMS’s Transforming Clinical Practice Initiative – the only one awarded to an Arizona entity and one of only 29 grants across the country. We will apply our Pii experience to participate in a Delivery System Reform Incentive Payment Program that achieves sustainable improvements in health care delivery - a critical feature for the success of any VBP program. We currently meet AHCCCS’ 2017 targets for VBP implementation and our strategies outlined in this response will enable us to meet the 2019 targets.

MCP Currently Exceeds AHCCCS’ VBP Targets

In our current GSAs, **MCP has 16 VBP arrangements that include our ALTCS membership and represent 78 percent (Medicare and Medicaid) of our entire ALTCS spend.** To meet the AHCCCS targets, we will implement new contracts and maturing our existing contracts, in alignment with the LAN alternative payment models principles.

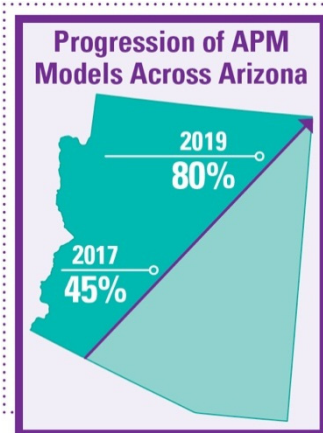
Pay for Quality: APM Category 2C

MCP has 13 current VBP arrangements that fall into APM Model 2C (pay for quality and value), representing 68 percent of our total spend.

Participating Providers: Two large high quality, high value providers who provide PCP services to members in Skilled Nursing Facilities (SNF) and in their own home and 11 other providers organized into PCMH-like models.

Performance Measures: We use highly reliable, universally recognized HEDIS, NCQA, PQRS, and AHCCCS MPS physical health and BH performance metrics such as Comprehensive Diabetes Care-Retinal Eye Exam, Follow-up after Hospitalization

Figure 1. MCP’s strategies support the progression of APM models throughout AZ.



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for Mental Illness, and Ambulatory Care-Emergency Department Visits to measure the quality, integration, accessibility and appropriateness of services. We use standardized performance measures to promote consistency across payers while retaining the ability to adapt measures to the demographics and needs of the populations served by the provider. For example, we use measures that include early childhood well care visits for pediatric populations and osteoporosis evaluation and treatment measures for appropriateness of care in elderly populations. We also developed MCP-specific measures for non-medical programs including SNF settings and HCBS services such as Antibiotic Stewardship and Attendant Care Agency Avoidable Utilization.

Outcomes: Members served by these APM Category 2C providers experienced a **28 percent improvement in Comprehensive Diabetes Care (A1C >9), 7 percent increase in A1C testing, 4 percent improvement in LDL testing, and 2 percent decrease in readmissions.** Further, **89 percent of attributed members received a flu shot.**

Performance-Based Contracts: APM Category 2D

We have two performance-based contracts in place, representing slightly over one percent of our ALTCS spend.

Participating Providers: These providers have met the NCQA level III PCMH designation and demonstrated the ability to deliver evidence-based services associated with improved health outcomes. Our contracts provide these performance-based payments as long as these providers maintain their certification.

Performance Measures: We use performance measures related to care coordination, after-hours and weekend accessibility, and use of information technology to improve health outcomes. We assess providers using the same standardized performance metrics as the 2C models to assure quality services.

Outcomes: **Our 2D contracts have the lowest readmission rates of our value based providers** while serving members with the highest needs/costs. These providers have demonstrated less duplication in services, decreased fragmentation in care, and reduced staff turnover as a result of improved care coordination.

Shared Savings: APM Category 3A

We introduced a shared savings model representing 10 percent of the ALTCS spend.

Participating Providers: This clinically integrated organization functions in an ACO-like arrangement with an upside shared savings model similar to that of a Medicare Shared Savings Program.

Performance Measures: We assess providers using the same standardized performance metrics as the 2C models. Through this total cost of care model, we incentivize the provider to coordinate services across multiple settings, including hospitals and specialists, promoting accountability for the members' entire care. Upon meeting quality metrics, we share 50 percent of the estimated savings with this ACO-like entity.

Outcomes: **Members experienced an 8.5 percent decrease in ED visits and 16.3 percent reduction in readmissions, resulting in a total savings of 1.7 percent in year two.**

MCP Integrates Medicare and Medicaid Payment Models to Align Incentives

MCP incentivizes providers to treat the whole person, regardless of need (biopsychosocial) and benefit structure (Medicare and Medicaid). Our focus is on keeping service delivery simple for the member and making sure all members have access to the same high quality care. We fully integrate our Medicare and Medicaid VBP programs in the new GSAs or expanded counties. All providers of Medicare allowable services receive the same VBP arrangements that cover their ALTCS and D-SNP payments. This encourages equality in treating members without regard to payment incentives and aligns the clinical quality outcomes between Medicare and Medicaid, both of which are crucial to improve member care.

Our VBP contracting arrangements for D-SNP providers address integrated BH and physical health service delivery, inpatient readmissions and emergency department visits, and relevant outcome measures. Our



strategies and contracts remain the same across lines of business and across providers to foster continuity of care and promote quality for all MCP members.

MCP’s Plan for Achieving AHCCCS’ Future Targets

To meet AHCCCS targets by the end of CYE 19, we will leverage our deep knowledge of Arizona’s delivery system to set specific, measurable, achievable, realistic and timely goals for our VBP strategies. In developing this response, we used the data provided to estimate membership numbers, cost and service category spending (less administrative costs) and made assumptions on the differences between Central and North GSAs. We rounded our estimates to simplify communication. Our proposed approach builds upon our current processes for promoting high quality care for our members and exceeds AHCCCS VBP spend targets. We outline these assumptions below:

Total Membership: 6,500 ALTCS members

Member Distribution: 75% (4,875) reside in the Central GSA; 25% (1,625) reside in the North GSA

Anticipated Setting Distribution (equal in both GSAs): 72% - HCBS (18% in alternative HCBS); 28% - facility

Total Spend: \$320 million

ALTCS Spend: \$254 million (\$60M – acute medical, \$129M – SNF, \$9M – community alternatives, \$56M – HCBS)

D-SNP Spend: \$66 million

Establishing Region-Specific VBP Targets

When developing our response, we established region-specific targets using our current VBP experience in Maricopa County and adjusted it to account for the expansion into Gila and Pinal Counties for the new Central GSA. As new entrants in the North GSA, we will continue the VBP arrangements currently in place. This will help maintain momentum towards overall VBP targets and support the providers in the community who have made investments toward improving the delivery system. We will bring our resources, expertise and capabilities to improve the legacy VBP arrangements wherever needed. This approach will help us exceed the goal for total VBP spend as well as achieve at least 10 percent of the spend in the more advanced APM categories of 3 or 4 as discussed in AHCCCS Contractor meetings. As shown in the table and figure below, we exceed targets in our current geography and will exceed all of AHCCCS’ future targets.

Region	Baseline estimates (CYE17)	AHCCCS CYE-17 Goal	MCP 2019 Targets	AHCCCS CYE-19 Goal
Central GSA	52% total <u>EPD</u> (40%) <ul style="list-style-type: none"> • 25% model 2 • 15% model 3 <u>D-SNP</u> (75%) <ul style="list-style-type: none"> • 64% model 2 • 11% model 3 	AHCCCS Goal: 25% in VBP MCP Status: Exceeded	80% total <u>EPD</u> (75%) <ul style="list-style-type: none"> • 28% model 2 • 47% model 3 <u>D-SNP</u> (90%) <ul style="list-style-type: none"> • 14% model 2 • 76% model 3 	AHCCCS Goal: 50% in VBP (minimum 10% in APM type 3 and 4) MCP Expected Status: Exceeded
North GSA	25% Total <u>EPD</u> (25%) <ul style="list-style-type: none"> • 23% model 2 • 2% model 3 <u>D-SNP</u> (25%) <ul style="list-style-type: none"> • 23% model 2 • 2% model 3 	AHCCCS Goal: 25% in VBP MCP Expected Status: Met	80% total <u>EPD</u> (75%) <ul style="list-style-type: none"> • 52% model 2 • 23% model 3 <u>D-SNP</u> (90%) <ul style="list-style-type: none"> • 77% model 2 • 23% model 3 	AHCCCS Goal: 50% in VBP (minimum 10% in APM type 3 and 4) MCP Expected Status: Exceeded



As shown in the figure below, MCP will build upon existing VBP strategies to increase the total spend in a VBP and move providers along the continuum towards more mature APM arrangements exceeding AHCCCS' VBP goals for 2017 and 2019.

Region- and Provider-Specific Strategies

We will create equity in VBP between rural and urban GSAs as well as acute medical providers and those in SNF, community

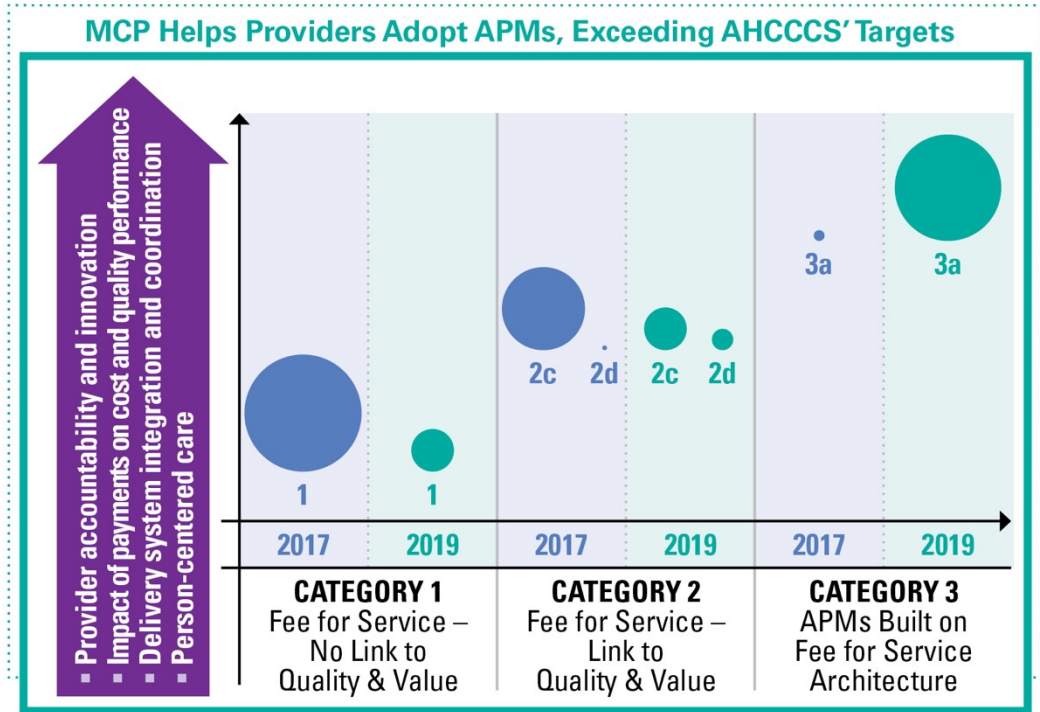
and home settings. We align Medicare and Medicaid services across all contracts, and we measure outcomes that assure integrated service delivery.

Central GSA: For the Central GSA, we will increase VBP arrangements from our current 78 to 80 percent by implementing APMs with additional providers in Pinal and Gila Counties. We will also increase the proportion of our current providers participating in more advanced (APM 3 and 4) models. We have already identified providers ready to serve MCP members in Pinal and Gila Counties and willing to participate in APM models. In Maricopa County, we will work with our two largest providers (SNF and in-home), moving them from an APM 2C to a 3A model by developing a shared savings model to further incentivize them to become accountable for members' entire care. These two arrangements account for 55 percent of the current VBP spend. Upon transformation to 3A models, we will achieve over 65 percent in advanced (3 and 4) model APMs.

In our current GSAs, we saved 1.7 percent in year two of implementing our more advanced APM models. As we meet this goal of expanded model 3A APMs in the Central and North GSAs, we anticipate achieving similar savings in year two (CYE 19). Using our existing strategy of sharing 50 percent of cost savings, **our approach will result in almost \$1.5 million share with the delivery system - \$1.1 M in the Central GSA and \$.4M in the North.**

Northern GSA: Our strategies in the Northern GSA require expanding the number and scope of VBP arrangements. We will use lessons learned from our expansion into Pima County to inform our development of region- and provider-specific models that make sense. For example, in Pima County, we implemented model 2 APMs specific to treatment and prevention of Urinary Tract Infections (UTIs) due to the high rate of inpatient admissions for this cause. As a result, members experienced fewer UTIs and the system realized a six percent decrease in costs. We will take this same regional approach to introduce APMs in the northern GSA.

Figure 1. MCP promotes provider adoption of APMs, exceeding AHCCCS' targets.





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Based on information from providers serving North GSA, the first expansion of VBP arrangements will relate to APM model 2. Because practitioner groups are typically smaller in this GSA and less able to take on more advanced risk, we believe a model 2 APM is appropriate, while still incentivizing quality and cost through performance measures such as comprehensive diabetes care, flu shots and antibiotic stewardship. To minimize differences between urban and rural areas, we set the same overall 80 percent target. We will extend arrangements to a variety of providers including PCPs, medical directors in SNF settings, and HCBS providers. As in the central GSA, we will use highly reliable, universally recognized physical and BH performance metrics to measure the quality, integration, accessibility and appropriateness of services. We will adapt measures to the demographics and needs of the populations served by the provider and use measures for non-medical programs serving members in SNF settings and delivering HCBS services.

We will also create 3A models for in-home service provider groups by recruiting local providers for members who are living in alternate community and home settings (about 20 percent of the spend for our projected membership). ***Through these efforts, we expect to achieve 23 percent of spend for the membership in the North GSA to APM category 3 by CYE 19.***

Addressing Provider Challenges for VBP Participation in Rural Areas

When implementing payment models in rural areas, we will consider the unique characteristics of the region such as provider density and distribution and the physical and BH needs of each community. As a member of CMS's Small Rural and Medically Underserved Affinity Group, we are aware of and working to address each providers' unique barriers: financial resources and risk management; health information technology and data; population health management care delivery; quality and efficiency performance measurement and reporting; and compliance.

We will address these challenges by leveraging the resources we devoted to supporting rural providers through Pii, which is currently serving providers in ***all 15 Arizona counties***. Pii practice consultants provide outreach, education, coaching, direct assistance, and processes and workflows to clinicians and practices to help them achieve transformation milestones. They educate providers on how to enhance their practices and programs to implement APMs, and provide tools such as population health data to help them better serve members. Additionally, we bring tools to help providers achieve success in meeting performance targets such as telemedicine and remote monitoring, which increase service accessibility.

MCP Brings Proven Leadership in Promoting Payment Reform and Practice Transformation

MCP has taken the lead in supporting integrated care by aligning incentives across BH and physical health providers. We developed the original "three-way" contract to reward integrated physical and BH between acute plans and Regional Behavioral Health Authorities. We have since enhanced the incentive program to reward providers for achieving high performance on both physical and BH measures. We further promote high value by connecting members to our high quality and high value providers, including PCMHs, clinically integrated organizations that function as ACOs, and high-touch provider organizations that meet members where they live in homes, groups and facilities. We will continue to drive to high quality high value care as we expand to additional regions.

MCP is committed to improving the lives of members and each community we serve. As a provider-sponsored, local, non-profit health plan that supports system transformation efforts, our work represents a significant investment in the delivery system. In both rural and urban areas, we will use the savings accrued by transitioning members from facilities to community-based settings to increase spending on HCBS. ***As we currently do in the regions we serve, we will distribute shared savings across providers and use this strategy to further promote high quality, access and improved member outcomes.***



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Administrative 10

The Offeror recently received an authorization request for an increase in attendant care hours for a member. The Offeror has already approved 20 hours a week of attendant care for this member, but the member's representative, who is also the member's spouse and caregiver, believes 45 hours are necessary due to the member's declining condition. The member's representative is very upset at the current allocation of hours and has contacted five different agencies, including the legislature. How would the Offeror address this situation, including an explanation of processes associated with approval and processes associated with denial of the request?



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Administrative 10

Mercy Care Plan (MCP) wants to hear members’ concerns so we can quickly implement a member-centered, mutually agreeable, contractually compliant resolution. During the initial meeting with Amy (our member) and Joe (her spouse and representative), they ask us to call them Amy and Joe and Amy gives permission for Joe to participate in her care planning. They received information from Amy’s Case Manager (CM) and through the Member Handbook about how to contact the CM during normal business hours or leave a message for a return call. If for any reason, Amy’s assigned CM is unavailable, a back-up CM or Supervisor addresses her concern and informs the assigned CM. Additionally, Amy or Joe may contact Member Services for immediate assistance regarding care needs that arise after hours. During each contact, the CM asks Amy and Joe about any concerns they may have.

Despite the availability of MCP staff, members may occasionally choose to directly contact state agencies, including the state legislature, who in turn notify AHCCCS. AHCCCS contacts MCP’s Quality Management (QM) Department via phone, email or an immediate “Care Needed Today” Quality of Care letter. Once received by QM, our QM Administrator or designee immediately reaches out to the internal business area – in this case, the Vice President (Administrator) of Long Term Care (LTC) and LTC Managers for immediate action. The LTC Manager informs the assigned CM. QM receives ongoing communication from the business area both for the immediate action and ongoing follow up. QM determines if a Quality of Care (QOC) concern exists and, if so, begins the QOC investigation process. QM summarizes all information and maintains communication with AHCCCS regarding the concern until it is resolved or closed by AHCCCS. QM stores all communications in a confidential database for tracking and trending. As shown in the figure below, our processes are consistent with the ALTCS principles and designed to make sure members receive the services they need. Additionally, MCP has implemented a coordinated “SWAT team” response to immediately address situations when these issues are shared over social media.

In our experience, we know that members with a complaint often value the trusting relationship with their CM and do not want to be assigned to a new one. Most members are pleased with their CM. Through a 2015 MCP survey with our members receiving Home- and Community-Based Services (HCBS), results showed more than a **99 percent satisfaction rate with Mercy Care CMs.**

MCP Helps Amy to Live as Independently as Possible in the Community			
<p>Member-Centered Case Management</p> <p>The CM collaborates with Amy and Joe to maximize Amy’s functioning, improve health, and enhance quality of life.</p>	<p>AMY</p> 	<p>Most Integrated Setting</p> <p>The CM supports Amy in remaining in her home for as long as she chooses and is able.</p>	
<p>Member-Directed Care Options</p> <p>The CM educates Joe and Amy on self-directed care, including benefits and limitations.</p>		<p>Consistency of Services</p> <p>The CM makes sure Amy receives attendant care and other services as outlined in the care plan.</p>	<p>Network Accessibility</p> <p>MCP’s comprehensive HCBS network enables Amy to choose the services and providers that meet her needs.</p>
<p>Person-Centered Care Planning</p> <p>The care plan focuses on helping Amy and Joe access appropriate services and supports.</p>			<p>Collaboration with Stakeholders</p> <p>The CM collaborates with all providers and systems involved in Amy’s care.</p>
<p>Key Facts and Innovations</p> <ul style="list-style-type: none"> ▪ Due to our extensive efforts to reach agreement prior to issuing a denial, MCP has only issued 11 denials out of 42,000 authorized HCBS in the past 12 months. ▪ 2015 survey of MCP HCBS members showed over 99% satisfaction rate with our Case Managers. 			



MCP's Member-Centered Case Management Process

MCP uses a comprehensive approach to member-centered case management that maximizes a member's level of functioning, health status and quality of life. We are in frequent contact with ALTCS members, both on a scheduled, routine basis and as their needs change. In this case, the CM reaches out to Amy and Joe immediately to discuss Joe's complaint and schedule an in-home visit as a priority to re-assess Amy's needs and modify the care plan as appropriate. The CM reviews any case notes for any information related to the complaint received as well as the last assessment and person-centered care plan. He/she may contact medical and non-medical providers to better understand the decline in condition. The home visit may include a Supervisor or another CM as a second person to validate completeness and accuracy of the re-assessment and modification to the care plan as appropriate.

The CM meets with Amy and Joe in their home, conducts a holistic assessment and discusses with them Amy's strengths, needs and goals. The CM uses a member-centered approach to Amy's assessment by supporting Amy in having a meaningful role in planning and directing her own care. During the visit, the CM focuses on reviewing with Amy and Joe the decisions regarding the number of hours authorized, and works with them so they can share reasons for requesting more hours. After this discussion, the CM may make changes to the number of hours authorized depending on the information shared. During the holistic assessment, the CM determines if the decline in Amy's condition has affected her medical, functional, social and/or behavioral needs. If Amy were unable to participate, the CM would observe Amy and attempt communication to determine her level of orientation and involve Joe, her representative.

Attendant Care Options

The CM explains Amy's options for delivery of attendant care services through traditional attendant care, spousal attendant care, self-directed attendant care or agency with choice attendant care and the benefits, limitations and challenges with each option. He/she also explains that if Joe is a paid caregiver, Amy is limited to a maximum of 40 hours of attendant care per each seven-day week. The CM explains to Amy the requirements regarding self-directed care and that, if chosen, she would be responsible to direct her own care. The CM includes Amy's choice of model for service delivery in her care plan and service plan.

Service Options

The CM discusses with Amy and Joe their goals and the services and supports needed to meet those goals, as well as whether the potential risk of Amy not receiving sufficient care she needs with the services chosen (choosing spousal attendant care over other options). The CM explores Skilled Nursing Facility, Assisted Living Facility and HCBS service options with Amy and Joe. He/she may recommend new services and supports due to Amy's declining condition, such as setting up in-home PCP visits, a physical therapy evaluation to address any durable medical equipment needs, home health nursing, or changes to supports for feeding and bathing. The PCP may determine that Amy's health has declined to the point that she is eligible to receive and would benefit from in-home palliative/hospice services along with Joe's roles as the paid caregiver. This additional palliative or hospice support would also serve to provide emotional and spiritual support to both Amy and Joe.

In conjunction with Amy and Joe, the CM creates a Managed Risk Agreement if the selected service option cannot safely meet all of Amy's needs. The Managed Risk Agreement identifies the risks of Amy's specific service choices and possible alternative services to avoid those risks. It is signed by Amy and kept in her record. The CM explains the Cost Effectiveness Standards (CES) that may limit the amount of services that MCP can authorize for Amy. The cost of home based services cannot be more than the cost of nursing home care but if the need is not expected to last more than 6 months it is allowable.



Family/caregiver support. We regularly consider the physical, psychological and social needs of caregivers, especially as their loved ones' needs intensify. The CM addresses Joe's potential need for support, training, relief or respite care to support him as a caregiver. The CM recommends resources to Joe to help him obtain behavioral health services to address the stress and fears he may be experiencing because of Amy's declining condition, his role as caregiver, and the potential that Amy may need to transition to end-of-life care, such as palliative or hospice care. Additionally, caregivers and families need support in addressing advance care planning with their loved one. During home visits, the CM guides a discussion with Amy and Joe to identify Amy's wishes for advanced illness care and end-of-life care to increase Amy's quality of life and likely help relieve stress on Joe as the caregiver. The CM provides Amy and Joe with our *Mercy Life & Health Planning Toolkit* to help organize critical information needed during life transitions related to advanced illness and end-of-life care.

Approval Process for Attendant Care Hours

During the home visit, the CM educates Amy and Joe about the process for completing the HCBS Needs Tool (Attendant Care Worksheet) and together they complete it to determine the amount of time needed to perform the tasks to meet Amy's needs. The CM uses motivational interviewing skills with Amy and Joe to determine if there are any other underlying issues, such as unpaid bills that may be influencing the request for more hours. He/she uses the Attendant Care Worksheet to review each task and allocate the amount of time needed to perform each task, asking for examples of where more time is needed and what has changed for Amy to need more hours. The CM explains the tasks that are within the scope of the attendant care program and that all tasks may not be counted or included if the spouse is providing care versus an agency model attendant care worker. The CM identifies all potential resources in addition to attendant care available to meet Amy's needs and determines if the request for 45 hours per week of attendant care is medically necessary and cost effective. The CM totals the number of hours, reviews the completed worksheet with Amy and Joe, and answers their questions to verify they understand how the hours were determined. The CM creates authorizations based on the hours indicated on the Attendant Care Worksheet.

We have found many situations where a request for attendant care actually has a root cause that can be solved through effective use of other health care resources or simple improvements in use of health services. An example of this came from our Member Advisory Council, where we learned that some "routine" parts of caregiving affect the hours needed for attendant care. We learned a member was getting medications filled through multiple visits per month to the pharmacy. MCP discussed the situation with the pharmacy and together we identified a solution called Prescription Synchronization that reduced the time going to pharmacies to fill the member's medications, thus freeing up time for the attendant care worker to do other tasks and resolving the need for additional hours.

Following discussion of Amy's needs, options and the cost-effectiveness and completion of the Attendant Care Worksheet, the CM completes a new service plan and asks that Amy or Joe sign it to indicate their agreement or disagreement. If Amy or Joe disagrees with the service plan, the CM asks for additional information Amy and Joe may have regarding the need for increased attendant care hours to confirm they fully understand the issue.

Re-Evaluation Process

Through our member-centered approach to case management, MCP makes every effort to understand our members and come to agreement on the services and supports to address their needs. We may use the following strategies to reach agreement before issuing a formal denial to Amy: 1) the CM completes a new Attendant Care Worksheet, 2) we send a second CM to the home to complete a new Attendant Care Worksheet to compare determinations about the number of attendant care hours, 3) we send the Supervisor with the assigned CM to discuss what Amy and Joe feel Amy's needs are for attendant care. In most cases, we can reach

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agreement with the member, thereby reducing the need for formal denials, appeals and State Fair Hearings. We conduct approximately 3,500 face-to-face assessments per month. Due to our extensive efforts to reach agreement with the member and caregivers, the number of Notices of Action (NOAs) that have been issued by MCP is minimal at only **11 denials out of approximately 42,000 authorized HCBS within the past 12 months.**

Denial Process

Following our efforts to reach an agreement with Amy and Joe on the number of attendant care hours needed, if Amy and Joe are still requesting more hours than determined appropriate on the Attendant Care Worksheet and they disagree with the service plan, we will issue an NOA within 14 calendar days of the service request. The NOA explains in plain language and a reading level of 6th grade or lower that the request for an increase in hours has been denied, and informs Amy about how to file an appeal should she choose to do so. The CM also verbally reminds Amy that she may appeal the action by calling or writing to the MCP Appeals Department within 60 days of the date of the NOA and that she can access information on her rights and the appeals process in the Member Handbook and on the MCP website. The MCP NOA template complies with AHCCCS requirements.

To ensure consistency, the CM's Supervisor completes the final version of the NOA and two additional Managers, one of whom is not related to the case, review it prior to release, thus providing additional opportunities for correction and resolution prior to the denial of services. This level of review exceeds that required by AHCCCS. Although not required for attendant care service denials, the case can be referred to an Interdisciplinary Team meeting that includes the Medical Director and other clinical staff for review specifically to address the decline in Amy's condition as it relates to the appropriateness of the denial. It may also be discussed with a specialty team CM (who is a registered nurse or behavioral health clinician). The Supervisor may decide to conduct his/her own home visit or attend a home visit with a different CM.

Member-focused Appeals Process

MCP respects and values our relationships with our members. Our member grievance and appeals process represents an important tool to validate we are providing our members with the highest quality and most responsive services. In the event that a member who has been determined to have a Serious Mental Illness files a grievance or appeal, MCP processes the member grievance or appeal in accordance with the additional requirements and rights as indicated in A.A.C. Title 9, Chapter 21, Article 4. MCP attempts to resolve all member concerns at the lowest level first before formal denials, appeals and State Fair Hearing become necessary. Under the direction of our Chief Operating Officer and with support from our Vice President of Member Services and our Dispute and Appeal Manager, MCP uses a grievance and appeals process that encourages and effectively responds to member concerns. We leverage member and provider input through these processes to identify opportunities for improvement. Our overriding concern has been and remains the safety, quality of care, accessibility and availability of medically necessary and covered services for members.

If Amy, or Joe as her representative, decides to file an appeal, they can submit it verbally or in writing within 60 days of the NOA date. The Appeals staff notify the LTC staff when the appeal is received. The LTC Manager, who coordinates appeals, schedules a meeting with the CM, LTC Supervisor and Manager to review the case again and determine if another assessment and/or Attendant Care Worksheet is appropriate, taking into consideration that Amy's condition may have changed since the time the NOA was sent. This gives us yet another opportunity to work with Amy and Joe to come to agreement on the number of hours of attendant care needed. The Supervisor or Manager may again decide to present the case at an interdisciplinary team meeting for review, specifically to address any further decline in Amy's condition as it relates to the appropriateness of the denial. If



agreement is reached with Amy and Joe before the appeal process is completed, the CM informs Amy to submit a request to withdraw the appeal.

If the appeal continues and a decision is made to uphold the denial, we notify Amy of the decision and provide information about her right to request a State Fair Hearing. The LTC Manager reviews the case with the Vice President of LTC to determine if there is anything that we can do to work with the member to resolve the issue and eliminate the necessity for a hearing. If the case does continue to hearing, the Supervisor, Manager and CM coordinate with the MCP attorney to review the case prior to the hearing. The Supervisor and CM attend the hearing with the attorney, as well as the Medical Director as appropriate. When notified, MCP complies with the decision of AHCCCS and the Administrative Law Judge.

Quality Reviews

MCP works to make sure members have access to the services and supports they need to achieve their goals for improved health outcomes and independence. We review the quality and effectiveness of our case management program and analyze grievance system data to identify opportunities for improvement.

Case Manager Reviews

Our CMs receive extensive training to appropriately assess all the needs of our members and identify the potential services and supports available so that members can reside in the setting of their choice per the member's and family's service goals. Supervisors monitor the quality of services using a standard chart audit tool to review two charts per month for each CM and 100 percent of cases during the first 90 days after initial training. Supervisors review monthly, daily and weekly reports out of Dynamo, our electronic case management system, to monitor compliance with contacting hospitalized members, following up on behavioral health and skin care needs, completing visits within 10 days of a placement change, and many other requirements. If a Supervisor identifies the need for improvement, the CM completes refresher training and we continue to monitor the CM's progress and address any issues on a case-by-case basis.

Grievance and Appeals Data Reviews

MCP collects, trends and analyzes grievance system data including member appeals data. Using this data for process improvement, MCP implements the Plan, Do, Study, Act (PDSA) process, with emphasis on identifying the root-cause of a problem and interventions that can be tested, assessing the test results, standardizing the interventions, and implementing and continuing the cycle of evaluation. The Dispute and Appeal Manager leads a workgroup for the review of member appeals and the Vice President of Member Services leads a workgroup for member grievances. These workgroups each have inter-departmental and cross-functional membership, including all relevant operational departments: ALTCS Case Management, Provider Services, Operations, Claims and Quality Management. Each workgroup identifies opportunities for improvement, recommends interventions, evaluates the effectiveness of those interventions and presents recommendations to the Quality Management/Utilization Management Committee for approval.

Our Grievance and Appeals Databases were each custom designed to capture, store and retrieve detailed information on grievances and appeals. Using these databases, MCP produces a suite of management reports that drill down to identify root causes. We generate ALTCS-specific reports by multiple combinations of data elements tracked in these databases. As part of quality improvement processes, other operational areas use grievance system data results along with other data sources (for example, provider utilization patterns and satisfaction survey results) to identify improvement opportunities.



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A provider who is a specialty surgeon, filed a claim dispute contesting the Offeror's recent recoupment of the entire payment amount for a claim it paid 26 months earlier. The Offeror's notification of recoupment to the provider stated the following language:

Claim reference number xxx for Member yyy will be recouped in the next payment cycle. Not all services are covered. No prior authorization obtained.

In its claim dispute, the surgeon insists that the recoupment was improper, stating that all services were critically necessary, and referring the Offeror to the extensive medical records previously submitted with the claim. The provider's medical records submitted with the claim indicate that the member was admitted to the hospital directly from another physician's office as a result of severe flank pain, inability to stand, vomiting, and fever. The surgeon is not employed by the hospital where the surgery was performed but has admitting privileges at the hospital.

Identify all steps and describe all activities the Offeror will take in response to the claim dispute as part of the grievance and appeal process. Include the type and full content of any communications the Offeror will send to the provider. Also, explain/describe how the Offeror will handle this dispute if the provider files a request for hearing and discuss the legal and factual arguments that will be made by the Offeror to support its position.



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Administrative 11

As a provider-sponsored and locally managed health plan, Mercy Care Plan (MCP)'s claims, prior authorization and concurrent review processes minimize the likelihood of having to recoup already-paid claims. We understand the differences in claims payment requirements across all lines of business and populations we serve, including MCP, MCP Long Term Care (LTC), Mercy Care Advantage, and members with a serious mental illness, developmental disability, or who are eligible for children's rehabilitative services.

Our Providers are our Partners

MCP has been part of the community for over 30 years. We are very proud of and value the close relationships we built with our providers. We know that effective partnerships with providers are critical to quality care for our members. We use the following avenues to educate and continually engage our providers to collaboratively resolve issues:

- **Provider Service Representatives** are locally based staff (available Monday through Friday, 8:00am to 5:00pm) who support providers through the prompt resolution of issues, inquiries and requests for information regarding claim submission, claim dispute requirements and prior authorization.
- We maintain a toll-free **Claims Inquiry/Claims Research Line** for providers.
- **Our website is available 24 hours a day, 7 days a week** to give providers access to materials on claim submission, prior authorization and the claim dispute process.
- Our **MercyOneSource portal** enables providers to request an authorization, find out what services require authorization or check on the status of an authorization.
- We make our **Provider Claims Dispute Policy** available to all new providers on our website and in our Provider Manual.
- We target messaging in our **Provider Newsletters** and the **Remittance Advice** to frequently include information on claims submission, prior authorization and the claim dispute process.
- **MCP's Provider Council** provides a forum to hear provider feedback and collaboratively identify solutions.
- **New provider training** covers claim submission, prior authorization and the claim dispute process as well as opportunities to contact MCP with concerns prior to filing a claim dispute.
- Providers have access to our **in-person technical assistance and ongoing training** as well as our full-time **Claims Educator**, a certified coder.

In the 2015 AHCCCS Provider Claims Survey, MCP scored the highest of any other ALTCS Plan on all survey questions.

MCP's Proactive Approach to Claim's Disputes and Recoupment

MCP proactively addresses claim disputes and recoupments by identifying and resolving critical issues that could result in provider claim disputes and State Fair Hearings. We continuously monitor, adapt and improve our processes to remain effective and to reduce administrative burden. We empower our staff to resolve claim disputes to prevent the need for a State Fair Hearing. We implement strategies that have proven effective in limiting the need of our providers to file claim disputes to receive appropriate payment, as well as the need for MCP to recoup payment from our providers. **As a result of our continuous improvement efforts, we have had zero inappropriate provider recoupments over the last 12 months.**

See Attachment 11-A *MCP Provider Appeals Process Workflow* and Attachment 11-B *120 Day Tracking Process for Recoupments and/or Refunds Workflow*.



Provider Claim Dispute Process

Under the direction of our Chief Operating Officer and with support from our Dispute and Appeal Manager,

MCP's provider and subcontractor claim dispute process encourages and effectively responds to provider concerns in accordance with written claim disputes policy. Our Appeals Supervisor, reporting to the Dispute and Appeal Manager and supported by Provider Appeals Coordinators, oversees the provider claim dispute process.

MCP's Proactive Systems for Minimizing Claims Disputes and Recoupment

- **Effective provider relationships** that foster ongoing communication to proactively resolve potential issues
- **Analyzing claim disputes, recoupments and State Fair Hearing requests** and trending overturned claim disputes and recoupments to identify improvements
- **Encouraging providers to use the reconsideration process** in which providers can submit additional information to MCP with a resubmitted claim for reconsideration before they file a dispute
- **Educating providers** with appropriate denials on how to provide services within the scope of benefits and steps they can take to comply
- **Empowering staff to resolve claims disputes** to prevent the need for a State Fair Hearing

Submission of a claims dispute. Any contracted or non-contracted provider may file a claim dispute in writing via mail or fax based on a claim denial, recoupment or dissatisfaction with MCP claims payment no later than 12 months from the date of service, 12 months of the date of eligibility posting, or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. We log information about claim disputes into our Appeals Database and send the provider an Acknowledgement Letter within five business days of

receipt of the dispute. We assign the claim dispute to a Provider Appeals Coordinator who uses applicable statutory and regulatory requirements, the provider's contractual provisions (if any) and our policies and procedures to thoroughly investigate the basis for the dispute.

Offering extensions. MCP investigates and resolves claim disputes within 30 calendar days of filing unless additional time is agreed upon by all parties. MCP may request an extension of up to an additional 45 calendar days, if necessary and in the best interest of the provider, to resolve the claim dispute. The Coordinator notifies the provider via the Extension Request letter.

Claim dispute investigation. The Coordinator identifies the last adverse action to confirm timeliness of filing. In this case, the claim dispute was filed in response to a recent recoupment. We seek AHCCCS's approval before initiating any recoupment of a claim that was paid over 12 months prior. In this case, the recoupment is for a claim that was paid over 26 months ago, which means we obtained AHCCCS's approval prior to initiating the recoupment. In cases where AHCCCS does not approve our request, we do not proceed with the recoupment.

The Coordinator then reviews all available documentation, authorizations, claims activities and member eligibility information to determine if the recoupment was appropriate. The Coordinator researches PMMIS to determine if the services were covered and looks for any retrospective changes. If the denial was found to be inappropriate, partially or in full, we reprocess the claim.

The Coordinator confirms if the services denied payment were previously reviewed for medical necessity and determined appropriate within the member's benefits. The review includes a comprehensive assessment of the member's benefits, a review of the applicable statutes and policies, coding practices, and appropriate guidelines for clinical determination of the medical necessity of the service that was rendered. If not, the Coordinator refers the claim dispute to the Chief Medical Officer (CMO) or delegated Medical Director for clinical review to determine appropriate action. The CMO or delegated Medical Director may contact the surgeon to conduct a peer-to-peer review to discuss alternatives that were tried and determine if there is any reason to make an



exception, such as any previously unsubmitted evidence-based criteria. Claim disputes forwarded for peer-to-peer review require turnaround within five business days.

Decision process. Following investigation, the CMO or delegated Medical Director determines the following:

- If all services initially denied payment do not meet medical necessity criteria and were appropriately denied, the Coordinator issues a Notice of Decision upholding the original denial decision and providing State Fair Hearing Rights.
- If all services initially denied payment meet medical necessity criteria or were denied inappropriately, the Coordinator issues an Overturned decision with the appropriate citations and sends the claim for reprocessing to pay for the covered services.
- If only some of the services initially denied payment meet medically necessity criteria or were denied inappropriately, the Coordinator issues a Partial Overturn decision with the appropriate citations and sends the claim for reprocessing to pay for the covered services.

Regardless of the decision, the Coordinator issues a Notice of Decision to the provider within 30 calendar days of receipt of the claim dispute and enters the decision into our Appeals Database. Whenever a claim dispute decision is overturned, we review and pay the claim consistent with the recommendation within 15 business days, including interest in our payment as applicable.

Provider Communications During the Appeals and Grievance Process

Through continuous engagement and communication with our providers, we attempt to reach a resolution satisfactory to the provider during the appeals process. The Coordinator sends the provider an **Acknowledgement Letter** confirming receipt of a claim dispute within five business days of receipt. If the provider agrees to an extension, the Coordinator sends the **Extension Request Letter**.

The Coordinator sends the provider a Notice of Decision within 30 calendar days of filing the claim dispute, unless an extension is granted. The **Notice of Decision** includes the following:

- The date of the decision
- Nature of the dispute
- The issues involved
- The reasons supporting our decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
- The Complainant's right to request a State Fair Hearing by filing the request with MCP no later than 30 calendar days after the date of our final decision

See the following Attachments: Attachment 11-C *Acknowledgement Letter*; Attachment 11-D *Extension Request*; Attachment 11-E *Notice of Decision/Medical Necessity Approval*; Attachment 11-F *Notice of Decision/No PA and Non-Covered Denial*; Attachment 11-G *Notice of Decision/Untimely Claim Dispute*.

State Fair Hearing Request

Upon receiving a request for a State Fair Hearing from a provider, our Coordinator logs the information into the Appeals Database and reviews the request for timely filing, which is within 30 days of receipt of the Notice of Decision. The Coordinator then forwards the complete request, including a cover letter and all supporting documentation, to the AHCCCS Office of Administrative Legal Services within five business days. The supporting documentation includes the written request for hearing, a copy of the entire file including the investigation and/or medical records and the appeal or claim dispute decision, and all applicable documentation used that would be necessary for resolution of the appeal or claim dispute. If a State Fair Hearing request is received more

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than 30 days following the date of receipt of the Notice of Decision, we still send the file to AHCCCS indicating the request was not made timely following notification to the provider of the untimely request and confirmation of intent to continue with the State Fair Hearing request.

Upon notification that a State Fair Hearing has been scheduled, the Coordinator logs the date in the Appeals Database. Prior to the State Fair Hearing, the MCP attorney researches and reviews the case with the LTC staff and a Medical Director, if required. The MCP Attorney also reviews the matter with the provider (or member) to discuss the issues and determine if he/she still wishes to proceed, or determine if the provider (or member) has any additional, relevant information in support of the claim dispute that should be considered. Since this claim dispute is in response to a recoupment, the MCP attorney confirms that the recoupment meets timeliness requirements, or is pursuant to AHCCCS' approval. Once the recoupment is confirmed as appropriate, the MCP attorney researches the underlying issue. As the State Fair Hearing appears to be requested to address the remaining services denied payment, the LTC staff or Medical Director confirm this in an additional clinical review. The MCP attorney, applicable LTC staff, and Medical Director (if the hearing is related to medical necessity) attend the State Fair Hearing to offer evidence as appropriate. As with any process in claim disputes and State Fair Hearings, the attorney's intent is to obtain the appropriate outcome, whether it is to support MCP's position or reach a resolution with the provider (or member).

Once the coverage determination and the legal argument are confirmed, the MCP attorney attempts to contact the provider to discuss the matter and explain MCP's position, including any relevant references, policies or legal arguments. This represents an educational opportunity for the provider and a further attempt to resolve the matter without burdening the administrative resources of the hearing office, AHCCCS and the parties involved by proceeding with a State Fair Hearing. If the provider presents any additional information, the MCP attorney reviews it to determine if it changes the claim dispute decision. If the claim is overturned, in full or in part, MCP reprocesses and pays the claim in a manner consistent with the decision within 15 business days of the date of the decision, including interest as applicable. In this case, we assume there is no additional information or information that changes MCP's position.

The relevant legal argument to support our position relies on various legal authorities and may include but is not limited to, the Arizona Revised Statutes (A.R.S.), Arizona Administrative Code (A.A.C.), and applicable AHCCCS policies:

- Pursuant to A.R.S. § 36-2939(A)(5), members eligible for LTC services are eligible to receive services that include, among other things, health and medical services as provided in A.R.S. §36-2907.
- A.R.S. § 36-2907 provides for coverage of medically necessary health and medical services, including inpatient hospital services, and authorizes AHCCCS to adopt rules necessary to limit the scope, duration and amount of services for inpatient services as well as rules requiring prior authorization of covered medically necessary services.
- A.R.S. § 36-2907(A) and (D). The A.A.C. includes rules as contemplated by the A.R.S. A.A.C. R9-28-202(A) provides that MCP must cover medical services provided for in Title 9, Chapter 22, Article 2 for a member, subject to any limitations and exclusions specified in Article 2 or as otherwise specified in Title 9, Chapter 28 of the Code.
- Pursuant to A.A.C. R9-22-202(B)(1) covered services are defined as only those services that are medically necessary, cost effective, and federally and state reimbursable.

We would further support our legal argument with AHCCCS policies or additional legal citations identified as relevant to the particular remaining denial being disputed. We present these arguments, including any links or copies of relevant policies, for review by the provider. Our goal always centers on educating and informing the



provider and avoiding a hearing request wherever possible. However, we will pursue the hearing to present our arguments, including witness testimony, before the presiding Administrative Law Judge at that Office of Administrative Hearings to support our position for a favorable outcome for MCP. The disputes that do continue through to the level of a State Fair Hearing involve among the most contentious and complex situations and often cover areas where judgment and opinions will differ even among the Administrative Law Judges and AHCCCS. Despite this complexity, as of the most recent year, **in all Medicaid lines of business, out of 231 completed hearings, only two issues (1 percent) resulted in a ruling that are contrary to MCP's determination.**

Process Improvement

MCP uses the results of provider input through the claim dispute process to identify opportunities for process improvement. Our overriding concern has been, and remains, the safety, quality of care, accessibility and availability of medically necessary and covered services for our members.

MCP collects, trends and analyzes grievance system data inclusive of claim disputes. Using this data for process improvement, MCP implements the Plan, Do, Study, Act (PDSA) process, with emphasis on identifying the root-cause of a problem and interventions that can be tested, assessing the test results, standardizing the interventions, and implementing and continuing the cycle of evaluation. The Dispute and Appeal Manager conducts a weekly Claims Operations Work Group led by Health Plan Operations that includes representatives from our Fraud, Waste and Abuse team, Claims, Claims Inquiry/Claims Research team, Claims Education team, Member and Provider Services Departments, Appeals, Finance, Compliance and our Medical Management Departments. The work group proactively identifies potential claims adjudication issues before they become problems for providers. They develop solutions to the issues and present recommendations to the Quality Management/Utilization Management Committee for approval. Topics such as contract implementation, claims payment, claims editing, audit findings, claims projects, system configurations, and provider data collection procedures are reviewed and, where necessary, solutions developed, tested, and implemented.

Our Grievance and Appeals Databases were each customized to capture, store and retrieve detailed information on grievances, appeals or claim disputes. Using these databases, MCP produces a suite of management reports to drill down to identify root causes. We generate LTC-specific reports using a combination of data elements tracked in these databases. As part of their quality improvement processes, other operational areas use grievance system data results along with other data sources (for example, provider utilization patterns or satisfaction survey results) to identify improvement opportunities.



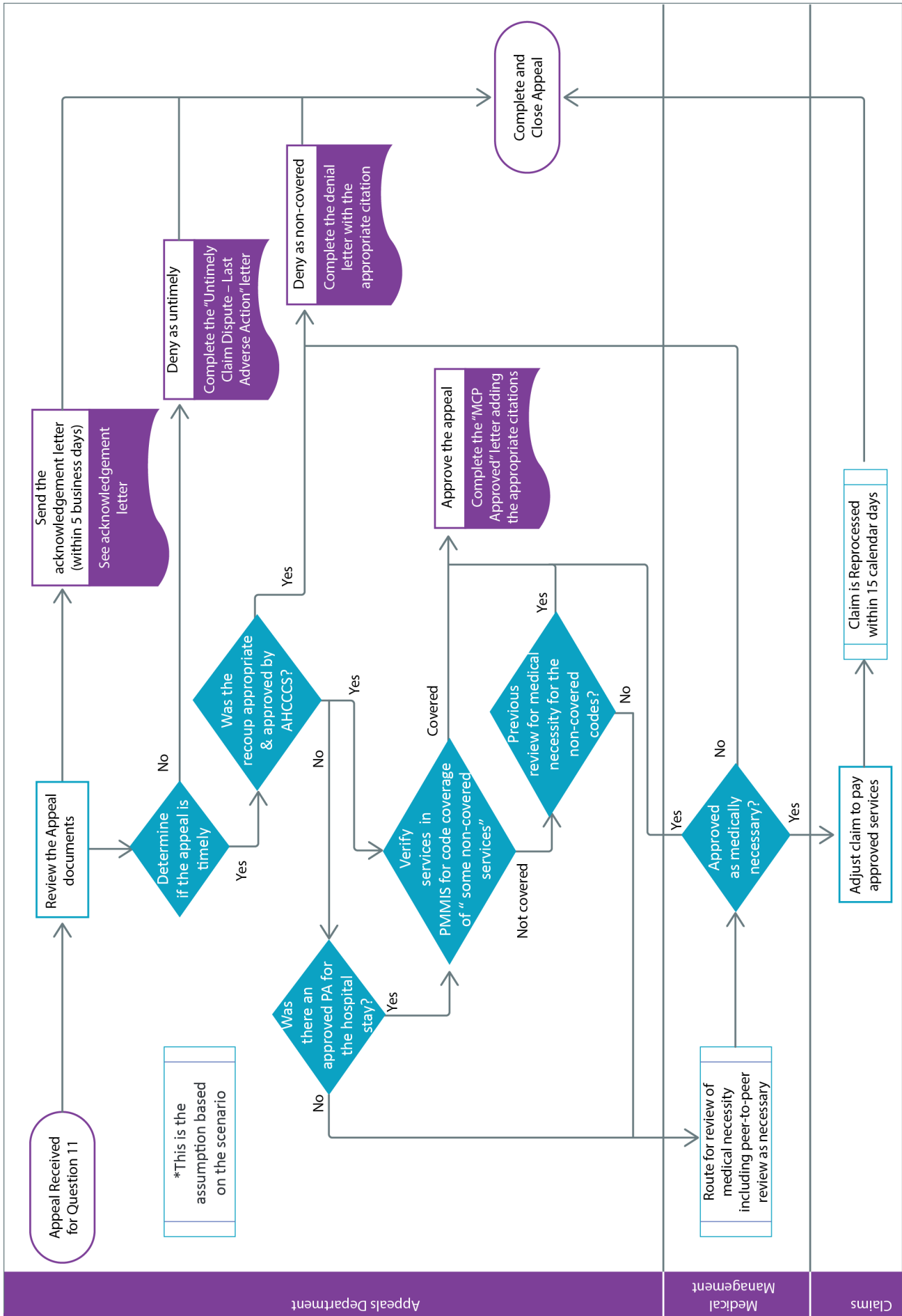
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Attachment 11-A: Provider Appeals Process Workflow



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Attachment 11-B: 120 Day Tracking Process for Recoups and Refunds Workflow



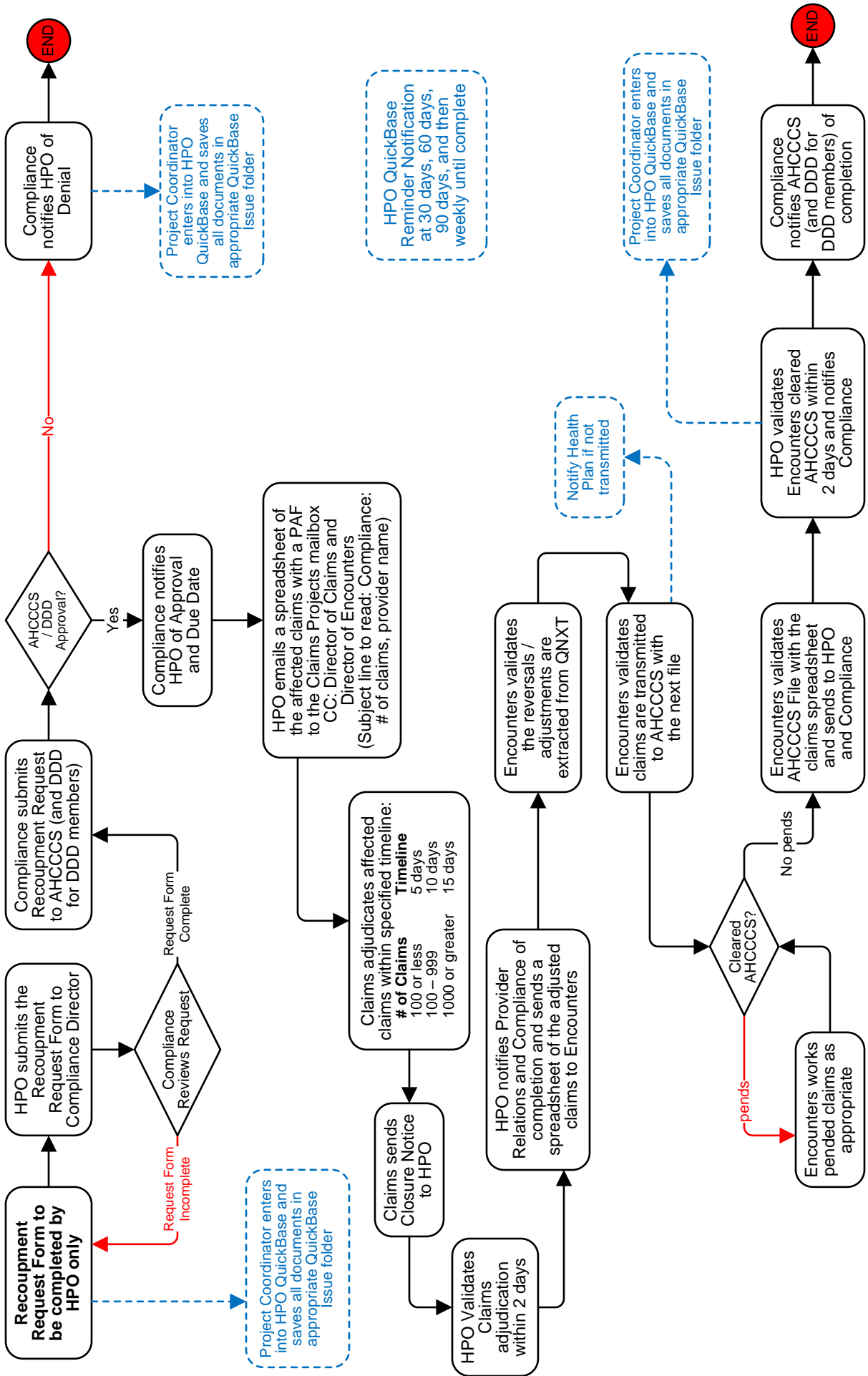
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120 Day Tracking Process for Recoupments and/or Refunds that are:

- 1) single recoupment in excess of \$50,000
- 2) recoupment of payments initiated more than 12 months from the date of original payment

(Committee Approved: January 2, 2014)

Line(s) of Business Impacted: MCRP ALTCS DDD



Revision Date: April 24, 2015

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Attachment 11-C: Acknowledgement Letter



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4350 E. Cotton Center Boulevard
Building D
Phoenix, Arizona 85040
Phone (602) 263-3000
Toll Free (800) 624-3879

Date

Provider
Attn:
Address

RE: Appeal Number:
Issue:

Dear [Appeal Requestor]:

This letter is to notify you that Mercy Care Plan received your appeal request on [Date]. You are requesting payment for the following claims:

Claim Number	Member Name	DOS Start	DOS End
---------------------	--------------------	------------------	----------------

We are currently evaluating the details of your request. You will be notified of our decision in writing within 30 days of receipt. If your appeal is denied in whole or in part, you may have the opportunity to request a fair hearing with AHCCCS. Your decision letter will include detailed information regarding this option.

Additional comments, documents or other information in support of your appeal must reference the appeal number and sent to:

Mercy Care Plan
Appeals Department
Attention: Marilyn Brown-Chiverton
4350 E. Cotton Center Boulevard, Building D
Phoenix, Arizona 85040

Best regards,

[Coordinator Name]
[Coordinator Phone]
Appeals Coordinator

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Attachment 11-D: Extension Request Letter



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4350 E. Cotton Center Boulevard
Building D
Phoenix, Arizona 85040
Phone (602) 263-3000
Toll Free (800) 624-3879

Date

Group
Service Provider
Attn:
Address 1
Address 2
City, State, Zip

RE: Extension Request
Appeal Number:
Issue:

Dear Requestor:

Mercy Care Plan respectfully requests an extension of 45 days to complete the investigation of your appeal requesting payment for the following claims:

Claim Number	Member Name	DOS Start	DOS End
---------------------	--------------------	------------------	----------------

We will continue to make every attempt to complete our review as soon as possible, but it is in your best interest to grant this extension. If you contact us because an extension has been refused, a decision will be made on the facts present at the time of the refusal, which could cause unwanted results. If we do not receive a written denial regarding this request, we will presume that you have agreed to our request.

If you wish to deny our extension request, you may do so by submitting your denial in writing. Please include the date, the appeal number shown above, your name and signature on your denial letter, and submit it to us by fax at (602) 351-2300, or send it to:

Mercy Care Plan
Appeals Department
Attention: Coordinator
4350 East Cotton Center Blvd, Bldg D
Phoenix, Arizona 85040

If you have any questions, please call Coordinator Phone. TTY users should call 711. We are available Monday through Friday 8:00 am to 5:00 pm. On behalf of Mercy Care Plan, I would like to thank you in advance for your cooperation in this matter.

Best regards,

Name
Appeals Coordinator

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Attachment 11-E: NOD Medical Necessity Approval



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4350 E. Cotton Center Boulevard
Building D
Phoenix, Arizona 85040
Phone (602) 263-3000
Toll Free (800) 624-3879

[Insert Date: e.g., August 28, 2009]

[Insert Provider Entity Name]
[Insert Appeal Requestor Name]
[Insert Provider Entity Address]
[Insert City, State, Zip Code]

Notice of Decision

Provider:	[Insert Provider's Name]
Member:	[Insert Member's Name]
Member ID Number:	[Insert Member ID Number]
Date of Service:	[Insert Date of Service]
Claim Dispute Number:	[Insert Claim Dispute Number]
Decision:	Approved
Approved Reason:	Claim Meets Coverage Criteria

Dear [Insert Appeal Requestor Name],

Mercy Care Plan has reviewed the claim disputes regarding reimbursement for the services listed on this Notice of Decision Letter. Mercy Care Plan reviewed the claim dispute regarding [Restate basis provided on provider's letter]. The decision to approve the claim dispute is based on the following:

1. Arizona Revised Statute (A.R.S.) §36-2903.01(E): The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.
2. Arizona Administrative Code (A.A.C.) R9-22-705(A): General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
3. Arizona Revised Statutes (A.R.S.) § 36-2904(G)(1): "Clean claims" means claims that may be processed without obtaining additional information from the subcontracted provider of care, from a noncontracting provider or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity. [. . .]

Review by the Mercy Care Plan Medical Review Nurse has determined that all the available documentation reviewed supports medical necessity of the services provided. Therefore, your claim



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Building D
Phoenix, Arizona 85040
Phone (602) 263-3000
Toll Free (800) 624-3879

dispute is approved based on medical necessity. Your claim will be forwarded to the Claim Department for reprocessing.

Mercy Care Plan will reprocess and pay the claim consistent with this Notice of Decision within 15 business days of the date of this Notice of Decision. These claim disputes are approved based on review of the initial reason indicated on the claim disputes. Upon reprocessing, if there are any other issues associated with the claims, the claims may be denied. In such an event, your claim dispute rights will be noted on the subsequent remittance advice.

If you do not agree with this decision you may submit a request for State Fair Hearing to the AHCCCS Administration pursuant to A.A.C. R9-34-405(D)(1). AHCCCS regulation requires that the request for hearing be filed in writing and received no later than 30 days after the date of receipt of this Notice of Decision.

Requests for State Fair Hearings should be mailed or faxed to the address below:

Mercy Care Plan
Appeals Department
Attention: Hearing Coordinator
4350 E. Cotton Center Blvd. Building D Phoenix, AZ 85040
Fax: (602) 351-2300

Please include "State Fair Hearing Request" on the cover letter.

The complete file will be sent to the AHCCCS Administration if a State Fair Hearing is requested. If you need further assistance please contact me at via email at [Insert your email address] or by telephone at [Insert your telephone number].

Thank you,

[Insert your name]
Appeals/Claims Disputes Coordinator



Attachment 11-F: NOD No PA and Non-Covered Denial



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4350 E. Cotton Center Boulevard
Building D
Phoenix, Arizona 85040
Phone (602) 263-3000
Toll Free (800) 624-3879

[Insert Date: e.g., August 28, 2009]

[Insert Provider Entity Name]
[Insert Appeal Requestor Name]
[Insert Provider Entity Address]
[Insert City, State, Zip Code]

Notice of Decision

Provider:	[Insert Provider's Name]
Member:	[Insert Member's Name]
Member ID Number:	[Insert Member ID Number]
Date of Service:	[Insert Date of Service]
Claim Dispute Number:	[Insert Claim Dispute Number]
Decision:	Denied
Denial Reason:	No Prior Authorization

Dear [Insert Appeal Requestor Name],

Mercy Care Plan has reviewed the claim disputes regarding reimbursement for the services listed on this Notice of Decision Letter. Mercy Care Plan reviewed the claim dispute regarding [Restate basis provided on provider's letter]. The decision to deny the claim dispute is based on the following:

1. Arizona Revised Statute (A.R.S.) § 36-2907(D): The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.
2. Arizona Administrative Code (A.A.C.) R9-22-202(A)(1): "Authorization" means written or verbal authorization by: the Administration for services rendered to a fee-for-service member, or the contractor for services rendered to a prepaid capitated member.
3. Arizona Revised Statutes (A.R.S.) R9-22-202(C): The Administration or a contractor may deny payment of nonemergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.



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Building D
Phoenix, Arizona 85040
Phone (602) 263-3000
Toll Free (800) 624-3879

4. Arizona Administrative Code (A.A.C) R9-22-702: a Mercy Care Plan eligible member cannot be billed for AHCCCS covered services. Member cannot be billed for services, which are not paid due to the failure of the provider to comply with Mercy Care Plan Authorization or billing requirements.

Our research indicates that the services performed were Non-Covered and Mercy Care Plan did not authorize the services performed. As such, this claim dispute has been denied for lack of prior authorization.

If you do not agree with this decision you may submit a request for State Fair Hearing to the AHCCCS Administration pursuant to A.A.C. R9-34-405(D)(1). AHCCCS regulation requires that the request for hearing be filed in writing and received no later than 30 days after the date of receipt of this Notice of Decision.

Requests for State Fair Hearings should be mailed or faxed to the address below:

Mercy Care Plan
Appeals Department
Attention: Hearing Coordinator
4350 E. Cotton Center Blvd. Building D Phoenix, AZ 85040
Fax: (602) 351-2300

Please include "State Fair Hearing Request" on the cover letter.

The complete file will be sent to the AHCCCS Administration if a State Fair Hearing is requested. If you need further assistance please contact me at via email at [Insert your email address] or by telephone at [Insert your telephone number].

Thank you,

[Insert your name]
Appeals/Claims Disputes Coordinator



Attachment 11-G: NOD Untimely CD Last Adverse Action



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4350 E. Cotton Center Boulevard
Building D
Phoenix, Arizona 85040
Phone (602) 263-3000
Toll Free (800) 624-3879

Date

Provider
Attn:
Address

Notice of Decision

Provider:
Member:
Member ID Number:
Date of Service:
Claim Dispute Number:

Decision: Deny
Denial Reason: Untimely Claim Dispute – Last Adverse Action

Dear ,

Mercy Care Plan has reviewed the claim dispute regarding reimbursement for the services listed on this Notice of Decision Letter. Mercy Care Plan has reviewed the claim dispute regarding XXX. The decision to deny the claim dispute is based on the following:

1. Arizona Revised Statute (A.R.S.) §36-2903.01(B)(4): A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later.
2. Arizona Administrative Code (A.A.C.) R9-34-405(A): For a claim for services rendered to a member enrolled with a contractor, the provider shall file a written claim dispute with the contractor under the timelines in A.R.S. §36-2903.01(B)(4).
3. Arizona Administrative Code (A.A.C.) R9-34-404: A claim dispute shall specify in detail the factual and legal basis for the claim dispute and the relief requested. AHCCCS shall deny a claim dispute if the factual or legal basis is not detailed.
4. Arizona Administrative Code (A.A.C.) R9-22-101(B): "Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

The Date of Service for this claim was [Insert MM/DD/YY]. The Date of Eligibility was posted on [Insert MM/DD/YY]. The last adverse action regarding a timely claim occurred on [Insert MM/DD/YY]. The provider was



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Building D
Phoenix, Arizona 85040
Phone (602) 263-3000
Toll Free (800) 624-3879

required to submit the claim dispute by [Insert MM/DD/YY]. Mercy Care Plan did not receive the claim dispute until [Insert MM/DD/YY]. Our research indicates that the claim dispute for this case was originally filed with Mercy Care Plan untimely, because the claim dispute was not filed within 60 days after the date of the last adverse action of a timely claim submission, which is the latest of the three dates. The time period for filing a claim dispute has passed.

If you do not agree with this decision you may submit a request for State Fair Hearing to the AHCCCS Administration pursuant to A.A.C. R9-34-405(D)(1). AHCCCS regulation requires that the request for hearing be filed in writing and received no later than 30 days after the date of receipt of this Notice of Decision.

Requests for State Fair Hearings should be mailed or faxed to the address below:

Mercy Care Plan
Appeals Department
Attention: Hearing Coordinator
4350 E. Cotton Center Blvd. Building D
Phoenix, AZ 85040
Fax: (602) 351 – 2300

Please include "State Fair Hearing Request" on the cover letter.

The complete file will be sent to the AHCCCS Administration if a State Fair Hearing is requested. If you need further assistance please contact me via email at (Email Address) or by telephone at (Phone Number).

Thank you,

[Coordinator Name]
Appeals/Claims Disputes Coordinator

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SECTION I: EXHIBITS

EXHIBIT C: NARRATIVE SUBMISSION REQUIREMENTS

Administrative 12

Information Technology (IT) Systems Demonstration

By participating in mock Information Systems scenarios over a 10-day period, the Offeror shall demonstrate its comprehensive understanding and its capability to accurately and timely:

- Process data exchanged with AHCCCS
- Administer actions based on the data processed

Supplemental materials to assist in preparation for this demonstration are available in the Bidders' Library under the heading "Information Technology (IT) Systems Demonstration," and include:

Guidelines
10-day Calendar
User Guides and Manuals

These mock scenarios will begin on Tuesday, January 24, 2017.

For this Submission Requirement, the Offeror shall provide written acknowledgement as follows:
<Offeror> acknowledges that its participation in the IT Systems Demonstration beginning on January 24, 2017, constitutes fulfillment of Submission Requirement No. 11. <Offeror> acknowledges that it will comply with the stated guidelines and calendar for this process. <Offeror> acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal.



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Administrative 12

Mercy Care Plan (MCP) acknowledges that its participation in the IT Systems Demonstration beginning on January 24, 2017, constitutes fulfillment of Submission Requirement No.11. MCP acknowledges that it will comply with the stated guidelines and calendar for this process. MCP acknowledges that the IT Systems Demonstration will be scored as part of MCP's Proposal.



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**NAMES AND TITLES OF
PARTICIPATING INDIVIDUALS**

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Arizona Long Term Care System (ALTCS) Elderly & Physical
Disability (E/PD) Program Contract for Contractors
Oral Presentations
Names and Titles of Participating Individuals

January 10, 2017

Arizona Health Care Cost Containment System (AHCCCS)
701 East Jefferson, MD 5700
Phoenix, Arizona 85034

RE: SOLICITATION NO.: YH18-0001 – Oral Presentations Resumes – List of Participants

Listed below are the individuals who will be participating in the Oral Presentations on behalf of Mercy Care Plan. Resumes for these individuals can be found on the following pages.

- **Chad Corbett**
- **Tad D. Gary**
- **Patricia Haren**
- **Sandra J. Verheijde**
- **Patricia Weidman**
- **Charlton Alan Wilson**

Sincerely,

Shareé Perry
Senior Project Manager

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**RESUMES OF
PARTICIPATING INDIVIDUALS**

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Chad D. Corbett

Vice President of Long Term Care

CURRENT RESPONSIBILITIES

Vice President of Long Term Care for Mercy Care Plan (MCP), the largest ALTCS (Arizona Long Term Care System) plan for the elderly and physically disabled in the state of Arizona, with over 15 years of management/supervisory experience in the health care field. Innovative, Versatile, subject matter expert in the field of long term care with management experience ranging in size from small departmental projects to assisting and taking part in full scale multi-million dollar high profile corporate projects. Ability to oversee and manage 18 Teams in multiple locations while ensuring timely completion of project deadlines, while remaining in compliance with state regulators and corporate policies.

PROFESSIONAL SUMMARY

Over 24 years' experience in social services, case management, education, and advocacy. Strong leadership with the ability to communicate with people of diverse ages, backgrounds, and skill levels. Experience in planning and program design. A team builder and inspirational leader proactively oriented toward transformation in healthcare to meet the future. Board member with the Alzheimer's Association, Desert Southwest Chapter.

CORPORATE EXPERIENCE

Mercy Care Plan, 2004 – Present

Vice President, Long Term Care, 2009 - Present

- Develops, implements, oversees and evaluates Mercy Care Plan Long Term Care program.
- Responsible for development of connections and partnerships in the area of workforce development, HCBS program operations and institutional transitions.
- Assisting in developing specialized Value Based Programs and specialized trainings which include goal setting, communication, motivation, and stress management.

Manager, Long Term Care, 2006 – 2009

- Managed case management services staff including the organization and development of high performing teams
- Evaluated case management and financial data and assigned resources accordingly to ensure cost effective quality outcomes
- Provided feedback to the business segments on ALTCS and its integration into medical services and prepared monthly and quarterly utilization reports
- Assessed developmental department needs and collaborated with others to identify and implemented action plans that supported the development of high performing teams

Supervisor, Long Term Care, 2004 – 2006

- Implemented day-to-day case management services, including recruiting, hiring, and training new case managers
-

Chad D. Corbett

Vice President of Long Term Care

Maricopa Long Term Care, 1995 - 2004

Manager, 2000 – 2004

- Trained, mentored, supervised, and evaluated 18 case managers
- Performed monthly audits on case management files to identify unmet needs
- Provided consultation and interventions to assure all responsibilities to ALCTS clients and families were met
- Trained, oversaw and upheld quality standards for contracted providers
- Conducted cost benefit analyses, monitoring gate-keeping practices to ensure cost effective use of resources to meet client needs
- Formulated financial and administrative goals, plans, and programs
- Developed and completed special studies and reports as requested

Program Coordinator/Trainer, 1998 – 2000

- Led the ALTCS alternative residential programs
- Responded to special project assignments, including programmatic, data analysis, and database management
- Conducted case management audits and compiled audit results

Case Manager II, 1995 – 1998

- Responsibilities included: admissions assessment, service planning, reassessments, maintaining records for compliance, reporting statistical information
- Completed referrals for therapy, psychiatric evaluations, medical supplies, and durable medical equipment

Yavapai County Long Term Care

Case Manager II, 1993 – 1995

- Performed admission assessments, developed service plans and maintained records for compliance
- Supervised the in-service training for adult foster care, performed public speaking functions

Meeting the Challenge – Home for Boys

Executive Director, 1990 – 1993

- Administer all aspects of the educational program and developed yearly budget and supervised line staff

Yavapai Big Brothers/Big Sisters

Case Manager II, 1989 – 1990

- Recruited, trained, and placed volunteers in appropriate community settings
-



Chad D. Corbett

Vice President of Long Term Care

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

M.P.A., Public Administration

Western International University, Phoenix, AZ

B.S.

University of Arizona, Tucson, Arizona

Certifications

- Member of the Public Policy Committee, Alzheimer's Association

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Tad D. Gary

Chief Clinical Officer at Mercy Maricopa Integrated Care

CURRENT RESPONSIBILITIES

- Serve as Chief Clinical Officer (CCO) of Mercy Maricopa Integrated Care (Mercy Maricopa), the Regional Behavioral Health Authority in Maricopa County, and parts of Pinal County.
 - Responsible for clinical program development and oversight of multiple large service delivery systems, including the Adult and Children's Systems of Care and the Maricopa County Behavioral Health Crisis System.
 - Other responsible areas include, Integrated Care, Individual and Family Affairs, Housing, Clinical Operations, Cultural Diversity, and Tribal Affairs
-

PROFESSIONAL SUMMARY

- Experienced behavioral health and case management professional
 - Demonstrated ability to participate effectively in an interdisciplinary team environment
 - Outstanding problem solving and conflict resolution skills
 - Proven leadership skills
 - Excellent written and verbal communication skills
 - Effective program development and implementation skills
 - Master's degrees in both the counseling and educational fields
 - Certification as a rehabilitation counselor (C.R.C.) and licensed as a professional counselor (L.P.C.) in the State of Arizona
-

CORPORATE EXPERIENCE

Mercy Maricopa Integrated Care, 2014 – Present

Chief Clinical Officer, 2014 – Present

- Roles and responsibilities
-

Mercy Care Plan, 2006 - 2014

Vice President, Integrated Care Management, 2011 – 2014

- Roles and responsibilities

Director, Integrated Care Management, 2010 – 2011

- Direct the activities of a large department that includes functions related to behavioral health and complex case management. Work to enhance the quality of care and services provided to members by pursuing opportunities to improve care coordination, integration, communication and use of resources within and across departments, as well as among the MCP provider network. Serve as technical, professional and business resource regarding integrated care, case management and behavioral health. Responsible to maintain positive inter- and intra-departmental relationships. Analyze and report department performance data. Develop policies and procedures. Recruitment and evaluation of staff. Assure department compliance with State and Federal regulatory requirements. Member of the Quality Management/Utilization Management Committee, Policy Committee, Medicare Joint Operating Committee, and the
-

Tad D. Gary

Chief Clinical Officer at Mercy Maricopa Integrated Care

Quality Improvement Committee.

Clinical Services Manager, Behavioral Health Department, 2010 – 2010

- Responsible for all day-to-day operations of behavioral health functions for all MCP lines of business. Responsible for recruitment of behavioral health staff. Ongoing consultation and clinical supervision of staff. Develop and monitor behavioral health policies and procedures. Clinical and operational interface with behavioral health provider organizations. Oversee annual Organization Financial Review and CMS audit for all behavioral health standards and regulations. Participated in efforts to integrate behavioral and physical health services to improve healthcare outcomes.

Behavioral Health Coordinator, 2008 – 2010

- Facilitate and monitor referrals for behavioral health services. Function as a liaison between MCP providers and behavioral health agencies throughout the state. Provide education and direction to internal staff and providers regarding behavioral health disorders and services available to members. Review appeals for inpatient psychiatric hospitalization services. Work closely with behavioral health utilization department to address system improvements and concerns. Audited Primary Care Physicians' medical records to ensure best practice standards are being met for the diagnosis and treatment of depression, anxiety, ADHD, as well as coordination of care. In addition, audited behavioral health programs to ensure quality member care, as well as monitor corrective action plans that address clinical deficiencies.

Senior Care Manager, 2006 – 2008

- Managed a caseload of high acuity behavioral health members who had a diagnosis of a serious mental illness, as well as a range of chronic medical conditions. Utilized clinical skills in a collaborative process to assess, plan, implement, coordinate and evaluate options and services to facilitate positive outcomes for assigned members. Coordinated care with a range of service providers, such as physicians, nurses, residential staff, rehabilitation providers, psychotherapists, various hospital staff and etc. Conducted crisis assessments to determine level of care required to ensure the safety of members. Acted as a consultant to general case managers, as well as RN case managers, who have members presenting with behavioral health concerns. Assisted in the mentoring and training of new case managers.

State of Arizona, Rehabilitation Services Administration (RSA), 1999 - 2006

Unit Supervisor, 2003 – 2006

- Managed an office of vocational rehabilitation counselors (VRCs) and support staff that serviced over 750 consumers diagnosed with a serious mental illness and other co-occurring disabilities. Interpreted and applied regulations and policies to operations of the unit and service provisions. Supervised the allocation of funds to VRCs' caseloads, averaging a total of \$1 million a year for the unit. Assisted with oversight and problem resolution relating to the Interagency Services Agreement (ISA) between the Arizona Department of Health Services (ADHS) and RSA. Participated in the ADHS/ValueOptions mentoring teams. Worked in partnership with ValueOptions Rehabilitation Department, rehabilitation service providers, and other RSA staff
-

Tad D. Gary

Chief Clinical Officer at Mercy Maricopa Integrated Care

members to ensure the delivery of quality services for consumers. Assisted with state-wide trainings to various Vocational Rehabilitation (VR) staff members, rehabilitation providers and community members. Conducted statewide case reviews in partnership with other state and federal staff members. Managed a caseload of individuals diagnosed with serious mental illness. Provided intensive counseling-related activities that included adjustment to disability counseling, symptom management, vocational counseling and other activities necessary for consumers to progress in their rehabilitation/recovery. Conducted assessments of consumers' abilities and vocational readiness to promote consumer success.

Program Representative, 2001 – 2003

- Assisted with the development and implementation of a VR program that serviced consumers civilly and forensically admitted to Arizona State Hospital (ASH). VR liaison between ASH and VR counselors in various geographical areas throughout the state of Arizona. Managed a caseload of individuals from Maricopa County admitted to ASH or transitioning from ASH, as well as consumers who had extensive involvement with the criminal justice system and/or chronically homeless. Provided training to various rehabilitation facilities on psychosocial rehabilitation. Assisted with the development and implementation of a training curriculum for ValueOptions' "New Employee Orientation" on VR as it relates to Maricopa County. Member of the executive committee for "Partners in Employment" conference. Developed policy for working with individuals who had sexual offenses that was implemented statewide. Provided training and consultation to VR staff relating to working with those who had sexual offenses. Additional job responsibilities as listed below under Vocational Rehabilitation Counselor III.

Vocational Rehabilitation Counselor III, 1999 – 2001

- Managed and oversaw caseload of individuals diagnosed with serious mental illness and other co-occurring disorders, such as substance abuse/dependence and/or various physical disabilities. Provided intensive counseling-related activities that included adjustment to disability counseling, symptom management, vocational counseling and other activities necessary for consumers to progress in their rehabilitation/recovery. Conducted assessments of consumers' abilities and vocational readiness to promote consumer success. Provided vocational consultations to ValueOptions' clinical teams, other rehabilitation providers and the general public. Prepared consumers to re-enter the job market through utilization of vocational adjustment, academic training, job development, job placement and supported employment. Mentored new counselors in VR policy and procedures, counseling skills and best practices. Assisted with vacant caseloads of consumers with various disabilities, such as back injuries, neurological impairments, respiratory disorders and etc. Member of the statewide Counselor Advisory Committee (2000-2003).

EMPACT-SPC

Crisis Therapist, 1998 – 2001 and 2002 – 2003 (PT)

- Provided brief, intensive, solution-focused counseling to individuals, couples and families. Conducted crisis assessments to determine level of care for individuals. Developed safety plans that allowed for community stabilization of individuals presenting as danger to self (DTS) or
-

Tad D. Gary

Chief Clinical Officer at Mercy Maricopa Integrated Care

danger to others (DTO). Assisted individuals and families that were in crisis with obtaining additional community resources. Provided behavior management consultation to parents, schools and various other agencies. Conducted Critical Incident Stress Debriefings within the community. Assisted with answering EMPACT-SPC crisis hotline on an as-needed basis. Assisted with the training of new crisis therapists.

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

M.A. in Rehabilitation Counseling

University of Arizona, Tucson, AZ

M.Ed. in Special Education

Southeastern Louisiana University, Hammond, LA

B.S. in Psychology

Northern Arizona University, Flagstaff, AZ

Licenses

- Licensed Professional Counselor (LPC, Arizona)

Certifications

- Certified Rehabilitation Counselor (CRC, national)



Patricia Haren

Arizona Long Term Care System EPD / Business Project Program Manager

CURRENT RESPONSIBILITIES

- Manage operations for Mercy Care Long Term Care Plan
 - Develop and implement new processes/desktops in compliance with contract requirements and Medicaid and Medicare regulations
 - Complete annual review of current processes
 - Monitor ongoing LTC activities to ensure compliance with requirements
 - Gather and present LTC data and program materials required for Medicaid and Medicare audits
 - Analyze data for internal case management audits and develop plans of correction and training materials
 - Write and implement plans of corrections for audits
 - Attend AHCCCS meetings as representative of Mercy Care Long Term Care Plan and participate in committee projects
-

PROFESSIONAL SUMMARY

40 years of experience in the field of long term care including front line case management, supervising case management, program management of adult day health care, case management training, contracting, managing case management departments, and management of long term care operations.

CORPORATE EXPERIENCE

Mercy Care Plan, 2005 – Present

LTC Operations Manager, 2012 – Present

- Manage operations for Mercy Care Long Term Care Plan
- Develop and implement new processes/desktops in compliance with contract requirements and Medicaid and Medicare regulations
- Complete annual review of current processes
- Monitor ongoing LTC activities to ensure compliance with requirements
- Gather and present LTC data and program materials required for Medicaid and Medicare audits
- Analyze data for internal case management audits and develop plans of correction and training materials
- Write and implement plans of corrections for audits
- Attend AHCCCS meetings as representative of Mercy Care Long Term Care Plan and participate in committee projects

LTC Case Management Manager, 2005 – 2012

- Directly supervise seven case management supervisors and one project manager
 - Indirectly supervise LTC 90 LTC case managers
 - Collaborate with other LTC Managers in development of policies and procedures to meet program guidelines
-

Patricia Haren

Arizona Long Term Care System EPD / Business Project Program Manager

- Assist case management supervisors in developing plans for meeting member needs in challenging member situations.

Maricopa Managed Care System

Long Term Care Case Management Administrator, 2004 – 2005

- Ensure compliance with AHCCCS contract and federal and state regulations
- Develop internal audit tools, implement and oversee audits
- Compile and analyse audit results
- Oversee annual ALTCS Operational and Financial Review and develop and implement plan of correction.
- Develop and implement plan o
- Monitor claims and other reports
 - Sub bullet roles and responsibilities

Long Term Care Case Management Manager of Training and Program Development, 1995 – 2004

- Development of policies and procedures
- Training new case managers and providing ongoing training for current case managers.
- Develop audit tools, compile results and analyze internal audits
- Resolve service delivery problems

Long Term Care Case Manger 1992-1994

- Provide case management services for members in nursing facilities and home settings.

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

Bachelors Degree in Sociology

Arizona State University 1970



Sandra Verheijde

QM Administrator/V.P. of Quality Management MCP

CURRENT RESPONSIBILITIES

The Director of Quality Management is responsible for leadership of strategic quality management strategies & activities which contribute to the overall performance of the health plan and promotes quality of care for all MCP members. The Director of Quality Management reports to the Chief Medical Officer of the health plan.

Responsibilities include: * Development and implementation of Quality Assessment and Performance Improvement (QAPI) programs and policies * Enhancing relationships with providers, facilities, plan sponsors, regulatory agencies * Key business partner in network development, product design, strategic planning

PROFESSIONAL SUMMARY

Innovative and versatile leader with over 20 years experience in healthcare managing large scale teams and projects, building and executing strategies, collaborating with all operational areas, improving team performance and reengineering business processes. Exceptional leadership and problem resolution skills.

CORPORATE EXPERIENCE

Mercy Care Plan, Sept 2011-present

Vice President of Quality Management

- Development and implementation of Quality Assessment and Performance Improvement (QAPI) programs and policies
 - Enhancing relationships with providers, facilities, plan sponsors, regulatory agencies
 - Key business partner in network development, product design, strategic planning
 - Clinical experience and 20 plus years in leadership and quality management activities. 10 years of Quality Management in a managed care environment with a focus on Medicaid or Medicare.
-

Department of Economic Security/Division of Developmental Disabilities

QM Administrator, 2007 – 2011

In my position as the Quality Management Administrator, I have effectively integrated Quality Management principles into all aspects of the Division of Developmental Disabilities. With support from administration, I have been successful in establishing Division-wide collaboration with all departments within the Division to advance and incorporate quality management/utilization management principles. Utilizing the skills developed from extensive administrative background in Long Term Care, Legal Nurse Consulting, and Mayo Clinic research coordination, I have substantially enhanced my understanding of regulatory requirements and its critical implications essential to the coordination and the quality of care delivery within the AHCCCS regulatory environment.

Sandra Verheijde

QM Administrator/V.P. of Quality Management MCP

Responsibilities current assigned include coordination and oversight of various aspects of quality management and utilization management for the Division. The oversight function pertains to transplant coordination, continuing education related to quality management, utilization management, disease management, as well as understanding and implementation of utilization management, concurrent review, prior authorization and case management implementation. In addition this position requires an in-depth knowledge of contractual requirements, AHCCCS AMPM, and ACOM regulations and requirements as well as Arizona Statutes and Rules. Additional responsibilities include having an excellent understanding of the BBA and the 1115 Waiver mandates that impact the regulatory requirements and responsibilities of the Division.

Mayo Clinic

R.N. Triage Nurse, 2005-2007 – Year Ended

- Responsibilities included telephone triage for patient's to provide support and assistance by evaluating health symptoms and directing them to the appropriate level of care. Job responsibilities required understanding of disease management best practices, utilization management principles and development and maintenance of a collaborative relationship with Primary Care Providers as well as Specialty Care Providers. Job responsibilities also required understanding of prior authorization, disease management, and the ability to connect each individual with case management to improve care outcomes.

Carl T. Hayden Veterans Affairs Medical Center

Registered Nurse, Ambulatory Care Services, Telephone Linked Care – 2004-2005

Responsibilities included telephone triage for patient's to provide support and assistance by evaluating health symptoms and directing them to the appropriate level of care. Job responsibilities required understanding of disease management best practices, utilization management principles and development and maintenance of a collaborative relationship with Primary Care Providers as well as Specialty Care Providers. Job responsibilities also required understanding of prior authorization, disease management, and the ability to connect each individual with case management to improve care outcomes. Job responsibilities included ability to recognize and direct patients with suicidal tendencies to specialty providers to maximize critical timeframes for immediate intervention.

Fountain View Village 2003-2004

Director of the Health Care Center

Job responsibilities included, infection control tracking and trending, staffing, utilization review, data analysis, member of care management team, receipt and resolution of patient rights and grievances, providing continuing education related to medical management practices, best practices, and disease management.



Sandra Verheijde

QM Administrator/V.P. of Quality Management MCP

Mi Casa Nursing Center 2002-2003

Director of Nursing Services

Job responsibilities included, infection control tracking and trending, staffing, utilization review, data analysis, member of care management team, receipt and resolution of patient rights and grievances, providing continuing education related to medical management practices, best practices, and disease management.

Highland Manor 2001-2002

Director of Nursing Services

Job responsibilities included, infection control tracking and trending, staffing, utilization review, data analysis, member of care management team, receipt and resolution of patient rights and grievances, providing continuing education related to medical management practices, best practices, and disease management.

Scottsdale Village Square 1996-2001

Director of Nursing Services; Acting Administrator for Maryland Gardens Skilled Care Facility

Job responsibilities included, infection control tracking and trending, staffing, utilization review, data analysis, member of care management team, receipt and resolution of patient rights and grievances, providing continuing education related to medical management practices, best practices, and disease management. Over all management of entire facility when acting Administrator for Maryland Gardens Skilled Care Facility. Responsible for all administrative functions including budget and payroll.

Mayo Clinic Scottsdale 1991-1996

- Registered Nurse, Department of Preventive Medicine,
- Cardiac Treadmill Clinician, Executive Wellness Program
- Registered Nurse, Department of Neurology

Subspecialty: Neuromuscular Diseases

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

- Master of Business Administration - University of Phoenix, Scottsdale, AZ
- Bachelor of Science of Nursing - University of Phoenix, Scottsdale, AZ
- Associate of Applied Sciences Degree, Nursing - Scottsdale Community College, Scottsdale, AZ
- Licensed Practical Nurse - Springfield School of Practical Nursing, Springfield, IL

Professional Certification

- Certified Professional Healthcare Quality. National Association of Healthcare Quality
 - CPHQ ID # 13868, expires 12/31/11.
 - Certified Corporate Compliance Professional. Health Ethics Trust, Washington DC
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Patricia J. Weidman

Director, Provider Relations

CURRENT RESPONSIBILITIES

- Oversee a team of 29 provider relations staff and two managers that provide training and education to over 22,000 network and non-network health care providers for an AHCCCS healthcare plan. Also, responsible for contract compliance for both Medicare and Medicaid contracts, network development, grievance and appeals, and provider communication.
- Developed a comprehensive business plan for non-profit organization, including: financial feasibility, market opportunities and strategies, business and operations requirements, policies and procedures, government health plan regulations, network contracting, and staffing needs. Instrumental with start-up implementation and staff hiring, training, and development. Created business acumen for Quality Assurance and Outcome Measures Monitoring, Compliance, and Reporting.

PROFESSIONAL SUMMARY

Innovative and strategic program manager with a verifiable record of achievement in conceptualizing, developing, and managing diverse healthcare initiatives. Leverage business acumen, operations management, and insurance industry expertise to devise high-impact strategies that exceed expectations. Serve as a collaborative partner to interdisciplinary teams; drive participation and facilitate goal attainment. Create operational efficiencies and reengineer processes to yield cost containment, fuel productivity and profitability. Build and lead high-performing teams that maintain accountability for results.

CORPORATE EXPERIENCE

Mercy Care Plan, 2013 – Present

Director, Provider Relations, 2013 - Present

- Oversee a team of 29 provider relations staff and two managers that provide training and education to over 22,000 network and non-network health care providers for an AHCCCS healthcare plan. Also, responsible for contract compliance for both Medicare and Medicaid contracts, network development, grievance and appeals, and provider communication.

Self-Employed, 2012 - 2013

Professional Healthcare Consultant, 2013 – Present

- Developed a comprehensive business plan for non-profit organization, including: financial feasibility, market opportunities and strategies, business and operations requirements, policies and procedures, government health plan regulations, network contracting, and staffing needs. Instrumental with start-up implementation and staff hiring, training, and development. Created business acumen for Quality Assurance and Outcome Measures Monitoring, Compliance, and Reporting.
-

Patricia J. Weidman

Director, Provider Relations

Phoenix Children's Hospital, 2011 – 2012

Director, Managed Care Contracting, 2011 – 2012

- Oversaw all contracting and operational activities within the Managed Care and Provider Enrollment Departments.
 - Conducted and initiated contract discussions with managed care entities and other health care service providers and/or organizations.
 - Managed contract negotiators to ensure that contract language and rate negotiations were in accordance with business and negotiation strategies; Ensured all contracts could be administered cost-effectively.
 - Facilitated problem solving of operational issues through collaboration and managed care organizations.
 - Restructured Provider Enrollment Department to work more efficiency, established clear definitions for accountability, and orchestrated hospital's move to establish Delegated Credentialing contracts with health plans to reduce claims denials by 20%.
 - Spearheaded and collaborated with key hospital leaders on several process improvement initiatives, including: provider onboarding process, urgent care expansions, & physician integration

Arizona Hospital and Healthcare Association, 2008 – 2011

Director, Workforce & Staffing, 2008 – 2011

- Directed registry and recruitment partners programs; managed a \$3 million operating budget; monitored expenses and analyzed financial performance. Hired, trained, and managed five program specialists. Developed and maintained key relationships, and strategic partnerships with senior hospital and agency staff. Partnered with legal team and hospital personnel to develop program criteria, contract requirements, compliance regulations, request for proposal (RFP) process for agencies, audit requirements, and performance targets.
 - Oversaw quality supplemental staffing program; administered contracts with 150 staffing agencies and 40 hospitals; conducted annual quality compliance audits.
 - Developed online training manual that equipped hospitals and agencies to be self-sufficient, reducing the need for customer support, and enabling the program to focus on quality and compliance initiatives.
 - Analyzed agency performance, provided feedback to hospitals through periodic reporting, and conducted monthly conference calls with hospitals and agencies to improve communication.
 - Administered penalties and sanctions policies for failure to meet contract requirements, which reduced administration by 85%, improved productivity, and generated revenue.
 - Improved and standardized internal processes, reallocated staffing resources, reduced travel expenses by 85%, developed process improvement protocols and communication plans to enhance customer service, and created database to track affiliated and unaffiliated healthcare providers.
-



Patricia J. Weidman

Director, Provider Relations

Cenpatico of Arizona (Centente Corporation), 2005 – 2008

Provider Services & Contracting Administrator, 2005 – 2008

- Contributed to the implementation team that transitioned behavioral health recipients as part of the newly acquired regional behavioral health authority (RBHA) contract for the state of Arizona. Developed a provider relations department; hired, trained, and managed a 10-person staff. Managed provider credentialing and negotiated managed care contracts with hospitals, inpatient and outpatient providers. Served as primary contact for state reporting and provider audits. Key contributions include:
 - Oversaw development of provider training manual, compliance, & provider communications,.
 - Prepared and executed annual network development and cultural competency plans in accordance with state performance reporting and contract requirements.
 - Established network and managed provider relations for RBHA in 4 counties and Bridgeway Health Solutions, a long-term care plan for Medicaid recipients in 3 three counties.
 - Reduced operating expenses by 65% through a reduction in staff and travel expenses.

UnitedHealth Group / Evercare of Arizona, 1998 – 2005

Provider Services and Operations Manager, 1998 – 2005

- Established and managed start-up operations to provide insurance products and healthcare benefits to Medicare and Medicaid long-term care clients. Directed enrollment, claims, grievance and appeals, and provider relations department; hired and trained staff and administered operating budgets. Developed and maintained a provider network; conducted credentialing, training, implemented and managed all provider contracts, including: Medicare and Medicaid, hospitals, & ancillary; Participated in cross-functional team lead meetings. Key contributions include:
 - Established and administered business model, operational processes, and procedures for 100,000 Medicaid and Medicare recipients.
 - Redesigned infrastructure and developed process improvement plans, including instituting a virtual office set up to enhance work flow efficiency in response to two downsizing initiatives. Transitioned 50 case managers, which yielded \$100,000 cost savings, & improved employee satisfaction by 85%.
 - Reorganized grievance and appeals department; implemented process improvement enhancements and developed quality initiatives that exceeded expectations and reduced grievances by 50%.

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

B.S., Business Administration

University of Phoenix, Phoenix, AZ

Licenses

- Arizona State Licensed Practical Nurse

Patricia J. Weidman

Director, Provider Relations

Certifications

- Paralegal, American Institute
- 91C-Clinical Health Specialist / Practical Nurse, U.S. Army



Charlton Wilson

Medical Director/CMO

CURRENT RESPONSIBILITIES

Provide senior leadership for Mercy Care Plan which is an Arizona-based, non-profit health plan with over \$1.7 Billion in annual revenues that manages care and improves quality for over 350,000 members with Medicaid, Medicare Advantage, Long-term care, and other related benefits.

PROFESSIONAL SUMMARY

A respected physician executive, board certified in both internal medicine and healthcare management, with a record of success in achieving strategic, operational, financial, and clinical quality outcomes in highly competitive managed care markets on behalf of not-for-profit and for-profit organizations. Leading and motivating people from all skills and professions in complex ambulatory and hospital settings in manner that improves employee engagement, fosters retention, and improves the quality of healthcare and health outcomes for the people we have served. Fostering innovation and research in complex public-sector healthcare systems which have improved the ability to achieve the objectives of Medicare, Medicaid, and Indian Health Service programs. Bringing together multiple stakeholders and building sustainable programs for the benefit of high-risk, high-needs populations in our community.

CORPORATE EXPERIENCE

Mercy Care Plan, 2010 – Present

Medical Director/CMO, 2010 – Present

- As **Chief Medical Officer**, provided senior leadership for Mercy Care Plan which is an Arizona-based, non-profit health plan with over \$1.7 Billion in annual revenues that manages care and improves quality for over 350,000 members with Medicaid, Medicare Advantage, Long-term care, and other related benefits.
 - Account for all clinical performance measurement, quality of care, quality improvement, member and provider complaints, credentialing, adverse actions, and fair hearing processes in a manner that brought consistency, fairness, and resolution, while increasing the respect for the plan among community physicians.
 - Directed, designed, and improved clinical programs for utilization and prior authorization management, clinical and non-clinical case management, discharge planning, and quality improvement across the entire network. The efforts reduced hospitalizations by 4%, readmissions by 30%, and increased member access to preventive and specialty services. Worked with providers, vendors, and finance to assure accurate capture of CMS-HCC data.
 - Maintained top-tier quality ranking among peer health plans through achievement of high performance in and improvements of HEDIS, CMS Star, and other State-directed performance measurement processes.
 - Implemented new information systems for utilization and case management. Directed multidisciplinary teams through workflow process redesign in a manner that improved efficiency by 30%.
 - Directed strategic priorities including Value-based Purchasing initiatives such as Patient-Centered Medical Home contracting and development of Accountable Care Organization shared-savings models.
-

Charlton Wilson

Medical Director/CMO

These efforts impacted the lives of over 45,000 plan members.

- Contributed to tactical and strategic network development as well as individual contracting initiatives.
- Contributed critical leadership that resulted in winning and implementing a new affiliated business (Maricopa Integrated Regional Behavioral Health Authority) with nearly \$1.0 Billion in projected annual revenues and created an integrated behavioral-physical health plan for people with serious mental illness
- Accountable to both the Mercy Care Plan Board of Directors as well as to national Aetna Medicaid Administrators corporate leadership. Supported all aspects of management and committees which required a sound understanding of both not-for-profit and for-profit business practices and regulations
- Full responsibility for compliance with all utilization and quality management standards achieving near perfect scores in operational reviews by the State and achieved highly successful outcomes of the CMS audits of Advantage programs.
- Full responsibility for internal (corporate) and external (community practices and physicians) communication regarding all aspects of plan performance

U.S. Public Health Service (USPHS), Indian Health Service (IHS)

Commissioned Officer, 1990 – 2010

- As a **Commissioned Officer**, provided service and leadership in this \$4 Billion public Agency that delivers acute/chronic healthcare services for over 2 Million beneficiaries.
 - Awarded USPHS Medals for excellence in clinical care and research efforts and over a 20 year career, continued clinical practice as a highly regarded primary care clinician with expertise in diabetes, HIV and other chronic diseases
 - Attained rank of Captain (O-6) with an exceptional capability promotion
 - As a national IHS consultant, travelled throughout the United States to develop and strengthen disease management and performance measurement programs which were recognized for improving quality and reducing costs. Designed, implemented, and improved specialty services for people affected by HIV, diabetes and cancer in a manner that resulted in sustained clinical improvements
 - Held senior leadership positions at the Phoenix Indian Medical Center, the largest and “most visible” IHS facility. As Chief Executive Officer (interim), and Chief Operating Officer, was fully responsible for Joint Commission accreditation, a \$140 Million annual operating budget, and direction for 1,000 employees. Programs delivered over 300,000 visits annually. Inpatient and outpatient services ranged from obstetrical to intensive care units and prevention outreach through oncology services
 - Fully accountable to Federal and State regulatory agencies, such as DHHS, IHS, CMS and AHCCCS, for operational and financial compliance and outcomes
 - Delivered comprehensive rural health as a physician and Clinical Director of the Mescalero Indian Hospital, Mescalero, New Mexico. This is a small acute care hospital and ambulatory facility serving people in remote southern New Mexico
 - Recognized by peers for expertise in Hospital Incident Command management and for support of the emergency preparedness activities of the USPHS
 - Authored over 40 peer-reviewed journal articles and book chapters, and delivered numerous lectures, newspaper, radio and television media segments. Collaborated with the National Institutes of Health on major research programs including the landmark Diabetes Prevention Program
 - Managed public health monitoring and coordination with States and Counties



Charlton Wilson

Medical Director/CMO

The John Hopkins Hospital, The John Hopkins University

Chief Resident and Faculty Member, 1989 – 1990

- Selected for a highly competitive, one-year position as **Chief Resident and faculty member** at this world-renowned major academic medical center in Baltimore, Maryland.
 - Assistant Chief of Service, Attending Physician, and Instructor of Medicine

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

M.D.

University of Texas Health Science Center, Houston, Texas

B.A., History

Texas Agricultural and Mechanical University, College Station, Texas, *cum laude*

Licenses

- Active Licenses in Arizona and New Mexico

Certifications

- Board Certified, American Board of Internal Medicine
- Board Certified, Board of Governors, American College of Healthcare Executives

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EXHIBIT F: A.R.S. §35-393.01 ATTESTATION

Recognizing legislation has been enacted to prohibit the State from contracting with companies currently engaged in a boycott of Israel, to ensure compliance with A.R.S. §35-393.01, this form must be completed and returned with the response to the solicitation and any supporting information to assist the State in making its determination of compliance.

As defined by A.R.S. §35-393.01:

1. "Boycott" means engaging in a refusal to deal, terminating business activities or performing other actions that are intended to limit commercial relations with Israel or with persons or entities doing business in Israel or in territories controlled by Israel, if those actions are taken either:
 - (a) In compliance with or adherence to calls for a boycott of Israel other than those boycotts to which 50 United States Code section 4607(c) applies.
 - (b) In a manner that discriminates on the basis of nationality, national origin or religion and that is not based on a valid business reason.
2. "Company" means a sole proprietorship, organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, limited liability company or other entity or business association, and includes a wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate.
3. "Direct holdings" means all publicly traded securities of a company that are held directly by the state treasurer or a retirement system in an actively managed account or fund in which the retirement system owns all shares or interests.
4. "Indirect holdings" means all securities of a company that are held in an account or fund, including a mutual fund, that is managed by one or more persons who are not employed by the state treasurer or a retirement system, if the state treasurer or retirement system owns shares or interests either:
 - (a) together with other investors that are not subject to this section.
 - (b) that are held in an index fund.
5. "Public entity" means this State, a political subdivision of this STATE or an agency, board, commission or department of this state or a political subdivision of this state.
6. "Public fund" means the state treasurer or a retirement system.
7. "Restricted companies" means companies that boycott Israel.
8. "Retirement system" means a retirement plan or system that is established by or pursuant to title 38.

All Offerors must select one of the following:

 X My company **does not** participate in, and agrees not to participate in during the term of the contract a boycott of Israel in accordance with A.R.S. §35-393.01.

 My company **does** participate in a boycott of Israel as defined by A.R.S. §35-393.01. :

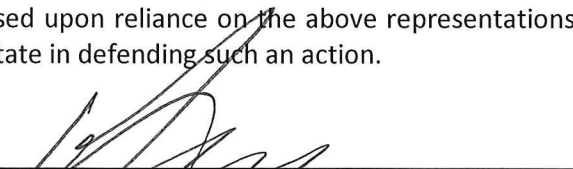
By submitting this response, proposer agrees to indemnify and hold the State, its agents and employees, harmless from any claims or causes of action relating to the State's action based upon reliance on the above representations, including the payment of all costs and attorney fees incurred by the State in defending such an action.

Southwest Catholic Health Network Corporation dba
Mercy Care Plan

Company Name

4350 East Cotton Center Blvd., Bldg. D
Address

Phoenix Arizona 85040
City State Zip


Signature of Person Authorized to Sign
Mark Fisher
Printed Name

President Chief Executive Officer
Title

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