

# Response to AHCCCS

RFP # YH14-0001  
COPY



THE UNIVERSITY OF ARIZONA  
HEALTH PLANS

University Family Care



January 28, 2013

SECTION I: EXHIBITS  
 EXHIBIT A OFFEROR'S CHECKLIST

Contract/RFP No. YH14-0001

EXHIBIT A: OFFEROR'S CHECKLIST

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

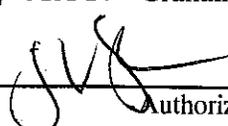
The Offeror must complete the Offeror's Bid Choice Form, Section A1 identifying the program(s) for which the Offeror is submitting a proposal. In addition, when bidding on the Acute Care Program, the Offeror must indicate the Geographical Service Area(s) (GSAs) for which the Offeror is submitting a proposal.

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

A. GENERAL MATTERS

Subject:	Page Number Reference	Offeror's Page No.
Offeror's Checklist (This Exhibit)	Exhibit A	1 - 3
Offeror's Bid Choice Form (Form provided below in this Exhibit and submitted with the checklist)	See A1 below	N/A
Offeror's Signature Page	1 and 2	5-6
Signed Cover Sheets of Solicitation Amendments, if any	Amend No. 1 Amend No. 2 Amend No. 3 Amend No. 4 Amend No. 5	7-45 46-128 129-137 138-139 Front Sleeve of Binder
Completion of all items in Section G: Representations and Certifications of Offeror	Section G	140-218

A1: OFFEROR'S BID CHOICE FORM

ACUTE CARE PROGRAM	
<input checked="" type="checkbox"/> Checking this box indicates the Offeror is bidding on the Acute Care Program.	
<u>University Family Care</u> Offeror's Name	is bidding on the ACUTE Care Program in the GSAs checked below:
<input checked="" type="checkbox"/> GSA 2 Yuma, La Paz <input type="checkbox"/> GSA 4 Apache, Coconino, Mohave, and Navajo <input checked="" type="checkbox"/> GSA 6 Yavapai <input checked="" type="checkbox"/> GSA 8 Gila, Pinal <input checked="" type="checkbox"/> GSA 10 Pima, Santa Cruz <input type="checkbox"/> GSA 12 Maricopa <input checked="" type="checkbox"/> GSA 14 Graham, Greenlee, Cochise	
 _____ Authorized Signature	01/28/2013 _____ Date
<u>James V. Stover</u> Print Name	<u>Chief Executive Officer</u> Title

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

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

**B. ATTESTATION**

Attestation	Requirement No.	Offeror's Page No.
	1-34	220-224

**C. CAPITATION SUBMISSION**

Capitation	Requirement No.	Offeror's Page No.
Acute Care Program Capitation Bid Submission Including Actuarial Certification	1	226-229
CRS Program Capitation Bid Submission Including Actuarial Attestation	2	N/A

**D. EXECUTIVE SUMMARY AND DISCLOSURE**

Executive Summary and Disclosure	Requirement No.	Offeror's Page No.
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	2	235

**E. ACUTE CARE NARRATIVE SUBMISSIONS**

Access to Care/Network	Requirement No.	Offeror's Page No.
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	2	242-246

SECTION I: EXHIBITS  
 EXHIBIT A OFFEROR'S CHECKLIST

Contract/RFP No. YH14-0001

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

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

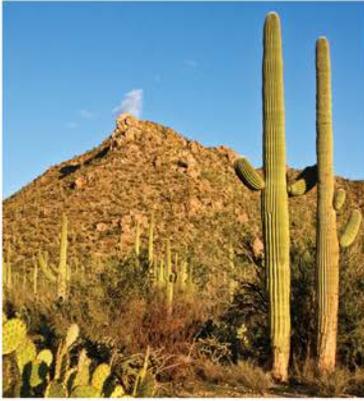
Program - CRS	Requirement No.	Offeror's Page No.
	12	N/A
	13	N/A
	14	N/A

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

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THE UNIVERSITY OF ARIZONA  
HEALTH PLANS



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

**Solicitation Contact Person**

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

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

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

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

**PROPOSAL**

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

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

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

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

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

[http://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOFR22\\_6.pdf](http://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOFR22_6.pdf)

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

[http://www.azsos.gov/public\\_services/Register/contents.htm](http://www.azsos.gov/public_services/Register/contents.htm)

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

Late proposals shall not be considered.

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

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

**OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.**



<b>Notice of Request for Proposal</b>		<b>AHCCCS</b> Arizona Health Care Cost Containment System
<b>SOLICITATION NO.:</b> YH14-0001	<b>PAGE</b> 2	701 East Jefferson, MD 5700
	<b>OF</b> 337	Phoenix, Arizona 85034

**OFFER**

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

Arizona Transaction (Sales) Privilege Tax License No.:

For Clarification of this offer, contact:

N/A Not-for-Profit

Name: Mary Consie

Federal Employer Identification No.:

Phone: (520) 874-5075

94-2958258

Fax: (520) 874-3462

E-Mail Address: mary.consie@uahealth.com

  
Signature of Person Authorized to Sign Offer

The University of Arizona Health Network  
Company Name

James V. Stover  
Printed Name

2701 E. Elvira  
Address

Chief Executive Officer  
Title

Tucson, AZ 85756  
City State Zip

**CERTIFICATION**

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

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

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

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

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

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

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

**ACCEPTANCE OF OFFER (to be completed by AHCCCS)**

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

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

Michael Veit, as AHCCCS Contracting Officer and not personally



**SOLICITATION AMENDMENT**

Solicitation No.: **RFP YH14-0001**  
 Amendment No. **1 (One)**  
 Solicitation Due Date: **January 28, 2013**  
**3:00 PM (Arizona Time)**

**AHCCCS**  
 Arizona Health Care Cost Containment System  
 701 East Jefferson, MD 5700  
 Phoenix, Arizona 85034  
 Meggan Harley  
 Contracts and Purchasing Section  
 E-mail: [Meggan.Harley@azahcccs.gov](mailto:Meggan.Harley@azahcccs.gov)

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

This solicitation is amended as follows:

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 27 <sup>th</sup> day of November, 2012, in Phoenix, Arizona.	
<b>OFFEROR</b>		<b>AHCCCS</b>	
<b>Signature</b> 	<b>Date</b> 01/28/2013	<b>Signature</b> 	
<b>Typed Name</b> James V. Stover		<b>Typed Name</b> Michael Veit	
<b>Title</b> Chief Executive Officer		<b>Title</b> Contracts and Purchasing Administrator	
<b>Name of Company</b> University Family Care		<b>Name of Company</b> AHCCCS	

ACUTE/CRS QUESTIONS AND RESPONSES AMENDMENT No. 1 TO RFP YH14-00014

Question #	Section	Paragraph #	Page #	Question	Response
1.				When will the Letter of Intent format be released?	Watch the AHCCCS website for major RFP decisions.
2.				Where can I find information on Duals?	Information can be found on the AHCCCS website; AHCCCS Duals Page: <a href="http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx">http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx</a>
3.				What is the projected enrollment for next year? Do you anticipate the number to continue to decline?	AHCCCS measures Historical Enrollment numbers. Projection of future enrollment is not posted. Information may be posted to the Bidders' Library.
4.				For entities that have a traditional CMS Institutional Special Needs Plan (I-SNP), could they maintain their patient population that has both Medicare and Medicaid coverage? Or, is the intent of the AHCCCS to move the long-term care residents (SNFs/ALFs) with Medicare-Medicaid status into a current ALTCS-contracted entity?	Under the AHCCCS proposal for the Dual Demonstration, all individuals who have AHCCCS and Medicare whether they are enrolled in a Medicare Advantage plan or Medicare FFS would be passively enrolled into their current ALTCS plan for Medicare in addition to Medicaid. Members will have a choice to opt-out of the Demonstration for Medicare and AHCCCS has proposed that members can opt out to Medicare FFS only. All details of the Demonstration are subject to change and negotiation with CMS until there is a signed Memorandum of Understanding with AHCCCS and CMS. You can find all the details of the AHCCCS proposal here <a href="http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx">http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx</a>

Question #	Section	Paragraph #	Page #	Question	Response
5.				<p>Is the Request for the Acute Care program of AHCCCS or is this a new program specific to CRS and Acute Services related to the CRS recipients? If it is a separate program, do you know when information for the Acute Care Program RFP will be posted? Based on the following, LOIs will not be required as part of the Acute Care RFP Process; has this been the case in the past?</p>	<p>Combined RFP to streamline services for our members and avoid members having to navigate multiple separate systems for care. RFP due out November 1, 2013. No LOI will be required as they have been in the past.</p>
6.				<p>Do plans have to be separately incorporated? Can plans be certified by AHCCCS to be a Medicare Special Needs Plan (SNP)? Is it a requirement to go through AHCCCS for certification?</p>	<p>Statute requires that a plan be separately incorporated for purposes of their Medicaid business with AHCCCS.</p> <p>Separately, statute allows AHCCCS plans to be certified through AHCCCS for their Medicare Advantage SNP business instead of licensed through DOI if they choose. This is not a requirement. AHCCCS plan SNPs are also able to receive licensure through DOI for their Medicare business instead of through AHCCCS if they choose.</p> <p>Although the Medicare SNP and Medicaid plans are separately incorporated, plans which offer companion AHCCCS and D-SNP plans that coordinate Medicare and Medicaid for dual eligible members meet AHCCCS requirements. The goal is for dual eligible members to be enrolled with an organization for both Medicare and Medicaid where coverage is coordinated and seamless to the member.</p>

Question #	Section	Paragraph #	Page #	Question	Response
7.				When is the procurement for the Duals Demonstration?	<p>There will be no separate procurement for the Duals Demonstration. For the ALTCS population, Arizona will use its current ALTCS Contractors. For the Acute population, plan selection will be determined through the upcoming Acute RFP. There will be no separate plans who serve the dual eligible population only, thus to participate in the Duals Demonstration, bidders must bid on the entire Acute Medicaid population in Geographic Service Areas they choose.</p> <p>Additional information can be found on the Acute RFP page:  <a href="http://www.azahcccs.gov/commercial/Purchasing/RFP/Info.aspx">http://www.azahcccs.gov/commercial/Purchasing/RFP/Info.aspx</a> under Presentation/Meeting Materials AHCCCS Duals Page:  <a href="http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx">http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx</a></p>
8.				<p>If AHCCCS pursues the alternative model and requires that health plans also be D-SNPs, then does that mean health plans will not need to submit documentation to CMS as specified by the CMS Duals Demonstration timeline (e.g., health plans are only required to go through the D-SNP application process)?</p> <p>Are timelines for the Acute Care/CRS RFP still firm despite the delayed MOU sign off from CMS?</p> <p>Under our umbrella of companies we have a business unit that specializes in Medicaid and a Medicare division that has been successful with Medicare Advantage, including the development of D-SNPs. Would it be acceptable for our Medicaid division to own the Medicaid contract with AHCCCS while using the expertise of our affiliated Medicare organization to</p>	<p>If a decision is made that AHCCCS will not be pursuing the Duals Demonstration then yes, plans would not be required to submit Demonstration required information. At this time, AHCCCS is still pursuing the Demonstration so Offerors are required to submit required information for both the Demonstration and D-SNP. See the RFP, Exhibit D, Medicare Requirements, for additional information.</p> <p>The delayed MOU timeframe does not impact the Acute Care/CRS RFP timeline.</p> <p>Yes, this is the situation with most of our current</p>

Question #	Section	Paragraph #	Page #	Question	Response
				<p>meet the requirements of the Duals Demonstration?</p> <p>If there is a delay in securing approval from CMS of the AHCCCS Duals Demonstration Proposal, should health plans continue to move forward with the CMS 2014 Duals Demonstration data submission requirements? These include the submission of the Notice of Intent to Apply (NOIA) in November 2012 and the Duals Demonstration Application in February 2013.</p> <p>Please provide clarification regarding network requirements if AHCCCS moves forward with its alternative model for the Duals and requires that health plans be a D-SNP. Specifically, if a health plan's D-SNP operates with a narrow network, will the State require the health plan to enlarge the network to meet AHCCCS network requirements as well? Or, can a health plan meet AHCCCS network requirements as part of its Medicaid operations and meet Medicare/Duals requirements under its D-SNP?</p>	<p>health plans. However, we are aware that changes may need to be made in the future if we pursue the Demonstration. We have no further details at this time.</p> <p>Yes, plans should move forward with all Demonstration and D-SNP requirements until AHCCCS notifies otherwise.</p> <p>Health plans will be required to meet AHCCCS network requirements outlined in the RFP. In addition, health plans will be required to meet CMS Medicare network requirements outlined in the Demonstration and/or D-SNP applications.</p>

Question #	Section	Paragraph #	Page #	Question	Response
9.				<p>I was hoping that we might be able to get some clarification/detail regarding the estimate that AHCCCS receives roughly a few hundred out-of-state claims per year. Specifically, my questions are: Are those few hundred out-of-state claims per year a reflection of only claims that AHCCCS pays direct? Or does it include contractors' out-of-state payments as well (based on encounter types that payors must provide AHCCCS)?</p>	<p>AHCCCS and our Contractors pay for out of state services when the services are emergent and when the medically necessary service was not available in-state. In addition, our contractors have out of state providers in their offered networks to provide services to members that live close to the border when it is closer for them to see a provider out of state than one in-state. We do not have the exact numbers, but would expect that there are far more than a few hundred out of state claims per year when both AHCCCS and the contractors are included.</p>
10.				<p>As we discussed, I would appreciate clarification regarding the "Plan B" option relative to an Acute Bidder being required to submit a Medicare-Medicaid Plan application to CMS for the Demonstration and/or a D-SNP Application to CMS in February 2013. As you are aware, The University of Arizona Health Plans (UAHP) provides management services to Maricopa Health Plan (MHP), which is owned by Maricopa Integrated Health Systems (MIHS). While MIHS is a current AHCCCS contractor, MIHS is no longer a D-SNP contractor with Medicare. Rather, their D-SNP partnership with The University of Arizona Health Plans ended in 2011. At that time, UAHP extended its D-SNP—University Care Advantage—into Maricopa County.</p> <p>Our question then relative to the upcoming AHCCCS RFP/dual demonstration is whether any of the following would fulfill either/both of the above SNP alignment requirements?</p> <ul style="list-style-type: none"> <li>• MHP to Partner/Align with UCA to supply the D-SNP component in Maricopa County;</li> </ul>	<p>Per our Oct 9th Major Decisions document we specify that: All Contractors will be required to serve dual members and to participate with Medicare as either a Dual Eligible Special Needs Plan or CMS Capitated Financial Alignment Demonstration Plan as required by AHCCCS in all GSAs awarded.</p> <p>Additional information about the Medicare requirement will be found in the RFP issued next week.</p>

Question #	Section	Paragraph #	Page #	Question	Response
11.				<p>Enter into a joint venture relationship with an existing D-SNP, such as UCA; or</p> <ul style="list-style-type: none"> <li>Contract directly with CMS as a D-SNP</li> </ul> <p>I am hoping for your guidance on the following points on behalf of a client that is planning to participate in the RFP. (Apologies if you covered this in last week's presentation—it was hard to hear some of the discussion for phone participants.)</p> <ol style="list-style-type: none"> <li>1. Can Medicaid MCOs propose to sub-contract with an MA SNP to satisfy the D-SNP requirement?</li> <li>2. Are there any limitations on the use of sub-contracting for care coordination?</li> </ol>	<p>It is the intention of AHCCCS for the Medicaid MCO to also have a Medicare product – through the CMS Capitated Financial Demonstration or as a D-SNP. See the RFP or other documents for additional details.</p>
12.	General Inquiry			<p>Does AHCCCS intend to adjust hospital rates and/or capitation rates based on readmission scores and/or performance outcomes in 2013 or 2014?</p>	<p>It is possible that hospital rates (using a DRG-methodology effective on or after October 1, 2014) could be adjusted for readmission scores or performance outcomes. It is also possible that capitation rates under this contract could be impacted by a Contractor's performance outcomes – see the discussion regarding Payment Reform – Shared Savings in Section D1, Paragraph 53, Compensation.</p>
13.	Policy 433			<p>What vendor does AHCCCS currently use to produce and distribute member ID cards?</p>	<p>The current AHCCCS Member ID Card Vendor is Custom Card Solutions.</p>
14.	IT Demo			<p>Will AHCCCS be sending any HIPAA transactions (820, 834, 837)? If so, which ones can the bidder expect?</p>	<p>Yes, as outlined in the Bidders' Library, Information Technology (IT) Systems Demonstration, Provisions and Calendar, it is AHCCCS' intent to develop and make available mock 834, 820 and 837 claims files.</p>

Question #	Section	Paragraph #	Page #	Question	Response
15.	IT Demo			Will a separate SFTP site be created for the IT demonstration files? If so, how will the bidder gain access to the site?	It is AHCCCS' intent to place and retrieve these files to and from specific secured folders. The Bidders' Library, Information Technology (IT) Systems Demonstration, Introduction is amended to add information on these folders. Instructions to gain access to the site are found in the Data Supplement in the Bidders' Library, General, Instructions to Electronic File Transfer - Secured File Transfer Protocol.
16.	IT Demo			Will the bidder be required to demonstrate electronic claim attachment functionality?	No, it is not AHCCCS' intent to include electronic attachment based scenarios as a component of this process.
17.	IT Demo			Will the claims being sent be only for the members within the membership files provided by AHCCCS?	Yes, it is AHCCCS' intent to send claims only for those members within the membership files provided by AHCCCS. The Bidders' Library, Information Technology (IT) Systems Demonstration, Provisions are amended to clearly reflect this intent
18.	IT Demo			Will the claim be all form types (dental, professional, institutional)?	Yes, the three form types listed are included; however, the pharmacy form type is not included. The Bidders' Library, Information Technology (IT) Systems Demonstration, Provisions are amended to clearly reflect this intent.
19.	IT Demo			Should the bidder expect to receive pharmacy claims?	No, it is not AHCCCS' intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders' Library, Information Technology (IT) Systems Demonstration, Provisions are amended to clearly reflect this intent.

Question #	Section	Paragraph #	Page #	Question	Response
20.	IT Demo			For what pharmacies will any pharmacy claims be sent?	It is not AHCCCS' intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders' Library, Information Technology (IT) Systems Demonstration, Provisions are amended to clearly reflect this intent.
21.	IT Demo	Provision Document		When can the bidder expect the formats and content for "processing summaries" to be provided by AHCCCS?	Processing summary layouts and required content will be provided as outlined in the IT Systems Demonstration Calendar with each related date provided by AHCCCS. The Bidders' Library, Information Technology (IT) Systems Demonstration, Calendar are amended to clearly reflect this intent.
22.	H	Section H: Enrollment Information		When will reports H1, H2 and H3 be available? Will these be posted to the website or the ShareInfo folder? If the latter, can you provide the sub folder these documents will be stored in?	Reports H1, H2, H3 and H4 from the Bidders' Library, Data Supplement for Offerors'-Acute Care/CRS, Section H, Enrollment Information, have been available since November 1, 2012. These reports are found on the EFT server, as indicated in the Bidders' Library. See Bidders' Library, Data Supplement for Offerors'-Acute Care/CRS, Section A, Data Supplement Instructions and Overview for instructions on where to find data and reports that are posted to the EFT server: The data and reports will be located in a secured folder named Acute Care-CRS-RFP14. Under that folder is a secured folder named Data Supplement Files in which the Offerors will be able to download the data.
23.	IT Demo IT Calendar			The third claims scenario group is to be available to the bidders on 2/6 and the summary is due to AHCCCS on 2/8. The second encounter submission is due to AHCCCS on 2/7. Is the expectation that the second encounter submission include the third claims scenario group?	No, the second encounter submission should not include the third claims scenario group. There is not an encounter submission associated with the third set of claims scenarios.

Question #	Section	Paragraph #	Page #	Question	Response
24.	N/A	N/A		Does AHCCCS intend to prepare and provide Offerors with template provider agreements?	No, AHCCCS will not be providing templates of provider agreements.
25.				When does AHCCCS intend to publish the Capitation Bid Templates?	The Capitation bid templates were published, along with instructions, on November 19, 2012. See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section F, Bid Submission Information.
26.				AHCCCS has stated that the bidding entity must have actual and legal authority [over the Medicare plan]. Assume holding Company A (wholly owned by two Arizona corporations) owns two entities: Company B, a legal entity which will be an Offeror and Company C; another separate legal entity that is a licensed health care services organization under Title 20. Companies B and C are sister corporations, each of which is a separate legal entity owned by Company C. Does this organizational structure satisfy the cited requirement?	The question is unclear. The first clause states that Company A owns both Company B and Company C; the last clause of the last sentence states that Company C owns Companies B and C. Second, the question does not clearly state that either Company B or Company C are separate corporations. Third, the question does not identify which business entity holds a Medicare Advantage contract. Based on information provided, we cannot determine whether business organizations comply with A.R.S. §36-2906.01 or whether the hypothetical Offeror has actual and legal authority over the Medicare Advantage plan.
27.	Pending Data Book			If not already included in the pending data book release, please quantify TPL recovery amounts. Also, please include an estimate for copay collection rates (where applicable).	The question is unclear. Does the Offeror mean TPL recovery amounts that are included in adjudicated encounters, or TPL recovery amounts that are self-reported by Contractors? Assuming the Offeror means TPL recovery amounts that are included in adjudicated encounters, such data was not extracted and will not be provided.  Copay data is available on 5010 transactions, thus this data only became available beginning with dates of service July 1, 2012. No copay collection rates are available at this time.

Question #	Section	Paragraph #	Page #	Question	Response
28.	A through B	N/A	100-101	Are bidders required to disclose ownership and managing employee information for subcontractors?	For purposes of the RFP, an Offeror will be considered to be in compliance with Section D1, 62, (A through B) if Offeror submits a completed and accurate Section G, Representations and Certifications of Offerors. Section D1, Paragraph 62, Corporate Compliance Bullet A, pertains to the Disclosure of Ownership and Control of the Contractor. Bullet B, requires the Contractor to obtain the information in 1 through 4 from its subcontracted providers and fiscal agents. Once an Offeror is awarded a contract they must meet these requirements.
29.	D1 and D2	62	101 & 86	The health plans have been having discussions with AHCCCS on the Corporate Compliance Requirements as specified in Paragraph 62. Will there be changes to this paragraph based on the outcome of these discussions?	At this time, the section should be considered amended by removing the requirement to routinely check the a. Social Security Administration DEATH MASTER FILE and b. The National Plan and Provider Enumeration System (NPPES) in the section regarding Disclosure of Information on Persons Convicted of Crimes. Future amendments may be included at a later date.
30.	D1	75	108-109	“AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved.” Please provide adjustments applied to the rate ranges (if any) to account for anticipated technology efficiencies.	AHCCCS will not adjust the rate ranges to account for anticipated technological efficiencies.

Question #	Section	Paragraph #	Page #	Question	Response
31.	D1	75	109	Proposition 204 was not passed. Please provide an estimate of the impact of KidsCare II enrollees transitioning to Medicaid.	AHCCCS' member month projections assumed that Proposition 204 would not pass, thus no revisions to the member month projections are necessary. See the Bidders' Library, Data Supplement for Offerors' - Acute Care/CRS, Section H, Enrollment Information, Introduction and H-3 Enrollment by Month (Historical and Projected) for more information.
32.	D-2-CRS	3	117	To ensure continuity of care, can existing ALTCS EPD/CRS members be grandfathered into the CRS Fully Integrated Coverage Type on 10/1/13 should they choose to?	No. ALTCS EPD members that have CRS eligible conditions will be fully integrated into their ALTCS EPD Contractor. ALTCS EPD Contractors are encouraged to contract with or authorize services with providers that have been providing services to the member for their CRS covered condition.
33.	D-2-CRS	Covered Services	124	Currently, there are services that have not been covered through CRS such as: ventilator services; chronic or acute infections related to a CRS condition; cancers related to a CRS condition; diapers/toileting items and dialysis.  These services are not clearly written as out of scope in the RFP Section D2 or in the AMPM draft for a partially integrated CRS member.  Can you confirm that these services will continue to be covered by the member's primary coverage, or will they be carved-in to the CRS capitation?	All covered services <u>related to the member's CRS condition</u> are the responsibility of the CRS Contractor currently and under the RFP.

Question #	Section	Paragraph #	Page #	Question	Response
34.	D-2-CRS	Performance Measures	148	<p>Currently, the AHCCCS performance measure for Initiation of First CRS Service is within the date specified on the member's ISP or within 90 days of positive CRS eligibility (Att J, CYE13, pg. 22).</p> <p>In the RFP, the Performance Measure is stated as "Initiation of Services (within 30 days)".</p> <p>We interpret this to mean that the initiation of services should be within 30 days of development of the ISP. Please confirm.</p>	<p>No, services for a CRS member will be measured based on an appointment completed within 30 days from the date of enrollment with the CRS Contractor.</p>
35.	Sections E1 and E2 Contract Terms and Conditions	Paragraph #8	199 & 217	<p>Under the Changes paragraph an amendment is deemed accepted 60 days after the date of the mailing by AHCCCS even if the amendment has not been signed by the Contractor. Paragraph 45 Term of Contract and Option to Renew states that an amendment will be deemed accepted 30 days after the mailing date. Which is correct?</p>	<p>Section E1 and Section E2, Paragraph 8, Changes, is amended to state "When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted 30 days after the date of mailing by AHCCCS, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment."</p> <p>This change will appear in a future version of the contract.</p>
36.	Sections E1 & E2	Paragraph 50	207 & 225	<p>Is the "Type of Contract" language correct on page 207?</p>	<p>No, the language has been amended to "Fixed-Price, stated as capitated per member per month, except as otherwise provided."</p> <p>This change will appear in a future version of the contract</p>

Question #	Section	Paragraph #	Page #	Question	Response
37.	Sections E1 & E2, & Section I, Exhibit B, Minimum Subcontract Provisions	Attachments E-1 & E-2, Paragraph F, and Attachment E-1, Item F. - Subcontractors and Attachment E-2 Item F.- Subcontractors	210, 214, 228, 232, 322, 326	Should the Offeror furnish to the State of Arizona separate certificates and endorsements of each subcontractor?	No, Item F. Subcontractors, is amended to read, "Contractors' certificate(s) shall include all subcontractors as insureds under its policies or upon request, the Contractor shall furnish to the State of Arizona separate certificates and endorsements for each subcontractor upon request."  This change will appear in a future version of the contract and the Minimum Subcontract Provisions.
38.	Sections E1 & E2 and Section I, Exhibits, Exhibit B, Minimum Subcontract Provisions	Attachments E-1 & E-2	210, 214, 228, 232, 322, 326	Where should the insurance verifications, for both Offerors and providers, be submitted?	Section E1 & E2 and Minimum Subcontract Provisions are amended to clarify that insurance verifications of the Contractor shall be sent to AHCCCS Contracts Unit, Mail Drop 5700, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. Additionally, all subcontractors are required to maintain appropriate insurance per the RFP and Minimum Subcontract requirements and to provide verification upon request.  These changes will appear in a future version of the contract and the Minimum Subcontract Provisions.
39.	Section G	4,5 & 6	278-282	When completing SECTION G, can responses requiring narrative (for example 4.c - Accessibility Assurance) be attached as a separate document if it is longer than the space provided on the form?	The form boxes expand to include the narrative response as it is typed. No additional pages are necessary.
40.	G	Item 5.b.	280	Please define "subcontractor" as it applies to this question? Does "subcontractor" by definition include a bidding entity's network providers? Please clarify	The definition of a subcontractor is defined in G-1, 42 CFR 455.101 Definitions, pages283-284. Section G, Item 5.b. pertains to the Offeror's ownership or control

Question #	Section	Paragraph #	Page #	Question	Response
41.	G	Item 6.b.	281	<p>whether AHCCCS wants the Offeror to submit this information, including social security numbers for all subcontractors (including providers) with submission of the bid.</p> <p>Please define “disclosing entity” and “Offeror” as both terms apply to this question?</p>	<p>interest in any subcontractor in which they have direct or indirect ownership of more than 5%. If the Offeror has ownership or controlling interest of 5% or more in a subcontractor then it must submit all the required information including social security numbers.</p> <p>Disclosing entity means any Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent. “Disclosing entity” and “Offeror” are synonymous as they pertain to this question. Refer to Section G, G-1, 42 CFR 455.101 Definitions, pages 283-284.</p>

Question #	Section	Paragraph #	Page #	Question	Response
42.	H	N/A	287	<p>This section states that all acute care Offerors, if awarded a contract, are required to be organizations that contract with CMS to provide and manage Medicare benefits for dual eligible member. However, this appears to conflict with the Arizona requirements that the AHCCCS Contractor be a separately organized entity whose only business is the AHCCCS contract. Please clarify the required legal relationship between the AHCCCS Contractor and the CMS-contracted entity for dual eligibles.</p>	<p>There is no conflict. A.R.S. 36-2906.01(A) provides that</p> <p>“Entities, including insurers as defined in section 20-104, hospital, medical, dental and optometric service corporations defined in title 20, chapter 4, article 3 and health care services organizations as defined in section 20-1051, are prohibited from contracting with the administration as a system contractor unless the entity establishes an affiliated corporation whose only authorized business is to provide services or coverage pursuant to a contract with the administration to persons defined as eligible in section 36-2901, paragraph 6, subdivisions (a), (f) and (g).”</p> <p>Thus, the legal entity that is an Offeror in response to this RFP can be an entity that contracts with CMS as a Medicare Advantage Special Needs plan and can also establish an affiliated corporation whose only authorized business is to provide Title XIX services pursuant to Title 36, Chapter 29, Article 1 of the Arizona Revised Statutes.</p>
43.	Section H	7	289	<p>How will the scoring be weighted for:</p> <ul style="list-style-type: none"> <li>• The narrative submissions</li> <li>• The IT demonstration</li> <li>• The Oral Presentations</li> <li>• Capitation Distribution</li> </ul>	<p>AHCCCS is not providing the actual weighting of the four components.</p>

Question #	Section	Paragraph #	Page #	Question	Response
44.	H.7 Acute Scoring	All	290	The proposal states, "The following four components will be evaluated and weighted in the order listed: - Capitation and Program (Program includes Oral presentations) - Access to Care/Network and Organization What is the actual weighting of each of these four components?"	AHCCCS is not providing the actual weighting of the four components.
45.	Section H, Number 7. EVALUATION FACTORS AND SELECTION PROCESS	Paragraph 1 "Acute Scoring"	290	Will AHCCCS please describe in more detail how will weights be assigned to the four RFP response sections? For example, if the four sections are weighted in decreasing order: 1) Capitation; 2) Program and oral presentations; 3) Access to Care/Network; 4) Organization, what are the weights assigned to each section, i.e. 30% for Capitation, 25% for Program, etc. Is each question within the four sections weighted equally, if not, how is each question weighted with respect to the section? What weight will the oral presentation receive in comparison to the written responses within the Program section?	AHCCCS is not providing the actual weighting of the four components.
46.	H	7	290	There are four components that will be evaluated and weighted for the Acute care bid. Can AHCCCS describe the scoring methodology and relative weights of the four components?	AHCCCS is not providing the actual weighting of the four components.
47.	H, Acute Scoring	4-5	290	Regarding the Acute Scoring process, please provide the percentages regarding how each of the four scoring components will be weighted. Will they be equally weighted at 25% each or differentially weighted? Or will each of the ten Acute Care questions be weighted 10%?	AHCCCS is not providing the actual weighting of the four components.

Question #	Section	Paragraph #	Page #	Question	Response
48.	H	9	292	Will a capped Contractor be required to be a Medicare Special Needs Plans (SNP) or participate in the Duals Demonstration? If a capped Contractor wants to participate in the Duals Demonstration, can they?	No, a capped Contractor will not be required to be a Medicare Special Needs Plans (SNP) or participate in the CMS Capitated Financial Alignment Demonstration. Dual eligible members will be disenrolled from the Contractor. Section H, Instructions to Offerors, Paragraph 9, Award of Contract, Capped Contract Awards is amended to disenroll dual eligible members from the capped Contractor.
49.	Section H	10	293	At the 11/19 meeting, it was stated that AHCCCS would not assign members to a plan that was unprepared to receive membership yet section H uses a more liberal phrasing of "may not." Please confirm whether the decision to assign to an unprepared contractor is at the discretion of AHCCCS.	The RFP document prevails. Responses given during the Offerors' Conference are not binding. The decision to assign members is at AHCCCS' discretion based on Readiness Reviews.
50.	H	12	294	The current RFP schedule includes only one round of questions after the data book is released and this 2 <sup>nd</sup> and final round is prior to the rate ranges being released. Will AHCCCS consider having another round of questions for any follow up data or rate range questions?	Due to the release of the capitation rates/rate ranges currently anticipated for December 14, 2012, AHCCCS will permit a third set of Technical Assistance and RFP Questions which will be limited to the published capitation rates/rate ranges. AHCCCS will not respond to any other questions. Questions will be due by 3:00 p.m. Arizona time Friday December 21 <sup>st</sup> , 2012. AHCCCS will issue the third RFP amendment on or around January 4 <sup>th</sup> , 2013.
51.	Section H	15	296	Does the offeror need to identify Section G as proprietary or will AHCCCS automatically deem it proprietary?	AHCCCS has automatically deemed Section G, Representations and Certifications of Offeror, as proprietary.
52.	Section H	15	296	Can offeror logos be included on the page outside of the 1/2" margin?	Yes, the Offeror's logo can be included in the margins.

Question #	Section	Paragraph #	Page #	Question	Response
53.	Section H	Number 16. SUBMISSION REQUIREMENTS, E. Narrative Submission	296	This section provides that responses to each submission requirement must be limited to five pages and permitted attachments. Can AHCCCS confirm that no attachments are permitted to the Narrative submissions outlined in Section H, Number 16. SUBMISSION REQUIREMENTS, E. Narrative Submission?	No attachments are permissible unless specifically noted. There are no Narrative Submission Requirements outlined in Section H, Instructions to Offerors, which allow attachments.
54.	H	15	296	AHCCCS will only consider the information provided within the allotted page limit and permitted attachments. What are the permitted attachments?	No attachments are permissible unless specifically noted.
55.	H-15	3	296	The instruction states: "Unless otherwise specified, responses to each submission requirement must be limited to five (5) 8 1/2" x 11" one sided, single spaced, type written pages". Narrative Submissions in section E are not identified as separate submission requirements. Is each "narrative submission" subject to a 5 page minimum (for a total of 45 page minimum for the 9 questions) or is the combined submission subject to the 5 page minimum?	Each individual submission requirement is preceded by a number (e.g. 1.) and each number is limited to five pages, unless otherwise noted. There are 10 narrative submissions for Acute Care plus 5 additional for CRS.
56.	H.	15. Contents of Proposal, 16. Submission Requirements, and E. Narrative Submissions	296 and 305	Please provide clarification regarding page limits for each response section. This RFP section states, "Unless otherwise specified, responses to each submission requirement must be limited to five (5) 8 1/2" x 11" one sided, single spaced, type written pages." In Section E. Narrative Submission, AHCCCS asks for responses to several sub-questions in each section. Does the five page limit apply to each sub-question, i.e. Access to Care/Network number 1-five page maximum, number 2, five page maximum, etc. or does the five page limit apply to the overall major section?	Each individual submission requirement is preceded by a number (e.g. 1.) and each number is limited to five pages, unless otherwise noted. There are 10 narrative submissions for Acute Care plus 5 additional for CRS.

Question #	Section	Paragraph #	Page #	Question	Response
57.	Section H	15	296	Is the Offeror required to include the question from the RFP in the response, or is it acceptable to reference the question number from the RFP without repeating the question in the proposal?	The Offeror is not required to include the question from the RFP in the response; however, the response must clearly identify which question is being answered.
58.	Section H	15	297	Can the page numbering fall within the 1/2" margin?	Yes, the page numbering can be included in the margins.
59.	H	5	297	Use of contingent language such as "exploring" or "taking under consideration" will not be given any weight during the scoring evaluation process. Narrative submission # 7 asks the bidder to describe any initiatives it will pursue to deal with waste and would pursue to improve quality. How should the bidder present future driven initiatives that will be favorably scored?	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
60.	H-15 and I-A	15 A	297 and 311	In Section H-15 it states that "each section shall begin with a table of contents" In Section I-A: Offeror's Checklist, opening paragraph it states the "Offeror's Checklist must be submitted with the proposal and shall be the first pages in the binder". Given that the table of contents is required to begin each section, is the table of contents to not be included in the sequential page numbering?	Yes, the Table of Contents for each section must be included in the sequential page numbering. The Offeror's Checklist (Exhibit A) must be submitted as the first pages in the binder and only appears at the start of the binder. The Table of Contents, however, accompanies each section and shall be sequentially numbered

Question #	Section	Paragraph #	Page #	Question	Response
61.	B	All	3	Should the bid amount include the cost of paying PCPs 100% of Medicare allowable in 2013/2014?	No, the capitation bid should not include the cost increase necessary to pay PCPs 100% of the Medicare rates. The Bidders' Library, Section B of the Data Supplement for Offerors – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
62.	H.	16. Submission Requirements, B. Attestation, Access to Care, number 28.	301	This section states, “ A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013 RFP, Section D, Paragraph 27, Network Development.” In addition to this attestation and the narrative description described in Section E.1 and 2, does AHCCCS expect the bidder to submit additional documentation relative to its network build out with the bid submittal? i.e. Do bidders have to submit a list of actual contracts and/or LOIs by network area as outlined in the RFP?	No additional documentation related to the Offeror's network build out, including LOIs, is required with the proposal.
63.	H	16	302	Can you please list what is included in the administrative fee limit of 8%? For example, is care management, health insurer fees, etc. included in this amount?	Funding for all administrative functions is included in the administrative fee limit. This includes non-encountered functions like care management.  The Health Insurer Fee should not be included in the administrative component. This Fee will be handled outside the administrative component, similar to the

Question #	Section	Paragraph #	Page #	Question	Response
64.	Section H	16-C	302/303	AHCCCS indicates that bids submitted with a medical component outside of the published range will receive zero points (page 302). AHCCCS indicates it will publish an actuarially sound rate range equivalent to the bottom half of the rate ranges from the minimum to the midpoint (page 303). Does this mean that a bid that is above the dollar value of the stated/published midpoint but yet still within the rate range will receive a score of 0?	Premium Tax.  Yes, a capitation bid outside (above or below) the published rate range will receive a score of 0.
65.	H	16	303	When the rate ranges are released, please indicate if any adjustments were made to account for generic launches. If so, please provide the adjustments applied.	AHCCCS did not make any adjustments for generic launches.
66.	Section H	E. Narrative Submissions	305	When responding to Section E or other sections requesting Offeror experience, is it acceptable for an Offeror to include information related to the experience its Management Services Subcontractor and its affiliate companies have owning and administering health plans, provided that the State prior approves the Management Services Subcontractor in advance?	Yes, this would be acceptable if the Offeror clearly identifies which organization's experience they are presenting.
67.	H	16	305	The additional 180,000 to 430,000 new members eligible for Medicaid will likely have pent-up demand. Does AHCCCS anticipate adjusting the rate ranges for this pent-up demand? If so, please provide the adjustments applied.	AHCCCS will not adjust the rate ranges for assumptions like pent-up demand.
68.	H	16	305	This may be addressed in the yet unreleased risk adjustment information but given the overall Medicaid population is expected to increase significantly (additional 180,000 to 430,000 new members eligible), how does AHCCCS anticipate risk adjusting for these	Information on risk adjustment is now available in the Bidders' Library, Data Supplement for Offerors' - Acute Care/CRS, Section I, Risk Adjustment Information.

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69.	H	16E	305-309	members? Will their risk scores be based on demographics only?  AHCCCS does not appear to be differentiating bidders based on their approaches to meeting contract requirements, but is using “value-adds” to distinguish among bidders. What types of “value-adds” are of most importance or how will AHCCCS consider them?	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
70.	H-16-E	6	307	Narrative Submission 6 states in part “....Describe processes that will be utilized to enhance and maximize care coordination and improve member experience for members being served for both Medicare and Medicaid services by the Offeror and for members who will <u>only be served for Medicaid by the Offeror....</u> ” Does the last section of this sentence (underlined) refer to dual members who are in the Offeror’s Medicaid plan and another entities Medicare plan or utilizing Medicare FFS?	Yes, the underlined section refers to a Contractor’s members that are dual (Medicare and Medicaid) that are enrolled with the Contractor for Medicaid but another entity for their Medicare benefits.
71.	H-16-E	5	307	Narrative submission #5. In the response to this case scenario, is it acceptable to add information to fill in the gaps of why and how certain circumstances came about and then use that information as the basis for parts of the response.	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
72.	H	Question 6	307	Assume Arizona Corp A and Arizona Corp B own (50/50 interest each) in Corp C, which is a holding company that owns the Offeror (Arizona Entity D). Is the Offeror in this question inclusive of the experiences of C as well as of A and B and any subcontractor that provides operational support to the Offeror; such as utilization management?	The Offeror may provide experience for Corp A, Corp B Corp C and entity D. The Offeror must specify which entity’s experience they are describing when providing the narrative response.

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73.	H	E – Narrative Submissions	307	Submission 6 states, “What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment” Can we assume that the question mark was left off and that this is the end of this submission requirement.	Submission requirement number six is complete and has been amended to include a question mark at the end of the sentence. The amended sentence reads as follows: “What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment?”
74.	H	16	307-308	Each Offeror must “provide specific initiatives and efforts... [they] will pursue to deal with ‘waste’ that exists within the existing system and improves outcomes.” Is AHCCCS planning on adjusting the rate ranges to account for such initiatives? If so, please provide the assumptions/adjustments used.	AHCCCS will not adjust the rate ranges for initiatives the Offeror will describe in its Proposal.
75.	H	E	307-308	Since the RFP states that there will be no points awarded for future strategies, how will your Narrative questions that are specifically soliciting future strategies be addressed/scored?	The RFP does not state that there will be no points awarded for future strategies. Future strategies will indeed be scored; however, use of contingent language such as ‘exploring’ or ‘taking under consideration’ will not be given any weight during the scoring evaluation process. Furthermore, the Offeror will be held to initiatives and strategies presented in their proposal.
76.	H	E. Narrative Submissions (Question 10)	308	Where are the user guides and manuals located, mentioned on page 308?	User Guides and Manuals are located in the Bidders’ Library, under the heading Current Reporting Guides and Manuals.
77.	H	E. Narrative Submissions (Question 10)	308	For existing SFTP access- Will the mock files/data for the scenarios be housed in the State's current SFTP site or will there be a different access point or requirement?	It is AHCCCS’ intent to place and retrieve these files to and from specific secured folders. The Bidders’ Library, Information Technology (IT) Systems Demonstration, Introduction is amended to add information on these folders. Instructions to gain access to the site are found in the Data Supplement in the Bidders’ Library, General, Instructions to Electronic File Transfer - Secured File Transfer Protocol.

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78.	Section H	16-E	309	At the 11/19 meeting, it was stated that an offeror's subcontractor could participate in the oral presentations. Will AHCCCS require any specific documentation supporting that the individual is employed by a subcontractor as opposed to being a consultant?	No specific documentation will be required beyond the resumes of the staff participating in the oral presentation. AHCCCS reserves the right to request additional documentation.
79.	H.	15. Contents of Proposal and E. Oral Presentations	309	AHCCCS states the following relative to the Oral Presentation: "The Offeror shall bring no more than six individuals to the meeting. All participants must be employees of the Offeror; no consultants may participate." If the Offeror plans to subcontract several of these functions, is it permissible to bring personnel who will be administering these operations who are not employees of the offeror to the Oral Presentation?	Yes, staff as you have described would be allowed to participate in the Oral Presentation. However, refer to D1 and D2, ¶16, Staff Requirements and Support Services and ¶37, Subcontracts for specific staffing/subcontract Contract Requirements.
80.	Section H	Number 16. SUBMISSION REQUIREMENTS, E. Oral Presentations Paragraph 3	310	This section provides that the offeror may not be permitted to bring laptops, tablets or any prepared handouts to the Oral presentations, but will be able to utilize hard copy material "including copies of policies and procedures as they prepare for the presentation." Can AHCCCS confirm that bidders may bring prepared background material for their own use, in addition to copies of policies and procedures?	The Offeror may bring prepared background material, policies and procedures to assist in preparing for the oral presentation. These materials will not be provided to or utilized by AHCCCS in the scoring process.
81.	H	Instructions to Offerors	312	The Instructions require the Bid Response to be in Times New Roman, 11 point font. Should the Capitation Bid Template also be in Times New Roman, 11 point font? How do we address page numbers as required by the Checklist?	No. The Capitation Bid Template is already formatted. Page numbers for the template and the Certification will have to be added manually.

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82.	Section I	Exhibit B – Minimum Subcontract Provisions – Attachment E-1	320	A reference to a new attachment E-1 was added to the insurance section within the minimum subcontract provisions (#17). Please explain the general purpose of this new attachment specifically, the requirement on page 321 for policies to be endorsed to include the additional language of: “The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor”. What actions, if any, does AHCCCS anticipate to be required by the provider and/or contractor to meet the requirement? Please address both existing contracts and newly contracted providers.	This requirement applies to all awarded contracts under this RFP. It is the responsibility of the Contractor (MCO) to ensure that each of its subcontractors (providers) are in compliance with the applicable insurance requirements as described in the contract, in addition to holding the State and its officers harmless. Each subcontractor shall have appropriate liability insurance and workman’s compensation coverage as evidenced by an insurance certificate which should be sent to the Contractor and compliance shall be monitored by the Contractor.
83.	I	Exhibit C, Item #10	329	“Change Control” can have many different meanings. In the context of this attestation, how does AHCCCS define “change control” as well any parameters regarding “change control”?	Change control is defined as a systematic approach to managing all changes made to a system, the purpose of which is to ensure that no unnecessary changes are made, that all changes are documented, that services are not unnecessarily disrupted and that resources are used efficiently.

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84.	Section I, Exhibit D	General	333	The Offeror is required to pursue its Medicare bid through a dual process: the normal bid process and the Demo bid process. What role will AHCCCS play in the CMS bid approval process, and how will AHCCCS validate or verify the Offeror's CMS application?	Under the Medicare Advantage SNP application process, AHCCCS will work with CMS when possible, but ultimate authority of approval is done by CMS. AHCCCS will work with CMS to verify submissions. Under the CMS Capitated Financial Alignment Demonstration, there is no bid process as there is in the Medicare Advantage process. Offerors are required to submit an Application to CMS in February as well as additional CMS required documents. AHCCCS will work with CMS to verify and review these documents.
85.	Section I, Exhibit D	General	333	Since the Offeror will be submitting its Network through the HSD table process with CMS, what is the timeline and process that AHCCCS will be using to evaluate the adequacy of the Offeror's Medicare Network?	Under the CMS Capitated Financial Alignment Demonstration process, AHCCCS will work with CMS, to evaluate the Offeror's Medicare network.
86.	Section D1	10	38	With regard to CRS eligibility – section D1 states that an acute plan would refer a member for CRS through notification to AHCCCS Division of Member Services but members are determined eligible by the CRS contractor. The 11/19 presentation, slide 106, stated that AHCCCS would determine medical eligibility for the CRS program. Which is accurate?	Section D1, Paragraph 10, Scope of Services, page 38 is amended to clarify that the Contractor is responsible for care of members until those members are determined eligible by AHCCCS, Division of Members Services. This change will appear in a future version of Section D of the contract.
87.	Section D1 and D2	16	50 and 135	Paragraph 16 states that Contractor shall "employ" certain Key Personnel. May the Contractor also arrange for the provision of these personnel through a Contractor's Management Services Subcontractor provided that the State prior approves the Management Services Subcontractor in advance?	Yes, the Key Personnel requirements may be fulfilled through a management services agreement subject to prior approval by AHCCCS.

Question #	Section	Paragraph #	Page #	Question	Response
88.	D.1.	Paragraph 5	51	Please define "multiple lines of business." For example, may a Key Staff member, such as the Dispute and Appeal Manager position, serve the bidding entity's affiliated entities depending upon work load?	<p>AHCCS considers multiple lines of business as a company/corporation/ organization that provides healthcare coverage under several product lines, among several markets, or multiple contracts. For example a company/ corporation/organization that provides Medicaid services in Arizona, New Mexico and Utah and also operates a commercial business and/or Medicare product.</p> <p>The Dispute and Appeals Manager could serve the Offeror's affiliated entities, as long as all staffing requirements are met.</p>
89.	D.1.	Paragraph 6, Key Staff Positions	51	Must each of the key staff positions be employees or can the bidder use contractors to fill these roles? Can the Contractor use employees of a parent company or affiliated company to fill these roles? Can these individuals share more than one role, either within the Contractor or between related entities?	<p>Yes, the Key Staff positions must be employees of the Offeror, or contracted/employed under an administrative service subcontract, as outlined in Section D1, Paragraph 37 Subcontracts.</p> <p>Yes, under Section D1, Paragraph 37, Subcontracts of the RFP administrative services subcontracts includes all Service Level Agreements with any Division or Subsidiary of a corporate parent owner. However, all staffing requirements outlined in Section D1, Paragraph 16, Staff Requirements and Support Services must be met.</p> <p>Yes, an individual can occupy a maximum of two of the Key Staff Positions.</p>

Question #	Section	Paragraph #	Page #	Question	Response
90.	H, Key Staff Positions and Corporate Compliance	N/A	51 and 99	Regarding Page 51, item "Key Staff Positions" and page 99, item "Corporate Compliance;" If the Corporate Compliance Officer can be shared with a related organization as indicated on page 51, please explain the requirement that the Compliance Officer must be "onsite" per page 99. Does "onsite" refer to part of the time, all of the time; presence in Arizona or presence in the office location of the contractor?	The Corporate Compliance Officer can be shared with a related organization; however, this position must be physically located in Arizona to conduct business during business hours.
91.	Section D1 and D2	Paragraph 23	59 and 144	<p>RFP states:                      "The contractor must ensure that the QM/PI unit within the org structure is separate &amp; distinct from any other units of departments such as Medical Management or Case Management...."</p> <p>"QM/QI Positions performing work functions related to the contract must have a direct reporting relationship to the CMO and the local CEO...."</p> <p>Question: Is State requiring the contractor to have two separate QM/PI units within the organization - 1 unit that is specific to Acute and 1 unit that is specific to CRS? Or is it permissible to have one QM/PI unit that supports both Acute and CRS Quality Management &amp; Performance Improvement?</p>	It is permissible to have one QM/PI unit that supports both Acute and CRS. Key staff members are limited in the number of key staff positions they may hold (see Section D1 and D2, Paragraph 16, Staff Requirements and Support Services.)

Question #	Section	Paragraph #	Page #	Question	Response
92.	Section D1	Paragraph 23, QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI),	61	When does AHCCCS anticipate releasing the “next generation” of quality performance measures?	The next generation of Performance Measures has been included in the RFP. AHCCCS will continue to monitor CMS quality measure expectations, review the availability of additional data sources such as Health Information Exchange, Electronic Health Records, etc. and consider implementing additional measures from the CMS measure sets based on penetration and use of these technologies within Arizona health care systems in future contract years.
93.	Section D1	23	62-64	When does AHCCCS expect to develop or release more specifics on the new Performance Measure methodologies and how it established or will establish Minimum Performance Standards for some of them?	Performance Measures were selected from NCQA HEDIS measure sets and from the CMS measure sets being established for CHIPRA, Well Child, Adult, Dual, and LTC. The methodologies are publically available on the measure set developers’ websites and through links on the CMS website. For those Performance Measures listed with a TBD for the Minimum Performance Standard (MPS), national Medicaid rate data is not currently available. AHCCCS will utilize national Medicaid rate data should it become available. If not available, AHCCCS will establish the MPS based on a stated CMS goal or where data is already available to the Agency, AHCCCS will analyze historical encounter data as part of the rate determination.
94.	D1	23	62-64	Please provide performance measures by GSA and risk group for the base period as well as the most current measurement period.	AHCCCS will not provide additional data related to performance measures by GSA or risk group. Offerors may reference the Performance Measure results published on the AHCCCS website.

Question #	Section	Paragraph #	Page #	Question	Response
95.	Section D1	23	64	For those performance measures that are in a TBD status, what time period does AHCCCS anticipate using for the baseline data?	Data from the first six months of operation of CYE 2014 will be reviewed to determine the appropriate Minimum Performance Standards and Goals. In instances where data is already available to the Agency, AHCCCS will analyze historical encounter data as part of the rate determination.
96.	D.1	27. Network Development	69	The RFP states, "The Contractor must pay all AHCCCS registered Arizona Early Intervention Program (AZEIP) providers, regardless of their contract status with the Contractor, when Individual Family Service Plans identify and meet the requirement for medically necessary EPSDT covered services." Please provide a listing of the AZEIP providers or advise where it can be obtained.	Arizona Early Intervention Program (AZEIP) provider (vendor) information is available on the Department of Economic Security, Arizona Early Intervention website.
97.	D.1	27. Network Development	69	The RFP states, "Homeless Clinics: Contractors in Maricopa and Pima County must contract with homeless clinics at the AHCCCS Fee-for-Service rate for Primary Care services." Please provide a listing of the Homeless Clinics in Maricopa County.	AHCCCS will provide a list of Homeless Clinics in Maricopa and Pima County upon award of the contract.
98.	D.1.	Homeless Clinics, Item Number 2.	69	What is the definition of "needed specialty services?" Does this requirement apply when such services are available in-network?	Contractors must utilize in-state, contracted network providers. If the needed specialty services are not available in-network, the Contractor must make the services available through an out-of-network provider.  In Section D1, Paragraph 27, Network Development, "needed specialty services" refers to services considered outside of standard medical-surgical services because of the specialized knowledge required for service delivery and management.

Question #	Section	Paragraph #	Page #	Question	Response
99.	Section C, Definitions	Day – Business/working	8	Is the word “day” left out of the first sentence?	Yes, the definition is amended to read “A business day means a Monday, Tuesday...”  This change will appear in a future version of the contract.
100.	D1	42	82	Will the data book include amounts for physician incentive payments (assuming such programs existed)?	The Data Books include expenditures by category of service, including several for physician services. If physician incentive payments were incorporated in adjudicated encounter data, then such payments are included.
101.	D.1	43. Management Services Agreement and Cost Allocation Plan	83	The RFP states, “If a Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management.” Does AHCCCS expect a new contractor to submit the management services agreement with its proposal?	Administrative services contracts will not be submitted with proposals. Once awards are made, any Administrative Services Agreements meeting the criteria in D1, ¶ 37 Subcontracts, pages 76 will be submitted for approval.
102.	D1	50-Financial Viability	86	This paragraph references ACOM Draft Policy 305. Is this the correct Policy reference? Should this be Policy 313?	Both ACOM Draft Policy 305 and ACOM Policy 313 should be included. D1 is amended to include ACOM Policy 313 in Paragraph 50, Financial Viability Standards. This change will appear in a future version of Section D of the contract.
103.	D1	51	86	Regarding the separate incorporation requirement, will the establishment of a limited liability corporation satisfy the separate corporation requirement?	No, a limited liability company is not a corporation. A.R.S. §36-2906.01 requires the establishment of an “affiliated corporation.”
104.	D.1.	51. Separate Incorporation	86	The RFP states that, “Contractor shall establish a separate corporation for the purposes of this contract.” Please clarify whether the requirement permits a bidder to establish a separate entity that is a limited liability company (LLC) rather than a corporation.	No, a limited liability company is not a corporation. A.R.S. §36-2906.01 requires the establishment of an “affiliated corporation.”

Question #	Section	Paragraph #	Page #	Question	Response
105.	Section D1 and D2	51	86 and 172	<p>Paragraph 51 states: "Within 120 days contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract."</p> <p>Would the State consider adding "or other contracts with CMS, AHCCCS, and/or another State regulatory agency," to accommodate a plan offering multiple programs (e.g., ALTCS, Medicare, etc.) through AHCCCS and/or CMS?</p>	<p>AHCCCS will add "or other contracts with AHCCCS" at the end of this sentence. The statute does not allow the addition of CMS or another State regulatory agency.</p> <p>Section D1 and D2, Paragraph 51, Separate Incorporation, are amended to include this additional language. This change will appear in a future version of Section D of the contract.</p>
106.	D.1. and H		86, 302	<p><u>Administrative Expense Limits:</u>                      We note an apparent conflict between RFP Sections D.1. and H regarding the issue of limitation on administrative expenses.</p> <p>Section D.1. page 86: "Administrative Cost Percentage = Total administrative expense divided by the sum of total PPC and prospective capitation + Delivery Supplement + All Reconciliation Settlements + Reinsurance less premium tax. Standard: No greater than 10%."</p> <p>Section H page 302: "Acute Care Program Capitation Bid Submission; item #2 – Offerors will submit an administrative component PMPM bid for each risk group by GSA. The administrative component is limited to a maximum of 8%. The administrative component percentage shall be calculated as: Administration/Gross Medical Component. Capitation bids submitted with an administrative component exceeding 8% will earn an administrative component score of zero points."</p> <p>Does this mean that the standard for actual</p>	<p>There is no conflict.</p> <p>There is one methodology to compute the administrative expense standard, and at this time AHCCCS allows a Contractor to report up to 10% according to the formula contained in D1, paragraph 50, Financial Viability Standards.</p> <p>Despite this, it is correct that an Offeror with an administrative component bid exceeding 8% according to the formula provided in Section H, Instructions to Offerors, Paragraph 16.C. will receive a score of zero points.</p> <p>Premium Tax is not considered an administrative expense; however, because it is included in the capitation paid, it is subtracted in the denominator according to the formula contained in D1, Paragraph 50, Financial Viability Standards.</p> <p>Premium Tax should not be included in the administrative component bid.</p>

Question #	Section	Paragraph #	Page #	Question	Response
107.	Section D1	50	86/86	<p>administrative expenses is 10% of total revenue, but that if a carrier bids more than 8%, they score zero points on the administrative component of the bid score?</p> <p>In addition, when determining the measure of administrative expense is premium tax considered part of administrative expense or is it not considered part of administrative expense?</p>	<p>No, AHCCCS will not apply the AHCCCS Acute Care standards to the financial viability ratios for the Contractor's Medicare line of business. AHCCCS will review the ratios included in D1, Paragraph 50, Financial Viability Standards but will only consider the Contractor out of compliance for the standards explicitly described for the Medicare Advantage Plan Certified by AHCCCS.</p>
108.	Section D1	Paragraph 53, COMPENSATION,	87	<p>Which national episodic/diagnostic risk adjustment model does AHCCCS use to establish prospective capitation rates?</p>	<p>AHCCCS has used the Optum (formerly Ingenix) Symmetry Episode Risk Groups (ERG) tool. More information on risk adjustment is now available in the Bidders' Library, Data Supplement, Section I, Risk Adjustment Information.</p>

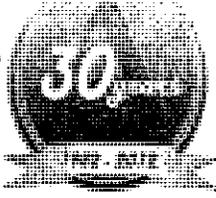
Question #	Section	Paragraph #	Page #	Question	Response
109.	D.1.	53, Question 1.	87, 2nd paragraph under Compensation.	<p>“AHCCCS provides the following data to its actuaries for the purposes of rebasing and/or updating the capitation rates... d. AHCCCS fee-for-service schedule pricing adjustments...”</p> <p>In its range of capitation rates expected to be released on December 14, 2012, has AHCCCS taken into account the recently released CMS ruling that Medicaid PCP reimbursement would be increased to at least the same as Medicare? If not, will there be an adjustment to capitation rates for this at a later date? Should carriers assume an increase in the PCP reimbursement from prior experience to account for this increase?</p>	<p>No, the rate ranges provided will not consider PCP rate parity. Additionally, the capitation bid should not include the cost increase necessary to pay PCPs 100% of the Medicare rates.</p> <p>Section B of the Data Supplement for Offerors – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.</p>
110.	D.1.	53, Question 2.	87, 2nd to last paragraph under Compensation.	<p>The second to last paragraph notes, “In instances in which AHCCCS has specialty contracts of legislation/policy limits the allowable reimbursement for certain services or pharmaceuticals, the amount to be used in the capitation rate setting process and reconciliations will be the lesser of the contracted/mandated amount or the Contractor paid amount.”</p> <p>Do bidders have information on all specialty contracts and all legislation/policy limits AHCCCS has so we may create a bid which appropriately reflects these limits? If bidders do not, when will they become available?</p>	<p>AHCCCS did not provide Offerors with information on specialty contracts or legislation/policy limits, but intends to provide such information prior to the start date of the contract. The encounter data in the Data Books is reflective of Contractors’ costs for related services and is the base data for the AHCCCS rates and/or rate ranges.</p>

Question #	Section	Paragraph #	Page #	Question	Response
111.	D.1.	53, Compensation - Payment Reform – Shared Savings	88, 2 <sup>nd</sup> to last paragraph.	<p>The second to last paragraph states, “AHCCCS anticipates that capitation rates will be reduced by a withhold of no less than 1% in CYE14, 100% of which will be paid to one or more Contractors according to relative Contractor performance.”</p> <p>Is this program an incentive program for Contractors who do the right thing based on what AHCCCS wants them to do? Or is this an incentive arrangement for Contractors to pass on to providers? Does AHCCCS assume that additional revenue to Contractors will be based on innovative arrangements between the Contractor payer and the providers, with this payment meant to be shared with providers of the awarded Contractor?</p>	<p>AHCCCS is currently developing the payment reform policy with the intent to drive innovative arrangements that will further enhance cost control and result in quality improvements, while also offering providers incentive to participate in these arrangements. AHCCCS will release the policy no later than six months prior to the start date of the contract.</p>
112.	D1	57- Reinsurance	91	<p>Why is the Reinsurance language different between D1 and D2 (p. 178)? The language regarding Catastrophic Reinsurance case notification states that the Contractor must notify Medical Management Unit of cases identified ‘within 30 days of initial diagnosis and/or enrollment with the Contractor, and annually within 30 days of the beginning of each contract year,’ but D1 language refers to the Chart of Deliverables.</p>	<p>The Chart of Deliverables referenced in D1, Acute Care Program Requirements, ¶57 Reinsurance, contains the same notification requirements as the language in D2, CRS Program Requirements, ¶57 Reinsurance. D1, ¶57 is amended to include the notification information and to delete the reference to the Chart of Deliverables. This change will appear in a future version of Section D of the contract. Notification/reporting requirements for both Programs are the same.</p>

Question #	Section	Paragraph #	Page #	Question	Response
113.	D.1.	58, Coordination of Benefits/Third Party Liability	96, Retroactive Recoveries, Paragraphs 1 and 2.	<p>Paragraphs 1 and 2 state, "The Contractor shall engage in retroactive third party recovery efforts for members for which a claim was paid, for up to two years from the date of service...After two years from the service date, AHCCCS will direct recovery efforts...Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS...The total recovery period...is limited to three years after the date of service..."</p> <p>We understand there currently is a three year retroactive recovery period. Does this section change the current period from a full Contractor recovery period of 3 years to only 2 years, and then AHCCCS gets the value of recoveries in the third year? This issue will be important to understand as we develop our medical expense bid.</p>	<p>Yes, current policy (ACOM Policy 412, Claims Reprocessing) permits Contractors to engage in retroactive third party recovery for three years after the date of service.</p> <p>Effective October 1, 2013, in accordance with Section D1, Paragraph 58, Coordination of Benefits/Third Party Liability and ACOM Draft Policy, Coordination of Benefits/Third Party Liability, the Contractor is required to engage in retroactive third party recovery for up to two years from the date of service.</p>
114.	Exhibit D-Medicare Requirements	General Question	n/a	<p>General Question about CMS/DOI regulatory oversight going forward. If a Plan currently has a DOI reporting relation for Medicare, with the dual integration proposal, will AHCCCS take over the oversight (i.e. NAIC DOI financial reporting requirements)?</p>	<p>No, AHCCCS does not intend to take over the oversight of the NAIC DOI financial reporting requirements or any other DOI requirements.</p>
115.	D.1 Attachment B.1 Deliverables	37. Subcontracts Administrative Services subcontracts	pp. 75-76 and 252	<p>The RFP states, "All subcontracts entered into by the Contractor are subject to prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to AHCCCS, Division of Health Care Management for prior approval as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. Administrative Services Subcontracts:                      1. Delegated agreements that subcontract;</p>	<p>Administrative services contracts will not be submitted with proposals. Once awards are made, any administrative services contracts meeting the criteria in D1, ¶ 37 Subcontracts, page 76 will be submitted for approval.</p> <p>The Chart of Deliverables requires Administrative Service Agreements to be submitted to AHCCCS for approval 60 days prior to the start date of the Agreement.</p>

Question #	Section	Paragraph #	Page #	Question	Response
116.	IT Systems Demonstration Provision and Calendar	6 <sup>TH</sup> Bullet under provisions and 4 <sup>th</sup> Row Under Calendar AHCCCS to Offeror		<p>a. Any function related to the management of the contract with AHCCCS,</p> <p>b. Claims processing, including pharmacy claims,</p> <p>c. Credentialing including those for only primary source verification (CVO).</p> <p>2. All Management Service Agreements;</p> <p>3. All Service Level Agreements with any Division or Subsidiary of a corporate parent owner.”</p> <p>Does AHCCCS expect a new contractor to submit any administrative services subcontracts, i.e. Medical Management, Quality Assurance, etc. with the proposal or are these to be submitted after contract award for AHCCCS prior approval? The chart of deliverables is not clear regarding this requirement for new contractors (page 252).</p>	<p>No, it is not AHCCCS’ intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders’ Library, Information Technology (IT) Systems Demonstration, Provisions are amended to clearly reflect this intent.</p>

Question #	Section	Paragraph #	Page #	Question	Response
117.	IT Systems Demonstration Provision and Calendar	8 <sup>TH</sup> Bullet under provisions and 5 <sup>th</sup> Row Under Calendar AHCCCS to Offeror	Provisions and Calendar	Trading partner set-ups and interface systems are often idiosyncratic for each trading partner. Currently we do not exchange 270/271 and 276/277 transactions with AHCCCS. Are we allowed to test with AHCCCS prior to the IT Systems Demonstration start date? If so, would that include testing with Transaction Insight?	No, the Offeror will not perform any testing with AHCCCS prior to the IT Demonstration start date. It is not AHCCCS intent that Offerors develop a process to exchange 270/271 or 276/277 transactions with AHCCCS. Offerors may exchange this data utilizing an automated system or a manual process. The intent of these demonstrations is to mimic key data exchanges related to eligibility and claims status inquiries that would occur between the Offeror and a provider or clearinghouse.



**SOLICITATION AMENDMENT**

Solicitation No.: **RFP YH14-0001**  
 Amendment No. 2 (Two)  
 Solicitation Due Date: January 28, 2013  
 3:00PM (Arizona Time)

**AHCCCS**

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

Meggan Harley  
 Contracts and Purchasing Section  
 E-mail: [Meggan.Harley\\_azahcccs.gov](mailto:Meggan.Harley_azahcccs.gov)

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

This solicitation is amended as follows, and supersedes any information previously provided that is inconsistent:

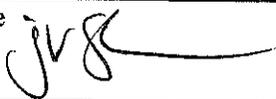
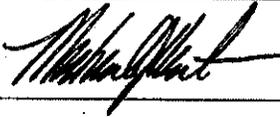
- Section H: Instructions to Offerors, Paragraph 16, Capitation, *Acute Care Program Capitation Resources*, page 303 is amended as follows:

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

- The Bidders' Library, Information (IT) Technology Systems Demonstration *Provisions and Calendar* have been revised.
- Section H: Instructions to Offerors, Paragraph 16, Submission Requirements, E. *Oral Presentations*, page 309, is amended as follows:

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 19 <sup>th</sup> day of December, 2012, in Phoenix, Arizona.	
<b>OFFEROR</b>		<b>AHCCCS</b>	
Signature 	Date 01/28/2013	Signature 	
Typed Name James V. Stover		Typed Name Michael Veit	
Title Chief Executive Officer		Title Contracts and Purchasing Administrator	
Name of Company University Family Care		Name of Company AHCCCS	

ACUTE/CRS QUESTIONS AND RESPONSES AMENDMENT No. 2 TO RFP YH14-00014

Question #	Section	Paragraph #	Page #	Question	Response
1.	Data Supp. C			Please provide a data supplement splitting out Rx by generic, pref brand, non-pref brand and specialty. If possible, please provide the same level of detail currently in the data book. At a minimum, please provide GRD by risk group, GSA and CYE.	No additional information will be provided.
2.	Data Supp. F			Please provide a cross walk from the data book service categories to those in the capitation bid template.	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, Crosswalk Acute Care Service Matrix to Capitation Bid Template posted on December 14.
3.	G	N/A	279-286 And all Excel Spreadsheet Pages	Should Offerors create a separate pdf file for Section G, Representations and Certifications of Offeror?	Yes. Create a separate .pdf file to include ALL of the required Section G documentation, including the spreadsheet information, in order for Section G to be removed from the published version of the proposal as stated on page 296, Instructions to Offerors.
4.	H			Can the state confirm that TPL offsets are incorporated into the Acute and CRS Data Book costs and will be included in the gross medical component PMPMs used to construct the rate ranges?	Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made. Capitation rate ranges were developed based on the Data Book data.

Question #	Section	Paragraph #	Page #	Question	Response
5.	Instructions to Offerors			Will the same evaluators scoring this RFP also score the Maricopa behavioral health RFP?	AHCCCS is not providing any detailed information regarding evaluators scoring the Acute/CRS or Maricopa RBHA RFP.
6.	Data Supp. C			CYE12 appears to be incomplete. If possible, please provide average completion/IBNR for CYE12 and CYE11.	Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14.
7.	Data Supp. F	Bid Template Tool		When using an original version of the template (i.e. unsaved) and cycling through the GSAs and Risk Groups (Select_GSA_Group tab), the template will occasionally load inputs (into the Input tab) even if the user has not stored any inputs for the selected GSA/Risk Group combination. While the inputs tab does not always clear when an un-stored combination is selected, it does not appear to impact the Summ_Bids tab. Can AHCCCS please confirm these observations?	The template as released to Offerors does not contain any stored inputs. Quality control testing took place before the release of the template. Subsequent testing was unable to recreate the scenario described. If you need further technical assistance please see Bidders' Library, Data Supplement, Section F, Bid Submission Information, Bid Template Overview for instructions on how to contact ISD.
8.	Data Supp. B	Attachment A		If possible, please provide general methodologies used to develop the PMPM program change estimates. For example, are the inpatient day limit PMPMs estimated using CYE11 data or projections of CYE12? Any information you can provide that will aid in the appropriate application of the program change impact estimates is greatly appreciated.	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
9.	Data Supp. C	Data Book		<p>Based on a cursory review of certification letters, it appears as if trend factors are developed based on normalized encounter data. Would AHCCCS be willing to share encounter data normalized for program changes?</p>	<p>No additional information will be provided.</p>
10.	Data Supp. C	Data Book		<p>There are a number of large PMPM changes by service category, risk group and GSA. For example:</p> <p>For TANF &lt;1 in GSA 12, the All Other Hospital Days PMPM changed from \$13.21 PMPM in CYE09 to \$10.10 in CYE10 to \$21.89 in CYE11.</p> <p>For AHCCCS Care in GSA 12, the Inpatient ICU Tier PMPM decreases consistently from CYE2009 to CYE2011 (from \$32.30 to \$25.79 to \$20.88). A similar trend exists in the IP Routine Tier service category (for this same risk group and GSA).</p> <p>We do not believe these year-to-year changes are fully explained by program changes. Any information you can provide to help us understand the underlying reason for these changes is greatly appreciated.</p>	<p>AHCCCS will not provide additional information regarding utilization or cost changes.</p>

Question #	Section	Paragraph #	Page #	Question	Response
11.	Data Supp. F	Pending Ranges		Does AHCCCS anticipate applying any Demonstration specific adjustments to the rate ranges? If so, please provide these adjustments and reasoning for said adjustments.	No, AHCCCS will not apply any adjustments to the rate ranges for the Duals Demonstration. The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
12.	Round 1 Questions Amendments	General (several locations)		If a specific adjustment made to capitation rates differs from the actual financial impact of the related program change in a manner that results in losses for the contractor, will the contractor be responsible for these losses that result from this specific divergence, or will there be some limitation on contractor liability? We are concerned that single or multiple program changes that cost the contractor more than the additional revenue obtained from the related capitation rate adjustments could eliminate significant profit margin (or result in losses), even if the resulting overall revenue remains within the defined risk corridor for profit and loss.	No, there will not be a limit on Contractor liability beyond the risk corridor defined in the RFP in Sections D1 and D2, Paragraph 53, Compensation.
13.	Data Supp. I	Risk Factors	1	Can you provide the risk factor ranges (min/max) for the previous 2-3 CYEs?	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
14.	Data Supp. I	Proposed CYE14 and CYE15 Risk Adj.	1	Is AHCCCS considering changing the risk assessment tool that uses ETGs (for example, move to the federal model using Medicaid weights)?	Yes, AHCCCS plans to research risk adjustment tools and is not certain at this time if we will continue using the current tool or will switch to another risk adjustment tool.
15.	Data Supp. I	Proposed CYE14 and CYE15 Risk Adj.	1	Will AHCCCS develop new risk weights for the retrospective risk scores in CYE14? Similarly, will new prospective risk weights be recalibrated for CYE15?	Yes, AHCCCS plans to develop new retrospective risk weights for CYE 14 and new prospective risk weights for CYE 15.
16.	Document J	1	1	Are medical expenses or third party liability removed from the databook text files when a contractor is no longer active in the GSA in which the expenses were reported to be incurred (in a similar manner to Document J)?	Data was only removed from the financial statement reports if a Contractor reported medical expenses or TPL in a GSA in a year when they were no longer contracted in that GSA (e.g. prior period adjustments).  Data Book files cannot include medical expenses in a GSA in a year where a Contractor is no longer contracted due to encounter edits which would reject the encounter.
17.	Document M	1	1	Please provide the necessary information to complete reinsurance amounts.	See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section M, Reinsurance Information. No additional information will be provided regarding reinsurance. The reinsurance offsets will be determined by AHCCCS' actuaries prior to October 1, 2013. This is stated in Section H, Instructions to Offerors.

Question #	Section	Paragraph #	Page #	Question	Response
18.	Document C – Databook Introduction	1	1	Please provide the appropriate completion factors by Category of Service for utilization and cost amounts in the databook, preferably by month, but at a minimum by year. This information is required in order to develop actuarially sound rates.	For information about completion factors used in developing the capitation rates/rate ranges, refer to the Rate Setting Document in Section C of the Data Supplement for Offerors’ – Acute Care/CRS which was posted to the Bidders’ Library on December 14.
19.	Document B	2	1	If the fiscal impact listed for any program change in Document B is not reflective of the population targeted in this RFP, please provide specific details for the population reflected, including membership counts by Category of Aid and GSA, total cost and utilization by GSA, Category of Aid, and Category of Service, and any other information necessary to adjust the impact of each program change.	The Bidders’ Library, Section B of the Data Supplement for Offerors’ – Acute Care/CRS, includes a Program and Fee Schedule Changes document that states on page 1 that the fiscal impacts provided are statewide figures that are not specific to the populations addressed in this RFP. Page 1 also states that Offerors can find additional information in the Actuarial Certifications and that those impacts, too, are not specific to the populations included in the RFP. AHCCCS will not provide the requested information.
20.	Document B	1	10	Will capitation rates be adjusted by AHCCCS for the effect of the expansion of the Breast and Cervical Cancer treatment Program (effective 8/2/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders’ Library, Section B of the Data Supplement for Offerors’ – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.

Question #	Section	Paragraph #	Page #	Question	Response
21.	Document B	2	10	Will capitation rates be adjusted by AHCCCS for the effect of the shift to Ambulatory Surgical centers (effective 10/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.
22.	Document B	4	10	Will capitation rates be adjusted by AHCCCS for the effect of Out of Network QMB Duals (effective 1/5/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.
23.	D1 & D2	62	101 & 86	Has the Corporate Compliance Disclosure of Information changed?	<p>Yes, sections D1 and D2, Paragraph 62, Corporate Compliance and Acute/CRS RFP YH14-0001 Bidders' Library, Solicitation Amendment No. 1 Q&amp;A, Response #28 and #29 have been amended as follows:</p> <ul style="list-style-type: none"> <li>Under the subparagraph titled, Disclosure of Ownership and Control, Contractors will no longer be required to collect ownership and control information for its subcontracted providers. Contractors will still be required to collect such information for all individuals with an ownership or control interest in the Contractor as well as the Contractor's fiscal agents.</li> <li>Under the subparagraph titled, Disclosure of Information on Persons Convicted of Crimes, Contractors will no longer be required to</li> </ul>

Question #	Section	Paragraph #	Page #	Question	Response
					<p>determine the exclusion status of its subcontracted providers or persons associated with its subcontracted providers. Contractors will still be required to determine the exclusion status of persons which have an ownership or control interest or managing employee interest in the Contractor as well as the Contractor's fiscal agents.</p> <ul style="list-style-type: none"> <li>Under the subparagraph titled, Disclosure of Information on Persons Convicted of Crimes, Contractors will no longer be required to query the Social Security Administration DEATH MASTER FILE or the National Plan and Provider Enumeration System (NPPES) databases when determining the exclusion status of persons which have an ownership or control interest or managing employee interest in the Contractor or the Contractor's fiscal agents. Additionally, letter "d" in this paragraph will be changed to read: "The System for Award Management (SAM) formerly known as the Excluded Parties List (EPLS)."</li> </ul> <p>This change will appear in a future version of the contract.</p>

Question #	Section	Paragraph #	Page #	Question	Response
24.	D1 Section 64	6	103	<p>Section 64 states "HIPAA Privacy and Security: The Contractor is required to have a HIPAA security audit performed by an independent third party. The initial audit must be conducted at contract award (prior to the first exchange of AHCCCS data) and annually thereafter, and must include a review of Contractor compliance with all security and privacy requirements."</p> <p>Considering that this provision is being reviewed by AHCCCS under the current contract, are there any additional guidelines pertaining to HIPAA Privacy and Security Audit?</p>	As noted this provision is under review by AHCCCS and further detailed guidance will be provided.
25.	Document I	1	11	Will risk contingency be adjusted for any years other than CYE10?	Risk contingency was adjusted in the CYE 10 risk adjustment methodology to recognize the change to risk contingency that same year. If risk contingency is changed in the future, AHCCCS would anticipate that an adjustment would be necessary.
26.	Document B	2	11	Will capitation rates be adjusted by AHCCCS for the effect of Part D drug changes (effective 1/1/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.

Question #	Section	Paragraph #	Page #	Question	Response
27.	Document B	3	11	Will capitation rates be adjusted by AHCCCS for the effect of Behavioral Health Services provider rate changes (effective 4/1/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
28.	Document B	4	11	Will capitation rates be adjusted by AHCCCS for the effect of Medicare Dual Demonstrations (effective 1/1/2014), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.

Question #	Section	Paragraph #	Page #	Question	Response
29.	Document B	5	11	Will capitation rates be adjusted for the effect of ACA Health Insurer Fee (effective 1/1/2014), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
30.	Document B	6	11	Is the databook data adjusted for the effect of any other programs effective on or after 10/1/2013?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

Question #	Section	Paragraph #	Page #	Question	Response
31.	Data Supp. B		12	We assume all MCOs were expected to modify their provider contracts to match the fee schedule changes outlined on page 12 or absorb the loss. Is this a fair assumption?	Capitation rates were developed assuming that Contractors would modify payment rates, though there was no contractual mandate to lower rates. Contractors that did not reduce rates would have to absorb losses as the capitation rates were reduced.
32.	Document B	1	12	Is the databook data adjusted to account for the fee schedule changes listed in the "Fee Schedule Changes" table?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
33.	Document B	1	12	Please provide a mapping between the service categories listed in the table of fee schedule changes and the Categories of Service in the Databook.	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
34.	Document B	1	12	Please provide total costs and utilization by Category of Aid, GSA, and the service categories listed in the ‘Fee Schedule Changes’ table.	No additional information will be provided.
35.	Document C	1	1-2	Please provide the most current analyses performed by AHCCCS’ actuaries to gauge the completeness of encounter data and to ensure the appropriateness of payment data.	No additional information will be provided.
36.	Acute Care Actuarial Certification CYE13	Appendix I	13	Are the utilization trends in Appendix I appropriate for use in CYE14?	No, the trends used to build the CYE 13 rates will not be the same trends use to build the CYE 14 capitation rate ranges. Refer to the Bidders’ Library, Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Rate Setting Document.
37.	Acute Care Actuarial Certification CYE13	Appendix I	13	If the CYE13 utilization trends in Appendix I are not appropriate for use in CYE14, please quantify the amount of deviation from the CYE13 trends that AHCCCS expects in its CYE14 certification	No additional information will be provided.
38.	Acute Care Actuarial Certification CYE13	Appendix I	13	Are the unit cost trends in Appendix I appropriate for use in CYE14?	No, the trends used to build the CYE 13 rates will not be the same trends use to build the CYE 14 capitation rate ranges. Refer to the Bidders’ Library, Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Rate Setting Document.
39.	Acute Care Actuarial Certification CYE13	Appendix I	13	If the CYE13 unit cost trends in Appendix I are not appropriate for use in CYE14, please quantify the amount of deviation from the CYE13 trends that AHCCCS expects in its CYE14 certification	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
40.	D-2	CRS Performance Measures	148	In the performance measure table on page 148, the language in the third and fourth rows, regarding access to a behavioral health provider (encounter for a visit) has different timeliness standards (7 days vs 23 days) and different MPS (75% vs 90%) and goals (85% vs 95%). Please clarify which standard should be used for this measure.	The Performance Measures are stated correctly in the RFP document. The Performance Measure requirements include two separate behavioral health access to care measures.
41.	DocC_Databook Introduction	9	2	The data book does not have inpatient admit information. Admit information would be very helpful to understand and project the effect of care management on admissions and the October 2014 change in hospital reimbursement from per diems to DRGs. Even though the change is not effective until October 2014, we would like to have admit information to project results from 2013 to 2014, to determine what risks may result from the change. Planning ahead will be helpful for setting our bid. Can AHCCCS please provide admit information for the same time period and rate categories as the data book?	AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offenders' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.

Question #	Section	Paragraph #	Page #	Question	Response
42.	Document C	1	2	Please explain the review processes that AHCCCS performs to ensure timeliness, accuracy and completeness of its encounter data.	<p>Encounter staff review encounter submission patterns, including per member statistics, in addition to validation studies.</p> <p>Actuarial and finance staff analyze expenditures by month, quarter and/or year of service:</p> <ul style="list-style-type: none"> <li>• Across Contractors</li> <li>• Across GSAs</li> <li>• Across risk groups</li> <li>• By form type</li> <li>• Compared to financial statements</li> <li>• In total and PMPM basis</li> </ul>
43.	Document D	All	2	Please define "Pay Code" as listed in the Outpatient Facility service category and any other service categories. Please include any relevant medical coding in this definition (ex. Bill Type) and the coding logic for assigning each pay code.	<p>In this instance, Pay Code indicates an encounter which appears to be an inpatient claim but, using the codes provided, should be classified as an outpatient claim. No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute care/CRS, Section D, Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.</p>

Question #	Section	Paragraph #	Page #	Question	Response
44.	Document D	All	2	Please define "Reimbursement Type" as listed in the Hospital Days service category and any other service categories. Please include any relevant medical coding in this definition (ex. Bill Type).	In this instance, Reimbursement type indicates the inpatient tier to which the claim is associated. No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.
45.	AHCCCS Operations Manual, Section 415- Provider Network and Development Plan-DRAFT-IV. Procedure	5 (page 2) and 1-5 (page 3)	2 and 3	Is our interpretation correct in that the Acute care contractor is responsible for having HCBS providers included in its Medicaid network?	Acute Care Contractors must be able to provide HCBS services as appropriate. Section D1, Paragraph 10, Scope of Services, Nursing Facility, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility.

46.	Prospective Offeror's conference presentation 11/8		22	How will the managed care industry fee in 2014 be considered in reimbursement rate development? Since the tax is not deductible, will the pre tax amount be reimbursed to the plans?	AHCCCS will add the full amount of the Health Insurer Fee to the capitation rates.
47.	CYE2013 Certification	Page 2, Paragraph 4 – Page 3, Paragraph 1	2-3	Please provide Co-ordination of Benefits amounts for each contract year by Category of Aid, Category of Service, and GSA	No additional information will be provided.
48.	SECTION F, Attachment A1	25	236	Item 25 ends with the incomplete sentence, "For service authorization decisions, the". Could the State please clarify whether this is a mistake or the sentence was meant to read into Item 26 on the following page?	This was a typing error, the language from page 236 will continue and the number 26 will be removed. The RFP is amended. Section F, Attachment A1, Enrollee Grievance System Standards will read as follows "...For service authorization decisions, the Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service."
49.	SECTION G	4	278	Section G, Question 4.b states: "License/Certification: Attach a list of all licenses and certification (e.g. Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates."  Question: For purposes of this item, does "organization" refer to Offeror, or to Offeror and its affiliates?	For purposes of Section G, Question 4.b, the term "organization" refers to the Offeror.

50.	SECTION G	4,5 & 6	278-282	<p>This is a follow-up to State's response to Round 1 Question: "When completing SECTION G, can responses requiring narrative (for example 4.c - Accessibility Assurance) be attached as a separate document if it is longer than the space provided on the form?"</p> <p>State's Response from Amendment 1: "The form boxes expand to include the narrative response as it is typed. No additional pages are necessary."</p> <p>Follow-up question: When inserting text into the current, locked word document provided for Section G, the full paragraph can be seen only by selecting text and dragging mouse down, however the text box itself will not expand. When the document is PDFd or printed, the response cuts off. Can the State release a revised word document that allows the text boxes to expand to show all text?</p>	<p>The RFP is Amended for the following areas: Section G Representations and Certifications of Offeror and Amendment 1, Question #39. If Offerors require additional space to answer a question, a separate Word document may be submitted with the response in its entirety. The document must clearly identify which section the response is for. Example, Section G, Offeror Representations and Certifications, #4b License/Certification.</p>
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51.	SECTION G	5	280	<p>Section G, Question 5.c defines "Managing Employee" as "A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency."</p> <p>Question: For purposes of this RFP, may we understand one "who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency" to mean (i) any of the key staff positions listed in Section D, paragraph 16, together with (ii) any individuals to whom those key staff positions report either directly or indirectly?</p>	<p>The definition of "managing employee" in Section G, Question 5.c is a federal definition, codified at 42 C.F.R. §455.101. An Offeror should consult with its attorneys and/or other professionals if the Offeror needs additional guidance in interpreting this definition.</p>
52.	SECTION G	5	280	<p>Section G, Question 5.e states: "Long-Term Business Transactions: List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end."</p> <p>Question: Is this section intended to include the phrase "wholly-owned" before the word "subcontractor"? If not, does "subcontractor" in this instance include health care provider contracts?</p>	<p>No. The phrase "wholly-owned in Section G, Question 5.e was not intended to be placed before the word "subcontractor". For purposes of Section G, Question 5.e the word "subcontractor" does not include health care provider contracts.</p>
53.	SECTION G	6	281	<p>Question 6, subsection (a) states:                  a. Board of Directors: List the Names, SSN, DOB, and Addresses of the Board of Directors of the Offeror</p> <p>Question: We understand the State's need for</p>	<p>No. The AHCCCS Administration will receive and secure this data as we do with all other confidential and sensitive information.</p>

				<p>this information, however given the environment related to identity theft, would the State agree to reimburse Plan for the cost of all liabilities that may be incurred by these individuals as a result of disclosing this information?</p>	
54.	RFP H	9	291	<p>Please verify that Offerors should not provide separate bid rates for Pima and Santa Cruz.</p>	<p>The Offeror should not provide separate bid rates for Pima and Santa Cruz counties. The Offeror should bid assuming they will win both Pima and Santa Cruz. If the Offeror wins Pima only, those rates will be adjusted after award.</p>
55.	H	15	296	<p>Is a footnote citation required to be outside of the ½ inch margin or may it be included within the ½ inch margin?</p>	<p>Yes, the footnote citation is required to be outside of the ½ inch margin.</p>
56.	AHCCCS Operations Manual, Section 415-Provider Network and Development Plan-DRAFT-IV. Procedure	13-16	3	<p>Our question relates to iii. Is it AHCCCS' expectation that an acute care contractor have Assisted Living Facilities, alternative residential settings, or home and community based services (minimum one per listed GSA) as required by contract, providers in its network?</p>	<p>Acute Care Contractors must be able to provide HCBS services as appropriate. Section D1, Paragraph 10, Scope of Services, Nursing Facility, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility.</p>

57.	Data Supp. F		3	<p>According to the bid template instructions, “when the Offeror chooses the Delivery Supp risk group...then only the service categories relevant to the delivery supplemental payment will appear...” A number of the hidden service categories contain data in the data book. For example, the Delivery Supp. risk group does show experience for transportation and Rx encounters. By hiding the transportation and Rx service categories in the bid template tool, is AHCCCS implying that these costs are not part of the delivery supp. and thus should be excluded (and possibly include them in cap rates)? Or, does AHCCCS intend for bidders to put these types of costs in the Misc. category?</p>	<p>Refer to the Bidders’ Library, Data Supplement for Offerors’ – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, Crosswalk Acute Care Service Matrix to Capitation Bid Template posted on December 14.</p>
58.	Document B	1	3	<p>Is the databook data adjusted for the discontinuation of dental sealant coverage (effective 5/1/2009)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: “The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the “Health Plan Paid Amount” is zero, the lesser of the “AHCCCS Allowed Amount” or “Billed Amount” is used in place of the zero. For BH encounters, the “Health Plan Paid Amount” is used if available. If there is no “Health Plan Paid Amount” then the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is</p>

59.	Document B	1	3	<p>Do the PMPM impact amounts in Attachment A for discontinuation of dental sealant coverage represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by \$1200 over the contract year. Would the table show a \$1 PMPM impact to account for the cost impact over the entire contract year, or a \$2.40 PMPM impact (\$1200/(100 members*5 months of program in effect)) to account for the costs after the program has gone into effect.</p>	<p>used to populate the cost field.”</p> <p>The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be \$1.00 PMPM.</p>
60.	Document B	2	3	<p>Is the databook data adjusted for DDD State only Transfers (effective 5/1/2009).</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: “The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the “Health Plan Paid Amount” is zero, the lesser of the “AHCCCS Allowed Amount” or “Billed Amount” is used in place of the zero. For BH encounters, the “Health Plan Paid Amount” is used if available. If there is no “Health Plan Paid Amount” then the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is</p>

61.	Document B	2	3	<p>Do the PMPM impact amounts in Attachment A for DDD State Only Transfers represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by \$1200 over the contract year. Would the table show a \$1 PMPM impact to account for the cost impact over the entire contract year, or a \$2.40 PMPM impact (\$1200/(100 members*5 months of program in effect)) to account for the costs after the program has gone into effect.</p>	used to populate the cost field.”
				<p>The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be \$1.00 PMPM.</p>	

62.	Document B	3	3	Is the databook data adjusted for changes related to High Needs Children (effective 7/1/2009)?	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
63.	Document B	3	3	Do the PMPM impact amounts for High Needs Children in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by \$1200 over the contract year. Would the table show a \$1 PMPM impact to account for the cost impact over the entire contract year, or a \$4.00 PMPM impact (\$1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	<p>The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be \$1.00 PMPM.</p>
64.	RFP H	16	302	When checking the administrative component	When the Offeror clicks the Save Bid button on

	And Data Supp. F			<p>(to determine if it is less than the 8% max) will AHCCCS use the rounded values produced by the Summ_Bids tab (in the bid template) or will AHCCCS use unrounded values entered into the Input tab? If rounded, please provide the rounding formula used in the bid template.</p> <p>Lastly, assume a bidder applies 8% admin to unrounded values. Furthermore, assume AHCCCS uses rounded values and calculates a bidder's admin component at 8.001% then will said bidder receive 0 points in this case?</p>	<p>the Input tab in the bid template, a warning box is produced if the value entered for admin exceeds 8% of the gross medical component. This box uses PMPM values rounded to four decimal places for admin and gross medical, but it is strictly informational. The scoring process will use the gross medical and admin component PMPM figures as shown on the Summ_Bids tab, and therefore found in the hard copy format, which are rounded to two decimal places. For scoring purposes, the ratio used to calculate if an Offeror's admin exceeds 8% of gross medical will not be rounded. The ratio will be calculated as: (admin PMPM rounded to two decimal places) / (gross medical PMPM rounded to two decimal places). If this ratio exceeds 8% the Offeror will score zero for that admin bid. For example, if an Offeror's admin component bid is \$8.01 and the medical component bid is \$100.00, the admin ratio would be <math>\\$8.01 / \\$100.00 = 8.01\%</math> which is greater than 8%; thus this bid would be scored zero.</p>
65.	Section H	E-Narrative Submissions	306 (question 3)	<p>It is our understanding that AHCCCS is going to move to HEDIS criteria for the performance measures. Since the current reporting period is the contract year (Oct. 1 through Sept. 30) and HEDIS is Jan. 1 through Dec. 31, how does AHCCCS plan to make this change?</p>	<p>AHCCCS does not intend to transition from contract year to calendar year for Performance Measure purposes. Please also note that Measure methodology owners vary within the CMS measure sets being implemented. Only a portion of the measures are NCQA HEDIS measures.</p>
66.	Section H	E-Narrative Submissions	306-307	<p>In question 4, the scenario refers to the individual in question as a member of the Offeror's health plan. In question 5, the scenario refers to the individual as an "AHCCCS member." For the purposes of responding to the scenario, since a member is required to be a member of an AHCCCS-contracted health plan, should Offerors</p>	<p>Yes, the Offeror should assume the individual is currently a member of the Offeror's health plan.</p>

67.	Section H	E-Narrative Submissions	307	<p>assume that individual in question is in fact a member of the Offeror's health plan?</p> <p>What is the State's definition of waste relative to this question?</p>	<p>“Waste” includes but is not limited to: fraud, excess administration, costs associated with failure to implement effective methods for prevention of disease, disability, or adverse health condition, and services provided to individuals which are either not medically necessary, not cost effective, or both.</p>
68.	H (IT Demo)		308	<p>Page 92 of Prospective Offerors' Technical Interface Meeting presentation: All Offerors will receive the same “mock” data files and scenarios</p> <p>Question: How do we get the scenarios, are they implied in the inbound 837 file per say, or do they provide an English description of the various scenarios in separate Microsoft excel/word document?</p>	<p>AHCCCS will provide the Offeror with a paper claim form or an electronic 837 claim record.</p>

69.	H (IT Demo)		308	<p>Page 93 of Prospective Offerors' Technical Interface Meeting presentation: Encounter submissions will be based upon claims adjudicated by the Offeror as part of the claims scenarios exercises                  Question: Assuming this means submissions from Offerer to AHCCCS?</p>	<p>Correct, AHCCCS will expect encounter submissions based upon approved/paid claims scenarios.</p>
70.	H (IT Demo)		308	<p>Page 93 of Prospective Offerors' Technical Interface Meeting presentation: First and second eligibility and claims status inquires will not exceed 5 records per iteration.                  Question: Assuming this means the HIPAA transaction inbound and outbound data files?</p>	<p>It is not AHCCCS intent that Offerors develop a process to exchange 270/271 or 276/277 transactions with AHCCCS. Offerors may exchange this data utilizing an automated system or a manual process.                   Additionally, note that AHCCCS will not, as a component of the demonstration, be asking for eligibility or claims status inquiries on more than 5 members or claims.</p>
71.	Section H	E-Narrative Submissions	308	<p>With respect to the IT Demonstration, will CRS eligibility and benefits data be part of the 834 file the Offeror will receive from AHCCCS?</p>	<p>No, CRS scenarios will not be included for purposes of this demonstration.</p>
72.	Section H	E-Narrative Submission	308	<p>Will we be expected to provide a paper provider remittance advice as part of the IT Demonstration?</p>	<p>No remittance advice will be required for purposes of this demonstration.</p>
73.	Section H	E-Narrative Submissions	308	<p>Can you confirm from an encounters perspective, will an 837 file be required or will the response be in the form of a summary template as all others?</p>	<p>AHCCCS will supply the Offeror with an 837 Template for purposes of encounter submission and will require that the Offeror submit the completed 837 Template and Summary of Encounters Processing. Refer to the revised Information Technology (IT) Systems Demonstration Calendar for additional information posted December 19.</p>

74.	Section H	E-Narrative Submissions	308	Will the encounter initial cycle results be provided in a 277 format or in a spreadsheet? Will corrected encounters from initial cycle be permissible or expected in the second encounter cycle submission?	The cycle results were incorrectly included in the Final 10/29 version of the Information Technology (IT) Systems Demonstration Calendar. The revised IT Systems Demonstration Calendar posted on 11/27 and revised again on 12/19 is correct and supersedes the 10/29 version.
75.	Section H	E-Narrative Submissions	308	For reference data extracts will this include a sample of reference files or a complete set of reference files, such as transition of care, COB, provider and fee schedule?	The reference data extract will include the full set of Reference and Provider data exchanges as outlined in the AHCCCS Encounter Manual.
76.	Section H	E-Narrative Submissions	308	If Encounter Submissions Response Files are required in an 837 format, are new TSNs required for system demonstrations?	No, new TSN's will not be required for purposes of this Demonstration.
77.	Section H	E-Narrative Submission	308	What is the earliest date/time that all the Offeror's will be able to view the Process Summary Templates for the each transaction	This information is included in the Information Technology (IT) Systems Demonstration Calendar.
78.	Section H	E-Narrative Submission	308	Will the summary of the initial 820 be inclusive of the first two daily 834 files only?	Yes, the information in the initial 820 will be inclusive of the enrollment information in the 834 files.
79.	SECTION H	E (Oral Presentation)	309	During the Oral Presentations, will AHCCCS pose "solutions to health care situations and operational challenges" for Acute Care, CRS populations or a combination of both groups?	AHCCCS is not providing assistance or clarification related to the submission requirements or the oral presentations.
80.	Document B	All	3-26	Please provide the impact to utilization and charge for each fee schedule and program change adjustment based on actual historical data.	No additional information will be provided.

81.	D1	10	38	<p>It is our understanding that AHCCCS will assume responsibility for determining CRS eligibility. Please verify this will be effective as of 10/1/2013.</p>	<p>AHCCCS will assume CRS eligibility determination processes as of 10/1/2013.</p>
82.	Arizona Medical Policy Manual, 520 Member Transitions	4 and 5	4	<p>In section D.1 it discusses transition from an ALTCS to an acute care contractor. The paragraphs referenced imply that an acute care contractor does not have to cover attendant care or home delivered meals as a part of its network or benefits? Our understanding was that an acute care contractor has to provide for necessary HCBS as a part of its network. Does an acute care contractor have to have attendant care, meals on wheels and other types of LTSS in its network? Please clarify this.</p>	<p>Acute Care Contractors must be able to provide HCBS services as appropriate, including those specifically identified (e.g. attendant care, home delivered meals). Section D1, Paragraph 10, Scope of Services, Nursing Facility, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility. .</p>
83.	AHCCCS Operations Manual, Section 415- Provider Network and Development Plan-DRAFT-IV. Procedure	7	4	<p>Please clarify the following: After number 15, there is a bold statement-“(For ALTCS EPD and DDD Contractors Only)” prior to number 16. Does this statement only apply to Number 16 or does it apply to items 16 through 23 which seem to apply to ALTCS contractors.</p>	<p>Yes, items 16 through 23 apply only to ALTCS Contractors.</p>

84.	Document B	1	4	<p>Is the databook data adjusted for changes related to Transition Age Youth (effective 7/1/2009).</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' - Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
85.	Document B	1	4	<p>Do the PMPM impact amounts in Attachment A for transition Age Youth represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by \$1200 over the contract year. Would the table show a \$1 PMPM impact to account for the cost impact over the entire contract year, or a \$4.00 PMPM impact (\$1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.</p>	<p>The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be \$1.00 PMPM.</p>

86.	Document B	2	4	Please provide a breakout of the \$2.5 million increase (CYE09 to CYE10) and \$2.5 million decrease (CYE10 to CYE11) caused by H1N1 Influenza by category of service, category of aid and GSA.	No additional information will be provided.
87.	Document B	3	4	Is the databook data adjusted for changes related to outlier hospital reimbursement rates (effective 10/1/2009)? Please provide the adjustment?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
88.	Document B	3	4	Which contract year of capitation rates was originally updated with the impact of changes for outlier hospital reimbursement rates?	CYE 08, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes.
89.	Document B	3	4	Please define "extraordinary operating costs per day"	Outliers are claims with extraordinarily high costs per day that exceed thresholds established by AHCCCS

90.	Document B	4	4	Is the databook data adjusted for changes related to dental service changes (effective 10/1/2009)?	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
91.	Document B	4	4	Which contract year of capitation rates was originally updated with the impact of changes for dental service changes?	<p>CYE 10, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 10.</p>

92.	Document B	5	4	Is the databook data adjusted for medical management changes (effective 10/1/2009)?	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
93.	Document B	5	4	Which contract year of capitation rates was originally updated with the impact of medical management changes?	<p>CYE 10, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 10.</p>
94.	CYE13 Acute Care Actuarial Certification	Section IV	4	Please provide a list of experience adjustments made to capitation rates for the CYE13 contract year.	<p>No additional information will be provided.</p>

95.	Document I	1	5	How frequently will risk weights be recalibrated? Please describe the recalibration process.	<p>AHCCCS plans to develop new retrospective risk weights for CYE 14 and also new prospective risk weights for CYE 15. See Bidders' Library, Data Supplement for Offerors' - Acute Care/CRS, Section I, Risk Adjustment Information, CYE 09 Risk Adjustment Whitepaper for a brief description on the recalibration process.</p>
96.	Document B	1	5	Is the databook data adjusted for changes in ADHS regulated transportation rates (effective 10/1/2009)?	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' - Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>

97.	Document B	3	5	<p>Is the databook data adjusted for the KidsCare Freeze (effective 10/1/2010)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' - Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
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98.	Document B	4	5	<p>Is the databook data adjusted for changes regulations related to the HPV Vaccine (effective 7/1/2010)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' - Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
99.	Document B	4	5	<p>Do the PMPM impact amounts for HPV Vaccine administration in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by \$1200 over the contract year. Would the table show a \$1 PMPM impact to account for the cost impact over the entire contract year, or a \$4.00 PMPM impact (\$1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.</p>	<p>The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be \$1.00 PMPM.</p>

100.	Document B	4	5	Is the databook data adjusted for the benefit redesign change (effective 10/1/2010)?	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
101.	Document B	4	5	Which contract year of capitation rates was originally updated with the impact of the benefit redesign change?	<p>CYE 11, as stated in Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.</p>
102.	D1	16	51	Will the State consider the CRS awarded Contractor's contract for both CRS and Acute services as one line of business for the purposes of Key Staff?	<p>The CRS contract for both CRS specialty and acute services (and behavioral health services) is considered one line of business for purposes of Key Staff.</p>

103.	Prospective Offeror's conference presentation 11/8		52	<p>What does "current rate setting methods" mean? If a dual eligible demonstration is approved, what savings rate will the state assume – either 1, 3, or 5% versus fee for service as preliminarily proposed by CMS?</p>	<p>For the Medicaid portion of the Dual Demonstration rate AHCCCS is proposing to use the same capitation rate setting methodology used for the Acute population. This methodology is subject to CMS approval. See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Rate Setting Document for more information regarding the Acute rate setting methodology.</p> <p>AHCCCS and CMS have not finalized the savings target percentages.</p>
104.	D1 & D2	18	55-56 (D1) 141-142 (D2)	<p>Is the CRS Contractor permitted to develop one set of member materials for Acute and CRS that highlight differences in procedures and network (similar to DDD information); or must the CRS members receive a separate set of CRS specific materials?</p>	<p>The CRS contract and the Acute Care contract are separate lines of business. Each line of business requires unique member materials.</p>
105.	D1 & D2	21	57-58 (D1) 143 (D2)	<p>For the purposes of care coordination, records may be shared with care team members. Will there be a definition of care team and what are the requirements for member/guardian acknowledgement/authorization?</p>	<p>Care teams are unique to the needs of each individual member. Participants in a care team for a member with cleft lip would be different than those needed in a care team for a member diagnosed with cystic fibrosis. AHCCCS is not anticipating establishing specific requirements for the composition of the care team at this time. The CRS Program is designed to include the member and the member's parent/guardian as part of the team with the ability to participate in the health care decision making process.</p>

106.	CYE12 Cert Letter		6	<p>The cert letter indicates a savings of \$28.2 million for hospital outliers. What is the basis year for this savings estimate? In addition, please provide the detailed adjustments applied to the CYE12 rates to account for this change.</p>	<p>This savings was estimated by using CYE 09 (10/01/08 - 09/30/09) outlier encounter data and CYE 09 member months. A PMPM was calculated and trended forward to estimate the savings. The CYE 12 actuarial certification explains that capitation rates would have increased by approximately \$28.2 million if AHCCCS had not made this change to outlier. AHCCCS did not apply an adjustment factor to the CYE 12 rates for this change, but assumed the future outlier trend would stay at the CYE 11 levels rather than growing as it had in the past.</p>
107.	Document B	1	6	<p>Is the databook data adjusted for changes in copay amounts (effective 10/1/2010)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>

108.	Document B	2	6	<p>Is the databook data adjusted for the shift to Ambulatory Surgery Centers (effective 10/1/2010)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
109.	Document B	2	6	<p>Which contract year of capitation rates was originally updated with the impact of the shift to Ambulatory Surgery Centers?</p>	<p>CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.</p>

110.	Document B	3	6	Is the databook data adjusted for the change in first 72 hours coverage (effective 10/1/2010)?	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
111.	Document B	3	6	Which contract year of capitation rates was originally updated with the impact of the change in first 72 hours coverage?	<p>CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.</p>

112.	Document B	4	6	<p>Is the databook data adjusted for the change in Behavioral Health Services prior period coverage (effective 10/1/2010)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
113.	Document B	4	6	<p>Which contract year of capitation rates was originally updated with the impact of the change in Behavioral Health Services prior period coverage?</p>	<p>CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.</p>

114.	Document B	5	6	<p>Is the databook data adjusted for the change in Cochlear Implants coverage (effective 10/1/2010)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
115.	Document B	5	6	<p>Which contract year of capitation rates was originally updated with the impact of the change in Cochlear Implants coverage?</p>	<p>CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the CRS Actuarial Certification for CYE 11.</p>

116.	Document B	6	6	Does the databook contain data for MED program enrollees prior to the elimination of the program (effective 10/1/2011)?	<p>No, data for MED members is not contained in the Data Book files. This information is stated in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Layout/File Description:</p> <p>“All Data Book Files exclude utilization, cost and member information for those populations that will no longer be covered by Acute Care Contractors, and by the CRS Contractor, as of October 1, 2013. For additional information on the excluded populations please refer below to “Data Book Files Exclusions” section.”</p> <p>“Data Book Files Exclusions Acute Care Bid All Data Book Files and member information exclude the following populations.... Those members in the HIFA or MED risk groups which are no longer covered.”</p>
117.	Document B	6	6	If the databook does contain data for MED program enrollees, please provide the volume of utilization and cost data by Category of Service, Category of Aid, and GSA associated with the MED program.	<p>Data for MED members is not contained in the Data Book files.</p>

118.	Document B	7	6	<p>Is the databook data adjusted for the transition of pediatric costs (effective 6/1/2011)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' - Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
119.	Document B	7	6	<p>Which contract year of capitation rates was originally updated for the transition of pediatric costs?</p>	<p>CYE 12, as stated in both the Acute Care Actuarial Certification for CYE 12 and the CRS Actuarial Certification for CYE 12.</p>

120.	Document B	7	6	<p>Do the PMPM impact amounts for transition of pediatric costs in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by \$1200 over the contract year. Would the table show a \$1 PMPM impact to account for the cost impact over the entire contract year, or a \$3.00 PMPM impact (\$1200/(100 members*4 months of program in effect)) to account for the costs after the program has gone into effect.</p>	<p>The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be \$1.00 PMPM.</p>
121.	D1	23	60	<p>Credential Verification Organization Contract:                  Is AHCCCS able to provide information regarding the Alliance? We are having difficulty in learning about the Alliance and its costs and because using it will entail cancelling other contracts potentially and additional work in switching to the Alliance any assistance on pricing, structure etc would be helpful.</p>	<p>AHCCCS does not have a copy of the AzAHP Credentialing Alliance contract nor the terms of the contract. Information may be available through the Executive Director of the Arizona Association of Health Plans, Deb Gullett, Gallagher &amp; Kennedy P.A. Law Offices, Senior Government Relations Specialist, deb.gullett@gknet.com.</p>
122.	D	23	60	<p>“The CVO is also responsible for conducting annual delegated entity site visits to ensure compliance with AHCCCS requirements.”                  Our understanding is that the AzAHP credentialing alliance does not include providers that plans have delegated credentialing to – but the above sentence refers to ‘annual delegated entity site visits’. Can you please clarify?</p>	<p>The RFP has been amended and the word “delegated” has been removed. The CVO is required to conduct annual entity site visits. The sentence now reads, “The CVO is also responsible for conducting annual entity site visits to ensure compliance with AHCCCS requirements.”                  This change will appear in a future version of the contract.</p>

123.	D	23	60	<p>“The AHCCCS Contractor must utilize the contracted CVO as part of its credentialing and recredentialing process regardless of membership in the AzAHP.”</p> <p>Does this mean that the Contractor must participate in the AzAHP credentialing alliance or simply utilize the same CVO that AzAHP uses for its credentialing alliance?</p>	<p>Contractors shall be required to participate in the AzAHP credentialing alliance.</p>
124.	D1 & D2	23	60 (D1) 146 (D2)	<p>The CVO is a delegated entity that will oversee the credentialing process for Acute Care contractors. Please verify that each contractor will not be required to evaluate the CVO in accordance with AHCCCS guidelines for delegated entities.</p>	<p>The AzAHP Credentialing Alliance has contracted with a Credential Verification Organization (CVO) to conduct primary source verification and site visit requirements related to the required credentialing processes. Contractors are required to use the information provided by the CVO and complete the credentialing process which includes a review of quality, utilization, performance data, etc. As is required for all delegated functions, Contractors are required to validate that the delegated entity is meeting the AHCCCS requirements. AHCCCS anticipates that the AzAHP will establish a collaborative process to meet this requirement.</p>
125.	D1 & D2	23	63-64 (D1) 148-149 (D2)	<p>Please clarify if AHCCCS will determine separate performance measures for CRS and Acute Care members. It is our understanding that CRS and Acute Care membership will be segregated for the purpose of determining responsiveness to the performance measures. Is this correct?</p>	<p>AHCCCS has established a separate performance measures set for each line of business. The CRS and the Acute Care programs are separate lines of business. Performance Measures for each of these lines of business contain measures specific to the population served. The results for each population will be calculated independently.</p>

126.	D1	27	68	<p>Regarding paragraph 27 "In accordance with the requirements specified in the ACOM Draft Policy, Acute Network Standards the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing Pima and Maricopa counties do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC). The Contractor must obtain hospital contracts as specified in ACOM Draft Policy, Acute Network Standards." Please validate that Offerors are not required to submit GeoAccess reports with the proposal to document that network responsibility and availability criteria have been met. Also, please validate that Offerors will not be required to submit a listing of their contracted network of providers with the proposal.</p>	<p>Offerors are not required to submit GeoAccess reports or a listing of their contracted network of providers with their offer. Adherence to network sufficiency standards will be assessed during the readiness review process.</p>
127.	Data Supp. B		7	<p>Please provide the methodology used to develop the estimated percentage impact for the Childless Adult Freeze change. In particular, what assumptions were used to convert an enrollment freeze into a PMPM impact?</p>	<p>As stated in the Bidders Library, Data Supplement, Section B, Program and Fee Schedule Changes, as part of the freeze, the elderly and individuals meeting the federal definition of disability (including SMI members) were transitioned to either the SSI with or without Medicare risk groups. In order to account for this movement, AHCCCS analyzed historical encounter and member data for those individuals who were transitioning to SSI with or without Medicare. The data for those members was moved to the appropriate groups to calculate the percentage impact by comparing the PMPM before the move to the PMPM after the move.</p>

128.	Document B	1	7	<p>Is the databook data adjusted for changes to the Best for Babies program (effective 7/1/2011)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
129.	Document B	1	7	<p>Which contract year of capitation rates was originally updated for changes in the Best for Babies Program?</p>	<p>While this behavioral health program was effective July 2011, the capitation rates were not adjusted until July 2012, thus impacting the CP (contract period) 13 capitation rates. Refer to the Behavioral Health Actuarial Certification for CYE 13 found in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section K, Capitation Rates.</p>
130.	Document B	1	7	<p>Do the PMPM impact amounts for changes in the Best for Babies Program in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100</p>	<p>The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be \$1.00 PMPM.</p>

				<p>members and costs will increase by \$1200 over the contract year. Would the table show a \$1 PMPM impact to account for the cost impact over the entire contract year, or a \$4.00 PMPM impact (\$1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.</p>	
131.	Document B	1	7	<p>Please define the "CMDP Child Population" and provide enrollment counts for historical contract years.</p>	<p>Children Enrolled in the Comprehensive Medical and Dental Program (CMDP).</p>
132.	Document B	1	7	<p>Please provide a list of members involved in the "Best for Babies" program in the same format as any detailed claims, encounter, or membership data provided.</p>	<p>No additional information will be provided.</p>

133.	Document B	1	7	Please provide a detailed list of services provided within the "Best for Babies" Program.	<p>The same services are available for all populations; however, the timeline is more structured for children in CPS custody and enrolled in CMDP. The difference for children in CPS custody and enrolled in CMDP is that timelines for certain services, primarily behavioral health (BH) are written into the CPS protocols. For example, children taken into custody must have a BH assessment within 72 hours. A follow-up full BH assessment must be completed within 30 days and services initiated based on those assessments. The CRS Contractor will need to meet those requirements. All other physical health needs should be consistent with other AHCCCS populations. Best For Babies does also have the tendency to have active judicial involvement. Judges overseeing the custody cases often order and expect care to be delivered in a specific manner, frequency and volume. The CRS Contractor would be responsible for considering the judge's order, but must only approve services that are medically necessary (not necessarily because it was ordered by the judge). Those care/services ordered by the judge that are not determined to be medically necessary would become the responsibility of the State (CPS).</p>
134.	Document B	1	7	Is the databook data adjusted for changes to the Best for Babies program (effective 7/1/2011)?	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-</p>

135.	Document B	1	7	Which contract year of capitation rates was originally updated for changes in the Best for Babies Program?	<p>capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p> <p>Duplicate question: #159</p>
136.	Document B	2	7	Is the databook data adjusted for the AHCCCS Care freeze (effective 10/1/2011)?	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is</p>

137.	Document B	3	7	Is the databook data adjusted for the effect of the inpatient day limit (effective 10/1/2011)?	used to populate the cost field.”
<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: “The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the “Health Plan Paid Amount” is zero, the lesser of the “AHCCCS Allowed Amount” or “Billed Amount” is used in place of the zero. For BH encounters, the “Health Plan Paid Amount” is used if available. If there is no “Health Plan Paid Amount” then the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is used to populate the cost field.”</p>					

138.	Document B	1	8	<p>Is the databook data adjusted for the effect of changes related to hospital outliers (effective 10/1/2011)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
139.	Document B	1	8	<p>Please provide hospital outlier cost thresholds before and after the changes effective 10/1/2011</p>	<p>Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section N, Hospital Rate Overview, Outlier Cost Thresholds posted December 18.</p>

140.	Document B	2	8	<p>Is the databook data adjusted for the effect of changes related to transportation services (effective 10/1/2011)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p>
141.	Document B	4	8	<p>Is the databook data adjusted for the effect of new drug approvals for Hepatitis C (effective 10/1/2011)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used</p>

142.	D1 & D2	51	86 (D1) 172 (D2)	<p>Section D1 and D2, Paragraph 51 of the RFP originally stated: "Within 120 days contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." The State has agreed to revise to state: "Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." Would the State consider further revising the end of this sentence so that it reads: "Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract or other contracts with or approved by AHCCCS"?</p>	<p>in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p> <p>No, the amended language stands. No further revisions will be made.</p>
143.	D-1-acute	53	88	<p>Is the 4.5% profit cap on a pretax or after tax basis?</p>	<p>Income tax is not considered in reconciliations. Please refer to ACOM draft Policy 311 - Acute Program Tiered Prospective Reconciliation in the Bidders' Library for a detailed explanation of the reconciliation calculation, as well as the example provided.</p>

144.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will AHCCCS provide the Contractor with detailed information to determine if the adjusted rates or rate range offered meet the requirements of the Social Security Act § 1903(m)(2)(A); 42 CFR §438.6(c)(1)(i)(2009); Pub. L. No 111-3, 123 Stat.8, 103; and the American Academy of Actuaries practice note on guidance for certifying Medicaid managed care rates?	With the exception of hospital admits and length of stay data, all information regarding capitation rates/ranges has been posted to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.
145.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will AHCCCS fully disclose its actuarial assumptions, including justification for why these assumptions were not included in the RFP capitation rate ranges published?	With the exception of hospital admits and length of stay data, all information regarding capitation rates/ranges has been posted to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.

146.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will amendments, clarifications or program changes expressly require the consent of the Plan (at least if they have a material, adverse effect on compensation or scope of work)?	The Contractor has the choice to sign or not sign contract amendments that include clarifications or program changes within a specified time period. No other express consent will be granted.
147.	Data Supp. B		9	KidsCare II program change – it appears as if the CYE13 rates were not adjusted for the KidsCare II program expansion. Please verify this is correct. Also, please provide cost and utilization relativities for those enrolled under the expansion (compared to those already in the program).	For CYE 13 rates, AHCCCS analysis indicated that the impact of additional KidsCare II members would not materially impact the rates. No additional information will be provided.

148.	Document B	1	9	<p>Is the databook data adjusted for the effect of changes to claims processing standards (effective 1/1/2012)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: “The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the “Health Plan Paid Amount” is zero, the lesser of the “AHCCCS Allowed Amount” or “Billed Amount” is used in place of the zero. For BH encounters, the “Health Plan Paid Amount” is used if available. If there is no “Health Plan Paid Amount” then the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is used to populate the cost field.”</p>
149.	Document B	2	9	<p>Is the databook data adjusted for the effect of increased reimbursements for family planning devices (effective 2/1/2012)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: “The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the “Health Plan Paid Amount” is zero, the lesser of the “AHCCCS Allowed Amount” or “Billed Amount” is used</p>

150.	Document B	3	9	Is the databook data adjusted for the effect of changes in taxi copays (effective 2/1/2012)?	<p>in place of the zero. For BH encounters, the “Health Plan Paid Amount” is used if available. If there is no “Health Plan Paid Amount” then the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is used to populate the cost field.”</p>
					<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: “The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the “Health Plan Paid Amount” is zero, the lesser of the “AHCCCS Allowed Amount” or “Billed Amount” is used in place of the zero. For BH encounters, the “Health Plan Paid Amount” is used if available. If there is no “Health Plan Paid Amount” then the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is used to populate the cost field.”</p>

151.	Document B	4	9	<p>Is the databook data adjusted for the effect of changes to 340B pharmacy pricing (effective 4/1/2012)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: “The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the “Health Plan Paid Amount” is zero, the lesser of the “AHCCCS Allowed Amount” or “Billed Amount” is used in place of the zero. For BH encounters, the “Health Plan Paid Amount” is used if available. If there is no “Health Plan Paid Amount” then the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is used to populate the cost field.”</p>
152.	Document B	5	9	<p>Is the databook data adjusted for the effect of changing responsibility for psychiatric consultations (effective 7/1/2012)?</p>	<p>No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors’ – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: “The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the “Health Plan Paid Amount” is zero, the lesser of the “AHCCCS Allowed Amount” or “Billed Amount” is used</p>

153.	Document B	5	9	<p>Will capitation rates be adjusted by AHCCCS for the effect of changing responsibility for Emergency Room transportation (effective 7/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?</p>	<p>in place of the zero. For BH encounters, the “Health Plan Paid Amount” is used if available. If there is no “Health Plan Paid Amount” then the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is used to populate the cost field.”</p>
154.	Document B	5	9	<p>Will capitation rates be adjusted by AHCCCS for the effect of the KidsCare II expansion (effective 5/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?</p>	<p>The Bidders’ Library, Section B of the Data Supplement for Offerors’ – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.</p>
					<p>The Bidders’ Library, Section B of the Data Supplement for Offerors’ – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid. Please note that, for CYE 13 rates, AHCCCS analysis indicated that the impact of additional KidsCare II members would not materially impact the rates.</p>

155.	Document D/Document E-3 – Provider Types	All	All	<p>Please provide coding criteria for grouping services by provider type. For example, the Physical Therapy section in Document D includes the selection criteria “Select all HCPCS that meet Provider Type requirements”. A list of the HCPCS codes referenced and the logic used to assign provider type would assist in our analysis of the data.</p>	<p>No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders’ Library, Data Supplement for Offerors’ – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.</p>
156.	IT SYSTEM DEMONS-TRATION CALENDAR	DATA FROM AHCCCS	Calendar	<p>The IT Systems Demonstration Calendar Final 10/29 included the 277U – Encounter Adjudication; Pend and Encounter Cycle Results’ Initial Cycle Results on Monday, February 4<sup>th</sup> and Second Cycle Results on Friday, February 8<sup>th</sup>. However the encounter cycle results for both the initial and second cycles were excluded from the Information Technology Systems Demonstration Calendar Final 11/27. Was the exclusion from the 11/27 Calendar deliberate? Adjudication/pend files and reports from each encounter cycle automatically provides feedback to Offerors. In addition, the pend correction files allow us to revise encounter submissions for a second cycle.</p>	<p>The revised Information Technology (IT) Systems Demonstration Calendar posted on 11/27 (and revised again on 12/19) is correct and supersedes the 10/29 version.</p>

157.	Document J	General	General	Does the data in Document J include claims for all services to be covered in the contract year?	Section J of the Data Supplement contains Contractors' unaudited financial statement data. This data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted. See the Introduction for Section J for more information about these reports. For questions regarding the data contained in Contractors' self-reported statements, see the Financial Reporting Guide for Acute Health Care Contractors in the Bidders' Library, Current Reporting Guides and Manuals.
158.	Document C	General	General	Does the data in the databook text files include claims for all services to be covered in the contract year?	Yes, the Data Book files contain all adjudicated encounters for covered services submitted to AHCCCS for the years included in the Data Books.
159.	Document A- Document O	General	General	Were there any significant issues regarding existing health plan data?	There were no significant issues regarding existing health plan data for the Acute Care data. Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS, which was posted to the Bidders' Library on December 14 to read about the true-up factors AHCCCS used to develop the CRS rates.
160.	Document C, Document J	General	General	Please provide a list of the adjustments made for any anomalies present in the databook text files and Document J.	Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-

					<p>capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."</p> <p>Contractors' self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.</p>
161.	Document J	General	General	<p>Are the PMPM amounts in Document J gross or net of copays?</p>	<p>For questions regarding the data contained in Contractors' self-reported financial statements, see the Financial Reporting Guide for Acute Health Care Contractors in the Bidders' Library, Current Reporting Guides and Manuals. This data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.</p>
162.	Document C	General	General	<p>Are the total cost amounts in the databook text files gross or net of copays?</p>	<p>Data Books reflect expenditures using encounter data as reported by Contractors. If payments were reduced due to copays, the Contractor should have reported paid amounts net of copays.</p>

163.	Document C, Document J	General	General	Please provide the dollar amount of the beneficiary copayments and cost sharing associated with total cost amounts in Document J and the Databook text files by fiscal year, region, rate cell, and covered service.	No additional information will be provided.
164.	Document C	General	General	Are third party liability payments included in the databook text files?	TPL payments are not separately reported in the Data Book text files. Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made.
165.	Document C, Document J	General	General	Please provide the dollar amount of any other adjustments made to the claims experience included in the databook text files and Document J for reasons other than third party liability by fiscal year, region, rate cell, and covered service.	Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Data Book Introduction: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then

					<p>the “Health Plan Approved Amount” is used. If neither field is available, the lesser of “AHCCCS Allowed” or “Billed Amount” is used to populate the cost field.”</p> <p>Contractors’ self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.</p>
166.	Document C	General	General	<p>Please provide the number of inpatient claim outliers and the associated utilization and cost in the development of the databook text files by fiscal year, region, and rate cell.</p>	No additional information will be provided.
167.	Document C, Document J	General	General	<p>Did the state do any smoothing of large claims in the development of the data?</p>	No, the data provided was not smoothed.
168.	Document C	General	General	<p>Were there significant changes (such as a noted increase or decrease) to utilization since the data period ended?</p>	AHCCCS has not noticed significant changes to utilization since the data period provided ended.
169.	Document J	General	General	<p>Please provide completion factors by Category of Aid, Category of Service and GSA for utilization and expenditures in Document J.</p>	Document J reports are self-reported financial statements submitted by AHCCCS Contractors. Completion factors are not included in this data. For questions regarding the data contained in Contractors’ self-reported statements, see the Financial Reporting Guide for Acute Health Care Contractors in the Bidders’ Library, Current Reporting Guides and Manuals.
170.	Document C	General	General	<p>Please provide the experience period paid-through date.</p>	The Data Book files were run after the first July 2012 encounter cycle. Paid dates could include any date up to the deadline date for encounter submissions for this cycle, which was July 5, 2012.

171.	Document J	General	General	Please indicate whether PMPM expenditures in Document J have completion factors applied.	Contractors' self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted. For questions regarding the data contained in Contractors' self-reported statements, see the Financial Reporting Guide for Acute Health Care Contractors in the Bidders' Library, Current Reporting Guides and Manuals.
172.	Document C	General	General	What flexibility does the MCO have in developing the formulary?	Refer to AMPM, Chapter 300 Medical Policy for Covered Services, Policy 310-V, Prescription Medication/Pharmacy Services.
173.	Document C	General	General	Are there any services provided to members through other departments or programs that have been cut this year or expect to be cut in the near future causing the services to be pushed into this program?	Information regarding known program changes is provided in various sections of the RFP and supplemental documents.
174.	Document C	General	General	If there are services provided to members through other departments or programs that have been cut this year or expect to be cut in the near future causing the services to be pushed into this program, how is the base experience data adjusted to take into account these changes in services since the base period?	AHCCCS rebases the capitation years every five years as part of the RFP process. Program changes that occur after a rate rebase result in adjustments to the capitation rates.

175.	General	General	General	How will the State account withhold for quality incentives in the risk sharing arrangement calculation?	The question is unclear. Assuming the Offeror is asking how AHCCCS will account for the Payment Reform/Shared Savings withhold in the risk sharing calculations, the withheld capitation revenue will be excluded from the reconciliation. For example, if capitation is \$100 and AHCCCS withholds \$1, revenue equal to \$99 would be used for the reconciliation.
176.	General	General	General	Will withhold for quality incentives be excluded from the gain sharing calculations?	The question is unclear.
177.	General	General	General	Please provide an estimate of reimbursement as a percentage of Medicaid allowable reflected in the dataset, by service category.	No additional information will be provided.
178.	General	General	General	How are Medicaid fee schedule increases developed for hospital, physician, emergency room and pharmacy rates?	Generally, when setting the capitation rates, the unit cost trend will be based on changes to the AHCCCS fee schedule for the categories of service which are impacted by these fee schedule changes. Categories that are not impacted by the AHCCCS fee schedule, include, but are not limited to: Pharmacy, Hospice and CRS Clinic Fees. The AHCCCS fee schedule rates are based primarily on changes to Medicare fee schedules, national trends, access to care and budgetary decisions.
179.	Document C, Document J	General	General	Are there other payments/settlements made outside of the claims system that will be the responsibility of the plans?	All expenditures for covered medical services are required to be submitted as encounters to AHCCCS. However, AHCCCS cannot speak to any Contractor-specific arrangements or circumstances which could result in payments/settlements outside of the claims' system.

180.	Document C, Document J	General	General	If other payments/settlements made outside of the claims system are the responsibility of the plans, will these be built into the rates?	No, payments outside of the claim's system will not be built into the medical component of the capitation rates. This component is developed based on adjudicated encounter data. Payments/settlements made outside the claims' system may be reflected in the Contractor's administrative expenditures and therefore may be accounted for in the administrative component.
181.	Document I	General	General	How many times per year will the Average MCO risk score be updated?	AHCCCS anticipates updating the risk scores one time per year.
182.	Document I	General	General	Please provide additional detail on how members who have enough months of enrollment to be scored, but who have no claim experience will be included in the risk adjustment process.	No additional information will be provided regarding risk adjustment. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section I, Risk Adjustment Information.
183.	Document I	General	General	If risk adjustment is designed to be budget neutral to the state, will the budget neutrality be on a statewide or regional basis?	Yes, risk adjustment is designed to be budget neutral to the state on both a statewide and GSA basis.
184.	General	General	General	Is premium tax included in the administrative expense level (excluding gain) in the actuarially sound rate ranges that will be used for scoring purposes?	This question is unclear. The rate ranges developed by AHCCCS are for the medical component of the capitation rates. There is no administrative expense in the rate ranges. The administrative component bid excludes premium tax.  For more information, see the RFP, Section H, Instructions to Offerors, and Acute/CRS RFP YH14-0001 Bidders' Library, Solicitation Amendment No. 1 Q&A, Response # 106.
185.	General	General	General	Please explain how the actuarially sound rate range will be developed by the state	Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute

				actuarial.	Care/CRS which was posted to the Bidders' Library on December 14.
186.	General	General	General	Please specify all assumptions including, but not limited to the experience period, trend assumptions, managed care saving assumptions, program changes considered (retrospective and prospective), and non-medical loads in the development of actuarially sound rates by the state actuaries.	Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14. Also see the Bidders' Library, Section B, Program and Fee Schedule Changes. No additional information regarding assumptions will be provided.
187.	Document C, Document J	General	General	Are there any pass-through payments reflected in the data? If so, please quantify these payments.	Data Books reflect expenditures using encounter data as reported by Contractors. To the extent encounter data includes pass-through payments, those payments would be reflected in the data. Likewise, if Contractors' financial statement data include pass-through payments, those payments would be reflected in the self-reported financial data. AHCCCS cannot quantify these payments.
188.	Databook, Document J	General	General	Please provide a reconciliation of membership and PMPM costs for all available years between the Databook and the financial summaries in Document J, including a summary of any data that is only included in one of these items.	AHCCCS will not provide a reconciliation. The Offeror may perform the requested reconciliation based on the data provided.
189.	Databook	General	General	We've observed significant negative changes in inpatient utilization across contract years. Please explain and quantify the primary factors driving these changes.	AHCCCS will not provide additional information regarding utilization changes.

190.	Databook	General	General	We've observed consistent reductions in Emergency Room utilization across contract years. Are there any Emergency Room avoidance measures in place beyond the change in copayments (effective 10/1/2010) that could be driving this change. If so, please quantify them.	The Offeror has access to information on program changes and AHCCCS initiatives across the years included in the Data Books. AHCCCS will not provide additional information regarding utilization changes.
191.	Databook	General	General	Please provide the utilization and charge trends used to develop the actuarially sound rate ranges for CYE14 by Category of Service for each category of aid and GSA.	Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14. No additional information will be provided.
192.	Databook	General	General	We've observed consistently negative and dramatic changes in utilization for Physician/OBGYN services across contract years	Observation noted.
193.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Maternity Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.

194.	Databook	General	General	<p>Please explain the significant decrease in utilization rates for Hospital days by NICU Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?</p>	<p>Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.</p>
195.	Databook	General	General	<p>Please explain the significant decrease in utilization rates for Hospital days by ICU Tier over all contract years. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?</p>	<p>Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.</p>
196.	Databook	General	General	<p>Please explain the significant decrease in utilization rates for Hospital days by Surgery Tier between CYE09 and CYE10. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?</p>	<p>Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.</p>

197.	Databook	General	General	<p>Please explain the significant decrease in utilization rates for Hospital days by Nursery Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?</p>	<p>Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.</p>
198.	Databook	General	General	<p>Please explain the significant decrease in utilization rates for Hospital days by Routine Tier over all contract years. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?</p>	<p>Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.</p>
199.	Databook	General	General	<p>Please provide coding criteria and a list of prominent services for the "Hospital Days by Routine Tier" service line.</p>	<p>Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section N, Hospital Rate Overview, Introduction.</p>
200.	Databook	General	General	<p>Please provide coding criteria and a list of prominent services for the "All Other Hospital Days" service line.</p>	<p>Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, Acute Care/CRS Service Matrix, and Section N, Hospital Rate Overview, Introduction.</p>
201.	Databook	General	General	<p>Please explain the spike in utilization rates for All Other Hospital Days in CYE10 within the TANF program, and overall. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?</p>	<p>Noted increases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental Data Book Reports. Please watch for updates to this Section.</p>

202.	Databook	General	General	Please explain the decreasing utilization rate trend over contract years for Physician Surgery.	AHCCCS will not provide additional information regarding utilization changes.
203.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "Physician Other" service line.	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, Acute Care/CRS Service Matrix.
204.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "Other Professional" service line.	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, Acute Care/CRS Service Matrix.
205.	Databook	General	General	Please explain the spike in utilization rates for Other Professional Services in CYE10.	AHCCCS will not provide additional information regarding utilization changes.
206.	Databook	General	General	The utilization rate trend for Other professional services from CYE11 to CYE12 appears to be significantly positive. Because of the timing of the data release, we assume that the CYE12 data is relatively incomplete. This would suggest that the CYE11 to CYE12 utilization trend for Other Professional services could be quite high after completion. Please explain the implied high utilization rate trend for this service category.	AHCCCS will not provide additional information regarding utilization changes.
207.	Databook	General	General	Please explain the significant decrease in utilization rates for Laboratory and Radiology Services between CYE09 and CYE10.	AHCCCS will not provide additional information regarding utilization changes.

208.	Databook	General	General	Please explain the significant increases and decreases for rentals and purchases of DME and Medical Supplies over contract years. For example, has there been an effort to shift DME and Medical Supplies expenses from purchases to rentals?	The Offeror has access to information on program changes and AHCCCS initiatives across the years included in the Data Books. AHCCCS will not provide additional information regarding utilization changes.
209.	Databook	General	General	Please explain the significant decrease in utilization rates for Dental Services between CYE10 and CYE11.	AHCCCS will not provide additional information regarding utilization changes.
210.	Databook	General	General	Please explain the significant increase in utilization rates for Non-Emergency Transportation between CYE09 and CYE10.	AHCCCS will not provide additional information regarding utilization changes.
211.	Databook	General	General	Please explain the significant decrease in unit cost for Non-Emergency Transportation between CYE09 and CYE10. The list of program changes in Document B specifies a 5% reduction in rates between these years; we observe a much more significant negative trend.	AHCCCS will not provide additional information regarding unit cost changes.
212.	Databook	General	General	Please explain the significant decrease in utilization rates for Pharmacy Encounters between CYE10 and CYE11.	AHCCCS will not provide additional information regarding utilization changes.
213.	Databook	General	General	The databook groups membership and claims for members age 14-44 by gender only. Because there are variations in coverage for children and adults within this population, utilization and cost patterns may be substantially different between these two groups. Please provide databook data, enrollment counts and enrollment projections broken out between adults and children for these groups.	No additional information will be provided.

214.	Acute Care Actuarial Certifications CYE09-CYE12	General	General	Please provide a list of experience adjustments made to capitation rates in CYE09-CYE12,	No additional information will be provided.
215.	Acute Care Actuarial Certifications CYE09-CYE13	General	General	Please provide a list of all adjustments other than experience adjustments made to capitation rates after bids had been made, for each contract year.	No additional information will be provided.
216.	Databook	General	General	Does AHCCCS anticipate any difference in utilization trend rates from the utilization trends apparent in the current databook based on emerging experience?	No, AHCCCS does not anticipate any difference in trends based on emerging experience. Refer to the Bidders' Library, Data Supplement for Offerors' - Acute Care/CRS, Section C, Data Book Information, Rate Setting Document.
217.	Databook	General	General	Does AHCCCS anticipate any difference in unit cost trend rates from the unit cost trends apparent in the current databook based on emerging experience?	No, AHCCCS does not anticipate any difference in trends based on emerging experience. Refer to the Bidders' Library, Data Supplement for Offerors' - Acute Care/CRS, Section C, Data Book Information, Rate Setting Document.
218.	Databook	General	General	Please provide a definition for "Pharmacy Encounters" (ex. prescriptions, or 30 day equivalents)	Refer to the Bidders' Library, Data Supplement for Offerors' - Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book.
219.	Databook	General	General	The utilization rate trend for TANF < 1 overall appears to be slightly positive between CYE11 and CYE12. Because of the timing of the data release, we assume that the CYE12 data is relatively incomplete. This would suggest that the CYE11 to CYE12 utilization trend for TANF < 1 could be quite high after completion. Please explain the implied high utilization trend for this category of aid.	AHCCCS will not provide additional information regarding utilization changes.

220.	Document H-3	General	General	Which category of aid will the members in the "PPACA Child Expansion" column be included in?	PPACA child expansion members are included in the column labeled "ACA Child Expansion" on H-3, Enrollment by Month (Historical and Projected), which can be found in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section H, Enrollment Information.
221.	Document H-3	General	General	It appears that the enrollment projections include the assumption that Arizona will participate in the PPACA Medicaid expansion. Please verify this assumption.	<p>The Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section H, Enrollment Information includes an Introduction document which states on page 1:</p> <p>"The projected member months assume the following:</p> <ul style="list-style-type: none"> <li>• Child expansion is mandatory beginning January 1, 2014</li> <li>• Restoration of the AHCCCS Care (Childless Adults) population beginning January 1, 2014</li> <li>• Some categorical woodwork beginning July 1, 2013</li> <li>• Increase due to streamlined redetermination beginning January 1, 2014</li> <li>• Kidscare II will end December 31, 2013, but it is anticipated that half of the population will move to child expansion"</li> </ul>

222.	Document H-3	General	General	<p>If the state's position on adopting the PPACA Medicaid expansion changes, will AHCCCS publish adjusted enrollment projections, or adjust capitation rates in any way?</p>	<p>As stated in the RFP, Sections D1 and D2, Paragraph 75, Pending Legislation/Other issues: "Governor Brewer and State lawmakers have yet to determine the course for the Medicaid program as it relates to options under the ACA." If something changes before the proposal due date, AHCCCS may choose to publish adjusted enrollment projections, if available.</p> <p>Also as stated in the RFP, Sections D1 and D2, Paragraph 55, Capitation Adjustments, "AHCCCS may, at its option, review capitation rates to determine if a capitation adjustment is needed for reasons including, but not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Program changes</li> <li>• Legislative requirements..."</li> </ul>
223.	N/A	N/A	N/A	<p>We want to make sure we provide appropriate bids for the populations covered, and want to be clear on which populations are to be included in the Dual SNP or Pilot program. There is a category of dual eligible called SSI with Medicare. These members and this category seem to continue to be included in the acute bid. Will these members be moved to the Dual SNP or Pilot? Should we include a bid for them in the acute bid?</p>	<p>Yes, include a bid for members who are in the SSI with Medicare risk group. If the Dual SNP continues, these members will be paid a Medicaid rate based on the bid. If the Dual Demo is implemented, the members are permitted to opt out of the Demo, thus the Medicaid rate paid for these members will be based on the bid.</p>

224.	N/A	N/A	N/A	<p>In addition, we understand that members in the SMI category have been removed from the data book for the acute population. Are there any SMI members with dual eligibility also included in the SSI with Medicare? If so, have they been removed from the data book also?</p>	<p>Only County 13 (Maricopa) SMI members have been removed from the Data Book for the acute population. However, the Acute Care Data Book will contain minimal County 13 SMI services, costs and member months for those members accounting for the transition window from the Acute Care program to the Maricopa RBHA. Example: If a member is in County 13 and determined SMI, there is a 14 day window to move the member from the Acute Care program to the Maricopa RBHA. During that 14 day period the member will still be on the Acute Care program, thus that data was not removed from the Data Book.</p>
225.	Supplemental Data Book Reports	N/A	N/A	<p>The data book does not break out prescription drug information into generic, brand, retail or mail. Can utilization and cost information be broken out by these additional categories and provided to bidders?</p>	<p>No additional information will be provided.</p>
226.	<p>Document F – Capitation Bid Template Acute Care and Book Files Acute Care Delivery Supplement Cost and Utilization.txt</p>	N/A	N/A	<p>When Delivery Supplement is selected as the risk group in the bid template (Data Book file 'Document F – Capitation Bid Template Acute Care.xlsm'), only limited service categories are shown; however, the Data Book file 'Document C- Data Book Files Acute Care Delivery Supplement Cost and Utilization.txt' includes Delivery Supplement utilization and costs in other service categories (e.g., Pharmacy). Should costs in those additional categories be included in Miscellaneous in the bid?</p>	<p>Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, Crosswalk Acute Care Service Matrix to Capitation Bid Template posted on December 14.</p>

227.	Document G – Crosswalk Acute Care CRS Service Matrix Financial Statements	N/A	N/A	Document G provides a crosswalk between most service categories, but does not specifically show how Physician OB/GYN Services, Physician Surgery, and Physician Other map to Primary Care Physician and Referral Physician, which are service categories in the bid template. Is there a direct mapping for these categories, or can you provide additional information on primary care vs. referral physician utilization?	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, Crosswalk Acute Care Service Matrix to Capitation Bid Template posted on December 14.
228.	Document C – Databook Introduction	N/A	N/A	We understand that the data book contains services provided through 3/31/12, and is not adjusted for completion factors. DocC_DatabookIntroduction.pdf indicates that the Data Book Files were run after the first July 2012 encounter cycle. Can you provide a specific "paid-through" date?	The Data Book files were run after the first July 2012 encounter cycle. Paid dates could include any date up to the deadline date for encounter submissions for this cycle, which was July 5, 2012.
229.	Document C – Databook Introduction	N/A	N/A	Is there information available on Third Party Liability (TPL) recoveries, beyond the PMPM values in Section J? Can lag tables be provided? Are TPL recoveries included in the data book?	Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made. Capitation rate ranges were developed based on the Data Book data. No additional information will be provided.

230.	Amendment 1	N/A	N/A	Please confirm that the entity awarded a contract must be a c corporation. Please also confirm that a successful incumbent bidder that is currently organized as an LLC would be required to reorganize as a corporation. If so, what is the deadline for such reorganization?	Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation. This corporation does not have to be a c corporation. A successful incumbent that is currently an LLC would be required to become a corporation within the same timeline.
231.	Databook	Utilization Data	Utilization Data	Please explain the large drop in utilization for AHCCCS Care between 2010 and 2011	AHCCCS will not provide additional information regarding utilization changes.

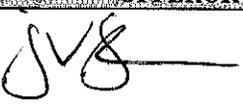
	<b>SOLICITATION AMENDMENT</b>	<b>AHCCCS</b>
	Solicitation No.: <b>RFP YH14-0001</b> Amendment No.3 (Three)  Solicitation Due Date: <b>January 28, 2013</b> <b>3:00PM (Arizona Time)</b>	<b>Arizona Health Care Cost Containment System</b> <b>701 East Jefferson, MD 5700</b> <b>Phoenix, Arizona 85034</b> 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

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

This solicitation is amended as follows:

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 4 <sup>th</sup> day of January, 2013, in Phoenix, Arizona.	
<b>OFFEROR</b>		<b>AHCCCS</b>	
<b>Signature</b> 	<b>Date</b> 01/28/13	<b>Signature</b> 	
<b>Typed Name</b> James V. Stover		<b>Typed Name</b> Michael Veit	
<b>Title</b> Chief Executive Officer		<b>Title</b> Contracts and Purchasing Administrator	
<b>Name of Company</b> University Family Care		<b>Name of Company</b> AHCCCS	

ACUTE/CRS QUESTIONS AND RESPONSES AMENDMENT No. 3 TO RFP YH14-00014

Question #	Section	Paragraph #	Page #	Question	Response
1.				<p>For the final capitation rate to be paid to the MCOs, can the state specify whether both the admin and risk margin will be calculated as a percent of the medical rate or as a percent of the final capitation rate?</p> <p>Please confirm or correct the following capitation rate calculation:</p> $\text{Medical rate} \times (1 + \text{admin}\% + 1\% \text{ risk}) + \text{Reinsurance offset} / (1 - 2\% \text{ premium tax}) = \text{Final capitation rate}$	<p>The admin used will be the admin that is bid, except for the capitation rates that are not bid (i.e. PPC). The risk margin is a % of the medical rate.</p> <p>For rates that are bid:  <math>(\text{Medical rate} \times (1 + 1\% \text{ risk}) + \text{Admin Bid} + \text{RI Offset (set by AHCCCS)}) / (1 - 2\% \text{ premium tax})</math></p> <p>For rates that are not bid (RI does not apply to these rates thus there is no RI Offset in the formula):  <math>(\text{Medical rate} \times (1 + 1\% \text{ risk} + \text{admin}\% (8\%)) / (1 - 2\% \text{ premium tax}))</math></p>
2.				<p>What is the projected membership distribution for the 4 CRS coverage types?</p>	<p>Projected FFY14:                      70.7% CRS Fully Integrated                      0.7% CRS Partially-Integrated – Acute                      24.7% CRS Partially-Integrated – BH                      3.9% CRS Only</p>
3.				<p>Will TPL be factored into the final capitation rate development? If so, at what point in the calculation will it be incorporated?</p>	<p>AHCCCS uses the Data Book files as a basis to calculate the final capitation rates. The Data Book files are based on Contractor submitted encounters. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made. Capitation rate ranges were developed based on the Data Book data.</p>
4.				<p>Can the state provide the trend factors, historical and prospective, used in the medical rate range development?</p>	<p>No additional information will be provided.</p>

Question #	Section	Paragraph #	Page #	Question	Response
5.				Can the state provide the medical codes and criteria used to identify the expenses for the Delivery Supplement categories of service?	Refer to the Acute Care/CRS Service Matrix and the Crosswalk Acute Care Service Matrix to Capitation Bid template in Section D of the Data Supplement for Offerors in the Bidders' Library.
6.				Will the Payment Reform Withhold be applied as a percentage of the medical rate only or as a percentage of the final capitation rate (medical rate + risk + admin + reinsurance + premium tax)?	AHCCCS anticipates that the payment reform withhold will be applied as a percentage of the final capitation rate. The draft Policy will be released 4/1/13 with more information.
7.				Can the state provide the true-up factors used to adjust the CRS data?	The BHS factors are 8.83% for CYE09, 4.40% for CYE10 and 2.63% for CYE11. For CRS Specialty Care, from the Bidders' Library, Data Supplement for Offerors' - Acute Care/CRS, Section C, Data Book Information, Rate Setting Document, "AHCCCS elected to use clinic fee expenditures from the financial statement data."
8.				Can the state provide the rationale for using equal weights on each contract year of databook data to build the prospective medical rate ranges?	AHCCCS reviewed multiple methods of weighting the adjusted base year data and for most risk groups/GSAs the results were very similar for all methods. Including the CYE12 data equally helps reduce uncertainty regarding the impact of the 25 day limit since CYE12 was the first year for that program change. Including the most recent data also reduces the number of months that would be included in a trend based on older data. And while CYE09 data is fairly old, it is complete. Overall the base would be lower if CYE09 were excluded.
9.	F - Acute Care Medical Component Ranges			Which rate ranges will be applicable to ACA Child Expansion enrollees shown in document H-3?	ACA Child Expansion enrollees would be included in the TANF rate ranges appropriate to their ages.
10.	F - Acute Care Medical Component Ranges			Do the rate ranges assume that under the RFP assumption that AHCCCS Care is restored for January 1, 2014, individuals who were transitioned to SSI categories as part of the freeze will transition back to AHCCCS Care?	No, AHCCCS Care rate ranges do not assume individuals who were transitioned to SSI Categories a part of the freeze will be transitioned back to AHCCCS Care since they are now in the appropriate category.

Question #	Section	Paragraph #	Page #	Question	Response
11.	Rate Ranges			Did AHCCCS make any adjustments to account for risk changes associated with ACA related membership growth?	No, AHCCCS did not make any adjustments to account for risk changes associated with ACA related membership growth. If AHCCCS determines such adjustments are necessary, the awarded capitation rates will be adjusted appropriately.
12.	Rate Ranges			Please provide the program change adjustments applied (by CYE, risk group and data book service category).	Refer to the Bidders' Library, Section B, Program and Fee Schedule Changes. No additional information will be provided.
13.	Rate Ranges			For some rate ranges (e.g. SSI W), the program changes (e.g. OON QMB Duals adjustment combined with other smaller program changes) significantly add costs. In order to get within the rate ranges provided (after program changes and completion are applied), significantly negative trends would be need to be assumed. Any insights you can provide to help us understand if other factors are being applied or if there is a justification for large negative trends would be appreciated.	AHCCCS did not apply significant negative trends. The average statewide total trend for the SSIW population is 1.70% varying by GSA from -0.11% to 2.85%.
14.	Rate Ranges			Were the rate ranges adjusted for additional COB/TPL recoveries (outside of those reported in the data book) or supplemental payments? If so, please provide said adjustments.	No, the rates were not adjusted for additional COB/TPL recoveries or supplemental payments outside of the Data Books.
15.	Section B Program and Fee Schedule Changes	general		In order to make sure we are applying the program changes to the rates appropriately and consistently with what is done with the rate ranges, can you clarify if savings estimates provided are based on the full contract year or just the portion of the contract year if a mid contract year adjustment. For example, if a program change was implemented 4/1 with savings of \$1 million from 4/1 through 9/30, are the savings shown as \$1 million for the entire contract year or will the savings stated be roughly \$2 million?	Section B numbers are stated as a full year of savings although most of the numbers in Section B are on a PMPM basis and not a total dollar basis. In the example provided, if the total dollar savings were provided rather than a PMPM, the document would show a savings of \$2 million.

Question #	Section	Paragraph #	Page #	Question	Response
16.	Section C – Rate Setting Document	Historical Program and Fee Schedule Changes	4	This section indicates that “the base data was adjusted for historical program and fee schedule changes”. Does this mean that adjustments were made to reflected current AHCCCS fee schedule levels, or only to reflect the changes in levels over time?	The base data, which is historical encounter data (i.e. data books), was adjusted for historical AHCCCS fee schedule changes to get the data to the current AHCCCS fee schedule levels.
17.	Section C – Rate Setting Document	Capitation Rates and Components Set by AHCCCS	5	Will AHCCCS adjust the final 10/1/2013 capitation rates to reflect the change in the third party recovery period?	Prior to 10/1/2013 AHCCCS will review and determine if the awarded rates need to be adjusted for any material changes including the third party recovery period.
18.	Section C – Rate setting document	1	2	In the absence of lag triangles, please describe the methodology used to develop completion factors in the development of the rate ranges and provide lag triangles for the periods under consideration by form type and GSA.	No additional information will be provided.
19.	Section C – Rate setting document	4	1	Please provide justification for weighting the partial CYE2012 experience equally with full contract year data from earlier contract periods.	AHCCCS reviewed multiple methods of weighting the adjusted base year data and for most risk groups/GSAs the results were very similar for all methods. Including the CYE12 data equally helps reduce uncertainty regarding the impact of the 25 day limit since CYE12 was the first year for that program change. Including the most recent data also reduces the number of months that would be included in a trend based on older data. And while CYE09 data is fairly old, it is complete. Overall the base would be lower if CYE09 were excluded.

Question #	Section	Paragraph #	Page #	Question	Response
20.	Section C – Rate setting document	4	1	Please provide justification for weighting older historical periods (CYE2009 and CYE2010) equally with the most recent full contract period data (CYE2011).	AHCCCS reviewed multiple methods of weighting the adjusted base year data and for most risk groups/GSAs the results were very similar for all methods. Including the CYE12 data equally helps reduce uncertainty regarding the impact of the 25 day limit since CYE12 was the first year for that program change. Including the most recent data also reduces the number of months that would be included in a trend based on older data. And while CYE09 data is fairly old, it is complete. Overall the base would be lower if CYE09 were excluded.
21.	Section C – Rate setting document	4	4	Did AHCCCS adjust historical data for program and fee schedule changes in the delivery supplement category of the bid?	Yes, AHCCCS adjusted historical data for program and fee schedule changes for all risk groups including delivery supplement. For simplicity sake, AHCCCS assumed the same program changes that impacted the TANF 14-44 F risk group would also impact the Delivery Supplement rates for the following categories of service (COS): Hospital Inpatient, Physician, Other Professional and Transportation.
22.	Section C – Rate setting document	4	4	If historical data was adjusted for program and fee schedule changes, please provide the adjustment amounts on a per-delivery basis	For simplicity sake, the TANF 14-44 F risk group PMPM program change impacts were applied to the delivery supplement per delivery per month rates. The fee schedule changes were left as percentage adjustments impacting the unit cost similar to all other risk groups. No additional information will be provided.
23.	Section C – Rate setting document	4	4	Were any of the PMPM adjustments provided in Section B of the Data Supplement recalculated based on actual historical experience in development of the rate ranges?	No, none of the PMPM adjustments provided in Section B of the Data Supplement were recalculated based on actual historical experience.

Question #	Section	Paragraph #	Page #	Question	Response
24.	Section C – Rate setting document	4	4	If any of the PMPM adjustments in Section B of the Data Supplement were recalculated based on actual historical experience, please provide the revised assumptions.	Not applicable.
25.	Section C – Rate setting document	4	4	On what summary level were base trends and projection trends applied in development of the rate ranges. For example, was each combination of GSA and category of aid given a trend assumption, were regional trends applied separately from trends for each Category of Aid, was there a single trend applied across all GSAs and all categories of aid, etc.?	In general, trends were developed and applied based on COS, by GSA and by risk group. All trends had thresholds applied to exclude abnormally high positive or negative trends. The thresholds for the negative trends were set fairly low to allow only small negative trends to continue. If a risk group within a GSA did not have enough credibility, the trends were blended with statewide trends.
26.	Section C – Rate setting document	5	5	As a point of clarification, the rate setting document states that the offeror should not consider risk contingency or premium tax in the bid; does this mean that risk contingency and premium taxes are not considered in the actuarial sound rate ranges?	Correct. The rate ranges are only for the medical component and do not contain risk contingency or premium tax components.
27.	Section C – Rate setting document	5	5	Are there any other items (similar to premium task or risk contingency), which would commonly be included in capitation rate calculations, that should not be included in the calculation of the offeror's bid rates?	As stated in the RFP, Section H, Instructions to Offerors, "Offerors will submit a gross medical component PMPM bid for each risk group by GSA. Neither reinsurance offsets nor capitation withheld for payment reform initiatives should be considered in the medical component bid."
28.	Section C – Rate setting document	6	4	Please provide the thresholds used for abnormally high or low utilization or cost trends in the rate development process.	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
29.	Section C Data Book Information Rate Setting Doc	Paragraph 4	1	<p>Please provide support for giving equal weight to all four years of data. In your response, please address the following concerns:</p> <ul style="list-style-type: none"> <li>Using CYE09 introduces uncertainty due to the number of program adjustment estimates required for normalization and 5 years of trend.</li> <li>Given the relatively large completion factors, using CYE12 also introduces uncertainty.</li> </ul>	AHCCCS reviewed multiple methods of weighting the adjusted base year data and for most risk groups/GSAs the results were very similar for all methods. Including the CYE12 data equally helps reduce uncertainty regarding the impact of the 25 day limit since CYE12 was the first year for that program change. Including the most recent data also reduces the number of months that would be included in a trend based on older data. And while CYE09 data is fairly old, it is complete. Overall the base would be lower if CYE09 were excluded.
30.	Section C Data Book Information Rate Setting Doc	Paragraph 5	4	The Rate Setting Doc states: "Please note that the SSIW category was not adjusted for most fee schedule changes..." Please list the fee schedule changes that were applied to the SSIW category.	Categories for SSIW that had AHCCCS fee schedule adjustments applied were: Dental, Transportation and Nursing Facility and Home Health.
31.	Section C Data Book Information Rate Setting Doc	Paragraph 5	4	Which program changes did AHCCCS apply to the delivery supplement payment ranges?	For simplicity sake, AHCCCS assumed the same program changes that impacted the TANF 14-44 F risk group would also impact the Delivery Supplement rates for the following categories of service (COS): Hospital Inpatient, Physician, Other Professional and Transportation.
32.	Section C Data Book Information Rate Setting Doc	Paragraph 6	4	We recognize that you will not be providing the trend factors applied but can you state whether the trend factors vary by the CYE to which they are applied or is one set of factors used and applied to all CYEs?	One set of trend factors are applied to the adjusted base data. The adjusted base data is a blend of all contract years.
33.	Section C Data Book Information Rate Setting Doc	Paragraph 6	4	Similarly can you state if negative trends are applied?	Negative trends were allowed, but they were capped at a lower limit (thus not allowing large negative trends) than the cap on positive trends.

Question #	Section	Paragraph #	Page #	Question	Response
34.	Section C Data Book Information Rate Setting Doc	Paragraph 6	4	If negative trend factors were used in the development of the rate ranges, please provide justification as to why AHCCCS believes negative trends are reasonable and sustainable.	AHCCCS did not allow large unsustainable negative trends to continue, but did feel it was reasonable to allow for some small negative trends to continue. After factoring in historical reimbursement (AHCCCS fee schedule changes) and program changes, negative trends by COS are reasonable in the short term due to changes in enrollment or service mix (e.g. reduced readmission rates, improved ER steerage).



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

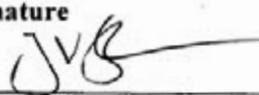
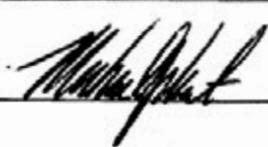
2. Section H: Instructions to Offerors, Paragraph 16, Capitation, *CRS Program Capitation Bid Submission (Submission Requirement No. 2)*, page 304 is amended as follows:

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

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

**Bid component requirements:**

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 10 <sup>th</sup> day of January, 2013, in Phoenix, Arizona.	
<b>OFFEROR</b>		<b>AHCCCS</b>	
<b>Signature</b> 	<b>Date</b> 01/28/2013	<b>Signature</b> 	
<b>Typed Name</b> James V. Stover		<b>Typed Name</b> Michael Veit	
<b>Title</b> Chief Executive Officer		<b>Title</b> Contracts and Purchasing Administrator	
<b>Name of Company</b> University Family Care		<b>Name of Company</b> AHCCCS	

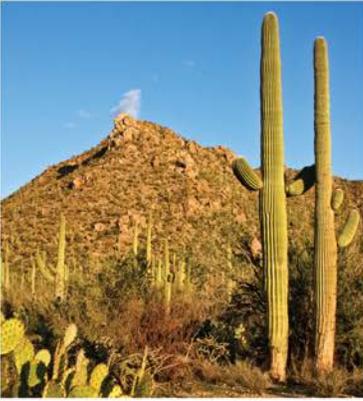
# Academic Medicine is Smart Medicine



B. Attestation



THE UNIVERSITY OF ARIZONA  
HEALTH PLANS



# Table of Contents

## **B. Attestation**

### **This Section Contains:**

Attestation..... 220

**EXHIBIT C: ATTESTATION FORM**

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

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

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

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

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

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

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

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

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

ATTESTATION SIGNATURE

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

Offeror's Name: University Family Care certifies the elements attested to in this document are true and it is understood that AHCCCS will rely on this attestation in determination of the award.

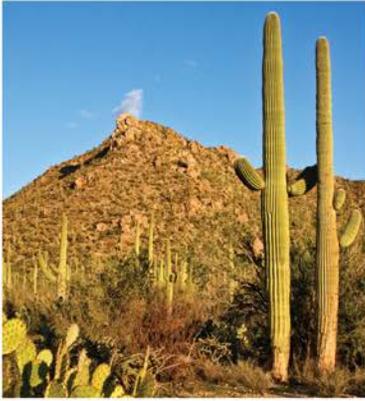
	01/28/2013
Authorized Signature	Date
James V. Stover	Chief Executive Officer
Individual's Printed Name	Title



THE UNIVERSITY OF ARIZONA  
HEALTH PLANS

# VISION

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## C. Capitation

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Capitation Administrative Component ..... 226

Actuarial Certification ..... 227

**Acute Care RFP Bid Template - University Family Care**

Gross Medical Component by Risk Group and GSA

<b>Risk Group</b>	<b>GSA 2</b>	<b>GSA 4</b>	<b>GSA 6</b>	<b>GSA 8</b>	<b>GSA 10</b>	<b>GSA 12</b>	<b>GSA 14</b>
TANF < 1	\$388.80	\$0.00	\$427.22	\$460.13	\$427.17	\$0.00	\$395.52
TANF 1-13	\$84.18	\$0.00	\$100.38	\$89.81	\$76.96	\$0.00	\$86.22
TANF 14-44 F	\$180.31	\$0.00	\$267.10	\$234.54	\$189.06	\$0.00	\$216.06
TANF 14-44 M	\$102.01	\$0.00	\$171.16	\$146.29	\$117.33	\$0.00	\$146.09
TANF 45+	\$285.65	\$0.00	\$389.81	\$414.09	\$319.51	\$0.00	\$353.68
SSIW	\$152.66	\$0.00	\$96.96	\$118.02	\$111.00	\$0.00	\$128.94
SSIW/O	\$793.11	\$0.00	\$860.44	\$686.71	\$712.05	\$0.00	\$821.80
AHCCCS Care	\$318.31	\$0.00	\$422.81	\$388.10	\$298.76	\$0.00	\$350.68
Delivery Supp	\$4,593.29	\$0.00	\$5,209.47	\$5,343.83	\$5,161.69	\$0.00	\$4,998.15

Administrative Component by Risk Group and GSA

<b>Risk Group</b>	<b>GSA 2</b>	<b>GSA 4</b>	<b>GSA 6</b>	<b>GSA 8</b>	<b>GSA 10</b>	<b>GSA 12</b>	<b>GSA 14</b>
TANF < 1	\$25.23	\$0.00	\$27.73	\$29.86	\$27.72	\$0.00	\$25.67
TANF 1-13	\$5.46	\$0.00	\$6.51	\$5.83	\$4.99	\$0.00	\$5.60
TANF 14-44 F	\$11.70	\$0.00	\$17.33	\$15.22	\$12.27	\$0.00	\$14.02
TANF 14-44 M	\$6.62	\$0.00	\$11.11	\$9.49	\$7.61	\$0.00	\$9.48
TANF 45+	\$18.54	\$0.00	\$25.30	\$26.87	\$20.74	\$0.00	\$22.95
SSIW	\$9.91	\$0.00	\$6.29	\$7.66	\$7.20	\$0.00	\$8.37
SSIW/O	\$51.47	\$0.00	\$55.84	\$44.57	\$46.21	\$0.00	\$53.33
AHCCCS Care	\$20.66	\$0.00	\$27.44	\$25.19	\$19.39	\$0.00	\$22.76
Delivery Supp	\$298.10	\$0.00	\$338.09	\$346.81	\$334.99	\$0.00	\$324.38

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January 26, 2013

milliman.com

**Actuarial Certification**  
**University Family Care**  
**AHCCCS Acute Care Capitation Bids: GSAs 2, 6, 8, 10 and 14**  
**October 1, 2013 – September 30, 2014**

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

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

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

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

<b>Risk Group</b>	<b>GSA 2</b>	<b>GSA 6</b>	<b>GSA 8</b>	<b>GSA 10</b>	<b>GSA 14</b>
TANF < 1	\$388.80	\$427.22	\$460.13	\$427.17	\$395.52
TANF 1-13	84.18	100.38	89.81	76.96	86.22
TANF 14-44 F	180.31	267.10	234.54	189.06	216.06
TANF 14-44 M	102.01	171.16	146.29	117.33	146.09
TANF 45+	285.65	389.81	414.09	319.51	353.68
SSIW	152.66	96.96	118.02	111.00	128.94
SSIW/O	793.11	860.44	686.71	712.05	821.80
AHCCCS Care	318.31	422.81	388.10	298.76	350.68
Delivery Supp	4,593.29	5,209.47	5,343.83	5,161.69	4,998.15



**Table 2**  
**Administrative Component by Risk Group and GSA**

<b>Risk Group</b>	<b>GSA 2</b>	<b>GSA 6</b>	<b>GSA 8</b>	<b>GSA 10</b>	<b>GSA 14</b>
TANF < 1	\$25.23	\$27.73	\$29.86	\$27.72	\$25.67
TANF 1-13	5.46	6.51	5.83	4.99	5.60
TANF 14-44 F	11.70	17.33	15.22	12.27	14.02
TANF 14-44 M	6.62	11.11	9.49	7.61	9.48
TANF 45+	18.54	25.30	26.87	20.74	22.95
SSIW	9.91	6.29	7.66	7.20	8.37
SSIW/O	51.47	55.84	44.57	46.21	53.33
AHCCCS Care	20.66	27.44	25.19	19.39	22.76
Delivery Supp	298.10	338.09	346.81	334.99	324.38

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

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

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

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



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

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

A handwritten signature in black ink, appearing to read "T. Snook", written over a horizontal line.

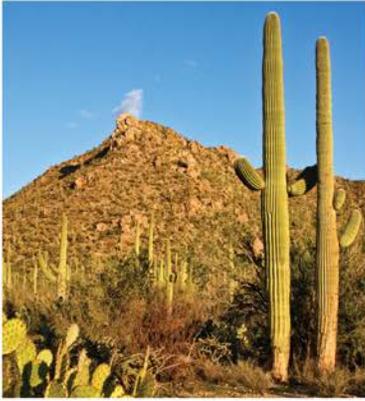
Thomas D. Snook, FSA, MAAA  
January 26, 2013



THE UNIVERSITY OF ARIZONA  
HEALTH PLANS

# MISSION

Advancing health and wellness  
through education, research  
and patient care.



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## D. Executive Summary and Disclosure

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## **D. Executive Summary**

University Family Care (UFC) is a subsidiary company of The University of Arizona Health Network (UAHN), and as required by A.R.S. §36-2906.01, will be established as a separate corporation within 120 days of contract award. The only authorized business of this corporation will be to provide services under this contract to AHCCCS-eligible persons enrolled to UFC. UAHN is an academic health system comprised of award-winning hospitals, The University of Arizona Medical Centers, the largest physician practice in Arizona, and a high performing health plan. The University of Arizona Health Plans (UAHP) owns and operates UFC and University Care Advantage, LLC (UCA), our Dual-Eligible Special Needs Plan (D-SNP). UAHP's Board of Directors and the UAHN delivery system are dedicated to improving health outcomes through education, research and clinical care innovation. The health plan has participated in the AHCCCS program since 1985 as either a direct contractor to AHCCCS or an administrator for another health plan, and is poised to make the next transition as health care evolves. In addition, to owning and operating its own plan, UAHP is the administrator for Maricopa Health Plan (MHP) which is owned by Maricopa Integrated Health Systems (MIHS). Since 2005, UAHP has managed MHP in a manner that has improved member and provider satisfaction, AHCCCS performance measure rates and minimized member churn.

Throughout this response UFC will demonstrate how we have met and will continue to meet our contractual obligations and bring added value to the AHCCCS program as well as our ability to effectively transition members through population growth and GSA expansion. Our strategy is built upon: 1) An organizational structure designed to fulfill the obligation of the contract, meeting the needs of our members and providers while promoting and adding value to the AHCCCS system; 2) A comprehensive network with a strong core of Patient-Centered Medical Home (PCMH) providers; 3) Innovative care and payment models that incentivize quality outcomes and efficiency; 4) Operational excellence and efficiency that is poised to reduce waste while meeting the requirements of integrating Medicaid and Medicare functions; 5) Effective use of technology to further the delivery of quality and cost effective health care.

UFC's local presence and experience has allowed us to build solid processes to deliver effective care management, design our network to meet the needs of the evolving membership and improve health outcomes, especially for under-served and high-risk populations. UFC has strong relationships with our provider network and partners with PCMHs to foster member-centric care coordination. These strong relationships have cut costs through reduced avoidable emergency room and inpatient utilization while improving performance measure rates. UFC uses the knowledge gained through these partnerships to develop similar models with additional provider groups to continue to improve care coordination and maximize capacity. UFC is currently developing fully integrated Patient-Centered Healthcare Homes (PCHH) that will continue to improve care coordination and outcomes in individuals with behavioral health (BH) disorders. UFC has begun and will continue to align payment incentive models that target improvements in utilization, quality and member experience.

Through the use of analytics, UFC identifies patient populations who have poorer health outcomes and higher medical costs than average. Such populations include dual-eligible members, individuals with BH disorders, chronic disease and members who churn on and off AHCCCS. UFC has identified that the churn population has an increased cost of \$50 PMPM. To address this issue, the health plan is establishing qualified health plans for participation in the Health Insurance Exchange to provide continuous coverage as members lose and regain AHCCCS eligibility. To address the needs of D-SNP members and better align Medicare-Medicaid integration, the health plan has developed a comprehensive health risk assessment tool to identify individuals for Case Management (CM) services. UFC uses risk stratification analytics to ensure that the appropriate level of CM is offered. In October 2012, CMS reviewed the UCA D-SNP Model of Care and gave us a "Superior" rating, citing our specialized employee training as a best practice. UFC utilizes an Interdisciplinary Care Team (ICT) consisting of physicians, utilization and CM nurses, BH CMs, and pharmacists who meet regularly to review member cases and engage the member in the development of their individual care plan. The team also assists members in meeting the established goals of their care plan.

UFC's organizational structure capitalizes on the efficiencies and value of being part of a larger delivery system, but retains authority and control of functions to ensure that the needs of members and contractual obligations are met. A primary example is our Compliance structure. UFC has a compliance department that reports to the CEO of the Health Plan that is focused on meeting contractual obligations and carrying out the responsibilities of the compliance plan. In addition, the Compliance Officer has direct access to the UAHN Board of Directors at any time. UFC also leverages the larger infrastructure of UAHN to collaborate on compliance training, technology and programs to improve fraud and



abuse detection. UFC has invested millions of dollars in the expansion and development of Information Technology (IT), impacting care delivery and reducing costs. These investments have and will continue to improve member self-care management through member portals and provider payment incentives to further promote the adoption of electronic health records. This will also include improved administrative efficiency designed with communication enhancements and reduction in administrative burden for the provider and members. UFC has designed its administrative and committee structure to ensure strong collaboration, communication and oversight amongst all health plan departments. Operational Excellence is the core foundation for UFC.

Member and Provider Satisfaction, as well as stakeholder engagement, are key to UFC's success. The plan places strong focus on meeting member and provider needs. This is demonstrated by a positive member loyalty score of 93.6% and a provider satisfaction rating of 80.6%, 2% above the national mean in 2012.

### **Medicare Structure**

UCA is the subsidiary health plan of The University of Arizona Health Network that currently contracts with the Centers for Medicare and Medicaid services as a D-SNP Medicare Advantage Part D (MAPD) plan. UCA received its Certificate of Authority by AHCCCS to operate a D-SNP and has contracted with AHCCCS to coordinate care for its members that are also eligible for Medicare. UCA has been caring for D-SNP beneficiaries since 2008 in Pima and Maricopa counties and expanded the service area to include Santa Cruz, Cochise, and Pinal Counties on January 1, 2011. UCA is dedicated solely to serving D-SNP members and has approximately 3,600 enrolled members. UCA filed a Notice of Intent to Apply for the Capitated Financial Alignment Demonstration (Demonstration) for Contract Year 2014 with CMS and was assigned a pending contract number for this application. UCA is in the process of completing the application for the Demonstration for submission on February 21, 2013. If the Demonstration does not move forward, UCA will continue to operate its D-SNP in 2014. In either case, UCA's current service area will be expanded to include Gila, Greenlee, Graham, Yavapai, Yuma and La Paz counties, consistent with UFC's 2014 AHCCCS bid.

### **Integration of Medicare and Medicaid Services**

The health plan has already taken several steps to integrate care to the extent possible under AHCCCS and CMS guidelines. This is demonstrated through organizational structure, design and management of the network, care models and administrative process, when appropriate. The health plan looks forward to, and is prepared for full integration to better meet the care needs of our members.

**Organizational Structure:** The health plans organizational structure is designed to ensure integration for D-SNP members. Leadership, Committees and oversight are designed to provide cross-functional responsibility, thus ensuring success and coordination for both lines of business. Additionally, all employees are trained and have cross-functional responsibilities to ensure they address the needs and requirements of both AHCCCS and Medicare.

**Network Management/Provider Relations:** A primary component to ensure integration of Medicare and Medicaid services is a comprehensive and aligned network that meets the needs of under-served populations with diverse healthcare needs. Currently, over 98% of UFC's participating providers are contracted with UCA, and the health plan intends to maintain this alignment in expansion areas. If the Demonstration moves forward, UCA will pursue a strategy of amending its current provider contracts to include the provider's participation with UCA as a Demonstration Medicaid Medicare Plan (MMP). The seminal provision of the amendment is that the provider or facility will be providing services to UCA's dual-eligible members under one plan, with one set of benefits, payment provisions, operations and regulatory requirements that will be integrated and not require coordination with two plans. To meet members' needs, the health plan contracts with integrative health homes, PCMHs that provide integrated behavioral health, geriatricians and providers dedicated to serving members with more challenging medical and psychosocial needs. UCA uses geo-mapping to identify "hot spots" of high-utilizing members and ensure that appropriate providers are nearby. As stated above, UFC/UCA have been aggressive in partnering with provider groups to build a PCMH infrastructure and sharing critical utilization data to improve member health outcomes, as well as payment incentive models designed to improve utilization, quality and member experience outcomes.

**Member Services:** Dual-eligible UFC/UCA Member Services Representatives (MSR) are highly trained, seasoned individuals and are responsible for assisting members on how to utilize both their Medicare and AHCCCS services and benefits. MSRs have access to an intranet library designed to provide up-to-date reference materials on AHCCCS and



Medicare. In addition, the Member Services leadership conducts both AHCCCS and Medicare training at its biweekly staff meetings and performs call monitoring to identify improvement opportunities and ensure quality for our members and staff. These training and monitoring processes ensure MSRs and MCSs are thoroughly trained and foster inter-departmental collaboration to ensure members understand their benefits and how to access needed care. Given the high degree of expertise MSRs possess in both Medicare and AHCCCS, MSRs can resolve members' issues at first point of contact greater than 90% of the time.

In order to minimize confusion for the D-SNP members and clarify the benefits of having a sole source of healthcare coverage, UCA initiated a member on-boarding concierge program that provides new members with a customized enrollment experience. This is conducted and coordinated by Member Care Specialists (MCS), individuals with specialized training in dual integration. The on-boarding concierge program is in partnership with a UCA CMs and Pharmacists. Should the Demonstration move forward, this model will be maintained and MSRs will receive specialized training and resources to address the changes associated with an integrated single MMP to ensure a smooth transition for members,

**Quality Management:** The health plans Quality Management program (QM) is integrated to the extent possible under current AHCCCS and CMS requirements and regulations. This is particularly true of our quality improvement initiatives, including addressing improvement in HEDIS and AHCCCS Performance Measures, and the QM structure. We have a comprehensive QM plan that will be fully transitioned to an integrated plan based on full integration. Our monthly Quality Management/Performance Improvement (QMPI) committees are held concurrently to ensure data is reviewed and improvement opportunities are addressed holistically. If the Demonstration goes forward, any measure of quality the MMP is subject to will be addressed under the current AHCCCS and Medicare STARS management structure.

**Medical Management:** Health plan Medical Management (MM) has already been highly integrated in its care management methods, structure and initiatives to improve member health outcomes. The health plan will continue to train employees and adjust processes based on full integration. The UCA population has a high percentage of members with multiple co-morbid medical conditions and behavioral health disorders. This requires complex care coordination of physical and mental disorders, as well as a focus on medication reconciliation. UCA has experienced CMs and Disease Case Managers (DCM) familiar with the array of resources that support successful care coordination. In addition, UCA uses an ICT that includes RN Adult CMs, DCMs, BH CMs, Pharmacists, and MM leadership, including Medical Directors. The team is responsible for reviewing the care coordination needs of our high-risk members or those who have been identified as continually having poor outcomes after initial interventions. In some cases, the CM staff has found it beneficial to organize ICT staffing at hospitals, BH clinics, medical clinics, or at home with the family to meet needs of the member. This ICT process has been successful at providing support to the member's personal CM, who develops a unique relationship with his or her members. Utilizing evidence-based guidelines in conjunction with the member and appropriate family members along with physicians, and community providers, a member-centric care plan is created. The care plan includes arrangement for all necessary health-related and support services covered by AHCCCS or Medicare, as well as education about self-care, medications and how to communicate with providers. This initiates an ongoing and supportive care relationship with the personal CM that includes monitoring the member's symptoms, well-being, and adherence to the care plan in a culturally competent manner, while keeping the member's provider care team apprised.

The organization has successfully utilized an innovative Interactive Voice Recognition solution, Warm Health, to monitor each member's personal experience and to engage members in their own care by providing evidence-based, disease-specific education. A key feature of these programs is the member's ability to generate an alert to the health plan's MSR, CM or PCMH Care Coordinator for a follow-up contact from the health plan. This program has successfully built efficiencies not only within the health plan, but also within the member's care team including his or her personal medical home. In coordination with other health plan initiatives during the past year, this program has played a role in our improved performance in a number of HEDIS/Performance Measures, such as diabetic testing. In order to improve services to members with behavioral-health needs UFC and UCA are actively pursuing the following strategies: 1) Contracting with integrated health homes; 2) Piloting the Health Passport data sharing program with Cenpatico in Pinal County; 3) Adding geriatric behavioral health providers to our network.

UCA also contracts with PCMHs that include integrated behavioral health programs and partners with The University of Arizona Family Medicine Department to provide incentives for improved health outcomes in individuals with BH



disorders. This resulted in 13% decreased costs due to 38% fewer admissions and 5% fewer ER visits, along with a 36% increase in preventive care. An additional care integration model is our innovative healthcare and payment initiative called the Healthy Together Care Partnership (HTCP). More than 475 current high-risk UCA members are part of the program and are being cared for by a team of nurses, behavioral and community health specialists, pharmacists, nurse practitioners and physicians. This program, a best practice identified by the Veteran's Administration system, aims to provide effective, innovative care for this high utilizing population by using a team-based, patient-centered approach. Members benefit from the use of coordinated high-touch care that has been demonstrated improved quality and utilization patterns.

**Corporate Compliance:** While Medicare and Medicaid have separate rules, requirements and reporting structures, the health plan has constructed its Corporate Compliance Program to ensure the greatest degree of integration and coordination between Medicare and Medicaid lines of business. This includes the following fully integrated components: 1) An annually updated Compliance Program that is compliant with both AHCCCS and CMS requirements and which contains a compliance plan and fraud, waste and abuse plan, 2) An annual risk assessment and audit work plan which identify and address potential areas of risk across the organization coupled with a robust auditing and monitoring program to ensure ongoing AHCCCS and CMS compliance, 3) Strong and continual oversight via a Compliance Committee, Fraud, Waste and Abuse Committee, Subcontractor Oversight Committee and integrated reporting to UAHP leadership and the Board of Directors, and 4) Employee, provider and member education and training on both AHCCCS and CMS compliance requirements. UAHP has comprehensive policies & procedures (P&P) for all lines of business and integrates P&Ps whenever appropriate. The Compliance Department is led by a Compliance Officer who has attained certification from the Health Care Compliance Association, an Audit Manager and eight additional auditors who have expertise with both Medicare and Medicaid. UAHP takes a collaborative approach to compliance—involving all departments and employees. In conjunction with Network Development and appropriate operational departments, the health plan's comprehensive structure ensures subcontractor collaboration and oversight. This includes monitoring and oversight to ensure compliance with AHCCCS and CMS requirements, established performance metrics and joint operations meetings. The health plan will establish a work plan that includes contract modification, training, consistent communication with members, and appropriate performance metrics and oversight of subcontractors specific to full integration. This internal and external collaboration has led to several achievements including receiving the highest possible marks from AHCCCS during its recent program integrity review. UFC and UCA's compliance program enforces the highest ethics and standards for employees, the Board of Directors, subcontractors and agents.

**Grievance System:** The health plan's grievance and appeals (GA) system is currently integrated in a single department. While current requirements under the program are not integrated, health plan employees are cross-trained and the structure is designed for a seamless transition to the requirements of the Demonstration. Through the use of the PDSA process, the GA department has improved member and provider resolution timelines. In addition, by cross-training employees and expanding technology the GA department has enhanced reporting, tracking and trending and streamlined processes. Enhanced processes and interdepartmental teams are established to monitor claims disputes, resolutions, and claims negotiations as mechanisms aimed at identifying avoidable grievances and appeals. Once identified, operational changes are implemented to ensure the avoidable grievance or appeal will not occur again in the future.

**Branding:** UCA is a brand that is successfully launched in five counties, largely due to its affiliation to UFC. Branding strategies, including graphic representation, website design and content, brochures, and communication methods promote the relationship between UCA and UFC. The sales and communication strategies are designed to target dual-eligible members with UFC as their health plan, to educate them on the benefits of care coordination through enrollment in the same AHCCCS and Medicare plan. UFC will employ these same strategies in new counties, and will employ a comprehensive communication and education plan if passive enrollment is realized.

## **Conclusion**

UFC has demonstrated its ability to meet contractual requirements and add value to the AHCCCS program for over 27 years. UFC has now aligned its structure, network, care management, technology and financial incentives to improve health outcome and reduce waste in the health care system. UFC's demonstrated experience, strong local presence and affiliation with premier provider groups allow us to be uniquely positioned for successful implementation of the Affordable Care Act and new GSA's.



## **D. Disclosure**

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

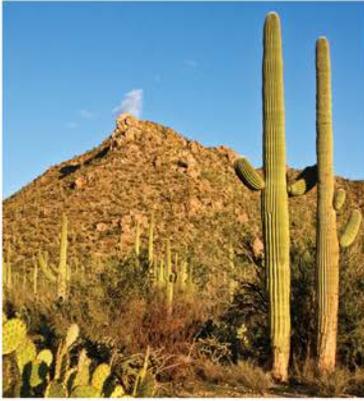
**University Family Care does not have any Moral or Religious Objections**



THE UNIVERSITY OF ARIZONA  
HEALTH PLANS

# VALUES

- We are all responsible for the lives we touch.
- Act with honesty, respect and honor.
- Treat patients and their families with care, compassion and support.
- Inspire hope in each other, our patients and the community.
- Be the standard by which others benchmark excellence.



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

The newly eligible population in Arizona is at risk of having poor health, complex health care needs and poorer health status. Barriers to care include limited English proficiency, relatively fewer numbers of general and specialty providers, members being previously un-insured and the associated delay for needed and preventive care and a lack of relationships with primary care providers (PCPs). In the following section, University Family Care (UFC) describes its philosophy and how its aligned operations and network reduce barriers for new members and ensure their access to high-value services. UFC is a nonprofit organization and uniquely Arizonan—its mission is focused on caring for Arizona’s under-served. A key strategy is to improve members’ access to care and experience. UFC is a division of The University of Arizona Health Network (UAHN), a comprehensive health care system based exclusively in Arizona that includes award-winning hospitals and providers, a health plan dedicated to serving those most in need and a strong link to The University of Arizona College of Medicine, Nursing, Pharmacy and Public Health Programs.

### **UFC Will Take Steps to Ensure Access to Care to Support the Influx of Members**

Morbidity measures among Arizonans – including poor-to-fair health, poor physical days, poor mental health days, and low birth-weight – exceed the national average as documented by the County Health Rankings and Roadmaps Program, which compares statewide and county-specific rankings to national benchmarks. UFC will take the following steps to reduce barriers to patient-centered care in order to meet newly eligible members’ preventive care needs and address their risk factors.

- ❑ UFC will expand its network to emphasize member choice; including contracting with additional Patient-Centered Medical Homes (PCMH) and will continue to support the development of new PCMHs and promoting the development of Patient-Centered Health Care Homes (PCHCH). UFC will extend incentives for guaranteed “access to care,” improved outcomes and reduced cost.
- ❑ UFC will build on its robust PCP network, – which significantly exceeds community norms and includes PCPs that offer home services, nurse practitioners (NP), physician assistants (PA) and OB/GYNs. UFC will recruit additional PCPs, mid-levels, OB/GYNs and high-volume specialists that meet the needs of under-served populations. Mid-level providers will be encouraged to act as PCPs and have assigned members.
- ❑ UFC has partnered with The University of Arizona College of Nursing to establish an Inter-Professional Collaborative Clinic, a NP-driven, team-based model that provides comprehensive care for members and families. UFC will continue to support the development of this model to increase the number of NPs practicing as PCPs in Arizona.
- ❑ UFC has partnered with UAHN and The University of Arizona Health Science Colleges (AzHSC), including medicine, nursing, pharmacy and public health, to improve inter-professional care (IPC). In collaboration with UAHN, UFC has developed an IPC team focused on improved outcomes and increased capacity for D-SNP members. UFC will identify additional populations that would have the highest positive impact in an IPC model by January 1, 2014. UFC has invested financial resources in the development of IPC education with AzHSC to address long-term care coordination and improved access to care needs in Arizona.
- ❑ UFC will continue to build a strong network of retail clinics to address the statewide PCP shortage. UFC will build a strong network of retail clinics to address the statewide PCP shortage by partnering with 3 of the major retail chains. These clinics increase access to care and by offering extended hours can divert members who might otherwise access the ER.
- ❑ By October 1, 2013, UFC will offer an access to care incentive to PCPs with the following: 1) An open panel; 2) Compliant appointment availability; 3) Extended hours and 4) Care for either AHCCCS-allowed behavioral health (BH) services or home-based care. This incentive will contribute to creating a continual supply of PCPs and will help overcome the cost barrier to extending hours and implementing other proven access to care solutions. This incentive will be part of a larger strategy that also focuses on improved health outcomes and positive member experience.
- ❑ In coordination with the member’s PCP, UFC will continue to contract with mobile providers – including PCPs that visit members in their home, dental, mammography, x-ray, and laboratory providers – which enhance service to members in medically under-served areas. Members, such as the homeless and those in remote areas, receive access to preventive screenings, immunizations, urgent care, dental evaluations, examinations and health education. Members are educated on how to access their medical records and to follow-up with their assigned PCP.
- ❑ UFC will continue to staff a Member Resource Center (MRC) in the community to help members navigate the health system, understand benefits and remove barriers to care. UFC will expand MRC outreach by hiring Community Care Partners to visit high-risk members at home to provide education and navigation assistance. They will coordinate with community resources including community health workers, thereby providing a seamless community workforce to



meet the newly eligible needs and support integrated care plans developed by UFC's Interdisciplinary Care Team (ICT), Care Transition Managers and PCMH partners.

- ☐ UFC will continue to promote the Teen Outreach Pregnancy Services program which provides pregnancy and parenting classes and baby supplies – particularly as increased rates of poor birth outcomes and high-risk pregnancies were among the poorer outcomes identified in Arizona's Community Health Needs Assessments (CHNA).
- ☐ Bilingual UFC employees and materials are available to serve the estimated 16%-80% of GSA residents whose primary language may be Spanish. 21% of UFC PCPs, 35% of dentists and 9% of specialists speak Spanish. To reduce barriers to care, UFC promotes the use of translation services for all members with limited English proficiency.
- ☐ UFC supports all AHCCCS-covered telemedicine and e-consultation services. UFC also partners with UAHN telemedicine programs including genetics, hematology/oncology, neurology, orthopedics, rheumatology, pediatric cardiology and wound management. UFC will evaluate for needed telemedicine services in under-served and remote areas and will begin design a plan to add these needed services by July 1, 2013.

The CHNA identified that Arizonans have increased rates of diabetes, heart disease, cancer, influenza, pneumonia, depression and substance-use disorder. A recent study published in The American Journal of Psychiatry predicted significant increases in the number of users of mental health services and anticipates potentially doubling of utilization when reform is fully implemented in 2019. Therefore, UFC will take several steps to expand capacity and increase coordination for new members with complex care and BH needs.

- ☐ UFC has a large network of specialists in heart disease, cancer, diabetic care, pulmonology and pediatric sub-specialties. UFC's hospital and ancillary network meets or exceeds AHCCCS standards in all GSAs.
- ☐ UFC will partner with UAHN to expand the number of sites serviced by visiting specialists. This 17-year-old program arranges for high-demand specialists to visit under-served areas based on identified need. This is important for newly eligible, federally-qualified Native American members in order to ensure access to Indian Health Service providers and specialists in a culturally competent setting. Three additional sites will open by 2015.
- ☐ By October 1, 2013, UFC will offer an access to care incentive to specialists with the following: 1) Open appointments for members, 2) Compliant appointment availability, 3) Extended hours, and 4) Offer telemedicine or another outreach program to under-served areas.
- ☐ UFC has partnered with Carondelet Health Network (CHN) and UAHN to promote its population-based diabetes care program for members. These team-based programs serve diabetics in Southern Arizona with direct patient care, telemedicine care, support for PCPs managing diabetics, community education sessions on nutrition and physical conditioning and quality improvement support for PCMHs.
- ☐ The Healthy Together Care Partnership (HTCP), a population-based program that includes home-based primary care is sponsored by UFC and UAHN and integrates BH care for D-SNP members with serious mental illness and medical co-morbidities. HTCP providers regularly participate in UFC's ICT for joint care planning and expands access to medical and BH services to this high-risk population. This model shares savings between AHCCCS, UFC and UAHN. In the next 12 to 18 months, UFC will seek out other partners willing to enter into a similar arrangement.
- ☐ UFC actively partners with Regional Behavioral Health Authorities (RBHA) to pursue integration opportunities and improve care coordination between the systems. Community Partnership of Southern Arizona (CPSA) is represented on the HTCP steering committee and consults on the HTCP project. UFC also partners with Cenpatico on its secure web-based PassPort portal, which is used to improve provider care coordination with functions like real-time availability of psychotropic medication information on members with an open episode of care. UFC and Cenpatico have also joined forces on a pilot to identify and intervene on mutual members who are frequent ER users with the goal of a 5%-10% reduction in avoidable ER visits in this membership by 2014.
- ☐ UFC has a strong BH network for its D-SNP members and more than 23% of UFC PCPs care for depression, anxiety and ADD/ADHD.
- ☐ UFC will expand its medication delivery program through its contracted transportation providers and mail order vendors. Members will receive timely refills and improved medication adherence while reducing unnecessary and duplicative transportation costs (a one-way trip from the pharmacy to the member versus a two-way trip).
- ☐ UFC will continue to work with providers, pharmacies and community agencies to encourage all members to get the appropriate flu and pneumovax vaccinations to promote good health and reduce unnecessary provider visits.

UFC recognizes the importance of engaging members early to receive services and support healthy lifestyles. All members are automatically included in outreach and engagement initiatives. UFC monitors claims and encounter data and lab and pharmaceutical data to identify members who may have access to care issues. When identified, case management



outreach and coordination is implemented. UFC will utilize its interactive voice recognition system, Warm Health, to inform and engage members in prevention, disease management and self-care. UFC will continue established and create new member engagement programs while increasing member participation.

- ☐ Warm Health has proven to improve health outcomes and a reduction in administrative infrastructure. It can be readily expanded with an influx and is targeted to members with diagnosed conditions such as diabetes, hypertension and depression, or who are pregnant. Members can also alert UFC directly to be screened for case management assistance.
- ☐ To identify level of member engagement, UFC proactively analyzes data and provides member engagement reports to all PCMHs in an effort to increase outreach and engage members.
- ☐ UFC will continue to contact pregnant members to ensure they have an assigned OB/GYN, are engaged in prenatal care and are educated about community-based resources, such as Arizona Healthy Start and Nurse-Family Partnership. By September 2013, UFC will expand to partner with each agency to contact pregnant members directly upon UFC notification and initiate the community-based prenatal care service. Agencies include: Nurse-Family Partnership, Healthy Start, The Parent Connection and Child and Family Resources.
- ☐ UFC will continue to partner with Child-Parent Centers, Inc., a Head Start grantee, to receive information on members who are non-compliant with immunization and EPSDT visits. This enables UFC to target its member engagement outreach and increase use of preventive care and wellness services.
- ☐ UFC has implemented a concierge pilot program for its D-SNP members to assist them with health plan and health care navigation. The goal of the concierge program is to ensure that newly enrolled dual eligible members experience a first-class enrollment experience. From the time of the completed application through the care coordination process, University Care Advantage’s (UCA) Member Care Specialists (MCS) ensure that the specific needs of the member are met. For example, the MCS will assist members with the transition of prescriptions, scheduling appointments and any other care coordination needs the member may have. The result is that we proactively identify the needs of our new members and ensure that there are no barriers to receiving the case and services they need.
- ☐ UFC subscribes to the Health-e-Arizona program. UFC’s employees have been trained and are actively facilitating member renewals. UFC will continue to partner with agencies such as Pima Community Access Program (PCAP) and the United Way to complete renewals. On-time renewals ensure continuity of care and reduce churning.
- ☐ UFC will continue to provide medication therapy management services for D-SNP members. One-on-one coordinated counseling is provided to high-risk members by UFC or the Pharmacy Benefit Manager (PBM), MedImpact.

UFC actively monitors access to care parameters to detect issues as they emerge and to assess the effectiveness of related initiatives. UFC has a dynamic information system that provides ongoing access to care data. UFC uses Quality Spectrum software from Inovalon, an NCQA-certified HEDIS vendor, to calculate monthly rates for AHCCCS performance measures, including Children’s Access to Care. As a result of UFC’s initiatives, from CYE 2010 to CYE 2012, UFC has realized a significant improvement with annual access to care rates as shown in Table 1 below:

**Table 1. UFC Access to Care Rates by CYE**

Access to Care Measure	CYE 2010	CYE 2012	Change
Access to PCP 12-24 Months	84.0%	97.8%	13.8% ↑
Access to PCP 25 Months to Six Years	80.6%	88.11%	7.51% ↑
Access to PCP 7-11 Years	82.4%	89.74%	7.34% ↑
Access to PCP 12-19 Years	83.8%	90.13%	6.33% ↑

Based on data from our NCQA-certified vendor, UFC’s 2012 performance exceeded AHCCCS contractual minimum performance standards, as well as met or exceeded the national Medicaid rates as reported by NCQA in “The State of Health Care Quality 2012.” UFC envisions several ways to expand continual monitoring of access to care as new members are enrolled.

- ☐ UFC quality management nurses conduct monthly provider site visits to review clinical practice guidelines, EPSDT requirements, and members in need of one or more services. By October 2013, UFC will expand the program to supply all provider groups with a member engagement report and implement initiatives designed to engage the member.
- ☐ UFC monitors access to care through quarterly appointment availability surveys, secret shopper calls or unannounced visits, and results show high levels of access. Results of these surveys are regularly reported to the Quality Management/Performance Improvement Committee and any corrective needs are addressed. Access to care is also communicated at UFC’s Director Team meeting to ensure all health plan leaders are aware of issues and plans to improve access to care.



- ❑ UFC monitors access to care through various channels, including member and provider feedback, and comments from local government agencies. Other channels include satisfaction surveys, outreach, the Member Advisory Committee, the Quarterly Provider Forum and member grievances. UFC has expanded monitoring to include monthly access to care grievances and have implemented corrective actions if grievances exceed historic benchmarks by 5% for two consecutive months.
- ❑ UFC continually monitors PCP panel status. When the number of PCPs with open panels drops below 80%, UFC begins immediate PCP outreach. PCPs may be required to re-open panels and UFC will recruit additional PCPs or related services to ensure adequate access to PCP care.

### **UFC Ensures a Sufficient Structure to Efficiently Implement Program Operations**

With the anticipated Medicaid expansion due to PPACA, UFC is projecting a 30% membership increase, with the largest influx occurring between January and September 2014. UFC's operational and administrative structure is knowledgeable, abundant, and adaptable and has managed successful transitions of increased membership by greater than 30% in both 2005 and 2008. UFC is confident they will be able to efficiently implement all program operations to support member influx.

UFC is governed by a Board of Directors that is accountable for the policies of the organization. The visionary board members are committed to help UFC achieve its goals with integrity. UFC's CEO, James Stover, has 14 years of AHCCCS experience and is responsible for interfacing with the Board, carrying out the Board's instructions and overseeing UFC administration and programs. UFC's centralized administration is also composed of a CFO, CMO and COO, who are responsible for managing programs and operational areas. Administrative and operational departments are led by directors and over 70% of UFC's combined management team has five or more years of experience with AHCCCS and over 50% has five or more years of experience with Medicare.

UFC's organizational structure has teams organized both horizontally and vertically. For example the claims team is a vertical unit led by the director of claims and composed of employees with specialized expertise. The leadership team is a horizontal unit composed entirely of officers and directors, which provides the cross-functional leadership necessary to achieve UFC's goals. This team-based approach synergizes individual competencies within the team. UFC balances structure and flexibility and takes pride in empowering management to be decisive and collaborative.

The administrative structure provides clear lines of accountability and communication to sustain dynamic program operations. With a sense of purpose at every level, UFC's 100% Arizona-based workforce is passionate about UFC's mission and employees are knowledgeable about AHCCCS and Medicare. In addition to its substantial work sites in Tucson and Phoenix, UFC also has effective telecommuting programs in Arizona. UFC has formal training programs for employees, including standard and specialized training to ensure in-depth knowledge of AHCCCS, Medicare and UFC.

UFC information systems are equipped to handle an increase in volume without degradation in performance, responsiveness or service. Technology is the backbone of UFC processes, and during the past four years, UFC has invested millions of dollars in leading-edge technological solutions to improve performance, ensure nimbleness and mobilize stakeholders. Multiple new implementations have changed how UFC accomplishes its work, including significantly reducing reliance on paper and manual processes which also results in reduced labor costs. UFC will continue to leverage technology and reduce manual operations to ensure efficient workflows that will absorb increased operational demands.

UFC employs project management as a core competency. When implementing the influx of members from the 2008 AHCCCS award, UFC gained experience in and knowledge of the importance of consistent project management. Since 2010, UFC has established project management practices and hired experienced project managers. This has significantly improved the success of initiatives such as the outpatient prior authorization (PA) project, the implementation of a new PBM, and many key operational and software implementations. Consistent project management tasks— such as task identification and regular monitoring, clear accountabilities and due dates, identification of efficiencies, inter-departmental communication, timeliness of training, thorough testing, risk management and mitigation, change management, approvals, and management of costs – have become standard-operating procedure. All of these activities ensure smooth transitions and minimal or no impact to members and providers. Initiatives surrounding membership increase will be managed using these standard practices to ensure UFC is prepared well in advance of increasing



membership, including any transition of members from a former AHCCCS contractor, which will be managed in accordance with AHCCCS “transition of member” requirements.

The membership influx will significantly impact several key operational areas, including Member Services, Medical Management and Claims. UFC will focus on these areas to guarantee readiness. UFC’s two primary strategies will be 1) Ensure proper hiring and training of needed staff prior to October 1, 2013 and 2) Continue to focus on technology and efficiency to reduce excess administrative costs. Member Services will ensure flexible staffing; extended hours of operations and back-up call center contractors are in place to manage the influx. For the past five years, Member Services has consistently performed above the AHCCCS performance standards during all of the programmatic changes. Current Medical Management systems will continue to be improved to decrease administrative burden for providers and improve internal efficiency. Improvements include a re-engineering of PA criteria, online searchable guides for PAs including CPT codes and implementation of Milliman Care Guidelines’ CareWebQI. The integration of CareWebQI will enable providers to enter an online PA request, along with responses to clinical criteria to generate an immediate decision. This phased implementation, beginning in late 2013, will ensure readiness to manage an increase in PA volume. The Claims Department is identifying operational efficiencies including increasing the claims auto-adjudication rate to 55% by December 2013 and ultimately to 70% by the end of 2014. This process improvement will ensure a minimal impact despite the influx of claims expected with membership growth.

UFC will develop an in-depth and redundant communication plan for both providers and members; including mailings, eBlasts, newsletters, automated messages when calling UFC, website notifications and direct member and provider outreach. Communication will happen first at 120 days before the projected influx begins and then occur again at 90, 60 and 30 days prior. Provider communication will focus on access to care expectations and resources available. Member communication will focus on engaging in care, obtaining preventive services and navigating the health care system.

UFC will use its member-management protocol to ensure those in need of care are identified and their care needs are facilitated. This includes contacting new members within 10 days and informing them about accessing care. Members are encouraged to complete and return the Health History Questionnaire (HHQ) included in their “new member packet.” When received, UFC uses technology to sort the HHQ data into high-, medium- and low-risk categories. High- and medium-risk members are contacted by mail or phone and offered case management services. High-risk members are reviewed by the ICT and engaged by case managers, PCMHs, home health, NP home visitors or community care partners.

UFC uses a variety of internal and National resources to benchmark staffing levels. UFC will ensure timely hiring of qualified employees. To ensure adequate staffing, UFC will begin hiring 120 days prior to member influxes. As needed, UFC will deploy multiple work shifts to ensure compliance with its timeliness and accuracy standards. UFC will also utilize services and staff augmentation, including a temporary-to-permanent model to overstaff at the onset of the membership influx, while maintaining the financial discipline to remain fiscally sound. UFC will ensure timely and thorough training of new employees. Group training will begin 90 days prior to the anticipated influx. The groups are delineated by job functions to ensure individualized training. At 60 days prior, hands-on training with experienced workers will begin. At 30 days prior, all specialized employees will receive relevant specialized training. For example, regardless of employment status, all Medical Management employees will receive Milliman Care Guidelines training and testing. To ensure understanding of D-SNP members’ needs, UFC’s “Model of Care” training, which was recently cited by CMS as a best practice, is supplied to all new employees. Hands-on-experience will continue until the population influx begins. UFC will evaluate readiness through testing and will reinforce training when needed.

To ensure ongoing compliance, all UFC departments conduct internal monitoring. The Compliance Department also conducts external audits. External reviews by AHCCCS have shown consistently improving performance. From 2007 to 2011, full compliance has increased by almost 4% and areas of non-compliance have decreased by 3.3%. This is significant given the high performance UFC has achieved on operational and financial reviews. UFC ensures Policies & Procedures (P&P) are in place, reviewed and approved annually. Policy and Procedure review is the responsibility of the leadership team and is a component of their performance review.

As a purchaser, UFC understands AHCCCS’ fundamental concern with access to care. UFC will work to ensure an adequate supply of high-quality providers is available for members to receive needed services in a timely fashion and that UFC’s administrative and operational infrastructure is ready to support and warmly welcome its incoming membership.



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## **Question 2. Describe how the Offeror evaluates and measures its network in order to ensure timely access to...**

As a long-standing AHCCCS contractor, University Family Care (UFC) understands AHCCCS network requirements builds, sustains, and improves the network to meet the member's healthcare needs, including medically under-served members. UFC's network is comprehensive, innovative, adaptable and focuses on continually improving members' experiences. This is accomplished by engaging all stakeholders, partnering with providers and implementing a network of innovative care models to support improved integration and coordination. Because network management is an inter-related process, tactics and tools used to evaluate and measure the network are also deployed to identify deficiencies, manage, make improvements to and sustain an adequate network in current and newly awarded GSAs.

### **UFC Evaluates and Measures to Ensure Timely Access for Under-served Populations**

UFC continually evaluates access to care for UFC's Medicaid and dual-eligible SNP (D-SNP) members. These evaluations are documented in UFC's annual Network Development (ND) and Management Plan. Both the Federal government and State of Arizona have identified medically under-served geographic areas in Arizona. The Department of Health & Human Services defines medically under-served areas by: the ratio of primary care physicians (PCP) per 1000 population, infant mortality rate, percentage of population with income below the poverty level and percent of population age 65 and over. ADHS includes the following additional under-served area designation criteria: percent of uninsured births, low birth weights, prenatal care, birth-life expectancy, infant mortality rate, minorities and unemployed. County Health Needs Assessments also identifies health care needs of its citizens. UFC uses Federal, State and County data to ensure appropriate services for the medically under-served and identify potential gaps in UFC's network. UFC recognizes that by the nature of the member's Medicaid eligibility, all members are considered under-served and as such, UFC utilizes the Federal and State government data to identify geographic areas that are at greater risk for timely access to medical services. Key evaluations and measurements include the following:

- ☐ **Utilization of Services:** Utilization trends are evaluated to support ND decisions. Trends may identify concentration of members and concentration of services in a given area or zip code. Out-of-network services, providers utilized, emergency room (ER) utilization, re-admission rates, PCP and specialty utilization are reviewed to identify outliers. This includes evaluating Letter of Agreement (LOA) trends to identify providers to add to the network.
- ☐ **Geographic Network Analysis Measures Adequacy of Provider Networks:** UFC compares its network to community norms to ensure timely access to covered services. For hospitals and other facilities, 94.3% of UFC's members residing within the boundaries of metropolitan Tucson travel no more than 10 miles to reach a contracted hospital. For PCPs and specialists, UFC utilizes U.S. Census and Arizona Medical Board data to identify community norms and compare provider-to-member ratios with GSA provider-to-resident ratios. UFC vastly exceeds community norms for primary care, specialist and ancillary services. Quarterly, UFC compares the AHCCCS scope of services to its network to ensure covered services are available. To ensure seamless Medicare integration, UFC performs a comparable analysis bi-annually for D-SNP members. Except where no Medicaid-eligible providers exist in a required area, UFC meets or exceeds AHCCCS requirements, including PCPs, dentists, pharmacies, specialists, ancillary providers and hospitals in each AHCCCS geographic service area (GSA) as well as UFC's overall non-emergent transportation network and home- and community-based services. For urban members, over 75% are able to access specialist care within 10 miles of their home. In rural communities with an insufficient number of specialty providers, UFC partners with local providers and members to identify referral patterns, preferred providers, and member preferences. GeoNetwork software is utilized to identify those areas where membership is most concentrated to ensure efforts are made to build robust networks that ensure timely access to care. AHCCCS will require that 90% of members residing in Maricopa and Pima County do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy. UFC's provider network significantly exceeds the new minimum standard: 100% of members are within 15 minutes or 10 miles of a pharmacy; 98.4% can reach a dentist that quickly; and 99.5% are within 10 miles of a PCP. UFC conducts a GeoNetwork analysis on all GSAs to determine member's proximity to care. UFC ensures PCPs and specialists have admitting privileges in at least one acute care hospital within the service area (or use hospitalists). UFC serves federally designated medically under-served areas and the Federal government has identified geographic areas within each county as medically under-served by zip code. UFC has analyzed these data elements and has determined that rural counties have a larger percentage of medically under-served areas than urban counties. One variable of medically under-served areas is the ratio of population to full-time PCPs, which is considered a shortage if the ratio is greater than 3,500:1. UFC's member to contracted PCP ratio is strong for medically under-served areas. For example: Gila County's ratio is 60:1, Graham County is 117:1, Greenlee County is 80:1 and Pima County is 30:1.



- ❑ **Population Health Monitoring Drives the Networks' Assessment of Care Models:** UFC considers special health care needs when measuring the network and implementing care models to improve member coordination and integration, including patient-centered medical homes (PCMH). The PCMH model is designed to improve care for members with chronic conditions, behavioral health disorder or other special health needs. UFC identifies members with chronic conditions and multi-morbidity including but not limited to diabetes, cardiovascular disease and behavioral health (BH) disorders and maps member locations to identify the best PCMH sites. Other under-served populations monitored to ensure network adequacy include members who have HIV, members who are homeless and children who qualify for AzEIP. UFC contracts with established PCMHs and collaborates with provider partners to develop PCMHs in high need locations, including those identified by the Federal and State government as medically under-served. UFC currently has seven contracted PCMHs in eight locations, including medically under-served areas such as parts of greater Tucson, Marana, Nogales, Rio Rico, Eloy and Sierra Vista. In response to National studies demonstrating that those with BH needs do not receive appropriate physical health care, UFC includes Patient-Centered Health Care Homes (PCHCH) in its network. PCHCH models use a wellness approach to offer complex members a robust array of physical and BH services and wellness education to support them in self-management. UFC has already established a PCHCH model within its University of Arizona Health Network (UAHN) Healthy Together Care Partnership.
- ❑ **Urgent and Extended-Hours Services are Critical to Ensuring Timely Access:** UFC's network focuses on providing the members with access to urgent care, extended hour and walk-in clinics to reduce unnecessary ER utilization. UFC has 27 clinics open after hours and on weekends and 46 urgent care and walk-in clinics including Chiricahua Community Health Center's Pediatric Center of Excellence. They adapt their schedule in real-time to accommodate an influx of patients who need same-day care. Other lower-cost alternatives to the ER that are available 24-hours a day include PCPs and on-call nursing staff. UFC realized a 5.4% reduction in ER utilization from 2011 to 2012.
- ❑ **Quarterly Evaluation of Appointment Availability and PCP Panel Sizes:** To ensure access to care within AHCCCS-mandated time frames, UFC performs in-depth appointment availability and wait time studies. UAHN reviews its availability monthly and community PCPs, dentists and high-volume specialists are surveyed quarterly to ensure appropriate wait times and access to care that is routine, urgent, emergent and pregnancy-related based on trimester. Additionally, appointment availability is monitored as part of the letter-of-interest (LOI) process, during credentialing and re-credentialing, before initiating new contracts, during new provider orientations (NPO), and for contracted PCPs who appear on the AHCCCS 1800 report. Appointment availability data is tracked, trended and reported to UFC leadership and multiple oversight committees. UFC takes pride in a high level of ongoing compliance. In 2012, 96% of PCPs were compliant with routine appointment availability. If a PCP is out of compliance or has trended issues, UFC closes the PCP's panel and requires corrective action. In serious cases, UFC presents the PCP at Contract Strategy Committee to determine if any additional steps to be taken. UFC works closely with PCPs to avoid panel closure and identify additional PCP recruitment needs.
- ❑ **Spanish Speaking Provider Availability:** Under-served members may not speak English and language barriers could impact access to care. UFC compares the languages its members speak to those of providers to ensure members will be understood when accessing care and to ensure culturally competent care. UFC compares the languages its members speak to those of providers to ensure members are understood when accessing care and to ensure culturally competent care. The top languages spoken by UFC members are English (79%) and Spanish (19%) and 21% of PCPs, 35% of dentists and 9% of UFC specialists have self-identified as Spanish speaking. In addition, 34% of PCPs, 6% of dentists and 20% of UFC specialists have Spanish speaking office employees. UFC contracts with Language Services Associates (LSA) for translation service, which translates 150 languages, and supplies this service to network providers. UFC receives "just in time" reports from LSA to ensure translation services have taken place.
- ❑ **Feedback Is a Key Component of UFC's Network's Evaluation:** UFC evaluates and measures member and provider feedback, including annual member satisfaction survey results, and trended member grievances and feedback that are obtained during member outreach activities, including UFC's Member Advisory Committee. The 2012 survey indicated that 94% of UFC members were satisfied with the health care received. UFC surveys members who receive non-emergent transportation services to ensure timely arrival and appropriate wait times and reviews that data to determine member needs. If "access to care" issues are identified, UFC implements interventions to address the issue or identify areas for growth. For example, continued complaints about UFC's non-emergent transportation services led UFC to change its non-emergent transportation contract.

## **UFC Identification of Network Deficiencies**

All of the above processes, including population health monitoring, geographic network analysis, provider wait times and provider and member feedback may reveal network deficiencies. UFC conducts a dedicated quarterly network gap



analysis for AHCCCS members and a bi-annual gap analysis for D-SNP members. The Contract Strategy Committee provides oversight of network gaps and identified gaps are evaluated. UFC conducts quarterly reviews of the NPI database, Arizona State Board of Dental Examiners website and other AHCCCS plans to identify new or departing providers who may be in a gap area and confirm that UFC's network is similar to competing plans. UFC utilizes the Arizona Medical Board's annual provider directory to identify potential network additions. Any provider entering a gap area is considered for expedited inclusion. Network gaps may occur if required provider types do not exist in a specific community or UFC removes a provider due to poor performance. UFC employs other methods to bring services to the community, such as use of the Arizona Telemedicine Project for access to specialists. UFC offers PCPs who care for members in their home, mail-order and specialty pharmacy services, home health care, Member Outreach which conducts more than 200 health education events a year, and is partnering with UAHN to launch a mobile, full-service PCP unit to augment PCP services in rural areas. UFC attempts to correct gaps to prevent interruptions to care and member and provider dissatisfaction. Any critical network gap is reported to AHCCCS immediately along with a proposed corrective action plan (CAP).

***Process for Maintaining Care in Case of Network Deficiency:*** If a network gap occurs, UFC executes its Business Continuity Plan to manage the process. Members are transitioned on a temporary basis to other providers with the same capacity to deliver AHCCCS covered services. The Member Services (MS) Department addresses inquiries regarding assigned providers and transitions of care. The Medical Management (MM) Department coordinates medical transition of care. If necessary, UFC refers members to out of network or non-contracted providers until contracts are in place. MM and ND employees work to identify non-contracted providers willing to care for the member, using member-specific LOAs on a case-by-case basis. If a critical gap occurs in a specific area and contracted services are available elsewhere in the network, UFC will transport the member. To fill a network gap, the CMO grants the provider approval to join within 14 days from receipt of a completed credentialing application and minimum NCQA-required documents. Provisional credentialing may be granted to increase available providers in rural or urban medically under-served areas. All providers in under-served areas and those affiliated with an RHC or FQHC are considered for provisional credentialing.

## **UFC Effectively Manages the Network**

UFC understands that it is imperative to not only build networks, but to manage provider partnerships in a systematic way to improve care and quality for members and their communities. UFC is committed to reducing waste, costs and providing quality care by creating and investing in programs that produce long-term, positive results.

***Integrated Network Services:*** UFC supports and promotes integrated medical and BH care for members. Providers are educated on the AHCCCS-endorsed BH Toolkits and the availability of psychiatric consultations from RBHA psychiatrists for PCP members being treated for depression, anxiety, or ADD/ADHD. To ensure UFC's network supports D-SNP members, all contracts are extended for both AHCCCS and Medicare. An integrated contract ensures members have access to care regardless of plan and coordinates provider payments. To integrate Children Rehabilitative Services (CRS), UFC is contracted with CRS in Southern Arizona to provide a full range of specialty pediatric doctors to serve the most vulnerable children. This treatment includes outpatient therapies, physical speech and occupational therapies. UFC has added providers to its network to provide Azeip related services to children in need.

***Provider Communication, Education and Support:*** Written notice is given to all providers regarding network participation and UFC's agreement contains terms and conditions necessary to participate, outlining provider and UFC obligations. UFC disseminates information to providers on behalf of AHCCCS as AHCCCS deems reasonable and prudent. During on-site NPOs providers are given a Provider Manual and Provider Resource Guide that explain member non-discrimination, cultural competency, prohibited practices and UFC's clinical practice guidelines. All of this information plus the UFC provider search at <http://www.ufcaz.com> is available on UFC's website. If UFC identifies a problem involving discrimination or prohibited practices, a prompt intervention and CAP is issued. UFC alerts providers through newsletters, education symposiums, webinars and recurring in-services. Each provider is assigned a designated Provider Relations Representative (PRR) to act as a liaison. UFC has added a dedicated Rural PRR to address needs and challenges for under-served populations. PRRs visit provider offices, maintain regular contact and are empowered to bring issues to any UFC department for resolution. UFC has a track record of utilizing employees up to the CEO and CMO to meet with providers and resolve concerns. Concerns are forwarded to Provider Relations by UFC employees, including case management (CM), utilization management (UM), prior authorization (PA), Claims, Grievance & Appeals (GA), and MS. UFC's Claims Educator is available to assist when billing issues are first identified. An area of particular attention is



assisting PCP offices with specialty referrals, including supplying UFC resources and explaining UFC processes. Providers are educated on how to reach the PA Department and UFC promotes provider's use of electronic health records to improve coordination—including promoting meaningful use initiatives.

**Provider Satisfaction:** Reducing provider hassle is important and, as a part of an integrated health system, UFC has perspective how the relationship of providers and health plans work. UFC has multiple resources in place to assist providers, including online portals that can be used to verify eligibility, check on claims status, provide PCPs with a roster of assigned members and allow providers to submit an electronic referral form or electronic PA request. UFC has a high retention of providers and a low number of grievances, appeals and fair hearings. From 2011 to 2012, trended provider complaints per quarter reduced from 53 to 15, a 71.7% improvement.

***Established Committee and Workgroups Ensure an Efficiently Managed Network:***

- ☐ The monthly Contract Strategy Committee collaboratively develops network and contract strategies. This committee, composed of representatives from ND, MS, MM (including the Medical Director along with UM or PA management) and Finance, has developed decision-support tools to review the network, identify gaps and deficiencies, and develop strategies for network design, provider recruitment and contracting. The team reviews LOIs for value, financial viability, geographic location and compliance to AHCCCS standards. Provider issues affecting UFC operations, performance, utilization or compliance are brought for discussion and review. UFC ensures providers are appropriately licensed or certified, fulfill credentialing requirements, are properly screened against Federal exclusion lists, are operating within their scope of practice, and are actively registered as an AHCCCS provider.
- ☐ UFC meets on a regular basis with the delegated network partners, transportation providers, large provider groups and most contracted hospitals to better coordinate operations. These Joint Operations Committees work to resolve service issues on behalf of both members and providers as well as identify any potential operational issues, such as reimbursement methodology and medical management processes.
- ☐ UFC coordinates with external organizations via our Community and Member Outreach Department, which educates members and residents in all GSAs about AHCCCS, UFC and the network. UFC coordinates with organizations such as Children's Rehabilitative Services and the Regional Behavioral Health Authority to ensure no barriers to care for qualified members. UFC has a Cultural Competency Liaison who works with AHCCCS, UFC employees, providers and members to ensure there is an awareness of cultural needs.
- ☐ Results of member dissatisfaction are reported to the GA Reporting Committee and a collaborative process is deployed to address systemic issues. If feedback indicates that member care may be or was impacted, it is referred to the Quality Management Department for review under the direction of the CMO.
- ☐ UFC monitors and manages health care utilization and implements solutions to reduce unnecessary health care waste. For example, UFC's ER Work Group is composed of representatives from many departments and has implemented multi-pronged interventions to reduce unnecessary ER use. Provider contracts contain language requiring availability after hours and weekends. UFC evaluates one-day hospital admits for opportunities to educate providers on lower cost care alternatives such as surgery centers. In 2011 UFC averaged 623 total ER users per 1,000 members and in 2012 this decreased to 589 per 1,000, a 5.5% reduction. UFC will continue these interventions and implement new programs focused on Accountable Care Partnerships and member engagement including working with PCMHs on a project directed at parents of young PCMH members.

**Ensuring Provider Compliance:** Contract compliance is transparently monitored to ensure the provision of accessible, timely and quality care. UFC posts overall quality improvement performance on its website and all PCPs receive a HEDIS performance measure report on a quarterly basis which compares their compliance to AHCCCS-required rates. A provider scorecard is also generated when there are issues with adherence to contract requirements, appointment availability non-compliance for two consecutive quarters, PCP providers exceeding panel-size requirements and high GA trends. The scorecard monitors network adequacy, membership totals, claims utilization, GA totals, provider appeals, appointment availability, contracting compliance and inquiries and is presented to the Contract Strategy Committee for guidance. Actions may include closing a PCP's panel, focused monitoring, re-education, issuing a CAP or termination. Scorecard outcomes are trended to identify opportunities for improvement.

**UFC Makes Improvements to the Network**

All UFC process improvements follow the PDSA model to ensure a consistent approach. UFC utilizes Siebel, a customer relationship management product implemented in 2009, to store, track and trend provider inquiries. Provider inquiry data



helps UFC identify network strengths and weaknesses. In response to feedback, UFC implemented a same day PA phone line for expedited PA requests and realized improved provider satisfaction. UFC effectively communicates changes and updates to providers through a comprehensive approach which includes written, electronic, website and in-person education methods. UFC held webinars on EPSDT, the UFC Member Resource Center, neglect and abuse, Quality Management's partnership with providers, claims education, in addition to a well-attended spring symposium and fall education sessions. UFC's steady promotion of electronic claims submission, electronic remittance advice and electronic funds transfer (EFT) capabilities resulted in gains in electronic interfaces with UFC providers. From 2011 to 2012, providers' use of EFT grew to 71.36%, a 5.25% increase. UFC created a cross-functional work group between Claims, ND and Information Systems, to address escalated provider issues and overall satisfaction has improved from last year by 2.4%. Each intervention is measured for effectiveness and The Contract Strategy Committee reviews the results and re-evaluates if the intervention does not resolve issues identified.

UFC is expanding PCMH and PCHCH partnerships and assisting providers build PCMH and PCHCH models through best practice development, resource and data sharing. UFC will offer financial incentives for improved outcomes and quality measures. UFC continually assesses its contract strategy to ensure rates align with AHCCCS and community standards. UFC negotiates cost effective contracts. For example, in 2012 UFC renegotiated its dental, pharmacy and laboratory contracts and realized an average of 7% in savings to overall health plan costs with no loss in service coverage or access to care. UFC ensures reimbursement is reasonable in order to sustain a viable network and UFC piloted several agreements to incent providers to improve quality and care outcomes. This includes a contract with UAHN to integrate care for D-SNP members to ensure focused care coordination and timely access. UFC will implement additional incentive agreements in both urban and rural settings to improve integration and access to care and health outcomes for high-need populations.

### **UFC Sustains a Robust Network**

Provider engagement is vital to UFC's efforts to sustain a robust network. UFC understands each community has unique circumstances and adapts to community needs. UFC has demonstrated its ability to adapt to changing local, regional and national health care requirements, including successfully implementing the 2010 and 2011 AHCCCS benefit changes, e.g. revising the podiatry network. UFC will implement a quarterly Provider Forum in major population centers as well as a Rural Provider Forum to inform, educate and collaborate with the providers. UFC collects tracks and trends provider grievances to identify barriers or concerns that may be contributing to provider's satisfaction with UFC. For example, UFC received several grievances regarding the ability to directly speak to PA employees. To enhance the authorization process, UFC now includes the PA Department in its call queue to field PA calls and has received positive feedback from providers. For 2012, 80.6% of UFC providers gave the network high marks as "excellent" or "very good" compared with 76% for other AHCCCS plans. This score is significantly higher than The Myers Group (TMG) benchmark of 80.4% for other Medicaid plans that comprise their 2011 Medicaid Book of Business of 34 Medical Plans. Since 2009, TMG, a NCQA-Certified Survey Vendor, has administered UFC's annual Provider Satisfaction Survey.

UFC's network has specialized expertise that corresponds with the target population. The diverse network includes a full spectrum of PCPs, specialists, dentists, pharmacies, inpatient facilities, dialysis facilities, surgery centers, nursing professionals, homeless clinics, outpatient clinics, durable medical equipment vendors, BH professionals, MSICs, and other providers. Specialties include endocrinology, cardiology, nephrology, psychiatry, geriatrics, pediatric specialists in MSICs, HIV and transplants. UFC benefits from a strong relationship with its integrated health system, UAHN, recognized as one of America's Top Hospitals and top academic medical centers with an affiliated residency program in 48 specialties and subspecialties and nurse practitioner training program. The U of A Cancer Center is a National Institute of Health Center of Excellence; it's Center on Aging is a U.S. News & World Report top 30 center; UAHN just opened a Diabetic Center at our South Campus to meet needs of diabetics in Southern Arizona and provides diabetic members access to innovative care. In conjunction with The U of A Sarver Heart Center, UAHN is a leader in cardiology, cardiac surgery, and cardiac transplantation. UFC works closely with UAHN to offer members innovative and cutting edge modalities, including UAHN's Birthing Center, a state-of-the-art center with neonatal specialists on site. UFC's entire leadership team is committed to sustaining a network that continues to improve quality of care and health outcomes while containing health care costs. To demonstrate this commitment, UFC will continue to be a high-performing health plan and through improved performance will re-invest added AHCCCS payments toward even greater performance.





**Question 3. AHCCCS supports efforts to reward desired care outcomes attained through care coordination...**

**Driving Improvement through Data and Evidence-Based Decision Support Tools**

University Family Care (UFC) uses a data driven approach to target resources in order to maximize coordination for members and enhance provider relationships that build upon shared goals through the development of rational value-based performance incentives. This approach, supported by evidence-based decision tools described below, has enhanced collaborative processes of care that improved health outcomes and cost efficiencies. UFC’s primary cost drivers are identified and regularly reviewed within their committee structure in relation to utilization, quality measurement and member experience. These ongoing reviews identify targets that guide initiatives and incentives to drive performance by our contracted providers and promote best possible member outcomes. The targets for UFC’s data driven initiatives and value/outcome based incentive models related to utilization, quality measurement and member experience are listed in the table below. UFC also anticipates that additional target areas may arise as membership is expanded and new practice variances and opportunities are identified.

**Table 1. Target Areas and Minimum Performance Standard Benchmarks**

Utilization		Quality Measurement		Member Experience	
Emergency Room (ER)	(>AHCCCS MPS)	Evidence-Based Care	(>AHCCCS MPS)	Access to Care	Appt. Standards Met
Hospital Bed days	(>AHCCCS MPS)	Health Risk Assessments (HRA) of High Risk Members	(>80% Completion)		
30 Day Readmits	(>AHCCCS MPS)	Preventive care	(>AHCCCS MPS)	Member Satisfaction	(>90%)

UFC drives improvements in these target areas by sharing this information with providers to support the coordination of members’ care. UFC applies evidence-based clinical guidelines with providers, departments throughout UFC and others involved in the members’ care to affect improved health outcomes. UFC tailors the format and process by which this information is delivered to meet the needs of their diverse AHCCCS network that includes provider groups throughout urban and rural Arizona with differing levels of systems sophistication. For example, telephones, faxes, and mail are used to deliver information to smaller providers. However, at the other end of the spectrum is The University of Arizona Health Network (UAHN), who is contracted with the software vendor Epic to create a single integrated electronic health record (EHR) system accessible by all providers across all locations within their safety-net health system, including the health plan. This allows seamless sharing of health information between UFC and UAHN providers, who currently provide primary care for nearly 20% of UFC’s members, in order to maximize care coordination opportunities and cost efficiencies, including automatic uploading of pharmacy fills by members. Epic will fulfill the requirements for ICD-10 reporting, meaningful use along with other requirements of the HITECH and Affordable Care Act. UAHN has contracted with third party vendors for multiple, enhanced decision support resources that are easily accessed and utilized within the Epic EHR environment. The decision support resources include: Zynx, an application for evidence-based clinical content, order sets, and care plan content; and Truven Health Analytics’ CareNotes for discharge patient information including instructions, knowledge, and readmission risks. Best practice alerts can be embedded within the system based on standards of care. Epic has comprehensive reporting capabilities that include health maintenance alerts that are flagged for the member and remind the provider at the point of care that the services are due, and trigger outreach by the provider.

UFC utilizes multiple evidence-based decision support tools internally such as: Milliman Care Guidelines; Hayes Technology Assessments; peer reviewed literature; pharmacy tools in conjunction UFC’s Pharmacy Benefit Manager (PBM), MedImpact, and The University of Arizona (UA) College of Pharmacy; reminders for case management outreach within *Acuity Advanced Care*; Inovalon QSI software and Oracle reports to identify gaps in recommended care; alerts are embedded within *Siebel*, UFC’s Customer Relationship Management application that notify Member Services Representatives when members are due for preventive services. UFC will also facilitate the delivery of evidence-based care at the point of care by embedding evidence-based prior authorization (PA) protocols with Milliman Care Web QI into our Cerecons Provider Portal. Within the next 18 months, providers will be able to view the guidelines against the authorization request and the provided clinical information to receive an immediate determination. This is expected to improve the efficiency of the PA process by 50% and reduce the average turnaround time for standard requests from 3.5 to 2.5 days. Using *Inovalon* NCQA-certified software, UFC generates reports identifying members who have evidence-based gaps in care. These data, as part of UFC’s provider profiles, are used as a tool to help providers deliver timely and



appropriate care. Contracted providers have appreciated this tailored, yet valid, data-driven collaborative approach from a local community partner.

UFC is committed to real-time clinical data sharing to reduce unnecessary care, improve care coordination and improve health outcomes. One strategy is fully supporting and participating in the activities of the Health Information Network of Arizona (HINAZ), the Health Information Exchange (HIE) for Arizona. An interim strategy until the HIE is fully functional is to collaborate with large provider groups and hospitals to allow data sharing between their EHR. UFC is targeting health systems that provide care to 50% of the membership by January 1, 2015. UFC is including HIE participation as a financial incentive for contracted providers. UFC will also take advantage of the new availability of encounter data history provided by AHCCCS. Through sharing this information with providers, creating a strong collaborative partnership and intervening directly, UFC has have been able to reduce the PMPY cost of care for several chronic conditions (Table 2) while improving related AHCCCS Performance Measures (Table 3).

**Table 2: UFC-Chronic Disease Total Cost of Care**

Condition	CY 2010	CY 2011	CY 2012	% Change (2 yr)
Diabetes	\$8184	\$7438	\$7061	14.0% ↓
COPD	\$5582	\$5277	\$5054	9.5% ↓
CHF	\$17,505	\$12,256	\$12,139	31.0 % ↓
Asthma	\$4881	\$4777	\$4512	7.5% ↓

**Table 3: UFC- Diabetic Metrics**

Indicator	CY 2011	CY 2012	% Change
A1c testing	69%	83%	20.3% ↑
Eye Exams	40%	58%	45.0% ↑
LDL testing	61%	75%	23.0% ↑
Admissions/K	33.19	30.09	27.8% ↓

The following sections describe UFC’s data driven approach to improving care, maximizing coordination and increasing efficiency in these initial target areas identified in Table 1.

**Utilization - ER visits:** UFC identified ICD-9 codes associated with avoidable visits to the ER, such as those for follow-up visits, medication refills, or a cold, based on available evidence-based peer reviewed literature and the review of member-level claims data. All members seen in an ER with an avoidable diagnosis receive a series of calls from UFC’s interactive voice response program, Warm Health, to provide education regarding the proper use of emergency services. This program also allows the members to alert the health plan and receive assistance from a Member Services Representative (MSRs) or Case Manager (CM) if they are encountering difficulty accessing their PCP or are in need of additional services. Members who have a second ER visit within five months of the first are referred to CM for outreach. UFC fosters care coordination and reduction of ER utilization by alerting providers of assigned members who only use ER for healthcare needs with our Member Engagement Report. UFC also furnishes the Patient-Centered Medical Homes (PCMH) with aggregate and member-specific data on their members’ ER utilization patterns. Comparing data six months prior and six months post implementation of the program resulted in an overall reduction in avoidable ER visits in the cohort by 72% attributed to 85% of the members having a reduction in avoidable ER visits.

**Utilization - Hospital Bed Days:** UFC utilizes predictive modeling developed by their Clinical Analytics Team in collaboration with The Center for Health Outcomes and PharmacoEconomic Research associated with The UA College of Pharmacy to identify members at high risk for admission on its monthly High Risk Report. The CM team then utilizes *Acuity Advanced Care* during outreach to assess risk and stratify members further in order to create individualized care plans consistent with *Milliman Care Guidelines*. UFC also provides a number of reports, including a similar High Risk Report, to its PCMH care partners using secure electronic transmission to provide timely, actionable information. These include daily facility discharges, admissions and readmissions; emergency room visit rosters; and missing service/care opportunity lists. The PCMHs have assigned care coordinators to manage the transition planning of members from an inpatient setting in order to facilitate the appointment of outpatient visits with their PCP and/or specialist within three days of discharge. Care coordination is maximized by regular communication as needed between the PCMH Care Coordinator and our PCMH Clinical Liaison along with monthly joint operations meetings with our Accountable Care Partnership team. Our Community Care Partners will provide home visits to High Risk members and support PCMHs and existing community health visitors for optimal care coordination. This systematic coordinated approach was associated with a 5-18% decrease in overall admissions from 2011 to 2012 across all UFC products, which include AHCCCS, Dual Eligible SNP (D-SNP), and Healthcare Group, thereby suggesting a causal relationship with the structure and processes rather than population changes due to eligibility and benefit changes. UFC experienced a 12% decrease in admissions from 2011 to 2012 in populations other than healthy births.



**Utilization - Hospital Readmissions:** Preventing readmissions requires care coordination with a number of stakeholders across the healthcare system, such as providers, home health (HH) agencies, durable medical equipment (DME) companies, and pharmacies, and results in improved outcomes and decreased costs. UFC has a multipronged approach to address readmissions that maximizes coordination and shared information across providers. The UFC 30 day readmission rate in 2011 was 10.6% compared the AHCCCS mean of 11.92% and this rate has continued to decline at facilities where we have on-site Care Transitions Nurses. For example, while Readmissions per 1,000 decreased 3.2% overall between 2011 and 2012, for UFC in Pima County the decrease was 11.8%. Based on this success, UFC is expanding this program such that by July 1, 2014 it will be implemented at facilities accounting for >50% of our admissions and by June of 2015 it will cover 60% of our admissions. UFC's tiered Care Transitions program implements stepped interventions to support coordination with AHCCCS providers to meet the needs of members with differing risks. In *Tier 1*, nurses use Milliman Guideline decision support tools to standardize calls made to each member discharged from an acute care setting within 48 hours to review their discharge plan following the four steps of: 1) Reviewing care plan including receipt of DME or other services as recommended, 2) Medication reconciliation, 3) Reviewing follow-up appointments and transportation needs, and 4) Need for home visit. In *Tier 2*, Members who have been identified as high risk for readmission (on dialysis, in case management, complex co-morbid conditions, or by predictive modeling) are visited by a Care Transitions RN assigned to their facility prior to discharge to coordinate both a smooth transition and longer term care planning in conjunction with our Interdisciplinary Care Team (ICT). The team, including Behavioral Health (BH) staff, assists the member and care-givers in engaging and developing an individualized care plan while identifying any potential barriers to their post discharge care. Once discharged, the Care Transitions RN calls members every day for five days to discuss: medication adherence/reconciliation, DME needs, HH needs, safety checks, and to determine if PCP and specialist follow-up appointments have been kept. In *Tier 3*, members with more than one readmission receive home visits by the Care Transitions RN in addition to support provided in *Tier 2*. UFC partners with both PCMH providers and acute facilities to improve readmissions by meeting regularly with both entities to provide aggregate data on its members' readmission rates. UFC will meet regularly with the Regional Behavioral Health Authority (RBHA) to review High Risk members with dual diagnoses in order to improve care coordination for members with frequent readmissions and mental health disorders. As a next step to UFC's Quality of Care reviews, of all 30-day readmissions in 2012, high volume hospitals will be provided with audit results of their discharge process to improve its effectiveness.

**Quality Measurement - Chronic and Complex Disease Management:** In 2011 the CDC released its evidence-based recommendations for patient-centered Health Risk Assessments (HRA). At that time UFC revised its HRA tool and began monitoring its completion on high risk members who were candidates for complex case management. UFC has increased the percent of our high risk members four-fold that complete their HRA though a multipronged initiative and utilize clinical analytics to identify the needs of those who do not complete the process. These HRAs are shared with providers and are the basis for creating an individualized care plan that is developed in conjunction with the member, their providers, and UFC's ICT. These rounds are attended by Behavioral and Medical CMs, Medical Directors, CM leaders and pharmacists with the goal of providing guidance and resources for successful transitions and to make sure the member has all appropriate resources to be successful upon discharge. As previously noted UFC has decreased the costs of care for multiple chronic diseases and improved quality metrics for those associated with AHCCCS Performance Measures. UFC's clinical initiatives aim to support providers with tools across the continuum of evidence-based decision support tools that include ready access to recommended nationally accepted clinical practice guidelines on our website and incentives for standardized order sets within their EHR. This supports patient-centered evidence-based decisions made at the point of care. UFC's improvement in the use of high value health care services is accomplished in part by strengthening the primary care provided to members that includes a high level of care coordination. The health plan has developed collaborative relationships with the PCMHs by furnishing member utilization data and care opportunities as previously described. The decision support tools developed by the health plan and used by the PCMHs allow for members to receive best practices of care delivery at the right time in a cost effective manner. UFC adapted the Warm Health program discussed previously to provide member alerts directly to the PCMH in order to improve continuity of care for members in chronic disease management programs. This will be offered to all PCMHs by December, 2013. UFC has established ongoing accountable care partnership joint operations meetings with Mariposa Community Health Center, El Rio Community Health Center, Marana Community Health Center, Sun Life Family Health Center, and The University of Arizona Health Network (UAHN).

**Quality Measurement - Preventive Care:** UFC shares a Member Engagement report with providers to support their efforts to outreach members not accessing care for needed services. Using *Inovalon* NCQA-certified software, UFC



furnishes all providers with aggregate and member-specific data on AHCCCS contractual performance measures and HEDIS measures in order to enhance care coordination for individuals with evidence-based gaps in care. In addition, The UA College of Pharmacy reviews our pharmacy data against nationally accepted evidence-based guidelines to identify members with evidence-based gaps in care. These data, as part of UFC’s provider profiles, are used as a tool to help providers improve AHCCCS performance measures and evidence-based care to members. The aggregated data is benchmarked against the contractual performance standards, NCQA HEDIS percentiles, and other contracted providers within the same geographic location. In order to facilitate provider use of evidence-based guidelines at the point of care UFC will embed evidence-based PA protocols from Milliman CareWebQI into Cerecons, UFC’s PA Management System. The net effect of these initiatives has resulted in improvements within our entire population, and greater improvements within our PCMH partners’ populations. As a result of our partnership, we have been able to improve our rates of preventive health services received among members with diabetes as shown in the Table 4 below. UFC, through Maricopa Health Plan, implemented an obstetric medical home pilot with Maricopa Integrated Health Systems that included the Warm Health program to educate and monitor pregnant members and resulted in a significant decrease in NICU admissions. Warm Health’s program is now available through a smart phone application. As such technologies demonstrate efficacy within the demographics of our pregnant members we will work collaboratively with AHCCCS, with full consideration to the unique needs of our Medicaid population, in order to offer them their benefits.

**Table 4**

PCMH vs. Non-PCMH	CY 12		
	A1c	LDL	Eye Exam
Non-PCMH	69%	61%	37%
El Rio	76%	73%	47%
Marana	71%	60%	39%
Mariposa	76%	69%	51%
UAHN	80%	76%	55%

**Member Experience - Access to Care:** UFC is well poised to meet the needs of current members, as well as anticipated membership growth. UFC uses GeoNetworks, appointment availability, member satisfaction, and other core metrics to ensure optimum network capacity. When access to care is limited, UFC reaches out to providers to address gaps. Member Service Representatives (MSR) inform members searching for PCPs in PCMHs near their home and, through Siebel notification, educate members due for a preventive service during phone interactions. UFC care coordination efforts have directly improved the members’ access to healthcare services as reflected by AHCCCS Access to Care Performance Measures which exceeded the MPS in 2012 for 12 month

through 19 year old members.

**Member Experience - Member Satisfaction:** The UFC MSRs resolve members’ issues 91% of the time during the first contact. The Member Resource Centers (MRC) are located in high volume clinics and assist members at the point of care. This includes the use of Health-e-Arizona to support continuous care. UFC will use Community Care Partners to extend the reach of the MRC by performing home visits and collaborating with existing community health visitors. UFC has also instituted a Member Advisory Committee in order to gather more focused feedback and member input regarding proposed interventions. Because of the unique needs of the D-SNP population, UFC surveys regularly according to CMS guidelines each SNP member using Warm Health. This interactive telephone program allows dissatisfied members to be contacted in order resolve their concern. UFC surveys the member experience annually and initiates appropriate interventions depending upon results. Our members consistently give UFC an approval rating of 92% with a 3 year average of 93%.

**Outcome and Value-Oriented Payment Models**

UFC’s data driven approach, combined with efforts to promote information-sharing and best practices, establishes a strong foundation from which to test and implement innovative value-based payment models. UFC has leveraged their strengths and relationships as a locally owned plan to create payment incentives that address clear targets (high costs, high burden utilization; high quality ambulatory care supported by measurement and member experience) to help ensure success in achieving improved outcomes and reduced costs, while investing in the local communities. UFC has carefully considered value-based and performance-based payment approaches, given that the approaches are new to providers and there is risk of potential unintended consequences as providers focus on aspects of care linked to payment. Conceptually, UFC views moving providers along the spectrum of value-based contracting as a three-staged process that includes supporting infrastructure, aligning incentives, and sharing risk. Arizona’s providers serving AHCCCS members are a diverse group, with providers at all stages of evolution from solo/small groups challenged with building infrastructure to large PCMHs delivering value and ready for greater alignment of payment incentives.



## UFC's Incentivized Payment Model

UFC has experience in implementing innovative payment models that incentivize providers for improved health outcomes through their participation in the payment reform pilot, Healthy Together Care Partnership (HTCP) - accepted by AHCCCS in 2011. UFC utilizes other incentivized payment models for programs that offer alternatives to costly and unnecessary ER utilization, chronic disease management, pharmacy and dental benefit management. UFC's incentivized payment models are flexible depending on the sophistication and readiness of provider groups for innovative payment models. UFC uses AHCCCS standards or creates standards based on national benchmarks or trended health plan data for the categories of utilization, quality and member experience. Provider incentives are based upon meeting the standard set forth in Table 1 above or a percentage of improvement.

Because of the diversity in sophistication amongst providers and health systems, UFC has a multi-tiered incentive structure, with the intent to move all providers to risk sharing in the future. The incentive program structure is as follows:

**Fee For Service (FFS) with Pay for Performance (P4P):** This system is used for providers who have little infrastructure to support new care models. This allows providers to have additional funds to support programs to achieve desired outcomes. The P4P is either an additional set payment for meeting the established targets, or a withhold that can be earned back if all targets are met. UFC will have all PCP's with 100 members or more and selected specialists on this type model, or an alternative incentivized payment model by September 30, 2014. Over the course of 24 to 36 months, UFC will move at least 10 large provider groups or health systems to a risk share model described in the following bullets.

- **Risk/Gain-Sharing:** For providers, like PCMHs or larger health systems that have been preparing for payment reform, UFC will be establishing a risk and/or gain share model. These models will identify the savings by meeting the utilization, quality and member experience targets, or making significant improvement in these targets, and will allow for the provider and health plan to share in the savings and continue funding programs that support continuous learning and improvement, as well as improve outcomes and reduce cost.
- **Full Risk:** For a select set of providers, UFC will enter into a full risk arrangement in which UFC will pay the provider a PMPM amount for the care of a member. In addition to demonstrating compliance with the performance standards established, providers must demonstrate they have a strong care model including interdisciplinary care, and must have a functional EHR.

To address access to care, UFC will offer an incentive to PCPs with an open panel, compliance with appointment availability standards, extended hours and care for either AHCCCS-allowed BH services or home-based care by October 1, 2013. UFC will offer the same incentive structure to specialists that have open appointments for members, appointment availability compliance, extended hours, and offer telemedicine or another outreach program to under-served areas. For hospitals, incentive alignment will have criteria for the categories of utilization (admission, readmission, and hospital acquired conditions), quality and outcome measures, member experience and access to care. Hospitals will have the same basic incentive programs: FFS with P4P, risk/gain-sharing and full risk. UFC will have 25% of contracted hospitals on an incentivized payment model by October 1, 2014; with high volume hospitals targeted first (those accounting for the care of 50% of the membership). UFC will continue to align incentive models for all contracted hospitals and enter into a full risk Accountable Care Organization contract with at least one healthcare system within 36 months of the AHCCCS contract effective date.

**Healthy Together Care Partnership:** In early 2012 UFC and University Care Advantage (UCA is our D-SNP plan) began an innovative care model with its UA clinical partners called Healthy Together Care Partnership (HTCP). HTCP's population-based care model has multiple components to meet the members' needs including: Home-Based Primary Care for those with advanced illness (based in part on the Veteran's Administration's Program), intensive BH support for those with serious mental illness, and care coordination for lower risk members. HTCP employs an evidence-based, high touch multidisciplinary care team approach that has been demonstrated to achieve improved health outcomes in a cost-effective manner. The program will stabilize and/or improve health outcomes while increasing the efficiency of healthcare utilization and reduce associated costs. The utilization metrics and goals associated with the pilot program are: achieve a 3.9% decrease in ER utilization; achieve a 2.4% decrease in hospital admissions; achieve a 2.25% decrease in hospital readmission; and save \$1.0 Million in medical expense in 2013. Effective financial incentive will be provided by employing a Gain/Risk sharing methodology that will share the resulting positive financial performance between UFC and UAHP providers (at the individual provider level). These utilization, quality, and member experience target metrics are designed to ensure that the positive financial performance will be realized only by the timely provision of the appropriate care, by the appropriate provider in the correct setting.



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

University Family Care (UFC) is committed to ensuring access to high-quality, cost-effective health care services to all members and to support the education and research goals of The University of Arizona Health Network (UAHN). In part, UFC accomplishes this through effective administration of case management programs in collaboration with community and provider partners. UFC has the distinction of being part of UAHN, which allows them to partner with a growing multi-specialty provider network and has a broadened presence through telemedicine and expanded clinics throughout the State. UFC's member-centric case and disease management programs are integrated into many aspects of their business and are adaptable to members living in locations rural and metropolitan. These strengths make us uniquely prepared to care for members with one or more chronic conditions. Our case management program, supported by an Interdisciplinary Care Team (ICT), utilizes well documented systematic data driven and evidence-based decision support tools to ensure that their unique physical, emotional, social and cultural needs are met. Our comprehensive member-centric, interdisciplinary care plans are developed from individual risk stratified assessments and other clinical data obtained during a Health Risk Assessment (HRA) process. This comprehensive member-centric, interdisciplinary approach incorporates all stakeholders in the care planning process to achieve success.

### **Care Coordination for Mr. Andrews**

#### **Referral and Intake Process**

Mr. Andrews would have been identified as needing case management through our monthly Emergency Room (ER) utilization report prior to receipt of a referral from his PCP. Mr. Andrews would also have been identified as an appropriate candidate for our Warm Health ER Utilization Program. Members who have had an avoidable ER visit are automatically enrolled. The program delivers educational content on the appropriate use of emergency services and offers members the opportunity to generate an alert should they be having difficulty accessing their PCP. At the time of Mr. Andrews' second avoidable ER visit a Case Manager (CM) would have contacted him directly. Within the last six months, 85% of the Warm Health-enrolled members had a lowered ER visit rate after a successful Warm Health outreach and this success contributed to an overall 5% decrease in ER utilization. In addition to Warm Health and UFC Case Managers, PCMH Care Coordinators in our network review emergency room discharge information sent weekly by the UFC Accountable Care Partnership Team and assist all patients with obtaining PCP appointments as appropriate.

In the scenario presented, UFC's case management involvement begins with the receipt of a referral from Mr. Andrews' PCP. Within the network, PCPs are able to initiate referrals to case management by telephone call, fax or secure email to the Case Management Department. Additionally, providers within UAHN can assign a task in Allscripts/EHR for a Case Manager (CM) to follow up with a particular member. Upon receipt of Mr. Andrews' referral, an Intake Nurse within the Case Management Department contacts the PCP to obtain information about the precipitating event for the case management referral. Medical Management employees has secure access to members' records within EHRs at contracted inpatient facilities and at most large ambulatory providers, which allows for a timely and comprehensive review of pertinent clinical information. After discussing the case with the PCP, the Intake Nurse conducts a clinical review of Mr. Andrews' utilization history, including ER visits, hospitalizations, pharmacy profile, current or past care plans, outstanding authorizations and any calls made to the Member Services Department, and initiates the HRA process. Once the clinical information has been collected, the RN contacts Mr. Andrews to discuss the opportunity for case management assistance and gathers information on his health status using the Pre-Screen Survey (PSS) tool.

The PSS is an internally developed, reportable health assessment housed in Acuity Advance Care, UFC's Case Management System. It ensures all members referred to any subgroup of case management are screened for medical, behavioral and social problems that would warrant additional individualized assistance. The PSS contains scripts and prompts developed from nationally recognized evidence-based clinical guidelines or algorithms from organizations such as Milliman, the American Lung Association and the American Diabetes Association. Patient Health Questionnaire (PHQ-2) depression and anxiety screening is embedded within the PSS tool. The case notes are documented within the Acuity System, also enabling the RN to establish follow-up alerts. Acuity assigns a risk stratification score based on the member's answers. An important part of the initial screening call is to determine Mr. Andrews' willingness to participate in case management services. Upon acceptance from Mr. Andrews, the RN creates a short-term care plan based on the clinical condition and the PSS risk stratification score, or refers Mr. Andrews to a long term level of case management. Short-term interventions — anticipated less than one month — consist of the RN working with Mr. Andrews to set goals



and developing interventions that can be accomplished within 30 days. Re-evaluation is conducted at 30 days to determine if case management assistance is still needed. Based on Mr. Andrews' medical and behavioral issues, his PSS score will most likely warrant on-going collaborative intervention at the Complex Case Management level with both a Medical and a Behavioral Health CM. If Mr. Andrews were to decline case management assistance, the RN would continue to follow his care behind the scenes to provide coordination of care and bridge gaps among his providers. The RN would continue to offer case management services periodically in hopes the member would accept case management intervention. Mr. Andrews would also be auto-enrolled in appropriate Warm Health Disease Management Programs designed to meet his needs. The RN would also discuss the care options available through a Patient-Centered Medical Home (PCMH).

### **Case Management Services**

UFC case management programs are designed to assess, plan, facilitate and advocate for options and services to meet each member's needs, especially chronic conditions and multiple co-morbidities. This is accomplished via one-to-one personal case management and provider collaboration. There is often more than one CM assigned, depending on the primary health issues needing attention. One CM will be the primary point of contact depending on case management goals. Both a Medical and a Behavioral Health CM are assigned to Mr. Andrews. The Medical CM takes the lead role in coordinating care for Mr. Andrews. The Medical CM makes contact with Mr. Andrews within 48 hours of the referral from the Intake Nurse. Contact may be made sooner depending on the urgency of the situation.

The Medical CM discusses the PCP's referral for case management with Mr. Andrews and obtains his perspective on the identified concerns. All concerns are discussed with Mr. Andrews to promote collaboration and engagement in the development of an individualized care plan. Prioritized goals for the care plan consider the member's medical and behavioral issues while also considering his psychosocial needs to proactively identify any potential barriers. The Medical CM meets with Mr. Andrews' PCP to discuss short- and long-term expectations for the planned interventions and to ensure they are appropriate. During the initial contact, the Medical CM introduces the idea of a colleague to assist with behavior-related aspects of care, including stress management, relaxation training and basic cognitive behavioral exercises. The Medical CM informs Mr. Andrews that a colleague, a Behavioral Health CM, will be calling him to discuss issues related to managing his anxiety. The introduction is done in this manner since Mr. Andrews does not have an identified behavioral health history and he may be sensitive to such a referral. After Mr. Andrews agrees, the Behavioral Health CM contacts him to discuss options that can help optimize his health. Upon completion of the assessment, the Behavioral Health CM consults with the Medical CM to determine how best to coordinate Mr. Andrews' medical and behavioral care.

The Medical CM continues to gather information through multiple sources, including ER summaries, to assess the member's condition upon arrival to the ER and the treatment interventions used to stabilize him. Coordination occurs between the Health Plan Medical CM and the hospital ER CM to compare insight. The Medical CM reviews Mr. Andrews' pharmacy profile and medication adherence report in collaboration with the Pharmacy Department to assess compliance and possible drug interactions. Medical Records are obtained from the PCP and other specialists, taking note of scheduled appointments, no-show appointments, physical findings and treatment plans. Through the information obtained via the member, PCP and medical records, the problems are identified for intervention and documented in Acuity using a Problem/Intervention/Goal format. This allows CMs to measure the effectiveness of the interventions and also produces an easy-to-read comprehensive care plan for the PCP and member. In addition to a discussion with his PCP, the Medical CM will contact Mr. Andrews' cardiologist and pulmonologist for additional input. The Medical CM works with the Behavioral Health CM to formulate a plan of care identifying interventions to best meet Mr. Andrews' short- and long-term goals for case management. The care plan is communicated to all treating providers and updated as Mr. Andrews' condition warrants.

The Medical CM and Mr. Andrews work together to identify his strengths, natural supports and community resources. The Medical CM compiles Mr. Andrews' problem list: multiple ER visits, COPD, CAD, Obesity, Anxiety, Decreased functional mobility and lack of family support. The CM utilizes Milliman Care Guidelines as a basis for evidence-based interventions, with further evaluation and Medical Director involvement for any interventions that are requested or may be indicated but fall outside the guidelines. Interventions are based on clinical need and may include: Home Health Nursing for safety evaluation and general health assessment and assistance in scheduling appointments with his PCP and subspecialists to avoid unnecessary ER visits. Home or outpatient physical therapy and DME needs (e.g. oxygen, nebulizer, walker, hospital bed) to support his physical conditions are also considered. He will receive education regarding



his chronic disease states and an assessment for sleep apnea. Other important interventions are identifying social support systems, behavioral management for stress and anxiety, and exploring established criteria for bariatric surgery.

**Short- and long-term goals:** Include decreased ER visits and 911 calls, knowledge of disease processes, anxiety management, self-management of symptoms, identification of a social support system, increased independence and connection with community resources. Community resources offered may include the Arizona Lung Association, local aging council, Lifeline® or Meals on Wheels. If Mr. Andrews’ is a smoker he would be referred to the ASHLine and Tobacco Cessation programs. The care plan monitoring and evaluation process is an ongoing process of working collaboratively with the member to review and assess his progress toward achieving the established goals. The evaluation process can result in modification to the previous short- and long-term goals by an adjustment to the care plan to accommodate changes in the member’s condition and/or environment. For example, if Mr. Andrews’ shortness of breath and anxiety are due to a fear of oxygen deprivation, discussions can be had with the PCP and UFC Medical Director regarding coverage of a home-pulse oximetry unit so he is able to self-manage his COPD and anxiety. The Medical and Behavioral Health CMs work closely together throughout the episode of care, determining call schedules and priorities according to the needs and preferences of Mr. Andrews. Contact with Mr. Andrews is more intensive at the beginning of the episode of care as he learns self-management skills and meets his goals, while continuing to provide support and encouragement. Case management services are concluded when any of the following criteria are met: 1) All care plan goals are met, 2) The member declines further assistance, 3) The member’s condition requires transition to ALTCS, or 4) The member becomes ineligible for coverage. The CM will conduct periodic monitoring for continuing needs after case closure.

## Improving Outcomes for Members with Chronic Conditions

### **Addressing the Impact of Chronic Conditions**

The prevalence of multiple chronic conditions increases the risk of unnecessary admissions, adverse drug events, duplicative tests, poor functional status and mortality. Internal data aligns with national trends. Over 80% of UFC’s highest cost members (top 5%) have at least one chronic condition and approximately 27% have three or more of the chronic conditions list below. Table 1 below outlines the prevalence breakdown across our highest cost members follows:

**Table 1. Prevalence of Chronic Conditions**

Hypertension	57%	COPD	37%	Depression	35%
Diabetes	27%	Hyperlipidemia	24%	CHF	20%

Since 2010, UFC has decreased the costs of caring for chronic diseases such as diabetes, COPD, CHF, and asthma by 9-31% while improving those AHCCCS performance measures associated with these diseases. As in Mr. Andrews’ case, UFC has found a behavioral health co-morbidity to increase the risk of hospitalization, ER use, and overall cost of care related to the physical chronic disease. UFC’s key strategies in addressing the rise of chronic conditions in members and improving their outcomes include better member education and self-care, coordinated care between the health plan and providers, and continuous quality improvement to ensure rendered services are evidence-based and positively impact member outcome. UFC accomplishes this by using well-established systems, processes, and programs, as outlined in the following sections: Prevention and Health Promotion Programs, Complex Case Management, Behavioral Health Case Management, and Provider Engagement.

### **Prevention and Health Promotion Programs**

Prevention and health promotion programs that assist the member with managing chronic conditions are key components of reducing health costs and improving health outcomes. Timely identification of those members who would benefit from inclusion in programs designed to help manage chronic conditions is where the process begins. Members are identified from pharmacy and claims data as well as referrals from providers. UFC contracts with *Inovalon*, an NCQA certified vendor, and uses their Quality Spectrum Insight software solution to identify members with one or more chronic conditions, such as hypertension, diabetes and asthma.

UFC participates in the Million Hearts™ program, a national initiative launched in 2011 to prevent one million heart attacks and strokes over five years. Member management of cardiovascular conditions includes the ABCS: Appropriate Aspirin Therapy, Blood Pressure Control, Cholesterol Management and Smoking Cessation. This prevention program



includes the delivery of evidence-based education to members through Warm Health outreach calls. Warm Health is an innovative Interactive Voice Response care management solution consisting of multiple health and disease management programs with an opportunity for members to generate an alert to the health plan if individual assistance is needed. Our Million Hearts Program includes a Warm Health education message delivered to members every two weeks. Upon receipt of the telephonic message, a member has the option to request live assistance from a Registered Nurse (RN) via the alert process. UFC continuously assesses the efficacy of the program in the following ways:

- Annual review of the NCQA HEDIS *Controlling High Blood Pressure* measure
- Annual review of the NCQA HEDIS *Cholesterol Management for Patients with Cardiovascular Conditions* measure
- Review of Inpatient Admissions – Admissions/1000
- Review of ER utilization

UFC assists members in management of their diabetes. Diabetic members receive the following four educational services in support of their chronic condition: 1) Quarterly letters informing the member about obtaining an annual HbA1c, LDL-C and retinal eye examination; 2) Quarterly educational mailings to assist the member with managing their diabetes; 3) Monthly Warm Health educational messages; 4) Periodic telephone calls from an RN to discuss diabetes care, to facilitate appointment scheduling and to ensure awareness of mobile lab services available to enable testing in the home. UFC continuously assesses the quality of the program by measuring member compliance with obtaining required diabetic testing. In addition, UFC conducts an annual medical record audit of diabetic members to assess the percentage of members whose blood sugar and cholesterol is in control. During 2013, UFC will be utilizing diabetic educators to provide education to diabetic members whose blood sugar and/or cholesterol is not in control.

#### **Warm Health Alert in Action**

A CM answered a Warm Health alert from female diabetic member who stated she was having numbness and shortness of breath for the last two weeks. The member also stated she could not move her arm that morning. When the member stated she was alone and had no transportation, Member Services in conjunction with Case Management arranged for emergency transport to a local ER. The member received treatment and was released with no negative outcome. The member continues to receive care from her PCP.

Another example is the assistance UFC extends to members managing their asthma through offering the following educational service: 1) Quarterly educational mailings to help manage their asthma, 2) Monthly Warm Health educational messages, 3) Periodic telephone calls from an RN in the event there is no evidence of members receiving the appropriate medication for asthma. UFC continuously assesses the quality of the asthma program by measuring member compliance with the AHCCCS performance measure, “Appropriate Medication for People with Asthma”.

#### **Complex Case Management**

UFC’s established three-tier health assessment process is designed to assess members’ health and appropriateness for case management.

- Tier One – Member-reported data, through the completion of a personal Health History Questionnaire (HHQ).
- Tier Two – A Medical Risk Assessment (MRA) on high-risk members who have not completed the HHQ, completed by the member’s PCP or Health Plan contracted Nurse Practitioner.
- Tier Three – High-risk report based upon member pharmacy, inpatient and outpatient utilization including RBHA engagement.

UFC nurses assess the member data and, if warranted, initiate contact with the member to offer case management services. In addition to the analysis of utilization data, UFC responds to members’ affirmative responses to the Warm Health alerts indicating the member could benefit from additional case management services. The Complex Case Management Program provides one-to-one case management to members with complex medical and behavioral health conditions. This is a collaborative process in which a CM assesses plans, facilitates and advocates for options and services to meet an individual member’s health needs through communication and available resources to promote cost effective outcomes. The CMs play an integral role in coordinating care for members with complex needs by utilizing an interdisciplinary team approach to ensure the optimal level of care coordination is being provided. The care plan



monitoring and evaluation process is ongoing. The outcome of the evaluation process can result in modification to the previous short- or long-term goals, an adjustment to the plan to accommodate the member’s current health status, a change in the treatment setting, or the implementation of further options.

**Behavioral Health Case Management**

Behavioral health integration is a necessary component for achieving the organization’s mission of delivering optimal care to AHCCCS members. UFC supports and promotes the integration of medical and behavioral health case management for its members internally and through external partnerships. UFC provides multiple levels of Behavioral Health Case Management to its membership and works in collaboration with Medical CMs for members with multiple co-morbidities. Behavioral Health CMs function within a three-dimensional model in that they perform utilization management, prior authorization and case management functions, and can facilitate services across the spectrum of care. For example, a member being discharged from an inpatient facility may need prior authorization for follow-up services as part of the discharge plan. The Behavioral Health CM can assist the providers with this process.

**Provider Engagement**

An effective health care delivery system is critical to improving health outcomes for members with chronic conditions. Developing and maintaining a collaborative partnership with its contracted providers to optimize care coordination is a UFC priority. This is evidenced by UFC’s alignment with PCMHs that emphasizes the core attributes of comprehensive primary care. These include preventative, acute and chronic care services; and active support for patients and family members in learning to self-manage their condition. Additionally important are care coordination across all aspects of the broader health care system, member access to care, and a commitment to quality improvement.

The health plan provides utilization data to its PCMHs, including daily facility discharges, admissions and readmissions, weekly emergency room rosters and missing service or care opportunity lists. Approximately 25% of the UFC population is assigned to a PCMH. Members enrolled in UFC’s prevention and health promotion programs, as well as those enrolled in complex case management are reviewed with the PCMHs at the joint-operating accountable care meetings. In 2012, UFC realized a cost savings of approximately \$144,000 through reductions in readmissions with nearly 75% of those savings coming through the collaborative efforts with our PCMHs. UFC’s Performance Measure improvements are outlined in Table 2 below.

**Table 2. UFC Performance Measure Improvements**

Indicator	CY 2011	CY 2012	% Change (relative)
Well Child Visits 3 -6	34%	40%	18%•
Adolescent Well Visits	58%	69%	19%•
Diabetic A1c Testing	69%	83%	20%•
Diabetic Retinal Eye Exam	40%	58%	45%•
Diabetic LDL Testing	61%	75%	23%•
Diabetic Admissions/1000	30.09/1000	27.75/1000	8%•

In addition, UFC has initiated and established collaborative working relationships with other contracted provider groups. UFC maintains ongoing communication with providers to ensure coordination of patient care through quarterly face-to-face contact with providers to review best practices, EPSDT guidelines and members missing important medical services.

Through this collaborative effort and commitment between UFC and its provider network, the health plan has realized a significant improvement as described in the table above. UFC is committed to continued care coordination improvement with its PCMHs that will improve health outcomes and drive down medical costs



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

University Family Care (UFC) has been effectively coordinating care for complex AHCCCS members with co-morbid conditions and special health care needs since 1997. UFC has continually worked to refine these care processes to meet the needs of its members and improve their physical and behavioral health along with overall quality of life outcomes. Care coordination is paramount to the Utilization Management (UM) and Case Management processes and is interwoven throughout UFC's contact with the member over the continuum of care. The UM and case management teams work closely to ensure successful transitions between levels of care and to anticipate the needs of individual members. They both work with families, hospitals, providers and community resources to develop the best care plan for the member. The approach is member-centric; outcomes are improved through member involvement and choice at the earliest juncture. The providers in UFC's network are integral partners in caring for members, and they work to ensure that members have access to the care and services they need for improved health status. UFC strives to communicate as frequently as needed with providers to ensure they have the necessary clinical information to deliver high-quality coordinated care. George's case affords an opportunity to highlight how UFC's clinical and organizational care coordination processes blend at all levels to effectively coordinate member care.

### **The UFC Approach to Care Coordination**

UFC has invested the necessary resources to develop and enhance care coordination practices, both internally and with providers. These resources include but are not limited to the use, development and promotion of decision-support tools, such as Milliman and Hayes clinical-care guidelines. UFC is also collaborating with its parent organization, UAHN, on the implementation of the EpicCare EMR solution (Epic) that features many decision-support functions for clinicians, such as general reminders, alerts and notifications of potentially dangerous drug interactions.

### **Decision Support Tools to Deliver Evidence-Based Utilization and Case Management**

UFC has implemented several technology solutions within the Medical Management Department that have enhanced the prior authorization, disease management and case management processes. Cerecons is the prior authorization management solution and Acuity Advanced Care is the case management and quality of care solution. Acuity includes modules utilized by concurrent review, case management, and quality management employees. The Concurrent Review Nurse (CCRN) and Care Transitions Nurse utilize Acuity to document a member's progress and discharge plan while the member is in a facility. The Milliman Care Guidelines collection includes ambulatory care, inpatient and surgical care, general recovery, facility care, home care, chronic care and behavioral health guidelines available within Acuity. These are used to assist the nurse in planning the member's discharge, adjusting the length of stay and as a guide for appropriate, evidence-based care. If the member has complex medical needs, the CCRN will involve a Health Plan Case Manager (CM) and possibly the Care Transitions Nurse at discharge to promote increased care coordination. The Acuity case management module utilizes standard evidence-based tools to support the CM and member in creating individualized care plans that are tailored to the member's unique needs.

***Alignment with Patient-Centered Medical Homes:*** Consistent with UFC's member-centric approach, we believe that affording members' choice in where and how they access health care services is essential in engaging them in care and supporting them in their journey toward wellness. To increase member choice while improving care coordination, UFC has made a substantial commitment to Patient-Centered Medical Homes (PCMH) and aligning its members with providers who are or will be nationally recognized PCMHs. Currently approximately 25% of the UFC members are assigned a PCMH and nearly 20% to The University of Arizona Health Network (UAHN). Care coordination in the PCMH model occurs through a practice-based care coordinator who facilitates ongoing communication between all providers involved in the member's care. Clinical and non-clinical data will ultimately be shared electronically with all providers involved in the member's care through the Arizona Health Information Exchange to further support care coordination, but is currently shared between UFC and UAHN providers through All Scripts EHR. In addition, data is exchanged at monthly Joint Operations Meetings with our PCMHs. The Network Development Department routinely assesses the network against the medical needs of our members. UFC has actively built innovative care models within our network by creating collaborative provider care partnerships that have developed into medical homes capable of delivering improved care to the most complex members such as those with chronic diseases or behavioral health co-morbid conditions.

***Technology and Data to Support Integrated Care for Members:*** UFC offers a robust technology and data solution to support member-centered care. UFC's technology platform will further integrate administrative, financial and clinical



functions to support ongoing management, monitoring and continuous program improvement while allowing for Health Information Exchange (HIE) across providers and plans. UFC actively supports and participates the Health Information Network of Arizona (HINAz), Arizona's HIE. UAHN is implementing an integrated EHR, Epic, and is already a participant with HINAz. Real-time HIE is an important component of our envisioned care coordination model. All participants of HINAz are afforded multiple-user access to EHR records simultaneously and in real-time. This design accommodates complex consultations and provides all users with a member's medical history (based on participant data contribution), allowing greatly improved care coordination. UFC will maximize the interfaces available with HINAz, in addition to promoting and encouraging its use. UFC will encourage and provide technical assistance for all network providers to transfer from a paper-based practice to use of an electronic health record (EHR).

### **Care Coordination for George**

Using these systems, processes and provider partnerships, much of what is presented in the case scenario for George would have been prevented through early identification, anticipation of his needs and better coordination of his care. For example, George's care within the RBHA would have been identified upon receipt of the AHCCCS 834 eligibility file. George did not receive the coordinated care to which all AHCCCS members are entitled, nor was he an active participant in the development of his individualized care plan. This may have significantly affected his level of engagement and compliance with his care plan. Offering care through one of UFC's nationally recognized medical home providers and utilizing integrated behavioral health services would have increased his level of engagement and provided support and possible solutions for his substance abuse issues and associated consequences. Better care coordination for George would have led to better health outcomes and a lower expenditure of health care dollars.

UFC's Medical Management Department utilizes a care model designed to specifically address all aspects of its members' unique needs. It employs well-documented systematic and evidence-based decision support tools that ensure members' physical, emotional, cultural and social needs are assessed. The model of care synthesizes UFC's interdisciplinary team based approach to problem solving and member outreach through various areas within Medical Management (Utilization and Case Management, Prior Authorization, Quality and Pharmacy).

George's plan of care would continue despite the fact that his injuries were the result of a motor vehicle accident. UFC uses a "pay and chase" approach and requires the reporting of any suspected Third Party involvement to the Third Party Liability (TPL) Team. In this circumstance, the CM assigned to George would notify UFC's TPL Team and advise them that a third party may be liable for George's medical expenses. A separate notification to report George's fall down the stairs would be required since this incident was unrelated to the motor vehicle accident. UFC delegates the TPL investigation and recovery function to Health Management Systems (HMS). HMS negotiates all TPL recoveries on UFC's behalf. It is likely that George's acute care inpatient expenses would have reached the reinsurance deductible levels. HMS is required to coordinate reinsurance cases with AHCCCS and in this case, any TPL recovery would be remitted to AHCCCS. UFC audits HMS on a quarterly basis to ensure they are compliant with AHCCCS contract terms and that due diligence has occurred to ensure that AHCCCS is the payer of last resort. Regardless of the outcome of the TPL issues referenced above, UFC would move forward in coordinating George's care. Based on the facts presented, a description of how UFC would have utilized their case management and oversight processes to coordinate George's care while responding to setbacks and risks is outlined below:

### **Hospital Coordination**

Upon notification that George had been admitted to Arizona General Hospital, trained referral employees ensure that the admission information is entered into (Cerecons) to initiate notification of the inpatient stay. Routed from Cerecons, the admission appears automatically on the Acuity work list for the CCRN assigned to Arizona General Hospital. This ensures there is ample time to verify eligibility and arrange for the initial clinical review within one business day of notification. In preparation for the clinical review, the CCRN checks Acuity to review George's previous utilization patterns, case management involvement, previous or current care plans, RBHA information and outstanding authorizations.

The CCRN documents that the member was in a motor-vehicle accident in the Health Plan claims system, GE Centricity Business MCA (GE MCA) indicating a potential alternate primary payer for his inpatient stay. This information is referred to UFC's TPL team and will be available to the Claims Department when the hospital claim is submitted.



The UM Team utilizes Milliman Care Guidelines to determine the appropriate level of care for George at the time of his admission and as he moves through the continuum of care. All CCRNs, CMs and Medical Directors are required to participate in annual inter-rater reliability training and testing to ensure consistent decision making by all employees. This process ensures members are receiving reliable, high-quality service in the correct setting and at the appropriate time.

At the time of the inpatient admission, CCRNs proactively begin discharge planning to prepare and support George through transitions that may involve multiple providers and facilities. They ensure a warm hand-off, including nurse-to-nurse dialogue when transitioning from inpatient case management to outpatient case management. The CCRN relates all relevant health information to the hospital CM. Jointly, the hospital CM and the CCRN begin to develop a discharge care plan to meet all of George's needs. Due to the extent of his injuries, George is identified as being at high risk for having complex continuing care needs. The CCRN discusses George's case at concurrent review rounds with her fellow CCRNs, a Behavioral Health CM and a Medical Director. Issues discussed include home care needs and a review of levels of care. In addition, both the Medical Director and Chief Medical Officer are available at all times to discuss members with inpatient or discharge needs that may be difficult to meet or might require additional resources. Finally, the Medical Director conducts reviews to identify issues or concerns and directs these to the CCRN responsible for that specific case. Members identified as having complicated inpatient and post-discharge needs are discussed at Interdisciplinary Care Team (ICT) rounds. These rounds are attended by Behavioral and Medical CMs, Medical Directors, Case Management leaders and pharmacists with the goal of providing guidance and resources for successful transitions and to make sure the member has all appropriate resources to be successful upon discharge.

Because substance abuse is an identified challenge for George and was a factor in his two accidents, a Behavioral Health CM schedules a visit with George at the hospital when he is stabilized and is able to receive visitors. Behavioral Health CMs use motivational interviewing techniques and the Transtheoretical Model of Change to engage and collaborate when working with members such as George. After establishing rapport, the Behavioral Health CM would attempt to gain an understanding of George's perspective regarding his recent health problems and to get an initial sense of George's readiness to engage in active recovery. Based on George's level of readiness and his agreement to work with the Behavioral Health CM, on-going interventions would be scheduled to best fit his stage of change and needs at the time. Likely interventions include coordination with the RBHA, referral to a PCMH that offers integrated behavioral health care and/or a Health Plan initiated case conference. Health Plan case conferences involve hospital CMs and providers, RBHA representatives, Health Plan CMs, the member and member's family, other community service providers and the respective Medical Directors as indicated.

### **Discharge Planning and Coordination During Care Transitions**

Through on-going monitoring the Medical Director and CCRN determine when George has met criteria for a lower level of care. The CCRN reviews physician, hospital case management, nursing and PT/OT records to ensure he is discharged to the most appropriate setting. An evaluation of home needs and community support services, including family and friends, would help determine an appropriate discharge. If a SNF stay was not deemed appropriate or the patient refused a SNF stay, prior to discharge, plans would be made for home-health nursing visits (for medical assessment and physical therapy instruction), appropriate durable medical equipment and follow-up for physician appointments. Additionally, the CCRN would attempt negotiations with the patient and his landlord to place George in a first-floor apartment to decrease stair use and reduce the likelihood of falls. The CCRN works through hospital CMs and social workers to ensure George's PCP is involved in discharge planning. If he was not engaged with a PCP he would be encouraged to select a PCP in a PCMH that provides behavioral health services.

The Health Plan's Transition of Care Team notifies the PCP of the transition/discharge within one business day of the change. A nurse from the team initiates the first of three calls to the member over the next seven business days to confirm that all components of the discharge plan are in place and working. The Health Plan Case Management Program uses *The Care Transitions Program* by Eric Coleman as a guiding principle. Following these principles, the Transition Case Manager confirms with George that he has follow-up appointments (PCP, Surgeon and Therapy) scheduled and transportation has been arranged for all appointments. Progress with home-health visits, durable medical equipment, medication reconciliation/adherence and safety issues are also addressed, ensuring the member is an active participant in his care. Once the Transition Case Manager has completed the seven-day transition monitoring, George is transferred to a Medical CM with BH collaboration secondary to his complex medical and behavioral conditions. In collaboration with his PCP, an individualized care plan is developed at the time of George's discharge and continues through the continuum of



care, updated as his conditions warrant. The Medical CM would continue to follow George until he reached an independent level of self-management. During this time, the Medical CM would be evaluating George's adherence with the treatment plan, assessing his self-management skills and reviewing the safety of his level of care.

The Medical CM offers community resources such as home delivered meals, supporting housing, legal aid and would assist in coordinating the service if indicated. The Medical CM and the Behavioral Health CM work closely on the case to ensure care plans for both the medical and behavioral aspects of his care are developed, along with coordinating care with the RBHA-contracted provider agency. The Behavioral Health CM would schedule a case conference at 30 days with the RBHA, including a Home Health Nurse and a PCP representative, to evaluate progress with the discharge plan and determine if changes are needed. Frequent interface with all involved agencies would occur at designated intervals. George will be provided access to additional case management support that he may initiate at any time. Once he is stabilized within the community, the Behavioral Health CM has an opportunity to explore underlying issues contributing to George, a young man, having been a member of AHCCCS for five years. If appropriate, the Behavioral Health CM would assist George in setting future goals, including the possibility of vocational training, college or use of community resources for job development.

***The Setback:*** Four weeks after discharge George was found lying at the bottom of the stairs at his apartment complex. He was taken to the Arizona General Hospital Emergency Room and admitted. Upon notification of the admission, the referral employees enter the admission information into Cerecons, with auto-routing to Acuity. George's case thereby appears on the CCRNs work list for clinical review and she informs George's personal CM of the readmission. George remains inpatient for four additional days. Because of the potential failure of the initial discharge plan from the first hospitalization and a re-admission within 30 days of discharge, the CCRN files a Quality of Care (QOC) concern with the Quality Management (QM) Department. The QM Department conducts a full investigation to determine if there were substantiated errors in the care coordination for George. The QOC review includes an analysis from the provider and system perspective, assessment and leveling by the CMO and notes any appropriate corrective actions being taken. We have found that some acute facilities can alter the timing of such transfers when members have exhausted their 25 day limit and we take our member-advocacy role seriously in such instances.

***SNF Coordination:*** Due to George's traumatic brain injury, his medical needs require treatment in a specialized SNF with qualified employees able to manage the impulsive behavior that frequently accompanies such injuries. The hospital discharges George to a non-contracted SNF that has the expertise needed to care for George. The CCRN reviews the appropriateness of the transfer with the Medical Director prior to approval to ensure George is ready to be moved to a lower level of care and this SNF is best suited to meet George's needs. Once George is approved for the specialized facility, the CCRN notifies the Network Development Department to secure a letter of agreement (LOA) that facilitates payment and determines the required level of care for George's SNF stay. The Network Development Department is constantly reviewing contracted facilities to make sure the Plan can meet its members' needs. If it were found that a facility with an expertise in care for patients with traumatic brain injuries was not contracted, Network Development would begin discussions with the facility to enter into a contract and bring it into the network.

The CCRN continues to monitor and review George's case via concurrent rounds and the ICT process, ensuring that his CM is aware of his status. The CCRN also confirms that any needed specialty care is being provided while George is in the SNF and that discharge plans are being discussed. The Behavioral Health CM begins reviewing options with the RBHA for providers trained to deliver services to adults with cognitive disabilities. George's current behavioral health provider for substance abuse treatment may also be engaged. Additionally, the RBHA Health Plan liaison may be contacted to assist if needed. When located, the RBHA-contracted specialty provider is requested to begin working with George during his SNF stay and to be part of the discharge planning team. George's discharge plan includes follow-up from many of the same specialty providers that he received care from during his inpatient stay. The CCRN and involved Medical and Behavioral Health CMs would work together to ensure orthopedic follow-up, outpatient physical therapy, home health care and DME as indicated, along with specialty care from the RBHA for any cognitive-impairment and substance abuse treatment.

The SNF Social Worker or SNF CM collaborates with the Health Plan Medical CM in assessing George for ALTCS eligibility and, if appropriate, initiates and monitors the application process. If approved for ALTCS, the Health Plan



follows the AHCCCS established process for transitioning members to the assigned ALTCS contractor, ensuring continuity and quality care is continued through the transition process.

**Risks and Challenges:** There were numerous setbacks and risks in George's situation. It is unclear why he was sent home with a broken femur when it was known that he lived in a second-floor apartment – the utilization of a SNF or at least transfer to a first-floor apartment would have been greatly beneficial for establishing a safe discharge plan. The lack of a coordinated, multi-disciplinary discharge plan with home and telephonic follow-up from both the medical and behavioral health arenas may have contributed to his inability to care for himself. His fall and subsequent traumatic brain injury may have life-long consequences that could have been avoided with better care coordination. The following issues are identified as the biggest challenges and risks George will face as he continues his recovery and they will be addressed as follows:

- Traumatic Brain Injury:** George's brain injury is the primary setback. If he has sustained a significant degree of cognitive impairment, it will present a significant risk to his ongoing recovery. George's level of cognitive impairment would need to be assessed, monitored and accounted for in the medical and behavioral health treatment and case management care plans.
  - Assessment for transition to ALTCS contractor
  - Behavioral Health CM engages RBHA for specialty provider
  - Medical CM connects member with a Neurologist
  - Health Plan authorizes a neuropsychological evaluation to guide the medical treatment plan; this demonstrates the seamless process of the Behavioral Health CM, performing three functions of case management, utilization management and prior authorization
  - Medical CM confers with Home Health nurse regularly to ensure member is at an acceptable level of functioning and relays information for PCP assessment/appointment when unforeseen issues arise
  - Medical CM connects member to St. Joseph's TBI Support Group in Phoenix
  - Medical CM reaches out to member's PCP to prepare for the nuances of caring for a member with special health care needs
  - George's individualized Care Plan is shared with his providers
  - Delivery of Home and Community Based Services (HCBS), coordinated as appropriate
- Substance Abuse Relapse:** The risk presented by George's substance abuse is commensurate with George's readiness to seek active recovery, the risk being greatest if he is not ready to engage in recovery or not honest about what his goals are in this area. Relapse prevention must be supported and facilitated to the greatest degree possible.
  - Behavioral Health CM stays in close contact with RBHA treatment team and advocates for George's provision of treatment at the appropriate level of care according to American Society of Addiction Medicine Patient Placement Criteria 2nd Revised Edition; it may be that George requires a higher level of care, having failed outpatient treatment with subsequent life-threatening injuries
  - George's brain injury will potentially complicate substance abuse recovery, so specialized care taking this into account will be sought
- Social Issues:** Through UFC's Member Resource Center, Member Care Specialists (MCS) engage in partnership with stakeholders and community organizations that share the vision of better health outcomes and cost containment. The MCS assists individual members like George with locating and obtaining needed services and resources. The MCS works in conjunction with the plans CMs to ensure George is able to access resources for which he qualifies, such as:
  - Housing assistance
  - Food boxes/Meals on Wheels during recovery
  - Assistance with money for co-pays as indicated
  - Legal assistance (Legal Aid) for any pending actions
- Other On-going Medical Issues:** In addition to George's traumatic brain injury and substance abuse, he sustained serious medical injuries during his two accidents. These injuries would need to be cared for and monitored for improvement. The Medical CM oversees and facilitates:
  - Orthopedic appointments
  - Medication adherence
  - Wound checks
  - Other medical appointments
  - Communication with PCP to provide care coordination and updates on George's care plan



**Question 6. Describe the Offeror’s experience in Medicare Advantage and/or Medicare Special Needs ...**

**University Care Advantage’s Arizona Experience and Accomplishments**

Since 2008, University Care Advantage (UCA) has been caring for dual-eligible beneficiaries in both urban and rural Arizona. The Medicare business is dedicated solely to serving dual-eligible SNP (D-SNP) members. Our coverage areas initially included Pima and Maricopa counties. UCA expanded its service area to Pinal, Cochise and Santa Cruz counties on Jan. 1, 2011. UCA has approximately 3,600 dual-eligible enrolled members, with nearly two-thirds in Maricopa and Pima counties. UCA has dedicated resources in order to build systemic efficiencies, coupled with proactive member and provider outreach to minimize confusion and maximize their experiences. The provision of non-emergency transportation and supplemental benefits has improved member satisfaction and care coordination. In addition, UCA provides guidance on members’ cost-sharing responsibility, which has reduced confusion. In the last four years, the organization has invested substantially in Information System (IS) upgrades and resources that largely support member care coordination and the management of complex populations. UCA funded the start-up operations of the Healthy Together Care Partnership (HTCP), a collaborative care management model with The University of Arizona Center on Aging that is designed to meet the complex care needs of dual-eligible members. Health outcomes, quality and the financial performance of HTCP will be monitored on a quarterly basis with revenue gain sharing dispersed upon attaining targets. As a continuous learning healthcare organization we have been able to become efficient, improve the care coordination and care processes for dual-eligible members, resulting in fewer readmissions and greater member satisfaction. As shown in the narrative below and in Table 1 below, their successes include:

- ≡ In 2011, UCA implemented a multifaceted Transitional Care program which produced a 32% reduction in 30-day readmissions throughout urban and rural Arizona.
- ≡ Through the interdepartmental Stars Quality Improvement Committee, UCA has improved many of the targeted Five-Star Quality Rating System measures during the past year, achieving four or five stars on 17 measures:

**Table 1, 2013 Four- and Five-Star Measure Results**

2013 Four- and Five-Star Measures			
C04 – Diabetes Care – Cholesterol Screening	4	C22 – Reducing the Risk of Falling	4
C07 – Improving or Maintaining Physical Health	5	C33 – Health Plan Quality Improvement	4
C10 – Adult BMI Assessment	5	D01 – Call Center – Pharmacy Hold Time	4
C11 – Care for Older Adults – Med Review	4	D07/C31 – Beneficiary Access Plan Performance	4
C13 – Care for Older Adults – Pain Screening	4	D11 – Rating of Drug Plan	4
C15 – Diabetes Care – Eye Exam	4	D13 – MPF Price Accuracy	4
C16 – Diabetes Care – Kidney Disease Monitoring	5	D14 – High Risk Medication	4
C19 – Controlling Blood Pressure	4	D15 – Diabetes Treatment	5

- ≡ By improving members’ on-boarding experiences and transitional-care coordination when they are enrolled in UCA, the disenrollment rate has decreased by 26% in the past year.
- ≡ Through a Medical Management process improvement project, UCA has increased its Health Assessment completion rate fourfold in the past year.
- ≡ The UCA Model of Care received a Superior rating during a recent Medicare Review. Its strength lies within our trusted relationships with Patient-Centered Medical Homes (PCMH) and other key specialty provider partners, along with its innovative collaborative care partnerships, such as HTCP, to meet the needs of this vulnerable population. UCA is actively working with seven different medical-home providers and has found that provider engagement and collaboration is critical to meeting the needs of our UCA beneficiaries. Approximately 50% of UCA members are assigned to a primary care medical home.
- ≡ UCA has a “Best Practice” designation from CMS on their Model of Care employee training program. The plan requires that each employee is knowledgeable, caring and respectful during every encounter. These staff trainings have increased first-call resolution rate to 91%.

**Maximizing Care Coordination and Member Experience**

UCA’s processes to coordinate care and interact with members are consistent regardless of a member’s alignment status. UCA recognizes that a percentage of members are dual-eligible via Fee For Service (FFS) Medicare or another managed



care plan. The Medical Management, Member Services and Member Outreach Departments work directly with members on care coordination or services issues if the member is Medicare FFS. If the member is enrolled in another D-SNP plan, they contact the Case Managers (CMs) or Member Services Representatives (MSRs) from that plan to discuss issues as needed. UCA's goal is to ensure that the member receives seamless, well-coordinated care regardless of their alignment.

UCA's internal care coordination processes are built on technology. Monthly reporting allows us to identify individuals who have the highest health risks and are in need of care coordination and intervention. Their information systems provide us with the ability to view a comprehensive picture of each member's case management profile and care coordination needs. This allows us to coordinate the delivery of needed services, manage the member's conditions and monitor outcomes. In addition, the medical management staff has access to real-time clinical information from various Electronic Health Records (EHR) systems for approximately 70% of our members. This helps streamline authorization of services, customization of care, planning for discharge from inpatient facilities and coordination of associated resources. This also prevents the duplication of services.

### **Health Risk Assessment and Member Outreach**

Because of the barriers to care created by our D-SNP population's low level of literacy, poor hearing, low self-reported mental and physical health along with lack of communication with providers regarding important health factors, UCA has designed a multi-tiered protocol to assess each member's healthcare needs contributing to successful care coordination. UCA accomplishes this with a three-tiered approach to completing a Health Risk Assessment (HRA) on each member: 1) Health History Questionnaire, 2) Medical Risk Assessment and 3) High Risk Reporting.

At enrollment, and annually thereafter, each UCA member is sent a Health History Questionnaire (HHQ) to complete and return to the UCA Case Management Team. This tool is risk stratified and generates a referral to an appropriate CM to contact the member to complete an individualized care plan. Initially, this process yielded a completion rate of 13%. Through process improvements, including follow-ups to complete the HHQ telephonically with a CM, we have increased the completion rate to 50%, and is expected to continue increasing with access to the HHQ on UCA's Member Portal. Through a Medical Risk Assessment program that involves Nurse Practitioners assessing members in their homes or other agreed upon locations, UCA has increased the completion rate an additional 5%. Many of the UCA members with a serious mental illness (SMI) prefer to meet at a location other than their home. For those members who, after repeated outreach attempts by UCA, fail to complete a health risk assessment, UCA utilizes a comprehensive set of analytics to identify their likely care coordination needs and assign them to an appropriate Case Management intervention risk strata. This includes, but is not limited to, use of demographic information, diagnostic codes available on the CMS Website, past AHCCCS utilization patterns and predictive modeling. The CM team receives a High Risk Report (HRR) every month that identifies members through ongoing clinical analytics who are candidates for CM outreach. This HRR is shared with PCMHs that also contact these members to complete a HRA. This multipronged process ensures UCA is being proactive to reach and engage all members in need.

### **Interdisciplinary Care Teams (ICT)**

The UCA population has a high percentage of members with multiple co-morbid medical conditions and behavioral health disorders. This requires complex care coordination of physical and mental disorders, as well as a focus on medication reconciliation. UCA employs experienced CMs and Disease CMs familiar with the array of resources that support successful care coordination. In addition, UCA uses an ICT that includes RN Adult CMs, Disease CMs, Behavioral Health CMs, Pharmacists, the Manager of Case Management and a Medical Director. The team is responsible for reviewing the care coordination needs of high-risk members or those who have been identified as continually having poor outcomes after initial interventions. In some cases, the Case Management staff have found it beneficial to organize ICT staffings off-site in order improve care coordination. Such staffings may occur in hospitals, Behavioral Health Clinics, Medical Clinics, at home with families and other sites as required for the benefit of the member. This ICT process has been successful in providing support for the member's personal CM, who develops a unique relationship with his or her members. Utilizing evidence-based guidelines in conjunction with the member and appropriate family members along with physicians and community providers, a member-centric care plan is created. The care plan includes arrangements for all necessary health related and support services, as well as education about self-care, medications and how to communicate with providers. This initiates an ongoing and supportive care relationship with the personal CM that includes monitoring the member's symptoms, well-being, and adherence to the care plan in a culturally competent manner, while keeping the member's provider care team apprised of updates.



All hospitalized members are reviewed by the ICT to ensure they have an effective care plan in place. For members with a 30-day readmission, Care Transition CMs visit these members while they are in the hospital, SNF or at home. The Care Transition CMs are bilingual and bicultural, and engage members and their families in a patient-centered manner. This has allowed them to assist members with advanced illnesses, along with their families, through the emotional challenges encountered near the end-of-life by facilitating access to palliative care or hospice services. In 2010, UCA’s 30-day readmission rate reached 25% due to a high number of readmissions among a very small group of members. These members were primarily those with behavioral health disorders or advanced physical illnesses. Through the introduction of multiple coordinated processes, UCA successfully reduced the 30-day readmission rate to less than 17%.

**Provider Expertise in Caring for Special Needs Populations**

A comprehensive provider network is critical for a population with such diverse healthcare needs. Consistent with UCA’s recent Superior rating for the Model of Care is the process of identifying the healthcare needs of UCA’s covered population through a Clinical Analytics Workgroup and then building an effective provider network. Examples include contracting with integrated health homes within Pima County, PCMHs that provide Integrated Behavioral Health, Geriatricians and providers dedicated to serving members with more challenging medical and psychosocial needs. UCA uses Geo-mapping to identify “Hot Spots” of high-utilizing members and to ensure that appropriate providers are nearby. UCA has been aggressive in partnering with provider groups to build the infrastructure of their PCMH. UCA actively supports providers’ applications to achieve national recognized status as a PCMH and, engage in contracting and form efficient partnerships to achieve the promise of the Triple Aim — improving the experience of care, improving the health of populations and reducing per-capita costs. Two key components PCMH partners want are actionable data and the availability of a clinical liaison. UCA regularly provides data on members discharged from facilities, members who received care in the emergency room, members with evidence-based gaps in care, and have an assigned clinical liaison for our medical home partners. UCA’s PCMH partners have appreciated this customized approach, which has allowed for effective sharing of actionable data to improve care.

**Case Management Programs**

UCA continually looks for innovative ways to connect with members that improve member engagement and health outcomes. The organization has successfully utilized an innovative Interactive Voice Recognition (IVR) solution, Warm Health, to monitor each member’s personal experience and to engage members in their own care by providing evidence-based, disease-specific education. A key feature of these programs is the opportunity for the member to generate an alert for a PCMH Care Coordinator or a UCA Member Services or Case Management employee. Due to the success of these programs, UCA has implemented a provider-facing component of this technology in partnership with the vendor. Currently, when members receiving the disease management program generate an alert, the Care Coordinator in the PCMH receives the alert and responds directly. This program has successfully built efficiencies not only within UCA, but also within the member’s care team including his or her personal medical home.

**Table 2. Diabetic Testing Improvements**

Diabetic Testing Improvements	A1c testing		Eye Exams		LDL Testing	
	2011	2012	2011	2012	2011	2012
UCA HEDIS	90%	91%↑	65%	76%↑	85%	86%↑
UFC Diabetes PM	80%	82%↑	49%	58%↑	71%	75%↑
MHP Diabetes PM	78%	83%↑	50%	60%↑	74%	77%↑

In coordination with additional UCA initiatives, this program has played a role in our improved performance in a number of HEDIS/Performance Measures during the past year, such as diabetic testing shown in Table 2 above.

**Integrating Behavioral Health Into Primary Care**

UCA’s D-SNP population reports 58% more mentally unhappy days than the average Medicare population, screens positive for depression 50% of the time, and has a high rate of co-morbid physical and mental disorders. Of our members with depression, 30% have heart disease, 43% have hypertension, 27% have diabetes, and 25% have asthma. The prevalence of these chronic physical diseases are only slightly less for our members with a psychotic illness, ranging from 16-31%. Therefore, in order to improve services to our members with behavioral-health needs, UCA is actively pursuing the following strategies:

- Contracting with Integrated Health Homes in Pima County and expanding UCA network to include Patient- Centered Health Care Homes



- ≡ Piloting the Health Passport data sharing program with Cenpatico in Pinal County
- ≡ Added geriatric behavioral health providers to our network

UCA also contracts with PCMHs that include integrated behavioral health programs and partnered with The University of Arizona Family Medicine Department to provide startup funds to add a Behavioral Health Consultant. This resulted in 13% decreased costs due to 38% fewer admissions and 5% fewer ER visits, along with a 36% increase in preventive care.

### **Innovative Program: Healthy Together Care Partnership (HTCP)**

UCA is partnering with The University of Arizona Health Network (UAHN) Center on Aging to implement HTCP, an innovative healthcare delivery and payment initiative. More than 450 current UCA members assigned to a UAHN PCP are part of the program and are being cared for by a team of nurses, behavioral and community health specialists and physicians especially assigned to the HTCP. This program aims to provide effective, innovative care for this high need population by using a team-based, patient-centered approach. Members benefit from the use of coordinated high-touch care that has demonstrated improved quality and utilization patterns. HTCP employs the following strategies:

- ≡ Focuses on helping members maintain health and functional status
- ≡ Focuses on the highest-cost patients, including those recently hospitalized with avoidable conditions
- ≡ Integrates chronic disease care and behavioral health care via a team of cross-trained inter-professionals
- ≡ Will utilize EpicCare EMR to manage members through shared clinical information and advanced evidence-based decision support tools
- ≡ Provides home-based primary care for those with advancing chronic conditions
- ≡ Integrates telemonitoring (weight, blood pressure, oximetry) for patients at risk of exacerbation, with in-home interventions for ER and hospital avoidance
- ≡ Promotes medication adherence for the entire membership using telehealth medication monitoring devices for high-risk medications, pharmacist-directed polypharmacy assessment and medication guideline fidelity

#### **Interdepartmental collaboration to Improve Member Experience and Improve Outcomes**

Mr. R took his prescription for diabetic supplies to Walgreens. Walgreens processed the claim for UCA-Medicare to receive 80% of the payment and billed Mr. R for the other 20%, rather than submit a claim to UFC-AHCCCS. Mr. R called his Member Services Medicare Advocate, Martha Lopez, who he had met during the on-boarding process with his concern. Although Martha working with our Pharmacy Department, Walgreens, and our PBM resolved this individual's issue, she began to receive additional calls from other diabetic members with the same concern. An ad hoc team met to understand the process breakdowns occurring within the Walgreens system, developed an action plan for resolution, and successfully executed the intervention in a timely manner. In collaboration with Walgreens, their billing process errors were resolved; our diabetic members received their supplies barrier-free, thereby supporting improved outcomes and member experience.

### **Member Engagement**

UCA's population characteristics include a lower level of literacy and a higher rate of mental illness than similar D-SNPs nationally, as reported through the Health Outcome Survey (HOS). UCA is responsible for assisting members in how to utilize the services and benefits. This is dependent upon the acquisition and maintenance of accurate member contact information (MCI). UCA began an initiative in May 2012 to capture accurate MCI upon enrollment. UCA is improving its system to store additional MCI, such as email or phone numbers for emergency contacts and places of employment that allows us to reach the member through alternate means.

The Member Services Department (serving both AHCCCS and dual-eligible members) created a web based SharePoint library to centralize updated reference materials. In addition, this department conducts Medicare training at its biweekly staff meetings. In order to ensure that Member Service Representatives are well trained, UCA has a call-monitoring system to listen into calls and identify opportunities for improvements in order to improve training and education. The goal is to resolve members' issues at first point of contact. UCA has expanded our efforts to resolve any questions or concerns during the first month of enrollment. In order to minimize confusion and clarify the benefits of having a sole source of healthcare coverage, UCA initiated a member on-boarding concierge program during which new members receive a customized enrollment. This is conducted and coordinated by a Member Care Specialist (MCS) in partnership



with a UCA CM. The process fosters the members' understanding of their benefits and how to access care when needed. The pharmacy staff also provides support to the on-boarding partners when needed.

Through Warm Health, UCA assesses each member's experience monthly for a period of six months (June – November). Warm Health allows each member to generate an alert should he or she have a question or concern. Our Member Retention Specialists (MRSs) contact each member who reports an inferior member experience in any one of six categories of service. These processes have allowed UCA to monitor performance and address member needs in real-time. In the past six months, 362 members have provided feedback to the plan through the Member Experience Survey. Thirty-seven were assisted by a MCS to resolve issues identified through the survey. UCA established Member Resource Centers (MRCs) at high-volume provider sites to service both AHCCCS members as well as our UCA enrollees. MRSs at these centers offer hands-on assistance. In addition, health education material, Internet access and help with accessing care or community resources are provided. A natural evolution from the MRCs was the creation of a Member Advisory Committee (MAC) as a means of obtaining member feedback on a number of UCA initiatives. The MAC meets quarterly to review pertinent Health Plan programs and processes. UCA anticipates this group being a valuable resource as members are added to the Quality Management/Performance Improvement Committee in 2013, consistent with AHCCCS' newly proposed policy.

The Prior Authorization and Grievance and Appeal (GA) employees engage members at key moments in their care continuum. Because receiving prior authorization determinations from both AHCCCS and Medicare can be confusing to D-SNP enrollees, UCA calls all members to provide them with their determinations and address any concerns or questions they have. To meet the needs of our enrollees who express a concern through a grievance or appeal, all GA staff are cross-trained so each coordinator can manage all lines of business and resolve questions, concerns or inquiries quickly.

### **Increasing Alignment of Dual-Eligible Beneficiaries**

The opportunity for the greatest positive impact to the members is when their Medicaid and Medicare membership is aligned with the same parent organization. To that end, UCA analyzes its AHCCCS membership data for those members who are dual-eligible. This information is then provided to employed and contracted agents who contact members and explain the potential benefits of receiving their Medicare and Medicaid coverage from UCA. While, by regulation, UCA will enroll any AHCCCS member who is eligible, UCA does not actively promote its plan to non-UFC AHCCCS members. In addition, UCA has the flexibility, per CMS regulations, to maintain the membership of a UCA member after that member loses AHCCCS eligibility for one to six months. UCA has chosen to maintain these members' eligibility for six months. This is done to minimally disrupt the members' healthcare and to increase the probability of maintaining alignment should the member regain AHCCCS eligibility within six months. Between January 2011 and March 2012, 278 members lost AHCCCS eligibility, and 12% regained AHCCCS eligibility within the extension period and were able to re-enroll. The recent launch of Health-e Arizona will be promoted, as it will allow us to assist in the AHCCCS renewal process by removing the barrier of a delayed renewal. UFC staff have been trained to complete the renewals and are readily available to assist. Our flexible schedule allows members to complete the renewals at times that are more convenient and therefore increases the probability of an on-time renewal.

The UCA claims-processing system coordinates benefits for the dual-eligible population enrolled with the D-SNP plan. The goal is to seamlessly adjudicate and coordinate claims payments to providers serving D-SNP members. For dual-eligible members covered by two different payers, claims are processed to calculate both the primary Medicare payment as well as the Medicaid payment as the payer of last resort. The claims system will not approve payment if the primary payer EOB information is not received and entered for the claim. For dual-eligible members covered by UCA and either UFC or MHP, the process is similar, however, the coordination of benefits for primary and secondary are both handled internally, with a single claim, and single prior authorization, if required. UCA has the expertise and infrastructure to seamlessly move to a full integration of dual eligible members, and looks forward to the implementation of the dual demonstration.





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

University Family Care (UFC) has identified three major initiatives with several strategies to address waste within Arizona's Medicaid system and improve outcomes. These initiatives are aligned to the areas of waste as identified in the Institute of Medicine (IOM) report "*Best Care at Lower Cost*" as well as the IOM's 10 recommended strategies and target obstacles to high-value care. UFC will continue its long history of improving value for AHCCCS through these initiatives that will lead to sustainable improved health outcomes and lower costs. UFC's goal is to continue with current initiatives and begin new initiatives on or before October 1, 2013, to realize measurable savings on or before October 1, 2014 and sustain those savings for the duration of the AHCCCS contract. The following pages describe these initiatives and their component activities. The three primary initiatives are:

- ≡ Initiative 1 – Improve Care (Unnecessary Services, Prevention, High Prices)
- ≡ Initiative 2 – Improve Operational and Administrative Efficiency
- ≡ Initiative 3 – Reduce Waste Resulting from Fraud

### **Initiative 1 – Improve Care (Unnecessary Services, Prevention, High Prices)**

The IOM has shown that unnecessary services represent \$210 billion in excess costs and is the largest obstacle to high-value care. Missed prevention opportunities and inflated pricing represent another \$160 billion in waste. UFC has five primary objectives to address this issue: A) Using Published Guidelines to Prevent Unnecessary Services, B) Prevention, C) Sharing of Electronic Health Record (EHR) Data, D) Provider Financial Incentives and E) Provider and Member Engagement for Education and Shared Decision Making.

#### **A) Using Published Guidelines To Prevent Unnecessary Services**

**Utilization Management/Finance Committee (UMFC):** To mitigate the occurrence of unnecessary services for AHCCCS members, the UMFC employs the IOM *broad leadership, digital infrastructure* and *transparency* strategies. It uses sophisticated software solutions to generate utilization reports and regularly reviews utilization patterns, including a monthly focus on specific areas, such as pharmacy and diagnostic testing. During the past two years, organizations such as the American Board of Internal Medicine, American College of Physicians, National Physicians Alliance and the Choosing Wisely campaign have published lists of unnecessary tests. Examples of steps UFC has already taken in this area include decreased MRI scans for cervical/lumbar pain which has already reduced waste by more than \$200,000, control of asthma through appropriate use of inhaled corticosteroids and Advair, and increased generic drug use to 84%. UFC will continue its focus on preventing unnecessary services by sharing this information with providers to ensure awareness. UFC will also introduce claims edits to review or deny inappropriate services as the above-named organizations update their recommendations. As reimbursement models continue to be introduced, UFC employs the IOM *financial incentive* strategy and incorporates these guidelines into its incentive program. UFC will implement current recommendations including unnecessary laboratory, radiology and other diagnostic testing. UFC analyses indicate that approximately 5%-10% of its diagnostic testing costs may be attributable to unnecessary services. UFC's goal is to reduce these unnecessary service costs and we will implement multiple tactics in order to realize a 5%-8% savings in diagnostic testing costs by October 1, 2014 and then sustain those savings throughout the term of the AHCCCS contract.

**Reducing Opioid Use:** UFC will employ the IOM *clinical decision support* strategy to implement an opioid utilization program before October 2013 that will adopt appropriate pain treatment guidelines, provide education on appropriate opioid prescribing and ensure monitoring of over- and under-utilization. This collaborative process will improve health outcomes and reduce costs through enhanced coordination between UFC and primary care providers (PCP), pain management and other specialists, case managers, pharmacists and AHCCCS. UFC's goal is to achieve a 5%-8% reduction in PMPM costs for this class of medication and population by October 2014.

#### **B) Prevention**

**Obstetrics (OB)/Preterm Birth:** AHCCCS is the single-largest payer of births in Arizona and many of the related pregnancies are high-risk and result in subsequent newborn stays in the Newborn Intensive Care Unit (NICU). Despite successful UFC programs that were associated with improved timeliness of prenatal care and decreased NICU admissions among the target group, over the past three years UFC's overall NICU days have steadily increased. In late 2011, The University of Arizona Health Plans (UAHP) employed the IOM *patient-centered care* strategy by partnering with Maricopa Integrated Health Systems to pilot a high-risk OB Medical Home program in Maricopa County. Early data indicated a 28% decrease in NICU bed days per delivery for newborns whose mothers were enrolled in the program as



compared to a non-medical home comparison group. Based on this success, UAHP will extend the OB Medical Home model to the UFC population and will implement this model with at least two high-volume OB providers by October 1, 2014. UFC is also employing the IOM *community links* strategy by focusing on improved prevention of preterm births. To reduce cost of care, UFC will refer 80% of eligible first-time pregnant women to Nurse Family Partnership Programs by October 1, 2013. Education based on the March of Dimes® “Healthy Babies are Worth the Wait” prevention initiative will also be provided to pregnant members. By decreasing elective deliveries prior to 39 weeks gestation through provider incentives and member education, UFC places added focus on reducing costs while improving outcomes. UFC’s overall goal of these multiple OB/Preterm Birth tactics is to begin these on or before October 1, 2013 and reduce NICU days by 10% by December 2014.

**Care Coordination:** Opportunities exist for UFC to cut waste through the IOM *care continuity*, *community linkage* and *transparency* strategies. This includes continued partnership development with community stakeholders to benefit specific populations who need greater integration of care. The results of poorly coordinated care are distinct for members with chronic conditions such as diabetes and cardiovascular disease, as well as those members with dual physical and mental health diagnoses. In addition, dual-eligible members and those who will churn between AHCCCS and the Health Insurance Exchange (HIX) may have difficulty navigating the complex healthcare system when providers and payers are inconsistent. Improved communication, coordination and regular follow-up will reduce duplication of services, thereby decreasing costs and increasing quality and outcomes. Key tactics linked to these strategies include:

- ≡ UFC has identified that members who churn on and off of AHCCCS cost approximately \$50 per member per month (PMPM) more than those continuously enrolled. UFC will participate in the HIX to engage this population and pursue reduced costs by \$15 PMPM in 2014 and additional cost-savings in subsequent years.
- ≡ UFC will continue to take advantage of the Health-e-Arizona program, helping AHCCCS members with on-time renewals to reduce churn and ensure continuity of care.
- ≡ UFC will capitalize on the success of on-site Care Transitions Nurses, which has decreased costs by 15% due to improved transition planning. This tactic will be extended to additional high-volume facilities by July 1, 2014.
- ≡ UFC will continue to develop Patient-Centered Health Care Homes (PCHCH) and focus on members with co-morbid physical/mental chronic conditions as those members cost an average of 20%-70% more. UFC’s goal is to improve care coordination and reduce overall cost in this population by 5% in 2014.
- ≡ UFC will extend successful integration programs such as those UFC has with the Cenpatico Behavioral Health (BH) program and The University of Arizona Health Network—Healthy Together Care Partnership with two to four provider partners by September 30, 2014 dependent on GSA awards.
- ≡ UFC will share cost, service and quality information to members and providers through our websites.

### C) Sharing of EHR Data

UFC supports and participates in the Health Information Network of Arizona (HINAz), the Health Information Exchange (HIE) for Arizona. Through participant data contribution, this solution employs both the IOM *digital infrastructure* and *data utility* strategies and provides an improved view of the member to both providers and payers. Access to these data will reduce the use of paper medical records, eliminate unnecessary duplicate testing, and improve care and outcomes for the member. As an interim solution until the HIE is fully operational in 2014, UFC will partner with large provider groups and hospitals to share EHR data reducing the potential of unnecessary services and duplicative tests. UFC will employ the IOM *financial incentive* strategy by including HIE participation as a financial incentive for appropriate contracted providers. Currently, UFC Medical Management employees have secure access to members’ records within EHRs at contracted inpatient facilities and at most large ambulatory providers, which allows for a timely and comprehensive review of pertinent clinical information. During the fourth quarter of 2013, UFC will take advantage of the new availability of encounter data history to be provided by AHCCCS.

### D) Provider Financial Incentives

UFC will continue to deploy the IOM *financial incentive* strategy through UFC’s robust spectrum of value-based contracting. This includes payment incentives and rewards to address utilization, team-based care, quality and member/family experience. Payment models are flexible and vary based on a provider’s level of sophistication and are modified as targets are met and greater levels of readiness are achieved. By October 1, 2014, incentive-based contracts will be written for PCPs, selected specialists and facilities. These payment models will be structured as pay-for-performance, risk or gain-sharing, based on achieving utilization, quality and member experience targets or goals.



- ≡ **PCP/Specialist Incentives:** By October 1, 2013 UFC will offer an Access-to-Care incentive for the following criteria: 1) An open panel, 2) Compliance with appointment availability, 3) Extended operating hours, 4) BH services or home-based care availability or telemedicine. In addition, by October 2014, UFC’s goal is to extend an incentive-based contract to all PCPs with at least 100 members that is designed to meet utilization, quality and member experience targets. UFC will continue to extend our Accountable Care Partnerships by improving efficiencies in our Patient-Centered Medical Home (PCMH) processes. Since some UFC members will continue to receive care from PCPs that will not qualify as a PCMH, UFC will also share successful PCMH strategies with these non-PCMHs.
- ≡ **Facility/Specialty Incentives:** By October 1, 2014 UFC will expand financial incentive models to high-volume specialists and 25% of contracted hospitals. By October 1, 2015 value-based contracts will be extended to all hospitals that care for 50% of UFC members. Incentives will support evidence-based care, such as decreasing elective deliveries before 39 weeks gestation.
- ≡ **Health Plan Partnering:** UFC will begin discussions with at least one other AHCCCS plan by October 1, 2013 to align financial incentives so that targets are more consistent and dollars are more meaningful for providers. Based on the success of the partnership, UFC will begin discussions with other AHCCCS health plans by July 2014.

**E) Provider and Member Engagement for Education and Shared Decision Making**

Chronic diseases, such as diabetes, are responsible for high medical costs, especially when coupled with a BH co-morbid condition. Care for such conditions will be improved through deployed IOM *care coordination* and *patient-centered care* strategies. These programs will improve care coordination between providers along with member education for self-care that supports PCP management and shared decision-making of the majority of cases. UFC’s goal is to exceed the AHCCCS diabetes Minimum Performance Standard (MPS) measures and a decrease in diabetes-related cost of care by 5% by July 1, 2015. UFC has decreased the cost of care for diabetic members by 14% since January 2011. However, this decrease has occurred only among our diabetics not listed as receiving services within the RBHA on the 834 Transaction-Benefit Enrollment file provided by AHCCCS. UFC will focus on decreasing the cost of care for diabetic members with a co-morbid BH condition who are receiving services within the RBHA, as this care currently costs 20% more. Activities to accomplish this goal include:

- ≡ UFC will hire two Community Care Partners by July 1, 2014 to complete in-home visits and coordinate outreach with existing community health workers to improve member engagement among our poorly managed diabetics.
- ≡ By September 30, 2014 we will initiate implementation of the evidence-based insulin Treat-to-Target protocol for uncontrolled Type 2 Diabetes under the direction of The University of Arizona Diabetologist and a Clinical Pharmacist. The Pharmacist will educate members on the protocol to support the PCP in their clinical management of the member.
- ≡ The Diabetologist and a Clinical Pharmacist will provide training to our contracted PCMH providers, especially midlevel providers, to improve the primary care of this chronic disease by October 1, 2014.
- ≡ UFC will launch a member portal to improve member engagement, transparency and education in fourth quarter 2014.

Initiative 1 Summary	Stakeholders (other than UFC, AHCCCS)	Timeline	Anticipated Outcomes
Unnecessary Services	Providers, PBM, Labs, Radiology Groups, Members	10/1/13 – 10/1/14	5%-8% Reduction in Diagnostic Testing Costs
OB/Preterm Births	Pregnant Members, Providers, Nurse Family Partnership	10/1/13-12/1/14	10% Reduction in NICU Days
Care Coordination			
HIX	Members, Community	10/1/13-1/1/15	\$15 PMPM Reduction for Churn Members
Renewals	Members, Health-e-Arizona	Ongoing	Reduce Missed Renewals
Care Transitions Nurses	Providers, Nurses, Members	10/1/13-7/1/14	In Place at Facilities Covering 50% of Membership
PCHCH Development With Physical/BH Focus	Members With Co-Morbid Conditions, Providers	10/1/13-12/31/14	5% Cost Savings for this Population
Sharing of EHR Data	HIE, Members, Providers	Ongoing	Increase Shared Data
Financial Incentives	Providers, Members, Other AHCCCS Plans	10/1/13-10/1/15	Incentive-Based Contracts with: 1) PCPs with at least 100 members, 2) High-Volume Specialists, 25% of UFC hospitals. Aligned Incentives with other Plans



Provider and Member Engagement	Providers, Members	10/1/13-7/1/15	Exceed Diabetes Performance Measures MPS; Reduce Diabetes Cost of Care by 5%, Launch Member Portal
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**Initiative 2 – Improve Operational and Administrative Efficiency**

The IOM has identified \$320 billion in operational and administrative waste, representing almost 42% of the total volume. UFC has two primary objectives to address this issue: A) Reduction in Administrative Expenses and B) Leverage and Invest in Technology to Optimize Operations.

**A) Reduction In Administrative Expenses**

UFC will employ the IOM *optimized operations* strategy continually to focus on cost savings for the highest areas of administrative expenses while maintaining appropriate resource levels to fulfill contractual obligations. Targeted expenses include full-time equivalent staffing levels (FTE), compensation, postage, printing, consulting, travel and office supplies. UFC’s goal is to reduce administrative expenses by \$2 million (12%) on or before September 30, 2014 and to sustain that savings for the remainder of the AHCCCS contract. Some of the cost-saving tactics include 1) Expansion of automated tool use, such as Cognos for business analytics, which has already reduced annual FTE costs, 2) Re-evaluation of printing costs, 2) Reduction of paper mailings, 3) Reduction of overtime, 4) Expanded use of college- and graduate-level interns and 5) Reducing other reliance on paper, to include contracting with a paper claims vendor that will be incentivized to transition remaining paper claim submissions to EDI, helping providers to find an electronic means of submitting claims and reducing the overall cost of claims processing for all stakeholders. UFC will continue to work with contracted vendors for software, services and maintenance, seeking favorable contract renegotiation, or replacement, at renewal.

**B) Leverage and Invest in Technology To Optimize Operations**

Technology will play a key role in generating efficiencies in operations, as well as enabling improved integration with stakeholders including providers, members, vendors, employees, partners such as the HIE and others. UFC has invested substantially in information system enhancements during the past four years that align with IOM *digital infrastructure*, *patient-centered care* and *data utility* strategies and plans additional significant enhancements during the next five years. This will ensure a reliable infrastructure of improved administrative efficiency, improved communication and integration, increased member and provider engagement, and ultimately supports the improvement of the care experience and patient outcomes. Some tactics are listed below:

- ≡ **Provider Information Management:** UFC recently launched a project to replace its Credentialing and Provider Information Management system (Visual Cactus) with a new solution: McKesson Provider Information Management and Contract Manager. The primary goal of this implementation is to improve efficiency and the quality of data. UFC anticipates an annual sustained savings of \$100,000. Additional benefits include consistency of data, single source-of-truth, detailed practitioner practice locations and affiliations, complete list of practice locations for prior authorizations and provider search for providers and members. Implementation is planned for the third quarter of 2013.
- ≡ **Increase Claims Efficiencies:** UFC will continue to increase the claims auto-adjudication rate to 55% by December 2013, and to 70% by December 2014, saving approximately \$250,000 in overtime expense. Increased provider use of Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) will contribute to the administrative savings mentioned above in 2A.
- ≡ **Member Portal:** In the fourth quarter of 2013, UFC will launch a member portal. The portal will support all product lines, will be implemented in phases and include existing features (provider/pharmacy locator, provider directory, pharmacy benefit/cost information) as well as others such as: medical and pharmacy benefit summaries, medical and pharmacy benefit usage, ID card print or order, PCP change, notification of other insurance, medical and pharmacy claims view, cost of care information, personal health record, medication list, calendar and reminders and secure messaging to UFC. The project plan is in progress and UFC’s goals are to increase member engagement and self-care, improve communication between member and UFC and provide readily available tools online around the clock.
- ≡ **Provider Portal:** UFC will continue to invest in its Provider Portals, eServices and Cerecons — a web-based Prior Authorization (PA) management system. During the second quarter of 2013, Cerecons will be enhanced to include a single-view face sheet that details the history of a member’s medical and pharmacy claims, lab results, PAs, health and wellness information, treatment alerts, medication lists and limited case data. Another phase includes re-engineering of PA criteria, online searchable guides for PAs including CPT codes and implementation of Milliman Care Guidelines’ CareWebQI. The integration of CareWebQI will enable providers to enter an online PA request, respond to clinical criteria, and potentially receive an immediate PA determination. This phased implementation, beginning in the fourth



quarter of 2013, will reduce overall, standard PA decision turnaround time by one day. By the fourth quarter of 2014, eServices will be enhanced to allow providers to submit claims, view an EOB, enroll in EFT/ERA, download HEDIS-like performance reports, communicate with UFC and view a library of information, including the provider manual. UFC’s goals are to increase provider engagement and communication and remove hassle factors, enabling access to robust online information.

Initiative 2 Summary	Stakeholders (other than UFC, AHCCCS)	Timeline	Anticipated Outcomes
Administrative Expenses	Vendors, Employees, Providers, Members	10/1/13-10/1/14	\$2 Million Sustained Reduction (12%)
Provider Information Management	Vendors, Providers, Members	10/1/13-10/1/14	\$100,000 in Savings is a Component of the \$2 Million Administrative Expense Reduction
Claims Efficiencies	Providers, Vendors, Members	10/1/13-12/1/14	\$250,000 in Savings is a Component of the \$2 Million Administrative Expense Reduction
Member Portal	Members, Vendors, Pharmacy Benefit Manager (PBM)	10/1/13-12/1/13	Member Engagement
Provider Portal	Providers, Vendors, Members	10/1/13-10/1/14	Provider Engagement, Reduced Provider Cost

### **Initiative 3 – Reduce Waste Resulting from Fraud**

The IOM advises that healthcare waste resulting from inappropriate or fraudulent activities involving payers, clinicians and patients is estimated at \$75 billion. UFC employs multiple IOM recommended strategies, such as *financial incentives*, *digital infrastructure*, *optimized operations* and *performance transparency*, to prevent and identify fraud and abuse. UFC takes steps to ensure billings are legitimate and payments are accurate and appropriate through multiple checks and balances. An example of tools deployed includes UFC’s contracted fraud and abuse detection vendor, Optum and our PBM, MedImpact. These vendors provide decision-support tools and services to identify and prevent fraud and abuse and assist UFC to uncover and report potential fraud and abuse cases to the AHCCCS Office of the Inspector General. While UFC has a robust fraud and abuse program in place, UFC will implement an annual fraud and abuse work plan to address changing and evolving fraud and abuse activities. This work plan will include quarterly fraud and abuse education that is specialized to separately address providers, members and employees. Educational effectiveness will be measured. It will also include three annual large-scale fraud and abuse analyses related to the following categories: 1) inappropriately inflated prices, 2) excess administration, or 3) unnecessary services. Each analysis will be cross-functional and involve external fraud and abuse detection vendors as well as multiple UFC departments and other appropriate stakeholders. UFC will provide transparency by supplying statistics on fraud and abuse reporting on UFC websites. By October 1, 2015 UFC’s goal is to increase fraud and abuse awareness by 25% and identify and implement three new prevention tactics that will protect AHCCCS funds from potential fraud and abuse. Based on past OIG referrals, UFC anticipates an additional 10 provider and 30 member referrals to OIG per year.

Initiative 3 Summary	Stakeholders (other than UFC, AHCCCS)	Timeline	Anticipated Outcomes
Reduce Waste from Fraud and Abuse	Providers, Members, OIG, Law Enforcement, local community, vendors	10/1/13 – Ongoing	<ul style="list-style-type: none"> <li>▪ Annual Work Plan</li> <li>▪ 25% Increase in Provider, Member and Employee Fraud and Abuse Awareness</li> <li>▪ Three New Fraud and Abuse Tactics Identified and Implemented</li> </ul>

### **Conclusion**

Reducing health care waste is vitally important to ensuring the availability of care for those with the greatest needs. UFC has experienced the challenges Arizona faces first-hand as it works to sustain important programs with limited financial resources. Reducing the overall cost for all stakeholders is of paramount importance. Continual gains in efficiencies will help to manage the complex delivery of care and our nation’s layered approach to care coverage. Reducing waste and cost must be balanced, carefully planned and considered to ensure that those administering the system do not cause barriers to care for those using it as we make strides to improve care and outcomes.



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

Health care fraud is a crime that significantly affects the private and public health care system. Program abuse results in unnecessary cost to AHCCCS and member abuse may result in emotional, physical or sexual trauma. Citizens pay higher taxes because of fraud and abuse. The Institute of Medicine's (IOM) *The Healthcare Imperative: Lowering Costs and Improving Outcomes* estimates fraud costs \$75 billion nationally. Because of this profound impact, University Family Care (UFC) has a compliance program designed to guard against fraud, waste and abuse and a culture that stresses prevention. UFC is a member of the Association for Community Affiliated Plans (ACAP) – a consortium of safety-net plans across the country. In 2009, ACAP evaluated its members' compliance programs and gave UFC's program a second-place ranking, citing its many best practices. UFC's compliance program contains all elements required in the RFP and AHCCCS policies. In 2012, AHCCCS conducted a targeted corporate compliance review based on the YH09-0001 contract. AHCCCS found UFC in compliance with the following standards and made no recommendations for improvement: 1) UFC has an operating corporate compliance program; 2) UFC and its subcontractors have a process for reporting suspected fraud and abuse to AHCCCS OIG; 3) UFC's compliance program is designed to prevent and detect suspected fraud and abuse; 4) UFC has an established compliance committee; 5) UFC effectively implements the Federal False Claims Act and monitors overpayments identified by AHCCCS OIG; 6) UFC has a fraud and abuse plan. UFC's compliance program enforces the highest ethics and standards for employees, the Board of Directors, subcontractors and agents. The following highlights additional activities and personnel deployed, which are all distinct but highly inter-related, to limit, identify, and address fraud and abuse – though, for this response waste is excluded. See response 7 for waste-specific initiatives.

**Activities Taken/Resources Deployed to Limit Fraud and Abuse**

***Risk Assessment:*** To effectively deploy resources, risk must be assessed. UFC completes an annual risk assessment (RA) for both the Medicare and Medicaid programs. This is an integrated approach to identify risk across UFC. The assessment identifies, measures and prioritizes risks that may materially impact UFC, including fraud and abuse risk. To build UFC's RA, data is utilized from multiple sources including AHCCCS and CMS guidance and audit findings, the OIG work plan, national trends and member and provider complaints. UFC leadership and key employees rank the risk potential of UFC operations through a survey. Results are compiled and weighted to identify high, medium and low risk. The 2012 survey results include the following: 1) Ensure adequate UFC employee training to identify and report potential fraud and abuse issues quickly; and 2) Ensure fraud, waste and abuse analysis on specific provider types are implemented and monitored based on trends, including DME. The RA results are presented to the Compliance Committee and after approval by the committee and Board, the RA is used to build UFC's audit plan. The Compliance Committee considers the RA a helpful metric-driven approach to manage and mitigate organizational risk. UFC evaluates the RA annually and adjusts it to ensure ongoing monitoring and oversight. UFC measured a 108% increase in employee fraud and abuse referrals to the Compliance Department after training – referrals went from 35 in 2011 to 73 in 2012.

***Enhanced Committee Structure:*** As an extension of its Compliance Committee and to ensure a company-wide collaboration to reduce fraud and abuse, UFC created a FWA Committee in February 2012. The monthly FWA Committee includes the FWA Analyst, cross-functional management and other key employees. The Committee ensures activities are implemented to prevent, detect, analyze and report fraud and abuse. The committee receives referrals from other areas, reviews tracked and trended analytics and is informed about national trends. When a trend is identified, the Committee develops interventions to detect whether this is occurring in UFC. A two-pronged intervention was developed to detect aberrant billing practices in claims data and implemented communication with members to confirm receipt of services. Results of the intervention detected no unusual billings and 100% of members surveyed confirmed receipt of services. This initiative will be re-launched to ensure no new changes in provider behavior. Through Committee collaboration, UFC has identified and reported an estimated \$48,000 of fraud and abuse to the AHCCCS OIG or MEDICS. AHCCCS program savings may be even greater.

The UM/Finance Committee ensures services are in line with a practical and conservative approach while maintaining high quality. The Committee reviews utilization data for multiple measures and compares providers on a peer-to-peer basis. It reviews high-risk and high-dollar members for aberrancies. When a potential aberrant pattern is identified, such as suspected up-coding or under-utilization, the Committee recommends steps, which may include further analysis, provider outreach, chart reviews and/or referral to the FWA Committee for further investigation. As part of its monthly evaluation of data from its Cognos-generated utilization management (UM) dashboard, the UM/Finance Committee



identified two providers with suspicious billing practices as well as nerve conduction studies as a potential area of abuse. These were referred to the FWA Committee and while the committee did not identify aberrant nerve conduction study billings or payments, the two providers were subsequently reported to the AHCCCS-OIG.

**Enhanced Training:** Training is vital to fraud and abuse prevention. UFC celebrates National Compliance and Ethics Week and the 2012 theme was “Fraud, Waste and Abuse Awareness or Prevention.” Employees received daily “Did You Know” emails, puzzles centered on fraud and abuse, and departments created posters on awareness and prevention. To reinforce the message, UFC displays the 10 posters created and will continue compliance week in coming years. Member Service Representatives engage members in fraud and abuse prevention by educating them directly and discussing fraud and abuse and, as such, UFC has provided direct education to 33 members since 2011. In addition to the mandated member handbook, UFC includes information regarding fraud and abuse in the semi-annual member newsletter and on UFC’s website. UFC supplies providers with enhanced training and education through webinars, eblast notifications, quarterly newsletters, reference guides and an annual Fall Education Symposium, in addition to mandated manual information on correct billing practices and fraud and abuse. Materials are distributed at the symposium on billing, fraud, kickbacks, excluded individuals, drug diversion, identity theft, patient abuse, neglect and waste. UFC’s FWA Analyst presented at a recent symposium on: 1) Examples of fraud, waste and abuse; 2) False Claims Act; 3) Stark Law; 4) Anti-Kickback Law; 5) Deficit Reduction Act; and 6) How to report fraud, waste and abuse. One-on-one training from the Claims Educator and FWA Analyst is also offered to UFC providers. By offering providers education on what constitutes fraud and abuse, providers are better prepared to submit appropriate bills, which will ultimately save time, money and effort. In 2011, a provider with poor billing practices was identified through a claims data-mining analysis. The FWA Analyst paid a personal visit to the provider’s office, gave training through specific examples and the provider modified billing practices. Analysis shows the importance of multi-dimensional provider education in reaching the provider and staff, including the biller, front-office and nursing staff. After offering education, providers identified with potentially incorrect billing practices decreased by 63%--from 55 in 2011 to 20 in 2012.

**Information Technology:** UFC employs multiple software solutions that allow it to efficiently prevent fraud and abuse. To support correct payment activities, UFC’s core claims processing system, GE Centricity Business MCA (GE MCA), formerly known as IDX, contains very flexible rule banks for identifying claims that should be pended for processor or manager review. UFC uses TriZetto Medical Data Express software for outpatient hospital claims pricing, which was customized specifically for AHCCCS standards to eliminate potential overpayment due to manual processing. UFC implemented Optum’s claims editing application, iCES. iCES supplies all AHCCCS required claims editing, and UFC has added functionality for fraud and abuse prevention. This includes incorporating AHCCCS reference-file content directly into iCES, which allows automatic editing for procedure attributes based on AHCCCS standards. For example, a GE MCA/iCES customized interface enables UFC to automatically take a multiple procedure discount when appropriate, whether or not the provider billed with a modifier 51. By not including the modifier, the provider received more funds than allowed, which is a form of upcoding and is potentially abusive. This enhanced edit allows UFC to catch cost avoidance earlier in the process. During the past six months, this resulted in savings of \$245,000 for UFC.

In 2009 UFC implemented the Oracle Siebel Customer Relationship Management (Siebel) application, a state-of-the-art customer relationship management solution. Siebel employs a workflow engine that allows technology-based cross-departmental communication and task/activity assignment. When members and providers contact UFC, their calls are uniformly logged. Employees operate within a workflow queue, completing their tasks in the appropriate sequence. Siebel then routes the task to the next accountable employee. Activities, timings, and results are stored and tracked for review and analysis of trends. The FWA Analyst receives referrals from Member Services through Siebel. The Medical Management Department (MM) also uses Siebel for retrospective claims review. This process identifies claims that result in outliers, which are routed for review by certified coders for errors, fraud or abuse. The task is initiated from the Claims Department and routed to MM. Upon completion, the results are routed back to Claims. Prior to Siebel, this and other processes were handled via paper, which resulted in delays, inefficiencies and payment errors. UFC continues to learn, enhance and adapt this system to support more efficient operations. Another technology solution is Cerecons, a prior authorization (PA) management system. Implemented in 2011, Cerecons is a web-based system that enables providers to send and receive PA requests and responses as well as communicate with UFC. These communications are stored within Cerecons. A member’s medical and pharmacy claims, lab results and other statistics can be viewed on a single screen (face sheet). The provider can access this feature for a complete view of UFC’s record of their patient, services provided and potentially identify unusual requests or patterns.



UFC has used a custom-developed provider portal since 2008, eServices to also support the prevention of fraud and abuse activities. eServices supplies providers with online eligibility verification, claims status inquiry and the ability to submit an electronic PA form. Providers who use eService can easily validate their member in real-time and avoid identity theft. One provider discovered a potential identity theft via eServices and reported this to UFC.

## **Activities Taken/Resources Deployed to Identify Fraud and Abuse**

**UFC Department Activities:** Fraud and abuse activities are not just the responsibility of the Compliance Department, but the responsibility of all the workforce. Below is a sample of various departmental activities deployed to identify fraud.

**Claims:** To ensure provider payments are appropriate, the Claims Department (Claims) monitors for fraud and abuse via iCES, which applies pre-payment system edits, live payment edits and coordination of benefits. UFC's Pharmacy Benefit Manager (PBM) employs point-of-sale edit software and coordination of benefits. Claims monitors for trends and provider patterns and reports suspicious activity to the FWA Analyst via Siebel. Claims conducts quality audits of its individual Claims Processors. Should the audit identify consistent or suspicious errors, Claims re-trains and may discipline the processor. When suspicious billing is identified, Claims can place a provider on manual review status in the GE MCA system and require review of all claims prior to payment.

**Compliance:** The Compliance Department deploys eight auditors, including a licensed R.N. and two Certified Professional Coders (CPCs), a Medicare Advisor (MA), along with the FWA Analyst. All focus on areas of risk – including fraud and abuse identification and annual audits of UFC subcontractors to ensure that fraud and abuse prevention programs are in place. Claims Auditors conduct monthly quality audits to review processed claims for financial and processing accuracy. They look for unusual claims payment patterns. Compliance also monitors sanction screening and exclusion databases to ensure employees and vendors are eligible to participate in federal and state programs.

**Network Development:** In the course of servicing providers, UFC Provider Relations Representatives (PRR) makes unannounced provider office visits. Sometimes the PRR is joined by other UFC representatives, including the CMO, Medical Director, Quality Management Director or Director of Medical Management. If a provider is confirmed by AHCCCS OIG, the Attorney General's Office or MEDIC to be engaged in fraudulent activity, immediate action is taken to terminate the provider. Network Development also monitors the sanction screening and exclusion database to ensure providers and subcontractors are eligible to participate in federal and state programs.

**Medical Management:** The Medical Management Systems Unit retrospectively reviews claims, including DME, professional and facility claims. Medical records are examined to determine medical necessity and appropriate care. The review evaluates services or treatment including medications that have been provided and are based on AHCCCS criteria, CMS guidelines and business decisions on correct coding and associated reimbursements. Should fraud and abuse be suspected, a referral is made to the FWA Analyst via Siebel. For example, while reviewing mobile anesthesiology claims, the Retrospective Review team noted the provider submitted lengthy documentation, but analysis determined the provider billed using a self-created formula for time spent on "oxygen while under conscious sedation." The case was reported to AHCCCS OIG. UFC identified \$6,214 in suspicious billings and the savings realized by AHCCCS may be greater.

**Quality Management:** The Quality Management Department (Quality) includes added steps to identify fraud and abuse. The Quality Manager supplies abuse of member reports to the FWA Committee and investigates member abuse allegations. When cases of suspected child or elder abuse are encountered by UFC staff, these are referred to Quality to ensure appropriate reporting occurs, including notification to AHCCCS. This includes but is not limited to investigations of unexplained deaths, inappropriate treatment by a caretaker and inappropriate use of chemical restraints with anti-psychotics in nursing homes for members transitioning to ALTCS. In 2012 a quality-of-care case was opened when a member complained of not being able to obtain medical records from his former PCP. When Quality examined the records, they discovered inadequate documentation. The Peer Review Committee reviewed the case and confirmed the results. A referral was made to the FWA Analyst and the same medical records were requested for review. Upon receipt it was evident the newly supplied records had been inappropriately modified to better support payment for services, in some cases they were modified a year after the service delivery. UFC met with an AHCCCS OIG investigator to collaborate and the case was immediately referred to an Attorney General's Office investigator. UFC identified \$21,740 in suspicious billings and the savings to AHCCCS may be greater.

**Pharmacy:** The Pharmacy Department works to provide safe and appropriate medications, but it sometimes identifies members who misuse medications, the most common of which are prescribed opioids. UFC's Pharmacy team developed processes to address the misuse of opioids. These include: 1) Pharmacy and Therapeutics Committee oversight, including PA edits for most long-acting opioids and carisoprodol, a medication commonly associated with inappropriate opioid use,



was removed from the formulary because there are safer alternatives to replace it; 2) Conducting a complete medication history review as part of the PA process for long-acting opioid prescription requests and any “refills too soon” or lost prescriptions are thoroughly researched; 3) Reviewing retrospective drug utilization reports from the PBM to identify members exhibiting drug-seeking behaviors, including multiple prescribers, multiple pharmacies and frequent prescriptions for small quantities of controlled substances; 4) Encouraging communication between PCPs, pain specialists and UFC to better manage member care; 5) Researching and responding to drug-seeking member referrals from the FWA Analyst, Case Managers, pharmacy providers and medical providers. When substantiated, the FWA Analyst reports the member to AHCCCS OIG and/or MEDIC, and AHCCCS members can be locked to a specific pharmacy and/or prescriber to better monitor care. Since 2011, UFC has identified 13 drug-seeking members. These members were offered case management and a care plan developed in collaboration with the PCP. Identification of drug-seeking members within the population has improved with UFC’s recent access to the State Board of Pharmacies Controlled Substances Prescription Monitoring Program (CSPM). This enables UFC to view all controlled-substance utilization by members, even if the medication is paid in cash and by-passes encounter data. Since August 2012, UFC has submitted more than a dozen queries to the CSPM and identified two members exhibiting drug-seeking behavior in their use of multiple prescribers and pharmacies. A comprehensive opiate utilization program is being implemented for members who over-utilize opiates. Additionally, UFC actively participates in the AHCCCS Behavioral Health Performance Improvement Project, which coordinates exchange of medication information between UFC and the Regional Behavioral Health Authority.

**Member Services:** UFC monitors members, including members who move out-of-area, no longer qualify for benefits or may be “doctor or prescription shopping” for illegal drugs. All Member Service Representatives (MSR) are required to report suspicious activity. UFC’s Member Services Department (MS) conducts outbound service verification calls and calls members to verify receipt of paid service. The call is documented in Siebel and reported to AHCCCS. Should a member indicate a service was not provided; a referral would be made to the FWA Analyst. Since 2010, MS has made 36 referrals, MM has made 62 referrals and QM has made five referrals. When a member is engaged in a suspicious activity, MS identifies that member in Siebel. When others use Siebel, including Case Managers, UM or QM, this is evident and a member’s care is managed with that in mind. In 2012, MS received a call from a DME provider. The provider was using the eServices portal to check eligibility and found a discrepancy for a member’s date of birth. MS checked AHCCCS On-Line and discovered two members with the same name – a father and son. The father was a member of Mercy Care and no longer eligible for service, but the son was still an active UFC member. After review, it was determined the father was likely using the son’s AHCCCS ID card to receive care. The FWA Analyst found claims tied to the father and discovered some were submitted and processed in error. The member was reported to AHCCCS OIG and \$2,029 in UFC claims were reversed. AHCCCS may realize even greater recoveries.

**Subcontractors:** UFC collaborates with providers and subcontractors to identify fraud and abuse. UFC’s PBM, MedImpact, provides fraud and abuse data-mining decision-support tools and services. The PBM evaluates claims data utilizing a prospective and retrospective process to detect patterns of deviant or abnormal dispensing behavior, MEDIC reported targets, areas of high incidence of fraud and other potential areas of abuse. The PBM reports suspicious activities to UFC’s FWA Analyst and uses the analysis to increase proactive interventions such as pharmacist education. The PBM supplies UFC with quarterly and annual reports that identify any prevented overpayments. In 2012, UFC’s FWA Analyst received a referral from its PBM regarding potentially inappropriate prescribing practices. The PBM reported that four UFC members received prescriptions for a combination of medication that mimics heroin. Medical-service claims data was compared to ensure the members in question received services from the physician, which would rule out a stolen prescription pad. The FWA Analyst confirmed medical services were provided around the time prescriptions were filled at the participating pharmacies. The information was compiled and submitted to AHCCCS OIG. UFC awaits the outcome of the investigation. PBM representatives are required to make unannounced pharmacy visits to confirm the location is a legitimate business.

UFC’s dental network subcontractor, DentaQuest (DQ), monitors its contracted providers via qualitative and quantitative utilization data management that compares dentists to identify aberrant practice or billing patterns. They analyze 100% of paid claim history and conduct medical record reviews on an average of 5%-10% of the network. Should aberrant patterns be identified, DQ may implement a provider education program to modify provider behavior and may report the provider to UFC’s FWA Analyst or directly to AHCCCS OIG. DQ identified an Arizona dentist with a billing pattern of multiple restorations on multiple teeth, with the same surface inclusion, on a single date of service. DQ conducted a clinical audit of the records and found the services were not supported. The provider was referred to the OIG which expanded the investigation to all contracted acute plans and identified a significant overpayment of Medicaid funds. This provider



surrendered his license to practice in Arizona. DQ representatives are required to make unannounced dental office visits to confirm the location is a legitimate business.

**Vendor Support and Data Mining:** UFC contracts with vendors to assist with fraud and abuse identification. UFC has contracted with Optum to provide decision-support tools and services to identify and prevent fraud and abuse since 2010. Optum conducts searches by analyzing UFC referrals and data mining UFC's claims data. Data mining detects potential overpayments, fraud or abuse by identifying patterns that are aberrant when compared to other like claims. These patterns are identified through techniques including visualization designed to reveal hidden relationships such as unbundling, upcoding, duplicate billing, services not rendered, and misrepresentation of services. Optum uses 36 months of claims data for the analysis. The FWA Analyst then validates Optum's findings. When suspicious billing or patterns are identified, UFC utilizes Optum to obtain additional documentation to further develop the case. Optum has proven valuable in identifying waste and has assisted in identifying some potential fraud and abuse. Optum's analyses have identified 45 providers who were referred to AHCCCS OIG or CMS-MEDIC.

### **Activities Taken/Resources Deployed to Address Fraud and Abuse**

**Additional Staffing:** UFC's Compliance Department employs a full-time FWA Analyst. UFC requires the position be held by an Arizona-based certified coder who has an extensive background in provider reimbursement and operation workflows. The FWA Analyst coordinates monitoring and analysis to validate suspicious activity, facilitates the FWA Committee and cooperates with investigators from the OIG, Attorney General, FBI and other law enforcement agencies. UFC's FWA Analyst receives reports of potential fraud and abuse from employees, providers and members. The Analyst researches CMS fraud alerts and AHCCCS OIG notices along with monitoring news reports for providers jailed for offenses, such as sexual or physical abuse. The FWA Analyst's position guarantees review, analysis and follow-up on every allegation. If an allegation arises, UFC makes timely reports to the AHCCCS OIG or CMS-MEDIC. UFC has referred 101 providers and 112 members to AHCCCS OIG and 2 providers and 5 members to CMS-MEDIC. In reviewing fraud and abuse trends, the most frequent member allegation received is "members who move out of area". For providers, misrepresentation of services, services billed were not rendered, unbundling and upcoding were top reasons.

**Continuing Education and Awareness:** UFC requires the Compliance Officer obtain compliance certification. UFC's Compliance Officer has CHC certification from the respected Health Care Compliance Association. Maintaining this certification requires continuing education, including training on innovative fraud and abuse techniques. Through UFC's ACAP membership, UFC participates in compliance and FWA workgroups and networks with similar plans regarding fraud and abuse. In addition, the Compliance Officer, FWA Analyst, FWA Committee members and other UFC employees are regular attendees of the quarterly CMS Fraud Work Group meetings, which are held throughout the U.S. by MEDIC. Attendees include Medicare, Medicaid, private insurance companies, State Attorney General Offices, State and Federal Office of Inspector General Offices, and federal and state law enforcement agencies. Attendees are encouraged to ask questions, obtain advice, discuss best practices and network with other plans and government agencies.

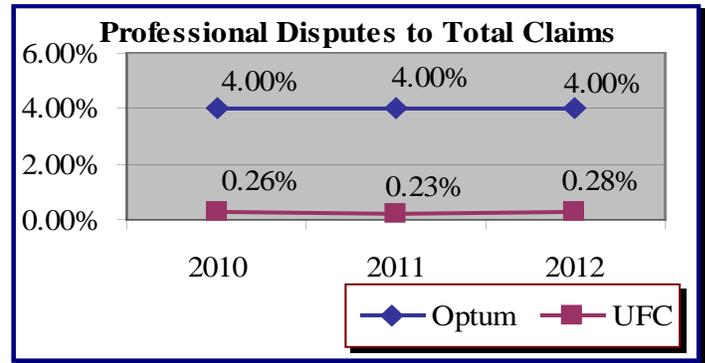
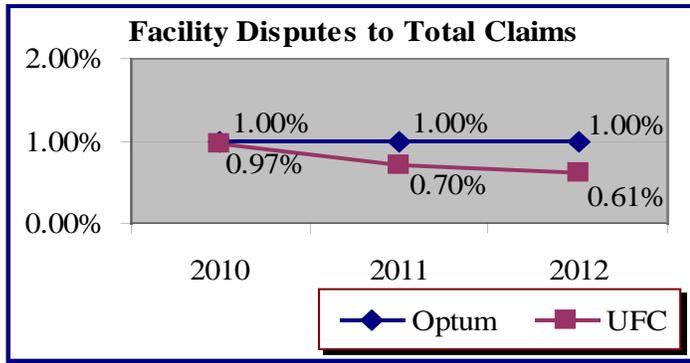
**Annual Work Plan:** UFC's FWA Committee is launching an annual work plan that will include a minimum of four fraud, waste and abuse education activities per year for providers, members and employees along with three fraud and abuse analyses per year based on current literature and findings. The FWA plan will be monitored annually, reviewed for effectiveness and updated as new elements are introduced. This work plan is included as a waste initiative in response 7.

**Reporting and Transparency:** In accordance with AHCCCS, Medicare and federal and state regulation, UFC has and will continue to report suspected/potential FWA activities to the appropriate governing body for further analysis and investigation. To enhance transparency, with AHCCCS's permission UFC will modify its website to prominently display "How to report fraud and abuse and include UFC's Call Center phone number" on both the home page, member and provider pages. Counts of UFC providers and members reported to the AHCCCS OIG or MEDIC will be provided along with top referral trends, such as upcoding. This raises awareness and lets stakeholders know UFC will take action when suspicious activity is identified. Through these methods, it is apparent that as a truly local organization, UFC is able to nimbly adapt to changing fraud and abuse trends. As a Medicare and Medicaid participant, UFC recognizes the public funding and accompanying public scrutiny of AHCCCS outlays. UFC's actions to limit, identify and address fraud and abuse demonstrate a compliance program in action, a desire to operate in a manner consistent with the public trust and a commitment to satisfy AHCCCS expectations.



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

University Family Care (UFC) recognizes that providers are an essential partner in the delivery of health care services. UFC has an Arizona-only focus and works efficiently and effectively for and with its providers who are viewed as colleagues and neighbors. UFC is a long-standing AHCCCS contractor and strives to pay claims swiftly and accurately. This approach improves operational efficiencies by reducing expensive re-work, ensures more satisfied providers and reduces claims dispute volume. UFC compares its claims disputes volume to other industry benchmarks. OptumInsight (Optum) processes 35 million claims per month for over 2,000 health care payers, including processing information that affects one in every three Medicaid dollars. Optum’s claims dispute benchmark is 1%-2% of total claims volume for facility claims and 4%-5% for professional claims. As the graphs indicate, UFC has much lower claims dispute rates:



**UFC Minimizes the Need to Utilize the Claims Dispute Process**

UFC will continue to be a high-performing health plan and has established two internal benchmarks: 1) Claims disputes filed will not exceed 1% of total claims volume for all claims types; 2) Provider satisfaction rates for resolution of claims payment problems/disputes will meet or exceed (by 2%) the 2012 satisfaction rate of excellent or very good responses. UFC will use several means to achieve these goals and minimize need for providers to use the claims dispute process. Measures include provider education and communication, a well-trained work force, optimized operations, provider feedback, continuous process improvement and transparent monitoring and oversight.

**Provider Education and Communication:** UFC ensures comprehensive provider education at new provider orientations, in-services, annual education symposiums and via webinars. Providers receive yearly provider manuals and resource materials that outline topics like proper billing practices and how to use the resubmission process, including provider inquiries, procedures for submitting claims disputes, how to obtain prior authorizations (PA), quick reference information and key UFC contacts. This information is also available on UFC’s website, which is updated regularly. From 2010 through 2012, over 6,000 training sessions have been held on proper billing practice education. Each provider is also assigned a dedicated Provider Relations Representative (PRR). By providing one-on-one support, the PRRs are able to address and resolve claims payment issues. UFC’s Claims Educator works directly with providers on billing issues and accompanies PRRs to provider offices when additional claims education is needed. UFC tracks provider inquiries managed by PRRs and the Claims Educator and categorizes inquiry reasons. UFC has noted a consistent downward trend in provider inquiries regarding claims issues; from 2010 to 2012, claims-specific provider inquiries reduced from 19.8% to 14.5% of total inquiries – a 5.3% reduction. UFC’s provider portal – eServices – enables online eligibility verification, claims status inquiry and the ability to submit an electronic referral form. As shown, providers rely heavily on eServices and re-visit it throughout the billing and payment cycle.

eServices Usage Statistics	2010	2011	2012
Claims Status	817,225	641,942	696,047
Eligibility Inquiry	380,654	371,312	359,114

In addition to the training programs already in place, UFC will supply quarterly education aimed at decreasing claims denials and improving provider awareness of changes in billing practices. Providers will be trained via meetings, webinars, newsletters and notifications, along with education that will be provided through the claims inquiry process. Seasoned UFC employees in the claims customer service queue review claims and assist providers with issues or concerns. UFC’s continual, multi-method, detailed education strategies ensure providers are informed on how to submit a claim that will result in timely and accurate payment. In 2013, UFC will develop job descriptions and interview templates



for providers' use in hiring and retaining qualified and experienced billers who are familiar with Medicaid/Medicare claims payment rules. To further assist providers, UFC will implement quarterly provider forums. The forums will examine trends and gather actionable ideas to help providers navigate delivery system reforms.

**Well-Trained Workforce:** UFC thoroughly trains all employees involved in the claims payment continuum – including employees in Member Services, Network Development, Medical Management, Finance, Information Systems and the Grievance & Appeals Department (GA). New processors hired into the Claims Department (Claims) are required to complete a rigorous six-week training course. While in training, their claims are subject to 100% audit to ensure the claims processor can meet the established 95% accuracy standards. After six weeks of training and continued achievement of compliant claims processing, the processor moves to an audit of 50% of claims. Once the compliance rate is met, on-going training is provided, including twice-monthly information sharing sessions – which are extended to Network Development, GA, Medical Management, Compliance and Member Services employees. Education on industry best practices is provided at the first session and the team must pass a written test to validate comprehension at the second session. The Claims team uses SharePoint as a virtual training library. Some of the most experienced Claims employees are part of the Adjustment Team, which manages claims re-submissions and disputes. The team's goal is to resolve issues within 15 days of receipt in order to expedite provider payments. The Adjustment Team produces a monthly report to identify individual- and group-training opportunities. Supervisors meet with Claims employees and perform a "5-why" process on identified errors, which was adopted from the automobile manufacturing industry and repeatedly asks "why" until a root cause is determined and an intervention is implemented, including follow-up training. UFC also evaluates provider feedback trends for training opportunities. To ensure continuity, the Claims Educator, Provider Relations Team, Claims Dispute Coordinator and Claims Auditors also receive in-depth claims and claims dispute education, including regular training on updated coding requirements from UFC-certified coders. To augment the knowledge-base of the PRRs, the Claims Educator provides ongoing training as it relates to trends, issues and coding updates.

**Optimized Operations:** UFC excels in the area of claims adjudication through strong, established processes and collaboration that utilize the entire organization to address complex and changing reimbursement requirements. UFC adjudicates claims using the GE Centricity Business MCA (GE MCA) system. GE MCA primarily supports UFC enrollment and claims processing functions and interfaces with supporting applications to provide a suite of solutions, enabling UFC to nimbly meet the rapidly changing needs of the market, as well as regulatory requirements. Key interfacing applications include iCES for claims editing, MDE OPFS and Burgess Reimbursement System (BRS) for claims pricing, Siebel for Member Services and workflow, Cerecons for PAs and Acuity for case management. iCES is customized to edit for AHCCCS-specific procedure attributes while maintaining Medicare attributes and edits for D-SNP claims. Other edits used to support industry and AHCCCS standards include: HIPAA 5010 837 data standard, enrollment edits, timely filing standards, benefit plan and coverage limitations, provider qualifications and credentialing, duplicate checking, PA, correct coding edits, Medicaid-specific NCCI and MUE edits, AHCCCS-specific limitations, COB, automated reductions, OPFS grouping/pricing and others.

To integrate claims processing for dual Medicaid and Medicare lines of business, BRS enables real-time, accurate pricing of Medicare fee-schedule-based claims. Pricing arrangements based on a percentage of the Medicare fee schedule are automatically priced in real-time or batch using BRS. BRS pricing improves accuracy, as the BRS tables are changed as soon as updated fees are effective with CMS. The BRS system also allows for creation of custom fee schedules. This pricing solution positions UFC well for DRG-based inpatient reimbursement, dual demonstration and participating in the Insurance Exchange. All ANSI X12 standard transactions are 5010 compliant. This enables greater efficiency in electronic interfaces and improves service to the provider community. More than 71% of providers, up 5.25% from 2011, now receive reimbursement via Electronic Funds transfer (EFT) and Electronic Remittance Advice (ERA/835). UFC's delegated dental network, DentaQuest, also has a portal that enables providers to submit claims electronically and to track claims status and payment. UFC and its delegated fiscal agents will continually enhance claims pricing and payment systems to maintain pace with current industry standards.

UFC ensures provider contracts are loaded efficiently and accurately into GE MCA. Contract implementation requires inter-departmental collaboration and UFC remains compliant with all contract load timelines. UFC completes an internal monitoring of contract loads, and the Compliance Department then conducts a redundant audit to ensure accurate load. Once contracts are loaded and tested, UFC employs an organization-wide approach to claims payment, involving all departments at all levels. Employees work together in a systematic way to maintain strong processes. Formally, UFC has



enforceable policies and well-functioning workflows. Claims Leadership monitors daily production to ensure claims are not aging past the department target. Claims Supervisors monitor assigned work queues to ensure timely processing. Claims that pend are escalated for resolution and are managed daily to ensure issues are resolved quickly. Timeliness of payments is consistently compliant with over 95% of the claims payments made within 30 days of receipt. UFC's delegated dental claims processing vendor has a processing- and financial-accuracy rate that is consistently above 99%.

UFC has committees and work groups focused on reducing the provider "hassle-factor," improving provider service and resolving provider issues. These groups include the AHCCCS Operations Team, Claims/Finance Joint Operations Committee, Provider Advisory Committee, Contract Implementation Work Group, IS/Claims/Encounter Work Group, Contract Strategy Committee, Provider Satisfaction Work Group, Appeals Committee, Fraud, Waste and Abuse Committee and the GA Reporting Committee. For example, the AHCCCS Operations Team meets weekly to evaluate AHCCCS operations, including ACOM and AMPM updates. The team determines the best approach, facilitates implementation and ensures communication to employees, providers and members. When a process is modified – including those that could impact billing and reimbursement – notification eBlasts are quickly sent to educate providers. Another team working to improve provider service is the IS/Claims/Encounter Work Group, which addresses encounter errors related to system or operational inefficiencies and has identified and acted on several issues that improved claims processing and encounter submissions.

**Provider Feedback & Collaboration:** UFC obtains provider feedback in many ways, including its annual provider satisfaction survey. UFC considers an "excellent" or "very good" response indicative of high satisfaction. UFC had a higher percentage of "excellent" and "very good" responses compared with other AHCCCS plans in the areas of claims payment problems (6% higher than other AHCCCS plans), accuracy (9% higher than other AHCCCS plans) and timeliness of claims processing (7.6% higher than other AHCCCS plans). The satisfaction survey also identifies attributes correlated most highly with overall provider satisfaction. "Resolution of claims payment problems or disputes" is a highly correlated attribute and is considered one of UFC's strengths. Additionally, trended provider complaints averaged 15 per quarter in 2012 and 53 in 2011 – a reduction of 71.7%. UFC attributes this, in part, to improvement in accuracy and timeliness of claims payment.

UFC has employees and systems to assist providers with claims issues, including the Claims Customer Service Team (CCS). CCS is a specialized group that answers provider claims questions – they fielded more than 30,000 calls in 2012. When a claims issue is identified, UFC opens a Service Request (SRs) in Siebel, a state-of-the-art customer relationship management solution and routes the task to the Claims Adjustment Team. Once complete, the results of the SR are routed back to the SR originator who then communicates with the provider. All SR activities, timing and interaction results are stored and tracked for review and analysis to identify claims processing issues, whether the issue is related to provider education, employee education or operational process. UFC will continue to utilize Siebel and enhance it to meet changing needs. UFC management meets directly with providers, including monthly meetings with our Claims management employees and the following provider groups: Sierra Vista Regional Health Center, and The University of Arizona Health Network. These meetings promote collaboration between the provider and UFC which reduces claims disputes. The Network Development Department regularly prepares scorecards for providers that include claim disputes data. PRRs discuss these with providers to identify and mitigate potential future claims disputes.

**Continuous Process Improvement:** Dedicated to continuous learning, UFC uses the PDSA model and employees are encouraged to question and challenge current practices. UFC has implemented several PDSAs in the Claims and GA Departments that improved operations, reduced medical expenses, and improved system efficiencies. On a larger scale, these PDSAs included implementing a paperless claims operation which reduced backlog and processing errors while significantly improving payment turnaround time. Improvement was measured by comparing Service Requests (SR) opened for provider claims payment issues. In 2011, UFC opened 14,893 service requests. In 2012, it opened 10,772, a 26.7% reduction. Another PDSA being piloted focuses on educating providers on billing errors. When the Claims Adjustment Team re-adjudicates provider claims, all adjustments are tracked and the data is analyzed for provider billing-error trends. If those trends are identified, the Claims Educator educates providers on preventing such errors. Providers are then monitored for change and early results of this PDSA are promising. For example, The Claims Educator noted billing errors for both Northern Cochise Community Hospital and Holy Cross Hospital and reached out with focused education. Both facilities were monitored for similar errors and demonstrated a marked quarter-over-quarter improvement: a 79.7% reduction for Northern Cochise and a 44.4% reduction for Holy Cross in similar billing errors.



UFC will implement a pilot program to expedite and address provider claims payment concerns via a rapid-response hotline. The provider’s payment issues will be resolved and tracked, and trends identified will be used to provide additional internal and external training to implement process improvements. Another process improvement project designed to continually monitor opportunities for reducing claim dispute volume, UFC will implement an annual work-plan to set priorities and define PDSA projects related to reducing the volume of claims disputes.

**Monitoring, Reporting and Oversight:** UFC employs multiple tools to monitor performance. UFC produces a monthly operational dashboard, a metrics-based tool that allows UFC to oversee performance. The dashboard trends data on claims accuracy, timeliness, dispute counts and dispute outcomes as well as other health plan metrics. The dashboard is disseminated to UFC’s management team and reviewed monthly at UFC’s Operations Team meeting and quarterly by UFC’s Director’s Team. If an element falls outside of compliance it is shown visually as red. This allows the management team to easily identify non-compliance and begin corrective measures. All issued corrective action plans are monitored by the Compliance Committee to ensure ongoing oversight of UFC activities and compliance with Arizona and Federal regulations and requirements. If there is a concerning trend, a root cause is determined and a team of experts implements an intervention to avoid a reduction in performance. For example, one of the key claim indicators is for electronic funds transfer (EFT) which has a minimum AHCCCS requirement of 60%. Until May 2011, this appeared as red on the dashboard. Corrective measures were collaboratively implemented to improve the indicator and this metric is now at 70.8%, which exceeds the AHCCCS minimum. This robust monitoring and oversight infrastructure demonstrates UFC’s commitment to keep claims disputes minimal and provide impeccable service.

Performance monitoring includes routine auditing (procedural and financial accuracy) by the Claims Department of 3% of claims processed per processor each month to ensure overall quality and accuracy is consistently above 95%. In addition, facility and professional claims over a specified threshold are reviewed by the claims auditor to confirm accuracy. In the GA Department, a series of inter-rater reliability reviews are conducted by the Review Nurse and Claims Dispute Coordinator to ensure a consistent application of criteria and decision-making. In addition, the Compliance Department employs two claims auditors who conduct additional routine audits as well as an auditor who does routine audits of the GA Department. Any identified non-compliance results in the issuance of a corrective action notice.

UFC delegates claims processing for some services and monitors/audits processing accuracy through the subcontractor oversight process. It does not delegate grievance or appeals. UFC can monitor a delegated entity’s payment performance and take action should UFC see an increase in disputes filed. UFC meets with delegated partners to review claims dispute trends and to better coordinate operations.

The GA Department and Claims Department management have a weekly meeting to address any immediate concerns. Secondary to the weekly meetings, Claims and GA meet monthly to review trends and identify providers with a high volume of disputes. The claims dispute categories are reviewed, as well as any provider with an abnormal volume of disputes. UFC may enhance processor training if the disputes have identified process issues, such as inappropriate denial, or it may arrange for provider education. One example is a provider that may be inappropriately unbundling services.

**Interventions/Strategies to Resolve Disputes without Resorting to the Hearing Process**

UFC monitors claim disputes to ensure, whenever appropriate, they do not escalate to the hearing process. As the table demonstrates, in 2012 UFC resolved more than 80% of hearing requests. Less than 1% of UFC claims disputes actually went to hearing in 2011 and 2012. By 2014, UFC will implement the following goals aimed at reducing claims disputes: 1) UFC’s commitment will be measured by a 20% reduction in claims resubmissions and a 5% reduction in provider calls; 2) An internal tracking mechanism will be utilized to identify reasons for claims resubmissions, pended encounters and provider calls. Information sharing training sessions will include additional training to review the identified errors, and 3) UFC’s Claims and GA leadership team will meet bi-weekly to design interventions and work with providers so claim disputes forwarded to hearing will not exceed 1% of total claims disputes.

Claim Dispute / Hearing Trends	2011	2012
Total Claims Disputes Filed	3529	3036
Total Hearing Requests	34	58
Total Claims Disputes Forwarded to Hearing	5	5
% of Total Claims Disputes Forwarded to Hearing	0.14%	0.16%



**Interventions:** Filed claims disputes are expeditiously addressed to determine whether the claim can be paid or whether UFC needs to reach out to the provider. UFC holds weekly appeals meetings to review current claims dispute cases, discuss trends and analyses and to develop intervention plans. After a claim dispute is filed, an evaluation is conducted to determine if the dispute can be attributed to provider practices or UFC operations. UFC also reports claims dispute trends at its quarterly GA Reporting Committee. This inter-departmental team reviews trended claim disputes to discern systemic issues and develop interventions to solve them. In 2010, identified systemic issues included: 1) Denials for lack of PA and; 2) Timeliness of claims submission. Interventions were implemented that considered both UFC and the provider. For example, providers were given additional training on PA requirements and the PA grid distributed to providers was updated to make it easier to read. The PA Department implemented enhanced PA automation to improve PA efficiency and accuracy. These claims dispute reasons were re-measured in 2012 and showed an 18.7% and 13.0% improvement, respectively.

On a quarterly basis, the GA Reporting Committee will monitor two elements; 1) Top 10 providers filing claims disputes (12 month rolling trend) and 2) Top 10 claim denial trends. Review of these reports will assist UFC to identify trends and act as a mechanism to prompt the PRRs to reach out to the provider to identify the root cause, develop an intervention to address the issues and identify an alternative to filing claims disputes. If the evaluation validates a systemic UFC issue, UFC will implement a CAP, including examining system set-up and audit validating to ensure the systemic issue is corrected. Once addressed, UFC will notify affected providers of the actions taken. All CAPs are reported to and monitored for completion by the Compliance Committee.

UFC also holds a weekly meeting with the Appeals Case Review Team, which is led by the Chief Medical Officer (CMO) to review new hearing requests. The goals are to determine whether an issue can be resolved without the need for a hearing and to ensure provider satisfaction. The CMO may make a peer-to-peer call with the provider to determine if additional medical information would provide an opportunity for overturning the decision. The team may determine that a negotiated settlement could occur and would propose this solution in an effort to avoid a hearing. For example, in 2012, a facility filed a hearing request for a claim that was denied for exceeding the 24-hour observation limit, a standard system denial. After initial review, the case was forwarded to the CMO who contacted the facility and determined there were extenuating circumstances, and it was appropriate to pay for a portion of the claim. UFC and the provider successfully negotiated a settlement that saved \$2600 and avoided a hearing. Through this process, UFC has also developed a tool / guide for claims dispute escalation. If GA identifies an anomaly on a claims dispute, this is immediately escalated to the CMO in order to follow-up with the provider in an effort to avoid a hearing. With these interventions, this team has greatly reduced the number of cases that need to be resolved using the hearing process, and combined interventions have resulted in avoiding 82 hearings from 2011 to 2012. This approach of using team dialogue to arrive at fair, yet firm decisions leading to proactive provider outreach is at the core of UFC's strategy.

In some instances, UFC has identified providers that abused the claim dispute process. Although UFC works to educate the provider regarding its rights to resolve claims issues, some providers consistently bypass the re-submission stage and use the claim dispute process. During the process of evaluating claims dispute trends, it was apparent that one provider group was an outlier. Further research revealed that 24% of all UFC's claim disputes submitted were from this particular group. The volume of claim disputes was so egregious that UFC's Contract Strategy Committee has decided to pursue a contractual remedy with the group.

UFC's GA Department has many tools to ensure efficient responses to filed disputes, including using Siebel to log, track and report claims disputes. GA works expeditiously to conduct all needed research and present the claims dispute case for review and resolution. In order to minimize the need for extensions, UFC has set an internal review timeline of 14 days. The average number of days to resolve a dispute (including extensions) was reduced from 33.98 in 2010 to 28.38 in 2012. By January 1, 2015, UFC is committed to resolve all claims disputes in an average of 25 days or fewer.

## **Conclusion**

Regular and consistent inter-departmental meetings and training guarantee that information is dispatched to front-line employees. Updates to policies and processes continue to reduce the need for future claim disputes. Continual monitoring and auditing of the claims process, stringent review of claim dispute data, trending issues, implementing process improvement and training employees reduces the volume of claim disputes. These elements together should ultimately reduce provider inquiries and claims calls, as well as increasing provider satisfaction.



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### **Question 10 - Information Technology (IT) Systems Demonstration**

Demonstrate, by participating in mock Information Systems scenarios over a 10-day period, that the Offeror will understand how to, and have the capability to, accurately and timely:

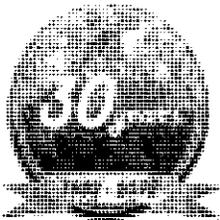
- Process data exchanged with AHCCCS
- Administer actions based on the data processed

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 29, 2013. For this Submission Requirement, the Offeror shall provide written acknowledgement as follows:

- University Family Care (UFC) acknowledges that its participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No. 10**
- University Family Care (UFC) acknowledges that it will comply with the stated guidelines and calendar for this process.**
- University Family Care (UFC) acknowledges that the IT Systems Demonstration will be scored as part of the UFC Proposal**

	<b>SOLICITATION AMENDMENT</b>	<b>AHCCCS</b> Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034
	Solicitation No.: <b>RFP YH14-0001</b> Amendment No. 5 (Five)	Solicitation Due Date: <b>January 28, 2013</b> <b>3:00 PM (Arizona Time)</b>

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page must be received by AHCCCS no later than the Solicitation due date and time. Notwithstanding, Section H: Instructions to Offerors, Paragraph 15, *Contents of Offerors Proposal*, for Amendment No. 5 only, one copy of signed Amendment No. 5 is required which may be submitted separately from the remainder of the proposal. However, the signed Amendment No. 5 must still be submitted by 3:00PM (Arizona Time) on the January 28, 2013 deadline. Offerors may submit the signed amendment electronically to the Offeror's SFTP folder noted in Section H: Instructions to Offerors, Paragraph 15, *Contents of Offerors Proposal*, or by hard copy to the Solicitation Contact Person.

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

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

**AHCCCS Response:**

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

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

OFFEROR		AHCCCS	
Signature 	Date 01/28/2013	Signature 	
Typed Name James V. Stover		Typed Name Michael Veit	
Title Chief Executive Officer		Title Contracts and Purchasing Administrator	
Name of Company University Family Care		Name of Company AHCCCS	