Response to Acute Care

RFP No. YH14-0001

Health CHOICE

Value-driven health care for Arizona communities.

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"Our collaboration with Health Choice of Arizona is exemplified through the Partnership for Quality Care Program and the many community outreach initiatives we have implemented. With support and resources from Health Choice, we have made significant strides toward optimizing the patient care experience for members and furthered our mission to improve the health of the communities we serve."

~Avein Tafoya, CEO, Adelante Healthcare, Phoenix, AZ

Health CHOICE

A. General Matters

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"I ran around in circles trying to figure out my children's healthcare benefits until I talked to Brenda at Health Choice. She was helpful, kind, sweet, funny and it was just a fantastic experience! You just can't find that kind of customer service anywhere anymore. Thank you Brenda for making it easy, and showing that I'm important!"

~Member call to compliment our Customer Service Representative.

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	4 - 5
Signed Cover Sheets of Solicitation Amendments, if any	289	
Completion of all items in Section G: Representations and Certifications of Offeror	Section G	6 - #

A1: OFFEROR'S BID CHOICE FORM

ACUTE CARE PROGRAM

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

Health Choice Arizona, Inc.
Offeror's Name

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

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

Authorized Signature

1/21/13
Date

Mike Uchrin
Print Name

CEO
Title

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

Authorized Signature _____ Date _____

Print Name _____ Title _____

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

B. ATTESTATION

Attestation	***Requirement No.***	***Offeror's Page No.***
	1-34	20

C. CAPITATION SUBMISSION

Capitation	***Requirement No.***	***Offeror's Page No.***
Acute Care Program Capitation Bid Submission Including Actuarial Certification	1	25
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.***
	1	29
	2	33

E. ACUTE CARE NARRATIVE SUBMISSIONS

Access to Care/Network	***Requirement No.***	***Offeror's Page No.***
	1	34
	2	39

Program	***Requirement No.***	***Offeror's Page No.***
	3	44
	4	49
	5	54
	6	59

Organization	***Requirement No.***	***Offeror's Page No.***
	7	64
	8	69
	9	74
	10	79

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

Offeror's Signature Page

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

Solicitation Contact Person

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

Telephone: (602) 417-4538
Telefax: (602) 417-5957
E-Mail: Meggan.Harley@azahcccs.gov

Issue Date: November 1, 2012

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

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

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

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

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

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

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

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

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

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

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

Late proposals shall not be considered.

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

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

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

OFFER

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

Arizona Transaction (Sales) Privilege Tax License No.:

N/A

Federal Employer Identification No.:

62-1796494

E-Mail Address: MUchrin@iasishealthcare.com

Health Choice Arizona
Company Name

410 N. 44th Street Suite 900
Address

Phoenix AZ 85008
City State Zip

For Clarification of this offer, contact:

Name: Mike Uchrin

Phone: 480-731-3505

Fax: 480-303-4436

Signature of Person Authorized to Sign Offer

Mike Uchrin
Printed Name

CEO
Title

CERTIFICATION

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

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

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

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

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

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

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

Michael Veit, as AHCCCS Contracting Officer and not personally

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

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

This solicitation is amended as follows:

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the **27th day of November, 2012**, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** 12-26-12	**Signature**
Typed Name Michael Ullrich		**Typed Name** Michael Veit
Title CEO		**Title** Contracts and Purchasing Administrator
Name of Company Health Choice Arizona		**Name of Company** AHCCCS

	SOLICITATION AMENDMENT	AHCCCS
	Solicitation No.: **RFP YH14-0001** Amendment No. 2 (Two)	Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034
	Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

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

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

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

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

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

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

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 19th day of December, 2012, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** 12-21-12	**Signature**
Typed Name Michael Ulrin		**Typed Name** Michael Veit
Title CEO		**Title** Contracts and Purchasing Administrator
Name of Company Health Choice Arizona.		**Name of Company** AHCCCS

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

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

This solicitation is amended as follows:

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 4th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** 1/7/13	**Signature**
Typed Name Mike Uehrin		**Typed Name** Michael Veit
Title CEO		**Title** Contracts and Purchasing Administrator
Name of Company Health Choice		**Name of Company** AHCCCS

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

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

This solicitation is amended as follows:

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

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

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

Bid component requirements:

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

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

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

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

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

Bid component requirements:

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 10th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** 1/18/13	**Signature**
Typed Name Mike Uchrin		**Typed Name** Michael Veit
Title CEO		**Title** Contracts and Purchasing Administrator
Name of Company Health Choice Arizona		**Name of Company** AHCCCS

	**SOLICITATION AMENDMENT** Solicitation No.: **RFP YH14-0001** Amendment No. 5 (Five) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

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

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

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

AHCCCS Response:

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

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

OFFEROR		**AHCCCS**
Signature	**Date** 1/25/13	**Signature**
Typed Name Michael Uehrin		**Typed Name** Michael Veit
Title CEO		**Title** Contracts and Purchasing Administrator
Name of Company Health Choice Arizona		**Name of Company** AHCCCS

Section G

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR

HEALTH CHOICE ARIZONA INC., PROPRIETARY AND CONFIDENTIAL

Pages 6-19 intentionally omitted from this document.

B. Attestation

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"...We appreciate the ability of Health Choice to focus on outcomes, paired with recognizing cost-saving measures that allow women to be seen in an outpatient setting such as we provide...drastically reducing the need for patients to seek care from an inpatient, emergency environment. As we have expanded across the Phoenix area, it has been great to have Health Choice as a true partner..."
~Nick Goodman, CEO, MomDoc, Phoenix, AZ

Health CHOICE

EXHIBIT C: ATTESTATION FORM

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

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

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

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

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

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

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

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

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

ATTESTATION SIGNATURE

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

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

Authorized Signature 1/21/13 **Date**

Mike Uchrin **CEO**
Individual's Printed Name **Title**

C. Capitation

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"We appreciate Health Choice and their dedication to us and those we serve. They have worked closely with our individual clinics, giving support services, and our business office to keep our companies aligned as we fulfill our mission to provide care to the under-served populations in all of the northern counties of Arizona."

~Marti Neff, Director of Operations, North Country HealthCare, Flagstaff, AZ
– Contracted Provider since 2003

Health CHOICE

Acute Care RFP Bid Template - Health Choice Arizona

Gross Medical Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$388.80	$410.21	$427.22	$442.25	$427.17	$463.43	$395.52
TANF 1-13	$84.18	$91.38	$100.38	$88.02	$76.96	$92.76	$86.22
TANF 14-44 F	$180.31	$221.96	$267.10	$229.85	$189.06	$210.74	$216.06
TANF 14-44 M	$102.01	$154.93	$171.16	$143.37	$117.33	$137.66	$146.09
TANF 45+	$285.65	$372.31	$389.81	$405.83	$319.51	$375.78	$353.68
SSIW	$152.66	$103.12	$96.96	$115.66	$111.00	$147.57	$128.94
SSIW/O	$793.11	$846.82	$860.44	$673.01	$712.05	$746.20	$821.80
AHCCCS Care	$318.31	$384.75	$422.81	$373.02	$298.76	$387.44	$350.68
Delivery Supp	$4,593.29	$5,109.50	$5,209.47	$5,237.17	$5,161.69	$5,447.17	$4,998.15

Administrative Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$25.86	$25.84	$26.91	$27.86	$27.13	$32.44	$24.92
TANF 1-13	$5.68	$6.03	$6.47	$5.81	$5.08	$6.68	$5.69
TANF 14-44 F	$11.99	$13.98	$16.83	$14.48	$12.01	$14.75	$13.61
TANF 14-44 M	$6.89	$10.23	$11.04	$9.46	$7.74	$9.91	$9.64
TANF 45+	$19.00	$23.46	$24.56	$25.57	$20.29	$26.30	$22.28
SSIW	$10.15	$6.50	$6.11	$7.29	$7.05	$10.33	$8.12
SSIW/O	$53.53	$55.89	$55.50	$44.42	$47.00	$53.73	$54.24
AHCCCS Care	$21.49	$25.39	$27.27	$24.62	$19.72	$27.90	$23.14
Delivery Supp	$310.05	$337.23	$336.01	$345.65	$340.67	$392.20	$329.88

1/23/13 10:29

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January 23, 2013

Actuarial Certification
Health Choice Arizona
AHCCCS Acute Care Capitation Bids: GSAs 2 - 14
October 1, 2013 – September 30, 2014

I, Matthew W. Anthony, 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 Health Choice Arizona to provide a certification of the actuarial soundness of its proposed capitation rates for Acute Care Services in GSAs 2 - 14 under the Arizona Health Care Cost Containment System (AHCCCS).

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

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

Table 1
Gross Medical Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$388.80	$410.21	$427.22	$442.25	$427.17	$463.43	$395.52
TANF 1-13	$84.18	$91.38	$100.38	$88.02	$76.96	$92.76	$86.22
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AHCCCS Care	$318.31	$384.75	$422.81	$373.02	$298.76	$387.44	$350.68
Delivery Supp	$4,593.29	$5,109.50	$5,209.47	$5,237.17	$5,161.69	$5,447.17	$4,998.15

Table 2

Administrative Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$25.86	$25.84	$26.91	$27.86	$27.13	$32.44	$24.92
TANF 1-13	$5.68	$6.03	$6.47	$5.81	$5.08	$6.68	$5.69
TANF 14-44 F	$11.99	$13.98	$16.83	$14.48	$12.01	$14.75	$13.61
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Delivery Supp	$310.05	$337.23	$336.01	$345.65	$340.67	$392.20	$329.88

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 - 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 Health Choice Arizona, and my judgment. In performing my analysis, I relied on data and other information provided by AHCCCS and Health Choice Arizona. 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 Health Choice Arizona's provider reimbursement descriptions without audit. My opinion that the rates are actuarially sound is based on the assumption that Health Choice Arizona'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 Health Choice Arizona 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.

Matthew W. Anthony, FSA, MAAA
January 23, 2013

D. Executive Summary and Disclosure

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"Nogales, Arizona is a unique place. Our international border brings with it needs that are very different from other rural Arizona areas. Health Choice has excelled in providing outstanding, culturally relevant services for our residents, with a very efficient network and staff who understand our community."

~Arturo R. Garino, Mayor, Nogales, AZ

Health CHOICE

EXECUTIVE SUMMARY

Health Choice Arizona is pleased to submit this proposal to the Arizona Health Care Cost Containment System (AHCCCS) to provide full risk, managed care services. Since 1990, Health Choice Arizona has been a long-standing AHCCCS managed care contractor and has served as a leading, innovative partner, contributing to AHCCCS's success as a nationally recognized care delivery model for Medicaid recipients and dual eligibles. Over the past several years, Health Choice has focused on developing a scalable and innovative health care organization, focused on providing core services and programs to enable both providers and members to achieve better coordinated care and outcomes, and to generate fiscal efficiencies for both Federal and State taxpayers. The Affordable Care Act (ACA) served as a catalyst for us to refine and enhance our efforts. We are well positioned to serve additional AHCCCS members, and dual eligibles, as well as underserved individuals and families throughout Arizona who will participate in Arizona's Health Insurance Exchange (HIX) beginning January 2014, ensuring continuity of provider network and care services regardless of members' Medicaid and Qualified Health Plan (QHP) eligibility levels and enrollment.

Health Choice Arizona has developed and maintained numerous key partnerships to better serve Arizona communities. An integral part of our strategy includes partnerships with community-based organizations that provide direct services and resources to AHCCCS membership, contributing to our solid reputation for understanding social and cultural dynamics of the populations we serve. We have implemented innovative programs and partnerships to address the needs of rural communities. We understand the unique needs of tribal communities, and have developed and continue to grow strong relationships with the Indian Health Service (IHS), Tribal Health Services and Urban Indian Health Programs, and we look forward to partnering with AHCCCS to further enhance coordination of care for tribal members who move between managed care plans and the AHCCCS fee-for-service program.

Over the next several years, AHCCCS and its managed care partners will continue to face challenges as a result of the requirements of the ACA and ongoing State and Federal budgetary pressures. This will require collaborative relationships among state agencies, managed care contractors and providers. Health Choice is committed to being an innovative leader and partner with AHCCCS, delivering sustainable models of care delivery for the individuals we serve. Below, we provide an overview of our organization, describe our key experience, provide a high-level summary of our approach to meet the requirements of this contract and describe how we meet the requirements specified in Section I, Exhibit D, Medicare Requirements, Section 2.

Overview of Organization

Health Choice Arizona, Inc. is a wholly owned subsidiary of IASIS Healthcare, LLC (IASIS). Our headquarters are located in Phoenix, Arizona. We understand the importance of having a local presence. We operate a satellite office in Tucson and have additional staff located in key rural communities, employing 330 full time employees in Arizona.

IASIS, founded in 1998, owns and operates 19 acute care hospitals and one behavioral health hospital throughout eight states – Arizona, Arkansas, Colorado, Florida, Louisiana, Nevada, Texas and Utah. Three of these facilities, as well as the behavioral health hospital, are located in Arizona and support the health care system locally. More than 15,000 staff are dedicated to providing patient care through the IASIS family of community-focused hospitals. Together, the people of IASIS share a common vision of quality care, customer service, cost control and capital investments designed to meet the health care needs of the communities served by IASIS hospitals and Health Choice.

The Health Choice executive management team is comprised of highly-qualified professionals with extensive knowledge of the AHCCCS and duals eligible programs. The executive team is supported by an interdisciplinary team of dedicated directors and managers who provide value-driven, quality health care for Arizona communities:

- **Mike J. Uchrin, MBA, MEng**, *Chief Executive Officer* (CEO), has been with Health Choice for more than 10 years and possesses extensive experience in all facets of health plan operations, as well as a deep understanding of the AHCCCS program, managed care and the dual eligible special needs population. His leadership competencies include a rigorous and insightful approach to strategic planning, and the ability to create scalable and effective health plan organizations with a primary focus on the well-being of the member.
- **Jaime Perikly**, *Chief Operating Officer* (COO), has 11 years of experience at Health Choice and a total of 15 years of experience in Medicaid managed care and provider administration. Ms. Perikly has a thorough understanding of all health plan operations and has a proven track record of developing and executing strategic initiatives that improve plan efficiency and care delivery.
- **Joe Schaller**, *Chief Financial Officer* (CFO), has been with Health Choice for 8 years, and has 11 years of Medicaid experience including AHCCCS Acute Care, Long Term Care and dual eligible special needs plans. Additionally, Mr. Schaller has 9 years experience in provider administration for a total of 20 years in the health care industry.

- **Jon Schwartz, M.D.**, *Chief Medical Officer* (CMO), joined Health Choice in 2011. Prior to joining Health Choice, Dr. Schwartz was a practicing family physician and obstetrician in rural Arizona with a focus on serving Medicaid members for more than 20 years. Dr. Schwartz brings vast clinical experience with women and children populations, and understands the inherent challenges to serving our rural members.
- **William J. Anderson, M.D.**, *Division President*, has more than 39 years of experience in the health care industry, and specializes in aligning incentives through innovative reimbursement models and bringing together fragmented segments of the delivery system through clinical and financial integration.
- **Carol Allis, MBA/HCM**, *Vice President of Health Services*, has more than 19 years of experience in the health care industry, including 17 years in Medicaid/Medicare managed care both in acute care facilities and health plan operations. Ms. Allis specializes in aligning health services with health plan delivery system operations and has been with Health Choice for 9 years.

Table 1: Summary of Health Choice AHCCCS Member Growth and Geographic Expansions

2003	2008
GSA Expansion – 10, 12 and added 4 and 8	New GSA – 2, 4, 10, 12 plus Santa Cruz
Membership growth - + 50,000	Membership growth- +80,000

Relevant Experience

As a locally operated, managed care organization, Health Choice has significant experience managing the complex needs of Medicaid and Medicare enrollees. A brief summary of our experience is outlined below:

- **AHCCCS –** Health Choice Arizona, Inc., has provided high-quality managed Medicaid services in the state of Arizona since 1990, and is currently contracted with AHCCCS for Acute Care services in the following counties: Apache, Coconino, La Paz, Maricopa, Mohave, Navajo, Pima, Santa Cruz and Yuma. Our award history demonstrates our experience and capability to support membership growth and expand into new geographic service areas (GSA) with no service disruptions or gaps in care (See ***Table 1***). We currently serve as the fourth largest AHCCCS health plan in Arizona. More than 42% of our members are in Arizona's rural counties, where Health Choice has the largest total share of membership of any AHCCCS health plan.
- **Centers for Medicare and Medicaid Services (CMS) –** For seven years, Health Choice Arizona has operated Health Choice Generations HMO, a Medicare Advantage Special Needs Plan (D-SNP) to serve beneficiaries eligible for both Medicare and Medicaid. In 2006, when CMS introduced the first opportunity for Medicare Advantage and D-SNPs, we established Health Choice Generations HMO. Health Choice Generations HMO covers Medicare Part A, B and D benefits for more than 4,000 of Arizona's most vulnerable health care recipients. In concert with Health Choice Arizona, our D-SNP plan has successfully implemented two major contract expansions in order to align Medicaid/Medicare service areas. As of Jan. 1, 2013, Health Choice Generations HMO serves members in ten Arizona counties: Apache, Coconino, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz and Yuma. To ensure access for dual eligibles statewide, we have expanded our full service network to include providers in all 15 Arizona counties, as well as border communities in Utah, Nevada and New Mexico. With fully integrated Medicaid and Medicare plan operations, we have submitted a Letter of Intent and will apply to CMS for a statewide service area for both D-SNP and the duals demonstration initiative in February 2013. This ensures we will meet the needs of AHCCCS and our dual eligibles no matter which alignment path is chosen by Arizona. To provide AHCCCS with maximum flexibility, this fully-aligned network can support any Acute Care contract award.
- **Utah Department of Health (UDOH) –** Health Choice was awarded a full risk Medicaid contract to serve Utah Medicaid members in both Salt Lake and Davis counties, beginning in May 2012. The impetus behind this award was Health Choice's proven competencies to support the future Utah ACO model through our ability to collaborate with providers and coordinate care throughout the delivery system. In January 2013, Health Choice Utah expanded into two new counties – Weber and Utah.

To ensure the highest quality operations, our organization has been engaged in system-wide preparation for application submission to URAC to achieve accreditation in 2013. The accreditation process has proven an effective approach to a rigorous review of all Health Choice operations, functional areas, and policies and procedures, to improve quality of care for our members and further enhance our program and operational excellence.

High-Level Description of Proposed Approach and Added Value

Throughout our tenure as an AHCCCS health plan, we have demonstrated the ability to meet or exceed contract requirements as evidenced by successful Operational and Financial Reviews (OFRs) and timely submission of routine deliverable requirements. As noted in the Health Services Advisory Group's AHCCCS External Quality Review Annual Report for Acute Care and DES/CMDP Contractors in June 2012, during the OFR conducted in 2011 we were the only

contractor without any standards scored as noncompliant. We received zero deficiencies in General Administration, Maternal Child Health, Third Party Liability and Grievance Systems.

We are leveraging new opportunities to enhance our operational infrastructure to bring additional value to AHCCCS. In the Request for Proposal (RFP), AHCCCS emphasizes the findings of the Institute of Medicine (IOM) and challenges bidders to propose a comprehensive approach to address the IOM findings. While many of the strategies and approaches are incorporated into AHCCCS's program model and Health Choice Arizona's operations, additional opportunities for improvement exist. We stand ready and prepared to partner with AHCCCS to further improve the program model.

In 2010, Health Choice Arizona began a comprehensive strategic planning process to prepare for the challenges and opportunities of health care reform. This RFP gives us the opportunity to display our planning efforts and initiatives to improve quality, enhance consumer outcomes and contain costs. As part of these efforts, we have identified multi-faceted strategies and programs to address the core challenges identified by AHCCCS in the RFP. These strategies and supporting initiatives, which are described in our response, include:

- **Payment Reform Platform –** Health Choice Arizona will continue to align reimbursement with the clinical performance (quality of care, patient safety and patient outcomes) and efficiency (cost and operational) of providers.
  Supporting Initiatives: Enhancements and expansions to value-based payment (VBP) models, such as expanded Medical Health Home Program, AHCCCS & Duals Partnership for Quality Care, Banner Rapid Clinic ER Triage Program, Payment Reform for Preventable Events and Hospital Readmissions, and Bundled Payments Programs.
- **Care Coordination and Delivery System Integration –** Health Choice Arizona has implemented initiatives – and will continue to enhance existing programs and launch new initiatives – to improve clinical outcomes, increase quality and safety, reduce waste and increase efficiency, and invest in Arizona's care delivery infrastructure.
  Supporting Initiatives: Enhancement of care coordination programs, expansion of Medical Health Home capacity and capabilities, development of Integrated Networks / Physician Pods model, participation as a Qualified Health Plan (QHP) in the Health Insurance Exchange (HIX), and expansion of the Health Choice Generation HMO D-SNP statewide or duals demonstration, among other programs to support continuity of care and improve health outcomes for Arizonans.
- **Member / Patient Engagement** – Health Choice Arizona will continue to implement new programs and tools to inform, educate and engage members to participate actively in their health care by encouraging the use of preventive services, active participation in care planning, adoption of healthy lifestyle behaviors and self-care management.
  Supporting Initiatives: Expansion of health and wellness programs, implementation of a pain management clinic, 24-hour nurse advice line, social media and opt-in mobile texting to improve member communications, and development of online member engagement initiatives such as a member portal, among other projects.
- **Quality Programs –** Health Choice Arizona will continue to implement and enhance programs to improve each of our plan's performance measures and quality of care focusing on quality triggers that drive better health outcomes and lower costs.
  Supporting Initiatives: Specific initiatives to support this strategy include obtaining URAC Accreditation, enhanced measurement and provider communication of quality outcomes, and a comprehensive quality improvement plan focused on continuous improvement of performance in HEDIS and Stars measures.

In addition to these prioritized strategies and initiatives, our proposal outlines a number of other key reforms and innovative programs to add value and meet AHCCCS's goals. These reforms and programs include:

- A comprehensive approach to ensure that Health Choice Arizona is prepared to provide access to the influx of new members as a result of possible new Medicaid enrollment, newly aligned duals and implementation of the HIX (Question 1).
- A significant internal planning effort to ensure that Health Choice Arizona is operationally and administratively prepared to accommodate membership growth. (Question 1).
- Ongoing enhancements to ensure timely access to care for underserved populations which include improvements to measure, evaluate, monitor and sustain our existing provider network. (Question 2).
- Implementation of state-of-the-art technology solutions powered by robust database algorithms to provide evidence-based decision support tools to providers, drive timely and targeted care coordination for members, and align incentives to improve quality of care and outcomes through payment reform initiatives (Question 3).
- Adoption of effective systemic processes and care coordination programs to address members with chronic illnesses and complex needs (Questions 4 & 5).
- Optimizing the alignment of dual members in our D-SNP or duals demonstration plan to drive coordination of services by increasing member and provider engagement (Question 6).

- Utilizing key strategies which leverage the functionality of our best-in-class systems to improve quality outcomes, reduce waste and contain costs (Question 7).
- Continued improvements and investments in our compliance program to limit, identify and address fraud, waste and abuse, including the expansion of our audit, detection and recovery activities (Question 8).
- Improvements to reduce the provider "hassle factor," including efforts to enhance the claims processing system, resolve disputes and settle cases to reduce the need for costly administrative hearings. (Question 9).

In addition to the core strategies and initiatives outlined above, Health Choice has developed four "Guiding Principles" (see ***Figure 2***) upon which we have based our organizational philosophy. These guiding principles serve to drive our care coordination and clinical case management approach described in Questions 3, 4 and 5.

Figure 2: OUR GUIDING PRINCIPLES
Driving Improved Outcomes

Principle 1: Retrieve and evaluate rich member-specific data to inform health care team workflow and interventions.

Principle 2: Providing culturally appropriate coordination of care and services is a key intervention which provides the highest value impact for Arizona Medicaid members and AHCCCS.

Principle 3: For us to have a long-term sustainable impact on the health of our Arizona AHCCCS members and their communities, we must employ strategies to effectively "manage the geography."

Principle 4: Adopting widespread value vs. volume payment models will cultivate desired care outcomes as well as a financially sustainable health care delivery system.

Health Choice Arizona believes that our foundation of efficient operations and the core strategies noted above, as well as other program initiatives identified throughout the proposal, will – collectively – meet and exceed AHCCCS's goals.

How Health Choice Arizona Will Meet Medicare Requirements to Coordinate Care for Dual Eligibles

Health Choice Arizona, Inc., has carefully reviewed the Requirements outlined in Section I, Exhibit D, Medicare Requirements, Section 2, and is fully prepared to meet all requirements outlined in this section.

First, Health Choice Arizona has, as required by A.R.S. Section 36-2906.01, established a separate corporation whose only authorized business is to provide services under this contract to AHCCCS eligible persons. Also, as described in the proposal, Health Choice currently operates Health Choice Generations HMO, a Medicare Advantage Special Needs Plan (D-SNP) contracted with the Center for Medicare and Medicaid Services (CMS) to serve beneficiaries eligible for both Medicare and Medicaid in ten Arizona counties. Together, Health Choice Arizona and Health Choice Generations HMO have developed a statewide fully aligned Medicare/Medicaid network to support any AHCCCS contract award. In the event that Arizona moves forward with the Medicare Demonstration Project, Health Choice will operate a Medicare Demonstration plan by Jan. 1, 2014. Health Choice has the legal and actual authority to direct, manage and control the operations of both entities to ensure the integration of AHCCCS and Medicare services for persons enrolled in both programs.

Second, Health Choice Arizona will ensure the integration of Medicare and Medicaid services within the key functional areas identified in Section I, Exhibit D, Medicare Requirements, Section 2. As described in the response to Question 6, the operations of both Health Choice Arizona and Health Choice Generations HMO are fully integrated under one managerial structure, with the same departments and managers providing services across both lines of business. We have also fully aligned our payment, care delivery and quality management reforms. In addition, we have developed and will maintain a single, fully-aligned provider network statewide for our Medicaid and Medicare covered services.

Finally, Health Choice will continue to maintain branding that is easily identifiable to members and providers. Our name, branding and marketing communications will continue to be coordinated and synchronized to minimize confusion among members, increase retention and enrollment alignment and show that we are a single, Arizona-based organization accountable to providers and members across all products.

In summary, Health Choice Arizona has the background, experience and expertise to deliver high-quality services to serve Arizona's rural and urban communities. Rigorous strategic planning processes; strong provider, community and tribal partnerships; enterprise-wide quality programs; member-centric care coordination programs; and implementation of comprehensive value-based payment, care delivery and other program reforms, as identified throughout this proposal, position Health Choice Arizona as a clear choice to continue to provide value-driven quality health care services to AHCCCS members throughout Arizona.

DISCLOSURE

Health Choice Arizona, Inc., has no moral or religious objectives regarding the provision or reimbursement of any covered services in the AHCCCS Acute Care Program YH14-0001.

E. Narrative Submissions

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"...Health Choice is widely known in this area to provide and deliver the best insurance coverage for their members..Health Choice has been extremely helpful with our Native American patients who periodically move [back and forth between the health plan and the state's fee for service] without any interruption in benefit coverage per patients...Please continue the great work! "

~ Dorothy Hernandez, Native Americans for Community Action, Inc. (NACA), Flagstaff, AZ

Access to Care/Network

Q1 Since 1990, Health Choice has operated as an Arizona Healthcare Cost Containment System (AHCCCS) managed care organization contractor committed to the highest access to care standards, and the delivery and coordination of effective, efficient health care. We have developed strong provider and community partnerships, and established expertise serving the underserved in Arizona's rural and urban communities. We understand the impact of the Affordable Care Act (ACA) on the health care delivery system infrastructure in Arizona resulting from the potential influx of Medicaid recipients and the newly insured through federally-subsidized coverage. We recognize that many of the newly insured may not have had recent access to timely medical services. As a result, pent-up demand for quality, proactive services will stress provider networks statewide. Health Choice has focused on building a scalable, flexible and innovative health care organization with core services and programs supporting an extensive delivery system enabling the members we serve to obtain high-quality, coordinated care.

Regardless of how the State of Arizona decides to approach health reform, we are committed to partner with AHCCCS to ensure timely access to quality health care for Arizona's underserved citizens. AHCCCS anticipates that more than one million Arizonans could get health insurance coverage through a combination of new Health Insurance Exchange (HIX) membership and Medicaid expansion. The so-called "woodwork effect" – people who are eligible, but not enrolled in Medicaid, and seek options as new HIX plans are marketed and the federal requirement for health insurance is implemented – will also play a role in adding new members to the AHCCCS program. Additionally, AHCCCS manages a population with considerable churn. Health Choice supports the AHCCCS strategy to provide care coordination to manage utilization and transition of care across the full continuum for churning members through implementation of HIX products fully aligned across our provider networks, data integration and care coordination platforms.

In 2010, Health Choice initiated a rigorous strategic planning process to meet the demands created by the ACA. To drive this planning, membership forecasts were levered from AHCCCS and other leading sources broken down by: childless adult return; currently eligible not enrolled; Medicaid expansion to 133%; current AHCCCS churn rates; newly aligned duals; and potential take-up rates for the HIX for individual and SHOP products. These forecasts were then further broken down by geographic service area (GSA) and county to clearly define the impact that additional membership volumes will have upon Health Choice's operations and its delivery systems. These impacts were further analyzed as part of our strategic planning process, resulting in: 1) Development of five initiatives to ensure access to care and support the possible influx of new membership; and 2) Development of detailed plans to identify and execute steps to ensure Health Choice is a scalable and flexible managed care organization to meet AHCCCS' current and future needs. These are outlined below.

Initiatives to Ensure Access to Care and Support the Influx of New Members

To prepare and successfully meet the needs of an expanded coverage population, Health Choice has implemented five initiatives to increase delivery system capacity and support the influx of new members through a comprehensive and multi-faceted approach. These initiatives include:

1) Expand provider network and services to provide continuity of care as members move between programs.
2) Develop collaborative partnerships with providers, and an effective structure and processes to manage, maintain and enhance our statewide network.
3) Align incentives to drive clinical and administrative efficiencies, to reduce unnecessary utilization and waste in order to free capacity for newly covered Medicaid, newly aligned duals and HIX populations.
4) Leverage all resources within the delivery system and develop new ways to deploy them more efficiently.
5) Engage members in the care planning process and educate them about how to access quality care and services.

1) Expand network and services to provide continuity of care as members move between programs.

The ACA provides the opportunity to deploy integrated care coordination programs – driven by data shared between health plans and providers – across the AHCCCS, dual eligible and HIX programs. Health Choice will leverage this opportunity by offering HIX products, in addition to AHCCCS and our Special Needs Plan (D-SNP) or Dual Demonstration plan for dual eligible members. Focusing on our established partnerships and expertise, the Health Choice HIX products will be designed for underserved individuals and families throughout Arizona whose income is less than 250% of the Federal Poverty Level (FPL). In combination with Health Choice Arizona and our dual eligible plan, Health Choice Generations HMO, we will offer a complete portfolio of products to ensure continuity of both provider network and health care services.

To ensure success in integrating care across all of these products, Health Choice will align benefits, clinical and operational programs, member education and outreach, provider network and access points, and available community resources to the fullest extent possible. We understand the distinct differences in structure and benefits for Medicaid and HIX, and will attempt to bridge gaps in education for providers to make it as seamless as possible. We have expanded our network in the nine counties Health Choice Arizona currently serves and built a new network in additional counties for a

complete network of more than 30,000 contracted providers in all 15 Arizona counties. As of January 2013, the Health Choice provider networks for its AHCCCS and dual eligible products meet or exceed all State and CMS access and capacity requirements for high-value, quality and member-centric primary, specialty and ancillary care services. It's important to note that this provider network was able to accommodate full childless adult coverage prior to July 2011. Health Choice contracts address both AHCCCS and dual eligible programs. Health Choice will also mirror our existing network to support our HIX products that will ensure continuity of care as members move between programs.

2) Develop collaborative, respectful partnerships with all providers in Arizona's health care delivery system, and an effective structure and processes to manage, maintain and enhance our statewide network.

We will accomplish this strategic objective through the following methods:

- Structure **organization and network management operations** to facilitate collaborative efforts that control costs and improve health outcomes, including Delivery System Management Teams who live in the areas they serve.
- Execute **network development and management strategies** powered by mechanisms to effectively assess and manage network quality and sufficiency, including a proactive approach to identify network gaps and deficiencies, make continual improvements to broaden network capacity and manage Arizona's geography.
- **Create value for providers through a collaborative approach** to provide a relationship that leverages Health Choice's clinical and operational expertise to deliver pertinent data and decision support tools that enhance the providers' critical role in the service delivery model and reduce the provider "hassle factor."
- Develop and **engage in partnerships that help ensure timely access to care** for underserved populations.

For more than 22 years, we have managed an extensive, accessible and cost-effective network built and sustained by garnering the trust of physicians through collaborative relationships and by delivering on our commitments. We simply do what we say we are going to do. This means paying providers accurately and timely for quality, medically appropriate care without burdensome administrative requirements, and providing innovative evidence-based decision-support tools and hands-on care coordination to enhance patient-centered care. As available delivery system capacity is stretched to meet increased demand, providers will create or ensure capacity for those health plans and partners they trust, while capping membership or utilization for health plans that do not deliver a similar level of services.

3) Align incentives to drive clinical and administrative efficiencies to reduce unnecessary utilization and waste in order to free capacity for newly covered Medicaid, newly aligned duals and HIX populations.

It is well-documented that current mainstream Fee-For-Service (FFS) reimbursement models incentivize providers to grow revenue by increasing volume, not by improving outcomes or reducing unnecessary utilization. As described throughout this proposal, Health Choice has implemented (and plans to significantly expand) outcome and value-based reimbursement models that will incentivize physicians and facilities to provide the right care, at the right time and in the right setting. As a result of the implementation of these models, unnecessary utilization will be reduced, freeing up capacity for newly covered Medicaid, newly aligned duals and HIX populations. In addition to implementing outcome and value-based reimbursement models, we will continue to maximize the ability of our providers to deliver quality patient care and minimize unnecessary utilization by promoting clinical efficiencies, incentivizing best practice and evidence-based medicine, and leveraging comprehensive data analytics and tools to provide relevant, actionable data to support more informed decision-making. Depending on final policy decisions regarding the 1% health plan shared savings withhold, we hope to use the potential health plan "earn back" for quality and outcomes to further fund these incentive programs, increasing their sustainability.

4) Leverage all resources within the delivery system and develop new ways to deploy them more efficiently.

We believe there is immense opportunity to better leverage the current resources in today's delivery system in Arizona to drive more effective, efficient care, thus increasing capacity to treat newly expanded or covered populations. Below are some of the opportunities Health Choice currently leverages, along with additional steps we will take in the future:

- **Share data:** After prototyping with a pilot group, we are working to exchange more real-time data to impact care and reduce redundant processes with all providers. By working with the local Health Information Networks (HINAz), as well as by creating files to "push" directly into provider EHR systems, we will enable providers to be more effective in the care they deliver, as well as reduce waste in the system by reducing unnecessary utilization.
- **After-hours care:** Health Choice incentivizes primary care providers through its current reimbursement methodologies, to offer after-hours care through an "access to care" capitation payment or through the FFS payment of after-hours E&M codes.
- **24-hour nurse advice line:** We will leverage a 24-hour nurse advice line (planned for Q4 2013) to provide prompt assistance for members' health care concerns and help reduce unnecessary emergency room utilization.
- **Physician extenders:** To enhance capacity in its network, Health Choice leverages both nurse practitioners and physician assistants allowing them to hold a membership panel.

- **FQHC partnerships**: We work collaboratively with FQHCs in rural and urban Arizona to enhance network coverage in underserved areas supporting FQHC outreach efforts through direct assistance and additional resources.
- **Graduate Medical Education (GME) programs:** Health Choice leverages the GME programs of its contracted hospital systems by assigning members to residents, and sharing data and decision support tools. Additionally, IASIS Healthcare is launching a GME program in July 2013 at Mountain Vista Medical Center. Health Choice will partner with this program to create rotations for the residents to underserved areas in Arizona. For example, if Health Choice is awarded GSA 8, Health Choice would staff a clinic to increase primary care capacity for that underserved area.
- **Integrated Networks / Physician Pods:** Inpatient care continues to drive the highest costs, however, hospitals have not traditionally been integrated with physician networks to increase efficiency. In 2012, Health Choice developed and piloted an integrated network called Health Choice Preferred, a physician-led organization comprised of more than 330 physicians and three hospitals in GSA12. The network is further broken down into "pods" – physician alignment around an acute care hospital to facilitate specialty and ancillary referral patterns. By engaging integrated networks and deploying value-based payment models for meeting quality and outcome targets, hospitals and physicians are fully engaged in improving outcomes and curbing costs, thus freeing up new capacity in the system.
- **Remote monitoring:** For certain high-risk members, such as disabled dual eligibles, we give providers the opportunity to use Remote Monitoring technology to monitor urgent symptoms and clinical progress of these patients.

5) Engage members in the care planning process and educate them about how to access quality care and services.
It will be critically important to educate newly insured populations to appropriately access the health care system, to proactively mitigate the increased demand for services and minimize overutilization. Health Choice has implemented and will employ processes and tools to ensure members are well-informed about how to access quality care and services, have evidence-based health education materials and tools at their fingertips and are actively engaged in participating in their health care. Processes currently in place to engage members include high-touch new member communications, online appointment scheduling using MyHealthDIRECT® and our Individualized Care Plan (ICP), which directly involves members in the care planning process. New tools that will be implemented in phases beginning in 2013 include: a patient education portal on our website, social media to engage members in health communities, opt-in mobile texting and smartphone/tablet apps to provide health and wellness tools; a secure portal giving members access to their health information; and a 24-hour nurse advice line to provide prompt assistance to members' health concerns and prevent the misuse of emergency medical services.

Steps the Offeror Will Take to Ensure Its Operational and Administrative Structure Is Sufficient

Health Choice has proven experience with large scale growth and transitions, demonstrating scalability and flexibility in partnership with AHCCCS. We have learned from those successes and understand the commitment that it takes as a system to absorb new members. We have used this experience to prepare for the changes resulting from the ACA and dual alignment, and have taken numerous steps to ensure that our operational and administrative structure can accommodate anticipated membership growth. Below, we will:

1) Describe our experience in accommodating membership growth and member transitions to demonstrate our ability to meet this challenge.
2) Outline the key strategies we have identified to drive organizational change.
3) Describe the specific organizational and process changes we have implemented to better position ourselves to absorb membership growth.
4) Identify the technology investments that have been made to improve operations and support D-SNP/duals demonstration, AHCCCS and HIX membership expansions.

1) Proven experience with large scale growth and member transitions.
Health Choice has proven its organizational structure, programs and processes can accommodate large membership growth over very short periods of time. On Oct. 1, 2003, Health Choice added more than 50,000 new members in six new counties. In 2008, Health Choice added an additional 80,000 members. For both of these periods of large growth, Health Choice's primary focus was our members ensuring all of their needs were met. Because of this primary focus on the member, there were no service disruptions or gaps in care. In addition, as a result of the 2003 contract award, a material percentage of AHCCCS membership needed to be transitioned between plans. Understanding the importance of a smooth and seamless transition at the system level, Health Choice partnered with AHCCCS leadership to develop member transition processes, many of which are still in use today. The cornerstone of the overarching process was plan data exchange of recent diagnosis, drug, lab and prior authorization data for all transitioning members to drive care coordination activities to ensure no members suffered disruptions in care. We have a deep understanding of all operational, functional administrative integration points across our health plan necessary to ensure a smooth and seamless launch and ramp-up to support an expanded membership and provider network.

2) Key strategies to drive organizational change and prepare for membership growth

Health Choice has identified the following four key strategies to improve quality, enhance outcomes, reduce waste and contain costs:

- **Payment Reform Platform –** Health Choice Arizona will continue to align reimbursement with the clinical performance (quality of care, patient safety, and patient outcomes) and efficiency (cost and operational) of providers.
- **Care Coordination and Delivery System Integration –** Health Choice Arizona has implemented initiatives – and will continue to enhance existing platforms and launch new initiatives – to improve clinical outcomes, increase quality and safety, reduce waste and inefficiency, and invest in Arizona's care delivery infrastructure.
- **Member / Patient Engagement** – Health Choice Arizona will continue to implement new programs and tools to inform, educate and engage members to participate actively in their health care by encouraging the use of preventive services, active participation in care planning, adoption of healthy lifestyle behaviors and self-care management.
- **Quality Programs –** Health Choice Arizona will continue to implement and enhance programs to improve each of our plan's performance measures and quality of care, focusing on those quality triggers that drive better health outcomes and lower costs.

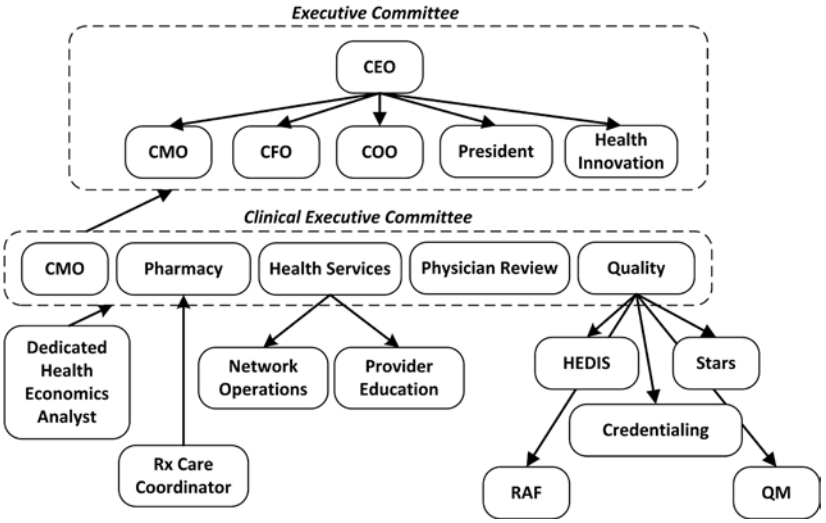
These four strategies are the drivers for the organizational changes described below. By implementing these strategies and their supporting initiatives, we will not only be prepared to absorb the anticipated membership growth, but to do so within a delivery system designed to improve quality, enhance outcomes, reduce waste and contain program costs.

3) Organizational and process changes to prepare for membership growth.

To absorb large increases of membership over short periods of time, Health Choice must have an efficient organizational structure with competent, effective and experienced people to develop and carry out scalable mission-critical programs and processes that enable the organization to fulfill its mission and goals while remaining flexible to deal with variation and change in process. When managing and coordinating care for members across Arizona, scalability is as much defined by the efficiency by which the organization is able to grow, as by its ability to cover large geographic spaces. Meaning, to be efficient, programs and processes must be effective across Arizona's large and disparate geography. After a thorough needs assessment and analysis of enrollment estimates, we decided it was necessary to retool parts of our organization to enhance scalability and to ensure that our key strategies (described above) to improve quality, enhance outcomes, reduce waste and contain costs could be achieved. These key process and organizational changes include the following:

- **Project management and oversight:** Due to the complexity of health care reform, strategic oversight is critical to the success of new initiatives. Health Choice has created a Director of Health Care Innovation position which is accountable for execution of health care reform initiatives, such as duals integration and Medicaid expansion.
- **Quality services and programs:** The delivery of quality care and services is paramount to drive better outcomes for our members. To this end, Health Choice has created a robust quality organization focused on performance measures, HEDIS / Stars, quality management, clinical risk assessments, appropriate coding, and provider quality and outcomes. These initiatives are aligned under our enterprise-wide effort to become accredited under URAC in 2013.
- **Health services:** Our care coordination and Health Home models increase our efficiency by engaging the member and delivery system in the reduction of cost and waste through identification of members who can benefit from chronic disease management programs. We have also scaled our operations to ensure the ability to efficiently complete care plans on all newly aligned duals as well as newly enrolled members.
- **Reduce administrative burden:** To focus resources more efficiently on those programs that provide the State and the taxpayers of Arizona the largest return by reducing cost and waste, and to reduce provider "hassle factor," Health Choice reduced its prior authorization program and redeployed internal resources to more effective services, such as Care Navigators for members and

Figure 1.1: Executive Committee Structures



supplemental administrative support for providers. These strategies create efficiencies allowing us to more effectively support large transitions and influxes of new members.

- **Organizational structure to increase effectiveness:** For key clinical programs to be effective, we recognized that Health Services must be closely aligned with Network Operations and Provider Education. Health Choice aligned both functional areas under one executive, the Vice President of Health Services. In ***Figure 1.1***, we further demonstrate our executive committee structure which is designed to ensure accountability to drive operational efficiencies, execute health reform initiatives, and maintain and continually improve program quality and integrity.
- **Delivery systems/network services.** We have acknowledged that, in today's environment, providers across Arizona need dedicated, responsive, and local contacts who can react quickly to requests or issues to keep the providers focused on quality care and not administrative red tape. Our new Delivery Systems Management Team model can ensure that we stay flexible for change while providing succession plans for future growth.
- **Health plan operations.** Increasing efficiency across all operational areas is important to ensuring sufficiency while scaling to accommodate large increases in membership. Our aggressive strategies include: auto-adjudication of claims; staffing our call center and health services with 90% bilingual staff to ensure that members aren't transferred from person to person to find resolution for their questions; and staffing to account for varying call, care coordination and claims volumes, without the need to sacrifice best-in-class customer service for both members and providers. For us to be truly nimble and react quickly to sudden growth, we have developed comprehensive staffing models and metrics. These models enable us to determine, at any point in time, the volumes of claims, call center statistics and referrals and if we have the right amount of staffing resources to manage the volume and maintain high operational standards. These models are reviewed frequently and recalibrated as we see changes in patterns of utilization.
- **Health care economics.** Decisions for changes are best supported with trusted data. Our Health Care Economics team is focused on this fundamental need and provides information on all aspects of our business including Provider and Member Profiles, Provider Scorecards and pricing analysis. We continue to invest in this department by adding qualified staff and data analytic tools to support innovative reimbursement models with robust provider and care coordination data analytics.

4) Technology to support operational efficiency.

We recognize that in order to develop an efficient, scalable and innovative organization to successfully support AHCCCS, D-SNP / Dual Alignment, and HIX plans and products, a robust infrastructure to support an operation comprised of "best in class" systems, programs and processes must exist. In the first phase of our strategic plan, Health Choice went through a rigorous evaluation of our infrastructure in 2010. All systems, programs and vendors were reviewed and evaluated. The result was the implementation of the following initiatives (see ***Table 1.2***) to improve Health Choice's core systems:

Table 1.2: Technology initiatives implemented

Initiative	Description	Timelines	Impacts to support growth
Robust, intuitive care management platform	Enterprise Care Management System Implementation - Care Radius™	Implemented: 1/11/2012	Customized care plans to help coordinate care more efficiently and effectively
Scalable communications	Install new Avaya Phone System	Implemented: 1/6/2012	Improve member communications and ability to manage volume
Comprehensive Data Analytics Platform	Develop and implement data warehouse and analytics solutions	Implementation: 7/1/2012 – 10/1/2013	Real-time data solutions for active care coordination and communications, supports data integration

Health Choice will continue to assess our organization and infrastructure as additional information regarding the timing and nature of ACA implementation and HIX membership expansion is made available, and as additional data drives new strategies, and we will make corresponding changes and launch new initiatives to accommodate increased membership.

In conclusion, Health Choice Arizona is prepared, ready and well-positioned to support the anticipated increase in membership. Health Choice has and will continue to develop collaborative partnerships with our providers, implement aligned incentives for care and leverage resources to create new access in the market. We have experience in operationally scaling for new members and have already begun to implement plans to prepare our administrative structure to react quickly to changing circumstances and ensure access to care and operational effectiveness. We are prepared to meet the needs of AHCCCS and Arizona's consumers, and support all of the possible decisions relating to ACA implementation made by the Governor and Arizona lawmakers.

Q2 For more than 22 years, Health Choice Arizona has sustained an extensive, accessible and cost-effective network that exceeds AHCCCS standards and ensures timely access to care for underserved populations. As of January 2013, the locally managed Health Choice network includes more than 30,000 high-quality providers in all 15 Arizona counties (see ***Table 2.2*** on page 40). Our network capabilities meet the complex needs of Arizona's Medicaid and dual eligible populations, as well as individuals who may be covered under potential childless adult restoration and Medicaid expansion.

Leveraging our ability to respond rapidly when a need arises from within the membership, within our provider network, internally or as requested from AHCCCS, we proactively ensure our underserved population can timely access medically necessary care at the appropriate level in accordance with the acuity and complexity of their health condition and encourage physician engagement at every level of the organization. We consistently develop and maintain partnerships with key physicians, community health clinics and safety net providers whose mission is to serve underserved populations. Health Choice also establishes and manages interdisciplinary collaborations with our providers, generating feedback to complement data analysis and outcomes evaluation to make quality improvements and remove barriers to care throughout the delivery system.

"An innovative leader…Health Choice continuously strives to develop more effective ways to work with us [providers] which reduces our administrative burden. This allows our physicians to focus on our patients and provide the best care possible."
John H. Cole, CEO
Genesis OB/GYN

At Health Choice Arizona, we recognize our fundamental responsibility is to maintain a delivery system that provides timely access to quality care and appropriate services for underserved populations throughout Arizona. Through proactive management of our network, we continually evaluate and measure our network, identify deficiencies if they exist, make improvements and implement initiatives to effectively sustain our network. We accomplish this objective through the following methods:

1) Structure network management operations to facilitate collaborative efforts that support processes for **managing, evaluating and measuring the network**, and implement improvements to control costs and promote better health outcomes.
2) Execute network development and management **strategies to effectively assess and manage network quality and sufficiency**, including a **proactive approach to identify network gaps and deficiencies**, **make continual improvements to the network**, **increase network capacity** and manage network geography.
3) Develop and **engage in partnerships that help ensure timely access to care for underserved populations**, and encourage participation in collaborative efforts to improve the network.
4) Create value for providers to enhance **provider retention and network sustainability** by leveraging Health Choice's clinical and operational expertise to deliver pertinent data and actionable decision support tools that maximize the providers' critical role in serving members and **minimize the provider "hassle factor."**

1) Structure Network Management Operations to Manage, Evaluate and Measure the Network

Employing strategies to use data to inform decision-making, provide culturally appropriate services and ensure timely access to care for underserved populations, we structured our network operations based on a Delivery System Management Team (DSM Team) model. The DSM Team model facilitates **managing, evaluating and measuring our existing network**, by offering a collective, full-service support system and promoting physicians engagement for network providers. After demonstrating its effectiveness in our rural GSAs, we expanded this service model to providers statewide. To follow is a description of the model, including the role of each of its members and how the model functions (see ***Figure 2.1***):

- Each team is led by a **Delivery System Manager (DSM)** who creates an environment of trust and transparency with providers that encourages collaborative dialogue through frequent face-to-face meetings. Equipped with an in-depth understanding of the economics of the health plan/provider relationship, the DSM analyzes utilization, outcomes, quality and cost performance, and manages the provider partnership and payment reform opportunities.
- The **Provider Operations Representative (POR)** serves as the day-to-day point of contact with providers ensuring timely

Figure 2.1 Delivery System Management Team (DSM Team) Model

communication and issue resolution, including fielding and escalating of billing, claims or prior authorization issues when they arise. Their goal is to improve the provider's efficiency in working with Health Choice and reduce the provider's overall administrative burden and "hassle factor." The POR monitors network adequacy by reviewing monthly GeoAccess reports, member/enrollment comparisons and appointment monitoring reports.

- The **Provider Relations Support Specialist (PRSS)** maintains provider demographic and contracting information, monitors and facilitates credentialing applications and performs various other operational and administrative duties to support the DSM Team.

The DSM Teams are strategically positioned based on network geography and population, and include staff who live and work in the local communities they serve. Each team works closely with all health plan departments to evaluate and measure network quality, coordinate education and resources, and manage provider contractual relationships. Through this tiered approach, we empower the DSM Teams to make on-the-spot decisions and quickly implement solutions to resolve issues, respond rapidly to specific requests and any address provider or member satisfaction issues.

Health Choice employs additional full-time team members to complement the DSM Teams, as follows:

- The **Provider Claims Educator (PCE**) offers general claims and coding education, as well as onsite customized assistance to individual provider offices, enabling prompter payments and reducing administrative burden. The PCE has full access to grievance, claims processing and network service systems, and facilitates the exchange of information with providers. As a direct result of this initiative, we reduced the denial rate for three large practices by 17% and decreased denials for timely filing by 7% from 2011 to 2012. In addition, education regarding changes in codes and streamlining of the prior auth grid helped decrease prior auth denials by 37% in 2012 (Q1 vs. Q4).
- Our **Provider Liaison (PL)** works with provider offices to review performance measures, identify and address barriers to meeting quality standards, and collaborate on interventions to improve health outcomes. The PL helps drive quality initiatives, educating providers and offering assistance such as the scheduling of EPSDT visits.
- **Care Navigators** are assigned to each large practice and to providers participating in the Health Choice Medical Health Home program. The Care Navigators share data, coordinate follow-up appointments with members and streamline internal processes to facilitate services for members, such as home health or durable medical equipment.

Last, to provide a forum for interdisciplinary communicate regarding provider feedback and to facilitate continual improvements to operations, Health Choice formed the **Provider Relations Improvement Committee (PRIComm).** Staffed by leadership from all Health Choice departments, the PRIComm committee meets bimonthly to review, analyze and discuss relevant data, reports and feedback gathered from throughout Health Choice operations that is reflective of the satisfaction of both contracted and non-contracted providers (see ***Table 2.3*** on page 41). Initiatives and solutions to issues resulting from discussions are reported to the Executive Team, which includes senior leadership from all operational areas. Solutions and identified improvements are assigned to appropriate departments for timely implementation.

Table 2.2: Ratio Health Choice PCP Network to All AHCCCS Members

County	Ratio Total PCP: All Members
Apache*	1:35
Cochise	1:247
Coconino*	1:55
Gila	1:43
Graham	1:48
Greenlee	1:56
La Paz*	1:151
Maricopa*	1:281
Mohave*	1:134
Navajo*	1:72
Pima*	1:150
Pinal	1:339
Santa Cruz*	1:202
Yavapai	1:438
Yuma*	1:277
AHCCCS Standard 1:1800	

**Current counties.*

2) Execute Network Development and Management Strategies

In order to effectively assess and manage network quality and sufficiency, we proactively identify network gaps and deficiencies, make continual improvements to the network, increase network capacity and manage the complexity of Arizona's physical and cultural geography to ensure access to care for underserved populations. A critical success factor in these strategies is the use and management of continual interdisciplinary feedback loops to identify, develop and integrate improvements throughout the care delivery system. As a result of our efforts during the 2009 - 2013 contract cycle, Health Choice had no gaps in the network, and consistently exceeded the PCP standard set by AHCCCS (see ***Table 2.2***).

Mechanisms used to evaluate network capacity, sufficiency, quality and timely access to care for underserved populations

As part of Health Choice's commitment to create a continuous learning environment, DSM Teams, the PRIComm Committee and appropriate leadership and front line staff from operational areas work together to: incorporate provider and member feedback, data analyses and recommendations from all operational, clinical, and financial areas; develop innovative solutions that create value for providers; and take immediate steps to address network deficiencies and gaps.

Additionally, each DSM Team routinely reviews, assesses and evaluates network adequacy and sufficiency of their respective service area on a monthly basis to ensure that members have timely access to care. Examples of analyses and reports reviewed to measure and evaluate timely access to quality services include, but are not limited to, the following:

Table 2.3: Reports and Analyses Used for Evaluating, Measuring and Sustaining an Adequate Network

Strategy	Report and Method for Measurement	Outcomes
Identify and Address Gaps in Care and Monitor Provider Capacity	***Geomapping:*** Health Choice performs two levels of geo-mapping on a quarterly basis, including: 1) Statewide analysis; and 2) County / GSA analysis. Geo-mapping reports are used to assess referral patterns and service needs, and evaluate the adequacy of the PCP, obstetrical care, oral health and pharmacy networks.	Health Choice standards: 1 PCP, within a 5 mile radius in urban areas and 1 PCP within a 50 mile radius for rural areas.
	Member enrollment reports: DSM Teams monitor daily enrollment reports to ensure the existing network meets anticipated growth in membership in respective geographic regions.	Health Choice exceeds the AHCCCS standard of 1:1,800 (PCP) and 1:3,500 (Specialist) in all GSAs. (See Table 2.2 for 2012 PCP access ratios)
	Summary of PCP capacity & PCP/PCO closed panel reports: DSM Teams conduct monthly reviews of PCP and Primary Care Obstetrician (PCO) member assignment panels to assess and evaluate provider capacity.	
	AHCCCS 1800 reports: DSM Teams survey and monitor providers who appear on the AHCCCS 1800 list quarterly to ensure that accessibility to quality care and covered services is not compromised.	
Assess Member Satisfaction and Timely Access to Care	***Member call coding:*** Customized call coding allows us to capture member complaint or inquiry information and perform categorical reporting to identify deficiencies related to access to care. All incoming calls related to accessibility issues are forwarded to our DSM teams for immediate follow-up and trended for use in network development.	Qualitative and quantitative data related to member satisfaction and timely access to care is monitored. Identified issues are shared directly with providers to improve access. Operational issues identified are brought to PRIComm and Administration team Committees, and identified solutions are implemented timely.
	Missed appointment logs: Member Services maintains missed appointment logs, which are monitored and analyzed to determine needs for increased provider capacity, education and outreach, or additional resource assistance.	
	Grievance, complaint, and Quality of Care (QOC) reports: Grievances, complaints and QOC concerns can be a reaction to utilization management efforts or accessibility issues. The Quality Department tracks and trends these reports by provider to ensure appropriate and timely access to care.	
	Member advisory groups: Beginning in 2013, Health Choice will host periodic member advisory groups to include both Medicaid and dual eligible members to provide a forum for deeper discussion of identified issues and development of new ideas from members to improve the network and access to care.	
	CAHPS survey results: The Quality Department conducts CAHPS surveys annually for dual-eligible membership to monitor member satisfaction and continually improve the network. Beginning in 2013, we will conduct CAHPS surveys annually for both Medicaid and dual eligible membership.	
Identify Network Deficiencies and Gaps in Care to Ensure Timely Access to Care	***Prior authorization requests:*** Health Services reviews incoming prior authorization requests for services from out-of-network providers (over 10 per year), for analysis of specialist availability and accessibility within geographic areas.	Prior Authorization Requests are reviewed on a case-by-case basis, with utilization reports, and claims and encounter data to identify **network gaps**, and approach with contracting opportunities.
	Utilization report: DSM Teams and Health Services review the following reports to track and trend over- and underutilization: physician referrals; real-time and claims Emergency Room (ER) and urgent care utilization; and member-specific gaps in care reports. Reports are reviewed at the specific provider-type level and at the GSA level to identify network deficiencies and gaps in care.	

	Provider profiles. The provider profile links claims and encounter data with physicians' assigned members to determine if established benchmarks are being met, as compared to peers both plan-wide and within the GSA.	
	Appointment availability measures. DSM Teams monitor appointment availability through a custom module in our proprietary web-based provider site visit tool which is integrated with the plan's provider and member database, enabling the DSM Team to generate and review reports of data gathered during site visits and secret shopper calls.	Health Choice is in full compliance with CMS and AHCCCS standards.
	3/30 report. To ensure that provider satisfaction is monitored throughout the resolution cycle when we receive a concern, we have tracking reports to follow the requirement that we acknowledge the issue within 72 hours (or 3 days) and resolve any issue within 30 days.	We have been able to anticipate trends in issues and retain high resolution rates.

Improving the network and addressing network deficiencies, if any exist

Data analyses provide the foundation for evaluating and measuring the network, and identifying gaps and deficiencies. Methods used by Health Choice to continually improve and enhance the network include:

- **Site visits**: DSM Team members regularly visit providers throughout Health Choice GSAs including urban and rural areas of Arizona. DSM teams are held accountable for visiting PCPs monthly and/or quarterly based upon size and status. Hospitals are visited monthly, and specialists and ancillary providers at least semi-annually. Visits are designed to create a collaborative environment to discuss day-to-day matters with providers and their office staff, such as contractual responsibility, compliance with Health Choice and AHCCCS policies and procedures, provider performance and appointment availability. DSM Teams are empowered to pursue opportunities for education and training, and provide assistance as appropriate.
- **Joint Operating Committee (JOC):** JOC meetings facilitate deeper discussions about challenges, opportunities and performance measures. JOCs include interdisciplinary staff from Health Choice to enhance collaboration and solution development to any issues that arise. During these meetings, the DSM Team is equipped to facilitate immediate, on-the-spot solutions to requests and issues, such as claims adjustments and provider demographic updates. PCPs and specialists with more than 500 assigned members, FQHCs, rural health clinics, ancillary providers and hospitals have JOCs scheduled monthly. PCPs and specialists with 250 – 499 members have JOCs scheduled quarterly.
- **Closed panel review:** The DSM Team reviews closed panels quarterly, contacts providers to conduct a site visit to discuss issues and develop strategies to assist providers with opportunities to reopen their panel and/or increase capacity to ensure continued access to care.
- **Provider recruitment:** Based on feedback garnered from multiple sources including reviewing data and reports discussed in ***Table 2.3***, as well as specific member and provider requests, each DSM Team recruit quality providers of all types including PCPs, specialists, large ancillary providers, facilities and hospitals in all GSAs.
- **Physician extenders & Graduate Medical Extenders:** We further enhance network capacity by extending primary care panel assignments to Nurse Practitioners and Physician Assistants and residence.
- **Border state provider contracts:** Network contracting includes providers in bordering states to meet the needs of members in rural counties who may have better access to a provider in a border state than within Arizona.

The Health Choice Integrated Medical / Mental Health Home in Coconino County includes North Country HealthCare, a contracted FQHC, in collaboration with the Northern Arizona Regional Behavioral Health Agency (NARBHA).This established Medical Health Home serves 20% of the Health Choice population in GSA 4 and promotes a holistic approach to physical and behavioral health services.

3) Develop and Engage in Partnerships to Help Ensure Timely Access to Care

Health Choice recognizes that equal access for all members requires a delivery system that is capable of reaching underserved populations that may otherwise experience barriers to care and services. In pursuit of our commitment to developing a robust and sustainable network to serve all members regardless of language, racial, ethnic, cultural, geographic and special health care needs, we draw from our history and expertise in serving urban and rural areas and communities. Our ability to manage network geography is demonstrated through our experience in forming community partnerships to appropriately understand and address the varying multi-cultural and socio-economical needs that exist within each GSA in Arizona. Examples of current strategies include:

- **American Indian communities:** Health Choice partners and contracts with tribal community health clinics to augment the current network and expand access to care for American Indian AHCCCS members in key service areas.

- **Community centers and clinics:** Health Choice partners with community centers and health clinics throughout Arizona to increase health literacy, encourage the use of primary care and enhance access to immunizations. In 2012, Health Choice partnered with the Maricopa County Public Health and other county agencies throughout Arizona, participating in more than 100 clinic events, encouraging members with children to obtain immunizations.
- **Homeless shelters:** Through our partnership with the Central Arizona Shelter Services (CASS), we coordinate care and services for our homeless members, with access to PCP, dental care and other resources in a centralized location. In 2013, we will expand partnerships to additional shelters in metropolitan Phoenix and Tucson.
- **Home-based Primary Care Program:** Our network includes physicians and nurse practitioners who make house calls for members who are disabled, frail, elderly, or whose chronic condition creates a barrier to access care at a clinic
- **Use of specialists as PCPs:** High risk, acute or special needs members can be seen by a specialist for both specialty and primary care services.
- **FQHC partnerships:** Health Choice has developed strong partnerships with FQHCs across all Arizona GSAs. Upon identification of a viable FQHC, we will fast track the contracting process for completion within 14 days. We provide added value to selected FQHCs through our Medical Health Home and AHCCCS & Duals Partnership for Quality Care programs, and by providing resources for health fairs to increase the health literacy of members.
- **Language and cultural needs:** Member Services is available to assist members with finding providers who speak their primary language and are knowledgeable about their cultural and religious preferences. Our provider directory includes information on languages spoken by providers, and is available by request or through our online provider directory. In addition, more than 90% of Member Services staff is bilingual and is available to assist members with understanding their benefits. Health Choice also offers interpretation services during medical visits.

4) Create Value for Providers that Promotes Provider Retention and Network Sustainability

Health Choice creates value for providers by leveraging Health Choice clinical and operational expertise to deliver pertinent data and decision support tools that enhance the providers' critical role in the service delivery model and reduce the provider **"hassle factor,"** including:

- **Management of claims and "fast payment" processing:** Health Choice claims processes ensure we pay providers within an average of five to seven days with a 98% accuracy rate.
- **Direct appointment scheduling:** Health Choice uses MyHealthDIRECT®**,** an integrated scheduling tool to facilitate direct scheduling of appointments with the member's PCP.
- **Appointment outreach:** Our Quality Service Coordinator conducts outreach calls to remind members on behalf of providers about critical visits and/or immunizations. Since launching in 2012, we have conducted outreach to more than 4,900 members, thereby assisting providers with additional resources.
- **Continual evaluation of prior authorization grid:** Based on provider feedback, we continually revise the prior authorization grid. In 2012, we eliminated nearly 50% of the existing requirements. We offer "gold card" status to physicians with a proven history of following evidence-based guidelines, allowing exceptions to certain authorization requirements and reducing "hassle factor" for high quality physicians.
- **Review of provider terminations due to reimbursement rates:** On at least a quarterly basis, we review provider contracts that were terminated due to rates. Despite the continued rate reductions over the past three years, Health Choice has successfully retained the vast majority of contracted providers. We promptly respond to providers who have concerns with rates, and negotiate within our ability to remain cost-effective.
- **Provider portal:** Provider information is updated daily, producing retrievable information and reports including claims status, EOBs, member eligibility, member demographics, COB, chronic disease codes, IP and ER census data, prior authorization request/status, utilization and quality performance with peer and GSA comparisons. Providers can download reports containing performance measure status at the member level and track their own performance progress and financial status.
- **Performance measurement and reporting:** During JOC meetings with providers, the DSM Team references performance dashboards providing a collective snapshot of individual provider performance on various dimensions of access to care including but not limited to: utilization rates (IP, OP, ER, generic prescribing), appointment availability, panel capacity, member satisfaction, and quality and HEDIS measures.
- **Enhanced member assignment algorithm:** Health Choice incentivizes providers for meeting quality and performance criteria by enhancing our member assignment algorithm to drive members to our highest quality providers.

In mid-2011, the Carondelet hospital system and physician group identified the need to renegotiate with health plans in order to continue serving Medicaid members in Pima and Santa Cruz counties. Health Choice addressed this key providers' concerns ensuring continuity of care and continued access to care in the rural and urban Arizona communities served by Carondelet.

Program

Q3 At Health Choice Arizona, we recognize that our proactive, data-driven processes to ensure underserved populations can access care at the appropriate level in accordance with the acuity and complexity of their health condition is critical to maintain a sustainable cost structure. To help drive our approach to maximize care coordination, improve outcomes and create cost efficiencies, we have identified the four "Guiding Principles" identified in ***Figure 3.1***. These guiding principles help frame our approach to care coordination as described in this narrative.

Figure 3.1: OUR GUIDING PRINCIPLES
Driving Improved Outcomes

Principle 1: Retrieve and evaluate rich member-specific data to inform health care team workflow to drive interventions.

Principle 2: Providing culturally appropriate coordination of care and services is a key intervention which provides the highest value impact for Arizona Medicaid members and AHCCCS.

Principle 3: For us to have a long-term sustainable impact on the health of our AHCCCS members and their communities, we must employ strategies to effectively "manage the geography."

Principle 4: Adopting widespread value vs. volume payment models will cultivate desired care outcomes as well as a financially sustainable health care delivery system.

Principle 1: A key to our success in coordinating care for members is how we use data to target individuals whose care is fragmented and to prioritize those members based on recent patterns of care. This narrative details the unique data we capture, how we use data and how we disseminate data to our own staff, providers and members.

Principle 2: Because we are a local health plan, we recognize that in order to achieve and sustain outcomes, our plan must address the health disparities and gaps that can occur because of our members' diverse, cultural beliefs and race/ethnicity, and that may present barriers to accessing quality care.

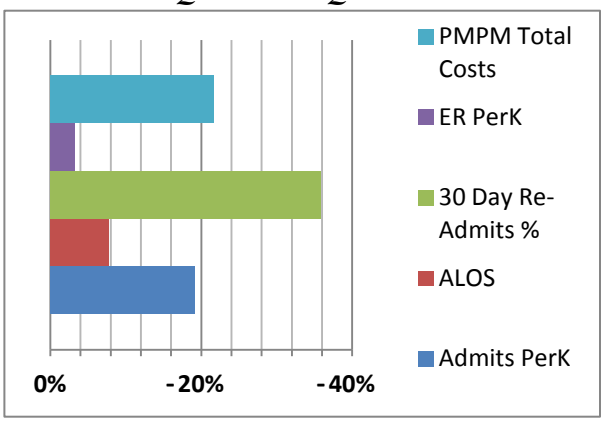
Principle 3: In order to identify our members' needs and to ease barriers they may have to accessing care, we must use community resources, leverage collaborations and share data with physicians practices, community clinics, ancillary providers and hospital partners in both the rural and urban areas of Arizona. Our care coordination and value-based payment models are tailored to Arizona's unique health care community.

Principle 4: We recognize that it is necessary to continuously reassess health outcomes through population measures at the macro level and individual outcomes at the micro level in order to continually refine individual care plans, identify systemic quality of care issues and leverage value-based payment models.

Consistent with our guiding principles, Health Choice has implemented an enterprise-wide redesign of our systems and processes to enhance our data-driven, evidence-based decision support tools and outcome- and value-oriented payment models to reward care coordination efforts. As part of this extensive redesign, Health Choice **invested in enterprise-wide system upgrades and developed foundational processes to enhance data collection and reporting tools**, including implementation of a health analytics solution powered by robust database algorithms to drive timely and targeted care coordination for members. We have also **developed innovative care coordination and value-based payment mechanisms**, in collaboration with AHCCCS and in partnership with key providers. These investments in care coordination and payment reform have already begun to improve plan-wide outcomes, as noted in ***Table 3.2***.

Below, we will: 1) Describe our three-step process to care coordination, which leverages the recent enterprise-system upgrades and evidence-based decision support tools to maximize care coordination; and 2) Discuss how we have used these tools and data to implement a range of outcome and value-based payment models. Our experience and specific results will be identified throughout this narrative.

Table 3.2: Health Plan Outcomes (All GSAs)
Utilization and PMPM Costs Percentage Decrease
Q3-2011 vs. Q3-2012



Maximizing Care Coordination Using Data and Evidence-Based Decision Support Tools

With more than 22 years of establishing relationships with hospitals, physicians and ancillary providers, Health Choice has access to numerous sources of rich data and leverages a wide range of demographic, diagnostic, historical, procedural utilization and financial data and information. We leverage sources of data and evidence-based decision support tools to maximize care coordination. Below we will describe the data, process and flow of information in our care coordination model as represented in ***Figure 3.3*** on page 46.

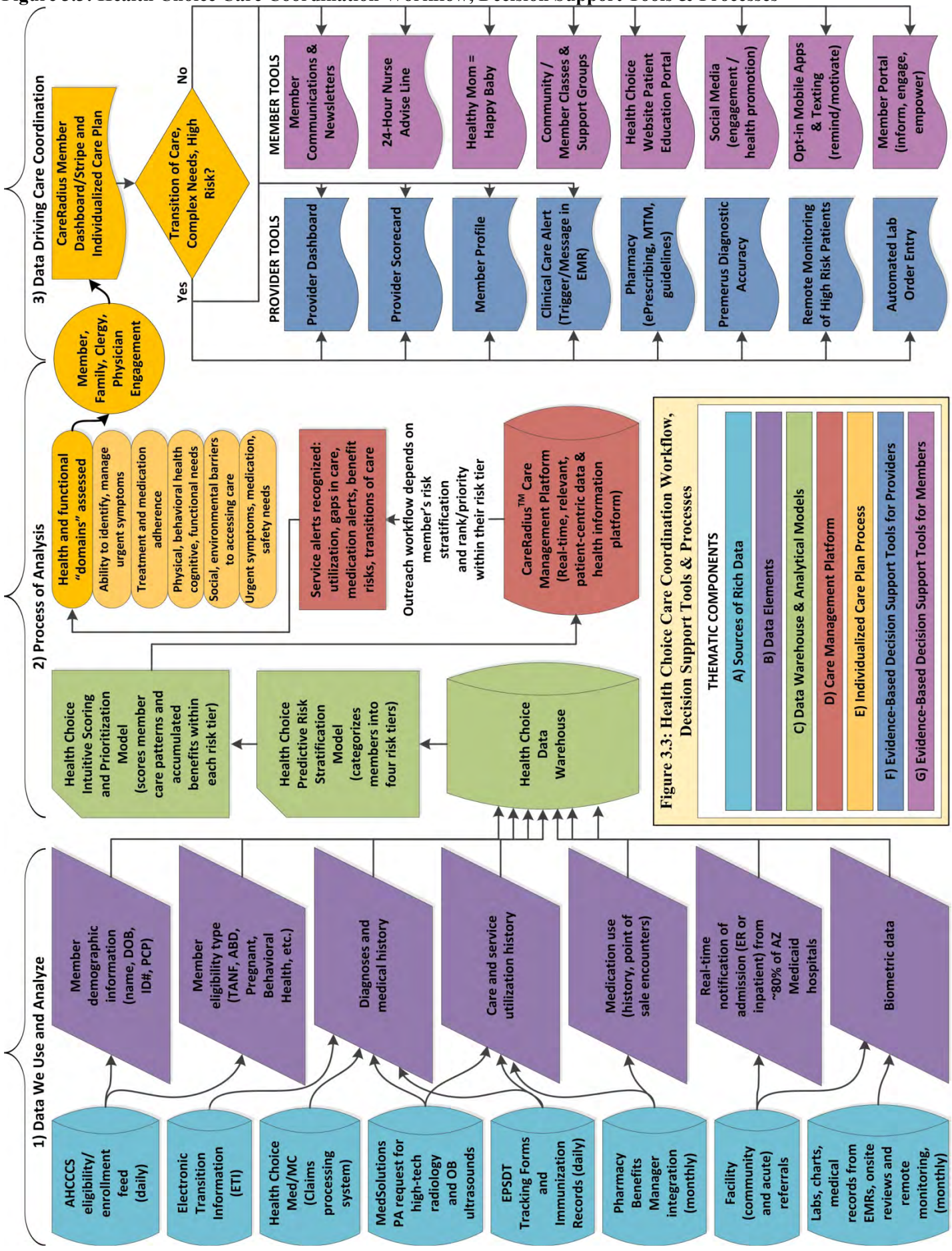
1) ***Data we use and analyze:*** A key to our success in coordinating care for members is to stratify our population and use real-time data to prioritize individuals based on recent patterns of care. As you can see in *Thematic Component A(in aqua)* in ***Figure 3.3***, which depicts our sources of rich data, we capture the most current, accurate data including but not limited to, alerts from hospitals of Emergency Room (ER) visits and inpatient admissions, pharmacy utilization and gaps in care reports. We then isolate relevant data elements, as depicted by *Thematic Component B (purple)* in order to identify members' acute symptoms or needs and gaps in medications or preventive care. This information is aggregated into our data warehouse, and then pushed through our predictive risk stratification and intuitive scoring and prioritization models, as depicted by *Thematic Component C (green)*. These models provide predictive power (leveraging members' eligibility category, medical history and utilization to predict the need for future resources) as well as drive staff and provider workflow towards members with most urgent/acute needs. By using evidence-based decision support tools, we can quickly engage members and providers through programs such as, but not limited to: Specialty Pharmacy Care Management Programs (Hep C, and HIV), Medication Management Therapy (MTM), High Tech Radiology (Premerus® Diagnostic Accuracy) and Radiation Oncology Program.

2) ***Process of analysis:*** As part of our data-driven approach, Nurses and Care Navigators reach out to dual and non-dual members identified with urgent/acute needs via telephone or face-to-face meetings to assess a series of "domains" in order to understand the member's ***most urgent*** need. Next, the Clinical Case Manager engages the member – and their provider, family, clergy and any other community support systems – in the development of an Individualized Care Plan (ICP). This process is depicted in *Thematic Components C, D and E (green, gold & rust)* in ***Figure 3.3***. In addition, with our CareRadius™ care management system as the platform for quantitative and qualitative member data capture, and with real-time, relevant, patient-centric data at their fingertips, providers are enabled to make well-founded treatment decisions based on recent utilization, medication history and identified gaps in care. The data analysis process drives information into key decision support tools for providers as presented in *Thematic Component F (blue)* of ***Figure 3.3***, including:
   - **Individual Member Profiles and Clinical Care Alerts**: Available to the Health Choice care coordination team and to providers through their dashboards, these tools facilitate care coordination efforts, alert the care team and providers to member transitions and urgent needs, and facilitate provider ordering of services and tests.
   - **Pharmacy**: ePrescribing supported through Pharmacy Benefit Management algorithms, specialty pharmacy guidelines and MTM decision support tools to reduce errors, and ensure appropriate medication and adherence.
   - **Premerus® Diagnostic Accuracy**: In partnership with MedSolutions, this decision support tool leverages the specialty and subspecialty expertise of some of the nation's leading diagnostic physicians leading to higher quality outcomes while reducing costs. In 2012, this program resulted in a total savings of $4,157,440.
   - **Remote Monitoring**: For high-risk members, this tool offers system "alerts" of urgent symptoms and data to assist with monitoring the progress of care plan goals, such as significant weight gain in a CHF patient.
   - **Provider Dashboards and Scorecards**: Monitors providers' overall performance measures and gives detailed member information to providers to drive treatments that improve members' health and wellness, and outcomes.

3) ***Data driving care coordination:*** At the member level, outcomes are continually monitored to evaluate and refine Individual Care Plans (ICPs) in collaboration with members, identified support systems and their providers. At the health plan level, data is monitored to facilitate continuous feedback loops between the health plan and providers to improve care coordination and processes, evaluate adherence (provider and member) to evidence-based guidelines and improve cost efficiencies. In this phase of the process, care coordination is further enhanced through our integration of member education, community resources and communication tools to engage members in active participation in their own health care. These member tools are described in *Thematic Component G (violet)* of ***Figure 3.3*****,** and include:
   - **Healthy Moms = Happy Baby** program involves face-to-face and telephonic outreach to moms and newborns within 48-72 hours to assist with follow-up appointments with PCP, pediatrician and community resources.
   - Collaborations with community resources to provide **health, safety and condition-specific classes, and support groups** for current members, their family members and for the general community.
   - Complete website redesign to enhance usability and promote member health education using an **evidence-based patient education portal** (Q1 2013). This portal is also used by the provider network and hospitals.
   - Use **social media**, **opt-in mobile texting**, **smartphone/tablet apps** and a **member portal** to engage members to actively participate in their health care (Q4 2013), and a **24-hour nurse advice line** to **provide prompt** assistance for members' health care concerns and reduce unnecessary ER utilization (Q4 2013).

(Narrative continued on page 46.)

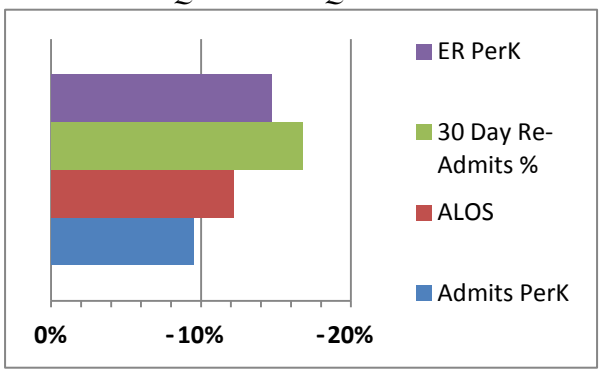
Figure 3.3: Health Choice Care Coordination Workflow, Decision Support Tools & Processes



Using Tools, Data for Outcome- and Value Oriented Payment Models

Our approach is to further encourage and reward providers for using data to improve member health outcomes. We are currently broadening two of our existing value-based payment innovations and will introduce another model targeted at our hospital partners in 2013. Like AHCCCS, we believe strategies that reward better care at a lower cost are the single most powerful method of creating a sustainable Medicaid program amid a growing number of eligible members and decreasing budget support. Health Choice has planned, piloted, implemented and committed to the following:

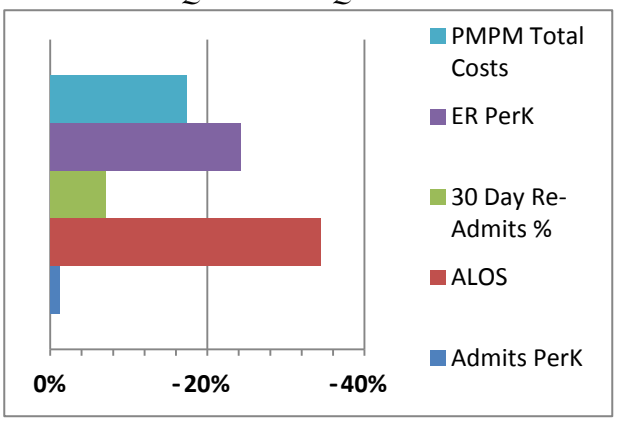
Table 3.4: SMI Members - GSA4
Utilization Percentage Decrease
Q3-2011 vs. Q3-2012



Patient-Centered Medical Health Home Programs
This model serves as a key mechanism in lowering overall costs by reducing inpatient visits, ER use and hospital readmissions, and provides a measurable path for community providers to take risk and be rewarded for providing quality care to AHCCCS members, including dual eligibles. Our model includes two components:

- In 2012 Health Choice launched its **Integrated Medical/Mental Health Home** in collaboration with North Country HealthCare (FQHC) and Northern Arizona Regional Behavioral Health Authority (NARBHA) to serve the complex needs of AHCCCS and dual eligible members in GSA 4. As part of this program, in addition to care coordination tools described above, entities take steps and share information to better collaborate. Health Choice shares a Daily ER Notification Report, Activity Report, Medical Home Roster, Inpatient Census/Discharge Notification, Individualized Care Plans (ICP), member performance measure gap report; NARBHA provides Crisis Report, Inpatient Psych Report (TGC); John Hopkins Predictive Member Report; and finally, North Country HealthCare supplies a Weekly Communication Log which captures member outreach for follow-up related to ER and inpatient/discharge, and members seen in the integrated clinic. By integrating data and decision support tools across all three entities, we have already made a significant impact in outcomes for seriously mentally ill patients served by the program. Positive outcomes for this model are in ***Table 3.4***.

Table 3.5: Medical Home
Utilization and PMPM Cost Percentage Decrease
Q3-2011 vs. Q3-2012



- The Health Choice **Medical Health Home** model was developed in collaboration with AHCCCS and is based on the national model for the "Patient-Centered Medical Health Home." To date, we have partnered with four practices, extending to 19 sites in three of our four GSAs. These providers manage nearly 5,500 of our members. We provide data and performance measurement tools to support each Medical Health Home, such as reports reflecting rates in HEDIS/Health Choice quality metric achievement, utilization and health care cost trends as well as Individual Member Profiles. Positive outcomes for this model are in ***Table 3.5.***

AHCCCS and Duals Partnership for Quality Care and Health Home Programs
The Partnership for Quality Care model incentivizes physicians for providing a comprehensive annual assessment to identify high-risk members by diagnosis and coding. This collaborative effort allows for improved risk stratification and targeting of members for case/disease management, and care coordination to assign members to PCP health homes which are diagnosis and disease-specific in nature.

Bundled Payment Programs
The Health Choice Bundled Payment Program incentivizes appropriate, quality hospital care and discharge planning by bundling payments over episodes of care. In 2011, Health Choice partnered with three of the Arizona hospitals owned by our parent organization, IASIS, to pilot bundled payments for cardiac and orthopaedic

Positive Outcomes for Bundled Cardiac Episodes:
*Average OP stents per encounter for 2012 is **22%** **less** with IASIS's bundled payment program than the Maricopa county average.*

*IASIS procedures had **ZERO** follow up stents within 30 days while the Maricopa rate was 4.3%.*

episodes as an alternative to volume-driven payment of multiple claims from multiple providers. Bundling payment compensates acute care facilities (and/or acute and ambulatory care teams) on a case rate for delivering health care services, Because this model creates funding opportunities for facilities and outpatient physicians, such as surgeons and cardiologists who effectively treat and discharge patients, bundling becomes a deterrent to providing unnecessary care and encourages instead comprehensive discharge planning and coordination across the delivery system.

Integrated Networks / Physician Pods Model

Inpatient care continues to drive the highest costs, however, hospitals have not traditionally been integrated with physician networks to increase efficiency. In 2012, Health Choice developed and piloted an integrated network called Health Choice Preferred, a physician-led organization comprised of more than 330 physicians and three hospitals in GSA12. The network is further broken down into "pods" – physician alignment around an acute care hospital to facilitate specialty and ancillary referral patterns. By engaging integrated networks and deploying value-based payment models for meeting quality and outcome targets, hospitals and physicians are fully engaged in improving outcomes and curbing costs, thus freeing up new capacity in the system. We are currently working with other hospitals to leverage their integrated networks to improve outcomes for members.

Payment Reform for Preventable Events and Hospital Readmissions

In the analysis commissioned by AHCCCS, 2-7% of hospital inpatient admissions in 2009 and 2010 (associated cost of $65 million in 2009 to $80 million in 2010) were defined as potentially preventable. We are committed to reducing the readmission rate for both Medicaid and dual eligible members within our plan by using data tools to report utilization patterns to hospitals, provide information to PCPs, specialists and clinical case management staff about members who are at risk for readmission, and then paying providers based on their rate of readmissions compared to their peers. By doing so, we believe we can contribute to AHCCCS's vision to reduce readmissions and reduce costs. To further bolster our efforts to create accountability for reducing inappropriate acute care services, Health Choice, in concert with AHCCCS, will launch its Payment Reform for Preventable Events and Hospital Readmissions Program by January 2014. This program will hold hospitals accountable for preventing certain readmissions. We will implement this program through reimbursement penalties and/or bonuses. Depending on final AHCCCS policy, bonuses would be funded from the 1% shared savings withhold. This program will be based on the tenets of CMS's Hospital Readmission Reduction Program and "No Place Like Home" campaign, but with enough flexibility to adapt the measurement criteria to the methodology that AHCCCS designs for its Readmissions Reduction plan in the future.

Table 3.6: Payment Models

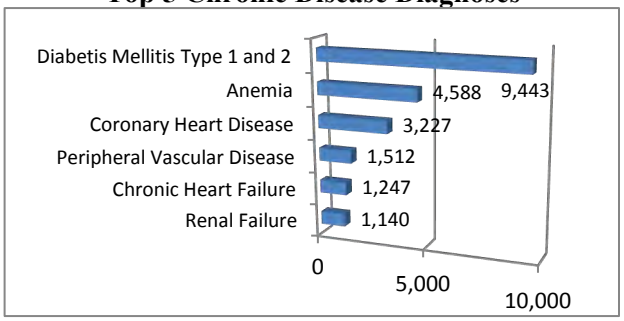
Payment Model	Monthly compensation	Min. Quality Performance required	Shared savings/Bonuses/One time payments	Current Participation	Expansion Plan
Medical Health Homes	Access to care PMPM	Yes	Shared savings - Based on reduction in utilization	4 provider groups	Align 4% of members with 2 or chronic conditions to a Medical Home
Bundled Payment Programs	N/A	Yes	Bonuses - Based on exceeding target pricing goals	3 facilities	Add two or more dual eligible centric conditions by 2013
Integrated Networks / Physician Pods Model	Quality improvement PMPM	Yes	Shared Savings – Based on reduction in utilization	330 physicians in Maricopa county	Statewide
AHCCCS & Duals Partnership for Quality Care Program	N/A	Yes	Incentivize providers w/ bonus payments for assessments and for achieving certain performance measures	Select physician groups	Increase 75% by 2013, 100% by 2014
Payment Reform for Preventable Events and Hospital Readmissions	N/A	Yes	Penalties and/or bonuses based on preventable events and hospital readmissions	None	In concert with AHCCCS, launch January 2014

Q4 The case of Mr. Andrews is not unfamiliar to the clinical team at Health Choice. We have more than 22 years experience managing AHCCCS members with unique and complex care needs. Like Mr. Andrews, 7% of our more than 175,000 members suffer from at least one chronic illness, such as respiratory, cardiac and metabolic conditions; 3.4% have two or more conditions, 2.7% have three or more conditions and 1.5% have four or more (see ***Table 4.1***). The majority of these chronically ill members are severely challenged in managing their condition due to complex, socioeconomic barriers and behavioral health conditions. Recognizing that members with complex needs often fall victim to a fragmented health care system, Health Choice leverages proactive and innovative approaches to quality care. These approaches engage members and support providers in their efforts to effectively manage patients with complex needs to improve member outcomes. Below, we will: 1) Provide a high level overview of our general approach to care coordination and describe the guiding principles we apply to drive improved outcomes for our members; 2) Outline the systemic processes that we have adopted to address members with chronic illnesses; and 3) Describe how we would apply our systemic process to the specific case of Mr. Andrews.

1) Health Choice's Approach to Care Coordination

Through care coordination, decision support tools, payment reform strategies, provider support and member-centric care processes, Health Choice would have identified Mr. Andrews early in his cycle of care. We would then develop an Individualized Care Plan (ICP) outlining specific goals and interventions to address his immediate and long-term needs.

Table 4.1: Health Choice Arizona Members with Top 5 Chronic Disease Diagnoses



To capture all aspects of Mr. Andrews' needs and preferences, the scope of an ICP incorporates member-specific data elements and utilization information, leveraging Enrollment Transition Information (ETI) data from his former AHCCCS plan in collaboration with Mr. Andrews and his health care providers, or friends, community resources, clergy or any other representatives he might designate. By assisting Mr. Andrews with an outpatient plan and providing education and resources to help him self-manage his conditions, his health would stabilize, his anxiety would be reduced, and with it, his reliance on the Emergency Room (ER). Our approach to addressing the needs of members with complex needs, such as Mr. Andrews, and improving health outcomes, is driven by our guiding principles (see ***Figure 4.2***) which shape our care coordination and health home strategies as follows:

Fig. 4.2: OUR GUIDING PRINCIPLES
Driving Improved Outcomes

Principle 1: Retrieve and evaluate rich member-specific data to inform health care team workflow to drive interventions.

Principle 2: Providing culturally appropriate coordination of care and services is a key intervention which provides the highest value impact for Arizona Medicaid members and AHCCCS.

Principle 3: For us to have a long-term sustainable impact on the health of our AHCCCS members and their communities, we must employ strategies to effectively "manage the geography."

Principle 4: Adopting widespread value vs. volume payment models will cultivate desired care outcomes as well as a financially sustainable health care delivery system.

Principle 1: Through its long-standing partnerships with hospitals statewide, Health Choice has the unique capability to receive real-time member utilization data from more than 80% of our Arizona hospitals. This data is distributed to the appropriate primary care physicians daily to drive timely follow up care. Additionally, through robust health analytic solutions, we are able to predict future service needs by analyzing historical data enabling us to proactively identify members who require immediate intervention. Most importantly, these analytic solutions drive relevant, real-time, member information to providers through systemic processes and tools, such as Clinical Care Alerts and Member Profile analytics (see ***Table 4.3***) which are available to providers in their monthly/quarterly dashboards and available to care coordination team, enabling them to make treatment decisions based on recent utilization, medication history and identified gaps in care.

Principle 2: Coordinating care and services, specifically for members with chronic illnesses, involves a multitude of methods, such as: face-to-face interventions and assistance, proactive coordination of follow-up appointments and transportation assistance. Language barriers and other cultural factors are always considered when developing interventions for members. Cultural differences are considered in every aspect of the member's care planning process – for example, diet, language, spiritual belief and family orientation – to ensure care planning meets each member's identified needs and beliefs.

Principle 3: A driving force in our ability to provide culturally competent health care services is our strategy to locate clinical, network and outreach staff throughout Arizona. The value of face-to-face communications is unsurpassed, and we regularly engage with the hospital case managers and discharge planners and community providers who serve our complex members in the urban, suburban and rural areas of Arizona. Face-to-face interactions can allow for hands-on assessment of the member's living situation and ability to self-manage their chronic conditions. In addition, we currently have agreements with 19 community clinics and FQHCs with sites in three of Health Choice's contracted GSAs to provide clinical support and care coordination, coordinate community services and outreach, and offer same day and after-hours appointments to ensure access to care and services for all Health Choice members.

Principle 4: For the past 18 months, Health Choice has engaged in system-wide initiatives to align our provider network and payment models with the overarching goal of improving quality of care and containing costs. Pilot projects involve sharing a portion of cost savings produced by reductions in ER and readmissions with Medical Health Home partners who meet specific quality metrics. As we enhance care processes and value-based approaches to reimbursement through collaboration with our providers, we will scale and grow these programs, which currently include: 1) Added focus on providers who manage our highest risk, chronically ill members; 2) Extended hours and clinic Health Information Technology (HIT) requirements; and 3) More aggressive savings and quality metrics. Payment reform innovations such as these are critical to creating a sustainable Medicaid program for Arizona's low-income, disabled and elderly constituents, particularly in alignment with dual eligible programs and the future Health Insurance Exchange (HIX).

2) Systemic Processes to Address Members with Chronic Illness

The structure and function of the Health Choice care coordination model incentivizes cooperation, accountability and information-sharing across care teams and settings. Health Choice uses three systemic care management processes: 1) Stratify, rank to proactively identify and reach out to members with complex, chronic conditions; 2) Assess, plan, agree and collaborate with the interdisciplinary care team to customize specific goals and interventions; and 3) Reassess needs, refine the ICP and monitor outcomes by incorporating member and provider feedback with data. These systemic processes give providers and the Health Choice care coordination team evidence-based tools to enhance member health outcomes and improve care planning.

Table 4.3: Example Member Profile

Member Profile
Date Created 1/7/2013

Member Name	Henry Andrews	Date of birth	1/1/1960
Member Home Address 1	1234 Main Street	Age	50
Member Home Address 2		Gender	M
City, State, Zip	Phoenix, AZ	Rate Code	
Phone Number	602-555-1234	First effective date	1/1/2009
County	Maricopa	Current effective date	1/1/2013
Member ID	A0001111	Risk Score	High
Dual Member (Y/N)		RHBA Member (Y/N)	
Primary Care Provider			
Practice Name	Maricopa Family Practice	Phone:	480-968-6866
Provider Name	John Smith MD	Fax:	480-760-4879
Address 1	1111 Main Street	Email:	
Address 2		Provider NPI	1234567890
City, State Zip	Phoenix, AZ 85008		
Speciality	Family Practice	Member's PCP since	12/1/2012
Health Diagnosis/Condition Information			
Most frequent diagnoses - Claims		Most frequent diagnoses - PA	
1st	250.03	1st	250.00
2nd	295.30	2nd	491.21
3rd	491.22	3rd	493.21
Case Management Information			
Case Manager	Nancy C. Manager		
Chronic Condition 1	Diabetes	Chronic Condition 4	
Chronic Condition 2	COPD	Chronic Condition 5	
Chronic Condition 3		Chronic Condition 6	
Utilization Information			
Date of Last IP Admission	5/3/2012	# Of ER visits last 12 mo	15
# of Days Last IP Admit	4	Date of last ER visit	12/10/2012
Reason for Admission	250.1	Reason for ER visit	276.51
# Of IP days last 12 mo	10	Date of Last PCP visit	11/15/2012
# Of IP days this CY	0		
Prescription Information			
# of Prescriptions filled in the last 120 days		3	
Date	Medication	NDC #	
10/10/2012	ACCU-CHEK AVIVA PLUS TEST S	657020407 10	
11/20/2012	NOVOLIN 70-30 100 UNIT/ML V	00169183711	
11/20/2012	CARVEDILOL 25 MG TABLET	00093729601	
Lab Information			
Labs/Results in the last 12 months			
Date	Lab	Result	
11/16/2012	CHLORIDE-CHEM 18	95	
11/16/2013	CALCIUM-CHEM 18	9.2	
11/16/2012	GLUCOSE-CHEM 18	518	
11/16/2012	GLOBULIN-CHEM 18	3.9	
11/16/2012	SODIUM-CHEM 18	134	
11/16/2012	PROTEIN,TOTAL-CHEM 18	7.5	

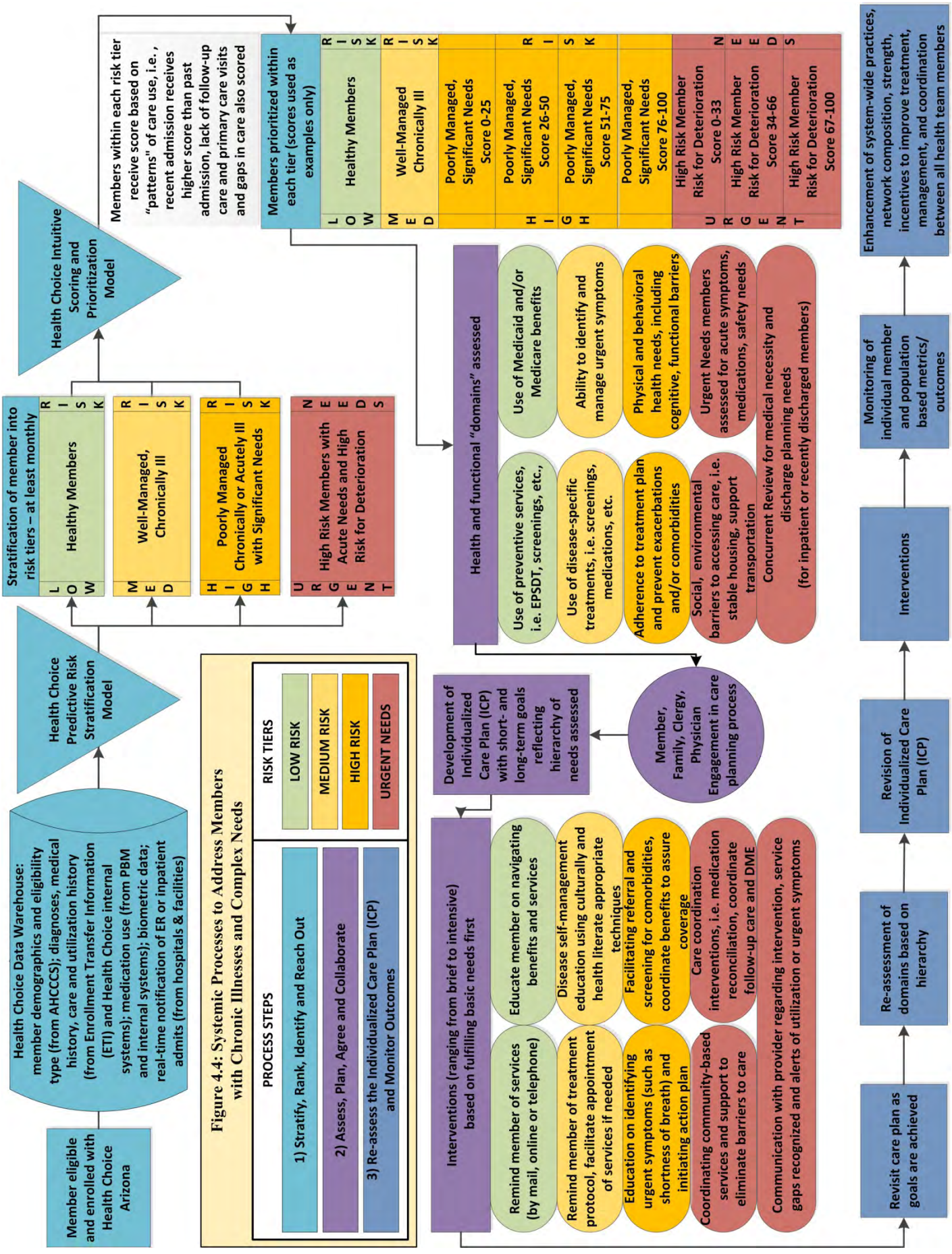
1) Stratify, Rank, Identify and Reach Out: Our first step is to identify our highest risk members through risk stratification and prioritization models, which extends to all aspects of the member's care, whether the root cause is non-adherence to the prescribed treatment plan or, the member has challenges navigating a fragmented health system. Population management focuses on members we can impact through interventions such as case and transitional care management, disease self-management, health promotion, coordination of care, community support and resources.

2) Assess, Plan, Agree and Collaborate: As part of our holistic approach toward evaluating members' needs, our nurses and care coordinators reach out to members with complex needs via telephone or face-to-face meetings to assess a series of "domains" in order to understand the member's *most urgent* needs. This process involves a comprehensive health and functional assessment aimed at identifying superseding issues or root causes, such as the member's ability to self-administer medications, need for durable medical equipment (DME), home safety concerns, potential environmental issues, and social and cultural needs and dynamics. Collaboration with the member, primary care physician and other care team members results in a comprehensive ICP for the member.

3) Reassess Needs, Refine ICP and Monitor Outcomes: Our care coordination team continually assesses health outcomes, while monitoring members' progress toward goals and utilization of health care resources. Health Choice's continuous quality improvement program focuses on creating a learning environment by incorporating provider and member feedback and outcome data to identify systemic quality of care issues, enhance internal processes, manage network composition and leverage value-based payment models.

See ***Figure 4.4*** for a complete flow chart demonstrating the components of each of these process steps, the workflow process, description of risk tiers, and detail on how each risk tier is stratified and managed through care coordination.

Figure 4.4: Systemic Processes to Address Members with Chronic Illnesses and Complex Needs



3) Addressing Mr. Andrews' Needs: A Health Choice Arizona Case Study

The scenario posed in this question demonstrates the important role a health plan should play in promptly identifying chronically ill members with acute symptoms and complex needs. Below we describe how our systemic processes would proactively identify Mr. Andrews, how we will manage and assess Mr. Andrews' conditions, and how we will perform timely interventions and engage him in care coordination preventing inappropriate utilization. Based on the description of Mr. Andrews, we understand and theorize the risk factors presented in the case scenario in ***Table 4.5*** as we outline an ICP to guide our approach to managing and engaging Mr. Andrews. The ultimate goal of clinical case management for Mr. Andrews is to enable him to self-manage his chronic conditions. Through personalized care management outreach, he will manage his episodes of shortness of breath, be adherent to his treatment plan and medication regime preventing development of additional co-morbidities, and be able to maintain his current living situation.

Table 4.5: Mr. Andrews's Risk Factors and Interventions for Developing an ICP
Risk: Inability to self-manage two or more chronic conditions. Challenges include managing his multiple co-morbidities (COPD, CAD), history of acute MI, bedridden, and lack of family support.
• Assign a dedicated Clinical Case Manager and single Care Navigator to coordinate all of Mr. Andrews' needs. • Complete an integrated comprehensive health and functional assessment engaging both Mr. Andrews and his PCP. • Conduct medication reconciliation to identify any drug therapy problems or contraindications. • Utilize best practice guidelines to promote consistency in care plan development.
Risk: High ER utilization. ER utilization is likely due to Mr. Andrews' lack of support in the home, poor understanding of his disease process, poor coping skills, and lack of education and engagement in his care plan.
• Encourage and facilitate member engagement in conjunction with his ICP. • Provide timely and appropriate follow-up with physicians, caregivers and other home based support services. • Provide education, tools and resources to improve and manage coping skills. • Home health evaluation to assess member safety and personal needs (such as Medi-set and DME).
Risk: Functional decline. Mr. Andrews' experiences challenges with obesity, induced anxiety secondary shortness of breath, limited mobility, and decline in physical activity.
• Enroll Mr. Andrews into a personalized disease management program to assure that care and services are aligned and coordinated including coordination of behavioral health services. • Explore available community resources to increase Mr. Andrews's activity and enhance his support system.
Risk: Behavioral health conditions. Anxiety (and possible associated depression)
• Coordinate care with Mr. Andrew's PCP to assess and evaluate Mr. Andrews's level of anxiety. • Work collaboratively with Mr. Andrews' PCP to engage Mr. Andrews in his plan of care. • Identify resources to assist Mr. Andrews with self-management of his anxiety and improve his coping skills. • If warranted, refer Mr. Andrews to RHBA.

Health Choice would then apply the systemic processes described in ***Figure 4.4*** to Mr. Andrews's case as follows:

1) Stratify, Rank, Identify and Reach Out: Because of his medical history (multiple co-morbidities) and utilization history (frequent ER visits and hospitalization), our Predictive Risk Stratification Model would have ranked Mr. Andrews into a high-risk category we term "Poorly Managed Chronically or Acutely Ill with Significant Needs" (see ***Figure 4.4***). Mr. Andrews's frequent visits to the ER would have also ranked him near the top of our Clinical Case Managers' list of members requiring outreach and assessment. Last, our care coordination team would have proactively identified Mr. Andrews multiple ER visits through the daily ER reports received from hospitals statewide. Our case management assignment process is structured to address our members' unique needs, which includes assigning staff with appropriate clinical and cultural backgrounds, and language proficiencies. Mr. Andrews would be assigned to "Nancy," one of Health Choice's Clinical Case Managers who has experience and expertise in managing members with multiple chronic co-morbidities in Arizona. Nancy would be dedicated to addressing ***all*** of Mr. Andrews' co-morbidities and care needs.

2) Assess, Plan, Agree and Collaborate: In this scenario, the PCP would likely reach out to the Care Navigator that Health Choice assigns to each large practice and medical health home. The Care Navigator assists with coordination of all the member's needs from setting appointments, transportation, specialist referrals and providing support and educational materials related to their chronic conditions. The Care Navigator would work collaboratively with Nancy to develop and implement the care plan. Nancy, who had already identified Mr. Andrews through our prioritized system alerts and a completed Health Risk Assessment (HRA), would then survey Mr. Andrews' PCP regarding the reasons for the referral, and walk through the completed HRA to understand the root causes for Mr. Andrews' ER utilization. Nancy would inquire about adherence to attending appointments, his satisfaction with his current care, what types of interventions have failed and his physician's ability to meet Mr. Andrews' complex clinical needs. Nancy, would then engage directly in a

dialogue with Mr. Andrews to understand his *most urgent* need, such as shortness of breath or safety concerns and potential risk for harm. Once she determines that Mr. Andrews does not have any acute needs, Nancy will then assess for social and environmental issues that present barriers to Mr. Andrews' ability to access appropriate care through the comprehensive health and functional assessment. For example, Nancy would ask about his housing situation and available transportation to his pharmacy and to medical appointments, and she would perform an initial screening for cognitive and functional impediments to Mr. Andrews' ability to care for himself and seek care from his providers.

Based on her assessment, Nancy will create an ICP for Mr. Andrews within our CareRadius™ care management platform. The ICP will cite obvious challenges to Mr. Andrews' ability to achieve optimal health outcomes, as well as specific, short-term goals or goals directed at satisfying Mr. Andrews' identified *most urgent* need. For example, Mr. Andrews should demonstrate an ability to identify an acute symptom and take action to prevent exacerbation of these symptoms such as: identifying triggers to anxiety or panic attacks, learning and applying calming exercises to help reduce or minimize panic attacks, and utilizing a "rescue inhaler" to facilitate breathing during panic attacks. Mr. Andrews' success in achieving short- and long-term goals is supported by Nancy, who will provide and review instructional materials with Mr. Andrews, and assist with scheduling training classes and locating support groups.

> ***"I don't even remember your name. I just have you programmed as angel."***
> *Member response to Care Navigator phone call for care coordination prior to hospital admission*

Nancy would engage Mr. Andrews in the development of his ICP goals and interventions, involving him in all decisions including selection of specialty providers, timing of appointments and his preferred methods for self-management education and training. During this phase of the process, Nancy will ensure any scheduled services or providers reflect Mr. Andrews' needs and preferences, which will involve input from his PCP, and possibly clergy or a spiritual advisor. Because Mr. Andrews does not have any family support, Nancy will also identify trusted neighbors, friends or community resources that Mr. Andrews may want to have involved in his care planning. Nancy and his health care team will then work to eliminate any barriers that might prevent Mr. Andrews' from achieving his goals. This may include providing communication tools to assist his PCP in the management of Mr. Andrews' chronic conditions, working with his PCP to facilitate a face-to-face visit from a Nurse Practitioner from our Home-based Primary Care Program – which leverages community primary care providers to render services to frail, elderly, and disabled members in their home to ensure access to care – or a Home Health Nurse to evaluate safety concerns at Mr. Andrews' home. Nancy might also evaluate any DME he has or needs, ensure medication adherence, conduct a nutritional evaluation, provide self-management techniques, perform a reconciliation of prescribed medications and coordinate efforts with the Home Health Nurse on how to improve Mr. Andrews' overall health and reduce unnecessary utilization of services.

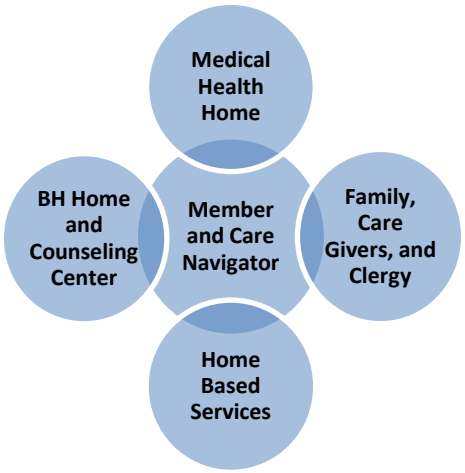
If Nancy determines Mr. Andrews is unsatisfied with his PCP or that the care delivered by his PCP is suboptimal, Nancy may consider helping the member select a new, high-performing provider. Ideally, Nancy would work with Mr. Andrews to select a provider with whom Health Choice has aligned incentives to provide quality, cost effective care, such as one of our Medical Health Home partners. Mr. Andrews' new Medical Health Home will be an integral component of his interdisciplinary care team, which will include: social workers to assist Mr. Andrews' social isolation, a cardio/pulmonary specialist; a respiratory therapist to assist Mr. Andrews in using an inhaler; a nutritional consultant for diet and weight; and Health Choice Care Navigators and Nurses to provide education and resources to help Mr. Andrews manage his chronic disease states. Engaging members like Mr. Andrews can be challenging, however, our interdisciplinary approach would inform, engage and empower Mr. Andrews to play a critical role in his own care plan, while incorporating additional assistance and support from those he trusts, such as designated representatives or clergy, as reflected in his ICP.

3) Reassess Needs, Refine ICP and Monitor Outcomes: As Mr. Andrews achieves the goals outlined in his ICP, Nancy would engage in ongoing assessments to identify any additional barriers to improving his health. As Mr. Andrews continues to progress, interventions would become more focused on weight loss education and how weight loss will impact his cardiac and respiratory conditions. Nancy would facilitate links to community centers such as A Bridge to Independent Living (ABIL) for exercise and physical activity, and would continue to support his ability to self-manage his chronic conditions. Health Choice would monitor quality and utilization metrics, inpatient and ER visits, medication use and adherence, and the care he receives in the outpatient setting to ensure it is aligned with evidence-based protocols for the treatment of COPD, cardiac disease and obesity. This "checks and balance" process evaluates care planning implementations and interventions to identify patient-centered outcomes for Mr. Andrews.

In summary, through Health Choice's systemic processes, Health Choice would have identified Mr. Andrews early in his cycle of care and developed a comprehensive Individualized Care Plan (ICP) through a collaborative approach that incorporates input from Mr. Andrews himself, as well as members of his interdisciplinary care team and any trusted advisors to address his medical, social and cultural needs, ultimately enabling him to self-manage his condition.

Q5 The challenges encountered by Mr. Robertson – a young, active, seemingly healthy 29-year-old man – are unique and present a complexity which is quite different than that faced by people with a chronic illness. Nevertheless, the four guiding principles upon which we've built our organizational philosophy and established a process for delivering care coordination can be applied. Our goal is to first demonstrate that by applying these key principles, **we have the capabilities to manage complex members** such as Mr. Robertson. Second, that by leveraging our systemic care coordination processes, **we can proactively mitigate the setbacks, challenges and risks for members like Mr. Robertson** (see ***Figure 5.1***).

Figure 5.1: Member-Centric Care



Below, we will: 1) Describe how our guiding principles are applied to coordinate care for complex members like Mr. Roberston; 2) Describe the greatest potential setbacks, risks and challenges faced by Mr. Robertson, and specifically describe the proactive Health Choice processes that would address these concerns; and 3) Outline Health Choice's approach to managing Mr. Robertson's care following his admission to a Skilled Nursing Facility (SNF) that specializes in traumatic brain injury (TBI) patients.

1) Addressing Mr. Robertson's Needs: A Health Choice Case Study

Below we describe how our guiding principles, see ***Figure 5.2***, extend to managing members who cope with severe medical, behavioral and social issues, and then navigate a complex system in order to achieve optimal health outcomes. Our goal, by committing to these principles, is to assure each member receives quality and consistent care in the right setting at the right time.

Principle 1: At Health Choice, we leverage many sources of data and utilize robust health analytic algorithms to target members with acute and chronic health care needs. A key component of this data analysis process is our Benefits Accumulator tool which considers a member's historical service utilization to calculate benefit limitations (i.e. inpatient day and SNF day limits). Our CareRadius™ Care Management Platform integrates this tool into the member stripe (a dashboard-like tool), informing care coordination team of the number of bed days used and displaying an alert for members who are in danger of reaching their benefit limits. This would have proven beneficial in the case of Mr. Robertson, as the alert triggers care coordination team to proactively coordinate alternative services or transition planning to ensure continuity of care for the member, payment for subcontractors, as well as to prevent premature discharges.

Fig. 5.2: OUR GUIDING PRINCIPLES
Driving Improved Outcomes

Principle 1: Retrieve and evaluate rich member-specific data to inform health care team workflow and interventions.

Principle 2: Providing culturally appropriate coordination of care and services is a key intervention which provides the highest value impact for Arizona Medicaid members and AHCCCS.

Principle 3: For us to have a long-term sustainable impact on the health of our Arizona AHCCCS members and their communities, we must employ strategies to effectively "manage the geography."

Principle 4: Adopting widespread value vs. volume payment models will cultivate desired care outcomes as well as a financially sustainable health care delivery system.

Principle 2: Successfully coordinating care and services for members such as Mr. Robertson requires strong working relationships with acute, subacute and long-term care facilities to ensure they complete comprehensive discharge planning. Care planning is developed based on cultural needs such as, language, spiritual beliefs, traditions and family orientation. In order to meet this demand, we've dedicated 13 nurses to regularly visit facilities to support appropriate, timely and effective discharge planning as part of our Concurrent Review process. For post-hospital or SNF discharges, we have a team of clinical and nonclinical staff assigned to provide Transition of Care support including: locating and facilitating links to community-based services—such as subsidized housing for TBI patients, communicating and coordinating care with the member's PCP, specialists and Regional Behavioral Health Authority (RBHA) providers. In addition, we provide dedicated Care Navigators to support members through the complex web of Medicaid services and/or Medicare benefits.

Principle 3: Positioning provider relations, case management and outreach staff throughout Arizona is key to our ability to "manage the geography." As important, our success in managing complex members across the health care continuum is enhanced through the development and utilization of mechanisms to deliver real-time, actionable member data to providers. Providing this data, through technology such as EMRs and our provider portal, allows us to bridge

the geographic distance between providers, the health plan and our members, ensuring members like Mr. Robertson receive assistance and services within their service area, and in a culturally competent manner.

Principle 4: Comprehensive discharge planning could have prevented Mr. Robertson's horrific fall, head injury and potential life-long disability. The case of Mr. Robertson exemplifies our motivation for investing in payment innovation focused on reducing readmissions by incentivizing facilities and physicians to reduce avoidable Emergency Room (ER) and hospital readmissions. We have established value- and outcome-based payment arrangements with several acute and long-term care organizations to reward these facilities for coordinating care and discharge services. In addition, we currently measure and rank our network partners, including SNFs, achievement in delivering quality, cost efficient care, and we focus our referrals on high-performing providers.

Although our systems and partnerships would likely have identified and prevented Mr. Robertson's situation in this scenario, we will next demonstrate how we would leverage our guiding principles to coordinate care for Mr. Robertson *going forward* in the event that the SNF referral was the first time we identified him. Our care management goals for Mr. Robertson are: 1) Function in the least restrictive level of care needed to manage his TBI; 2) Prevent further decline; and 3) Improve his quality of life and address his substance abuse concerns.

Our care coordination team would monitor his progress, utilization of services, and perform a comprehensive health and functional assessment aimed at facilitating care transition to a lower level of care. The discharge plan would include coordinating services to allow him to successfully recover, secure assistance/benefits from applicable support services such as Social Security and/or Arizona Long Term Care Services (ALTCS), and connect him to community resources. This discharge plan is created with input from Mr. Robertson, and shared with his treating physicians. The following describes the processes we would use to coordinate care for Mr. Robertson as he moves through the continuum of care.

2) Mr. Robertson's Greatest Setbacks, Risks and Challenges: Health Choice Solutions to Address Concerns

In this section, we describe the greatest potential setbacks we believe Mr. Robertson encountered during his treatment and recovery prior to his admission to the SNF, and our proactive approach to addressing these concerns. Inherent within these challenges are risks for additional incidents, particularly:

- Possible risk of losing Medicaid eligibility if he originally qualified as a childless adult member.
- Risk for addiction relapse due to pain, isolation, depression or anxiety.
- Risk of incarceration due to possession of illegal substances, and/or losing housing and becoming homeless.
- Risk of premature discharge / transition to SNF due to 25-day inpatient benefit limit.
- Risk of deficiency in receiving services in the most appropriate setting, such as a TBI group home.

Table 5.3 is organized to describe each of the potential risks to Mr. Robertson's recovery and to his ability to achieve optimal health outcomes, which influence the challenges that his care coordination team will face in mitigating his risks. In the first column, we consider the risks, setbacks and challenges that are the result of misaligned, fragmented care, services, benefits and providers. The second column identifies Health Choice processes that would have proactively addressed these concerns had Mr. Robertson been identified during his first admission. The third column displays the positive outcomes that would have occurred with the involvement of Health Choice's care coordination programs.

Table 5.3: Solutions to Mr. Robertson's Risks, Setbacks and Challenges

Risks, setbacks and challenges	Health Choice process that will proactively address these concerns	Expected care outcome for member
Potential Risk: Poor quality of care on first admission		
Possible failure to treat for pain according to substance abuse protocol. **History of substance abuse prior to the accident.**	• Inpatient and Emergency Room (ER) admission census daily reporting • Concurrent Review of all inpatient admissions • Discharge planning support, case management	Prompt notification of admission would have prompted concurrent review and discharge planning resulting in: • Informed hospital providers of behavioral health issue and outreach to RBHA for coordination of care and treatment planning • Assured delivery of evidence-based treatment of pain for patient with history and in active treatment for substance abuse (possible non-narcotic treatment for pain) • Possibly avoid a substance abuse relapse • Reduce risk of fall down stairs

Failure to perform appropriate discharge planning – **Specific to housing:** physical barriers such as stairs, substance abuse triggers at home or in his neighborhood, etc. **Specific to services required:** eligibility, housing, physical and occupational therapy, durable medical equipment (DME). • ***Risk:*** Mr. Robertson could lose his eligibility if he fails to re-enroll • ***Risk:*** Unsuccessful management of condition at home could further exacerbate injury	• Inpatient and ER admission daily census reporting • Concurrent Review of all inpatient admissions • Monitoring eligibility, benefits and utilization • Discharge planning support, case management	Prompt notification of admission would have prompted concurrent review and discharge planning resulting in: • Proper monitoring, alerting the Health Choice nurse to reach out to DES for onsite re-enrollment, facilitating Mr. Robertson's (likely eligibility under childless adult program) continued eligibility process • Initiated monitoring of eligibility/benefits • Ensured appropriate services were in place post-discharge, i.e. stair training, DME, outpatient specialty providers such as pain management and orthopaedic surgeon would have been coordinated • Coordination with the RBHA to meet the full scope of Mr. Robertson's behavioral health needs • Assessed Mr. Robertson's housing issues by evaluating income, family resources, potential community placements or community resources/benefits. • Evaluated ability to relocate to a ground level apartment within the same apartment complex.
Potential Risk: TBI Complications, substance abuse relapse, physical limitations after fall on stairs		
Likely permanent disability due to TBI, complex needs related to substance abuse relapse and physical injuries • ***Risk:*** Post-traumatic stress disorder from motorcycle accident, depression, anxiety, further relapse into addiction due to pain	• Inpatient and ER admission daily census reporting • Concurrent Review of all inpatient admissions • Discharge planning support, case management	Prompt notification of admission would have prompted concurrent review, discharge planning, and case management resulting in: • Ensured quality of care and d/c plan was monitored and adhered to • Potential avoidance of Mr. Robertson's fall and/or readmission to the hospital • Arrangements for neuropsychiatric evaluation, follow-up care with orthopaedic surgeon, non-emergency transportation to appointments • Assistance with Mr. Robertson's application for SSI or SSDI and/or application for ALTCS and/or guardianship (Public Fiduciary) • Evaluated appropriateness and availability of alternative supportive services, i.e. vocational rehabilitation, *Rehab without Walls* • Coordinate outpatient services with RBHA for possible assessment by a substance abuse specialist.
Potential Risk: Illegal substances discovered after fall by law enforcement		
• ***Risk:*** Poor health outcomes due to incarceration, disruption in continuity of care and loss of eligibility	• Discharge planning, case management support to assist with timely and appropriate discharge	Appropriate discharge planning would have ensured the following: • Quality of care and discharge plan are monitored against InterQual evidence-based guidelines and practices • SNF is communicating with justice system
Potential Risk: Placement of member in non-contracted Skilled Nursing Facility		
• ***Risk:*** Potential delay in services or gap in services (due to provider's unfamiliarity with Health Choice structure, processes, and authorization requirements)	• Discharge planning support, case management • Engage the provider (i.e. via contracting, and network support services), ensuring education, knowledge	Discharge planning and case management would have: • Reached out to the provider to ensure current placement is maintained; i.e. secure an LOA • Assured that quality care and services appropriate for his needs are provided in SNF with specialty in TBI • Ensured the SNF is AHCCCS-registered, facilitated the Health Choice contracting process and negotiated a specialty rate based on level of care required for

• ***Risk:*** Potential delay or lack of notification to Health Choice of admit; potentially further delaying concurrent review and effective discharge planning.	and understanding of Health Choice and AHCCCS.	continuity of care • Identified additional providers as needed and help with transition (including ALTCS where applicable) • Communicated any necessary transition of care elements to member and/or social supports • Pursued contract with identified specialty providers
Potential Risk: Exhaustion of inpatient day benefit		
Exhausted 25-day inpatient benefit limit thus Mr. Robertson was readmitted after his fall, he was sent to a SNF for rehab care. • ***Risk:*** Stakeholders/hospital may be forced to pay for services as inpatient bed days are exhausted • ***Risk:*** Inappropriate level of needed services received while in the SNF	• Inpatient and ER admission census daily reporting • Concurrent Review of all inpatient admissions • Monitoring eligibility, benefits and utilization • Discharge planning & support, case management • Health Choice Utilization Review Nurses conduct weekly review of physician's and nurse's progress notes to ensure services are being performed by a licensed professional are medically necessary (following evidence-based criteria) and meet the needs of the member.	Prompt notification of admission by the facility to the plan, concurrent review of treatment, monitoring of eligibility and benefits, and would have: • Resulted in successful management of this hospital stay within 25-day inpatient benefit limit, while decreasing the potential of readmission • Alerted Health Choice to Mr. Robertson nearing his benefit limits • Prompted early identification of potential loss of benefits for re-enrollment with AHCCCS • Resulted in services being provided within benefit limitations, thus eliminating exhaustion of acute care benefits and risk of non-payment of services to stakeholders • Allowed for appropriate "level of care," including transfer of Mr. Robertson to step-down facility, potentially eliminating Mr. Robertson's subsequent fall and hospital readmission. • Maximized physical and occupational therapy benefits within acute facility or SNF • Identified third-party liability payment through motorcycle/auto insurer, and/or apartment building owner and pursued recovery management • Ensure the member received quality services which meet the needs of his TBI

In conclusion, the challenges Mr. Robertson experienced after his first admission came as a result of his discharge home to an apartment where he had to navigate two flights of stairs on crutches or another mobility device. This led to Mr. Robertson falling down the stairs of his building causing a cascade of further medical complications, the most grave being his TBI and the symptoms he will have to cope with – behavioral or mood changes, chronic headaches, problems with memory, concentration, attention or thinking, fatigue, weakness and balance problems – that may encumber his ability to function as he once did. Beyond the clinical obstacles, Mr. Robertson confronted a benefit limitation in the number of inpatient bed days he could use in the acute setting which was exhausted after his second admission. Thus Mr. Robertson's condition and medical status would have been appropriate for an acute rehabilitation setting during his first discharge, which could have provided the intense services needed for discharge home decreasing the likelihood of a readmission.

3) Health Choice's Approach to Managing Mr. Robertson's Care Moving Forward

The major challenges for his care coordination team now are: assure continuity of coverage and benefits; assure continuity in treatment in the SNF for a full 90-days; avoid readmission and subsequent SNF admission; maximize the benefits afforded in the SNF level of care, such as physical (PT), speech (ST) and occupational therapy (OT) – *only has a maximum benefit of 15 visits of outpatient PT and no outpatient benefit for OT/ST*; and, finally to provide comprehensive discharge and postdischarge planning to allow Mr. Robertson to care for himself at home or an alternative care setting. The Health Choice care coordination team would leverage four core processes, which are aligned with our guiding principles to proactively address these concerns:

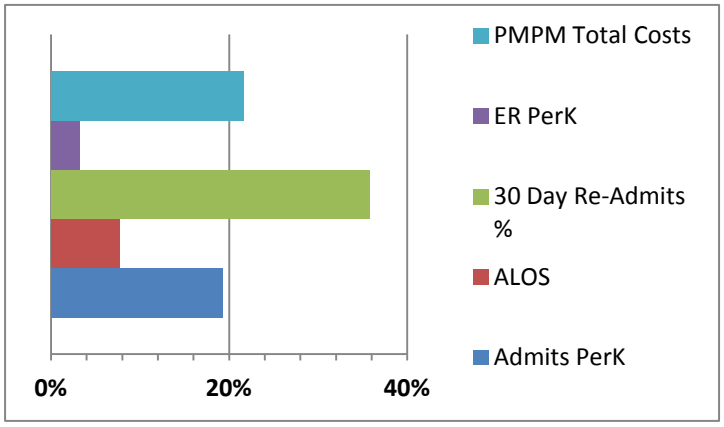
- ***Retrieval of inpatient and ER admission census daily reporting from hospitals:*** Health Choice receives notification of plan members seen in ERs and inpatient settings within 24 hours of admission. We have relationships with 98% of our acute facilities and 80% of our ERs to ensure this notification process is in place.

- ***Concurrent Review of all inpatient admissions:*** We initiate Concurrent Review upon notification of the member's admission, reviewing admitting diagnosis using predefined evidence-based criteria. We also support the hospital's case management team in treatment and discharge planning, and member transitions to the community or other facilities. This allows us to ensure appropriate placement, level of care, and monitor quality of care and length of stay.
- ***Onsite and telephonic discharge planning support:*** Health Choice has positioned clinical staff around the state to provide Concurrent Review and postdischarge support by communicating in person with hospital case managers and discharge planners. We also leverage staff located in our Phoenix headquarters to coordinate care and services, and regularly engage with the RBHA network to meet the full scope of behavioral health needs.
- ***Monitoring of benefits utilization:*** Through our CareRadius™ Care Management Platform, we are able to access our Benefits Accumulator tool that considers historical service utilization to calculate benefit limitations (i.e. inpatient day and Skilled Nursing Facility (SNF) day limits). If members are approaching their benefit limitation, an alert appears on their member stripe so the care coordination team can react immediately to coordinate an appropriate transition of care and/or utilize community-based resources/services to support the member's needs.

By initiating discharge planning upon notification of admission, Mr. Robertson's will be assigned a dedicated Care Navigator who will assist with coordination of all of his needs, such as setting appointments, transportation, specialist referrals and providing support through the delivery system. The Care Navigator works collaboratively with "Linda," the Clinical Case Manager, to coordinate services as described in ***Table 5.3*** and as referenced above. As Mr. Robertson approaches discharge, his care team will assess his overall functionality, and work with him to determine his placement, which could include one or more of the following:

- TBI Home if he is experiencing challenges with his daily living activities.
- An Independent Living Facility where the care team can coordinate outpatient services including vocational and physical rehabilitation.
- Additional assistance through organizations such as A Bridge to Independent Living (ABIL), that can ensure his new living accommodations are accessible.

Table 5.4: Care Coordination Outcomes
Utilization and PMPM Costs Percentage Decrease
Q3-2011 vs. Q3-2012



Regardless of the determined placement, our care team ensures that discharge planning is conducted in collaboration with Mr. Robertson, facilitating his engagement and participation in the planning process, and ensuring his medical, social, emotional and spiritual needs are met. Linda, his Clinical Case Manager, and the Care Navigator remain actively involved in continued monitoring and reassessment of Mr. Robertson postdischarge, promptly addressing any identified care needs or concerns. To continue to effectively manage Mr. Robertson's care, Linda will remain his point of contact, available to provide immediate follow-up and monitor all interventions relating to his care. Despite the challenges Mr. Robertson experienced, Linda and the Care Navigator will collaborate to effectively coordinate timely and appropriate delivery of services and care to achieve maximum functionality.

"I really appreciate you checking up on me, sometimes it helps just to talk to someone that cares."
Member response to Care Navigator phone call after ER visit

In conclusion, the care coordination team provides clinical case management support through programs and interventions developed from rich data sources and outcomes, and serves as the bridge for continuity of care to the member's transition cycle and interdisciplinary care team as described in our systemic process and approaches to addressing Mr. Robertson's case. By leveraging strong working relationships with providers and community resources to support members and implement interventions, and by adopting value-based payment models to incentivize quality, integrated care, Health Choice has seen significant decreases in utilization and cost year-over-year as portrayed in ***Table 5.4***. These decreases in per member/per month percentages are attributed to the care coordination through our Transition of Care model, which utilizes an interdisciplinary team approach to facilitate discharge planning and transition to appropriate disease management programs and services. The Transition of Care model proactively monitors high risk populations through inpatient admissions, pharmacy utilization, prior authorization, emergency room utilization, and provider referrals on a daily basis. The team provides direct outreach to coordinate care and decrease utilization of medically unnecessary services while improving the overall health of our members.

Q6 The policy, clinical and fiscal imperatives for the integration of Medicaid/Medicare for dual eligibles are well understood. Full-benefit dual eligibles are the nation's most costly, medically complex, and physically and socially vulnerable population. Absent genuine integration of Medicaid/Medicare service delivery, comprehensive care coordination, operational integration and alignment of enrollment, dual eligibles – along with their care providers and families – face a daunting task navigating two complex programs. The result is poor outcomes for patients, high costs for taxpayers and frustration for every stakeholder. Fortunately, through effective use of managed care, AHCCCS and Health Choice have demonstrated the benefits – improved outcomes and lower costs – of care coordination for Arizona's frailest people. More than a third of Arizona's dual eligibles receive their Medicare and Medicaid services through their Medicaid health plan. As a long-standing partner, Health Choice Arizona shares AHCCCS's objectives for duals integration, member retention, maximizing care coordination and improving member outcomes and satisfaction.

Health Choice maintains a solid infrastructure and established provider partnerships. Our commitment to maximize care coordination and improve the member experience includes a single, dedicated Care Navigator assigned to each dual eligible member, to coordinate the entire scope of the member's needs. As a financial lever to maximize care coordination and drive cost-effective care, we have fully aligned value-based reimbursement models, such as our Medical Health Homes, across both Medicaid and Medicare services to improve care delivery, reduce waste and increase efficiency.

Below we describe our:

1) Extensive experience as a successful Medicare Advantage Special Needs Plan for dual eligibles (D-SNP) in Arizona.
2) Models, programs and processes for maximizing care coordination across the full spectrum of Medicaid/Medicare services, including "carve outs" for services for which we are not responsible as a plan.
3) Processes for ensuring a positive member experience to increase dual alignment and retention.
4) Value-based strategies to improve outcomes, increase integration and enhance dual alignment and retention.

1) Experience as Medicare Advantage Special Needs Plan

Health Choice Arizona has seven years experience operating a Medicare Advantage Special Needs Plan for dual eligibles (D-SNP), called Health Choice Generations HMO. Created in 2006 – the first year SNP plans were allowed in Medicare – our D-SNP is an Arizona-based plan covering the full range of Medicare Part A, Part B and Part D benefits, including supplemental benefits such as dental, hearing and vision services, to more than 4,000 of Arizona's most vulnerable citizens. We serve an additional ~9,000 full-benefit dual eligibles who receive Medicare services through CMS on a fee-for-service basis or through another Medicare Advantage plan.

Health Choice Generations HMO seamlessly integrates Medicaid and Medicare benefits, care delivery and plan operations in full alignment with AHCCCS and CMS policy objectives and requirements. We have successfully implemented enhancements to care delivery, quality improvement, reporting, beneficiary protections and other systems and processes to meet expanded CMS and AHCCCS requirements. We also successfully implemented two major contract expansions for CMS contract years 2010 and 2013 to achieve full geographic service area alignment with our AHCCCS plan.

Currently, Health Choice Generations HMO serves dual members in 10 counties: Apache, Coconino, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz and Yuma. To ensure access for dual eligibles statewide, we have expanded our full service Medicaid/Medicare network to include providers in all 15 counties in Arizona, as well as providers in border communities in Utah, Nevada and New Mexico. With fully integrated Medicaid and Medicare plan operations, we have submitted a Letter of Intent and will apply to CMS for a statewide service area for both D-SNP and the duals demonstration initiative in February 2013. This ensures we will meet the needs of AHCCCS and our dual eligibles no matter which alignment path is chosen by Arizona.

Figure 6.1 ***(as of January 2013)*** **Health Choice Generations HMO D-SNP Membership Demographics**

Total members	4, 112
Avg. age	60, 53% <65, 47% >65
% members continuously enrolled since 2006	24%
Avg. time on plan	44 months
% of members in rural areas	34%
Avg. # comorbidities	3
% with diabetes	32%

Compared to the average full-benefit dual eligible, our members have disproportionately high-needs, as highlighted in ***Figure 6.1***. Our experience is demonstrated by our performance in the following areas:

Member Satisfaction, Retention and Alignment

We are able to retain dual members and subsequently achieve alignment as shown in our consistently high retention rate (average length of enrollment is 44 months) and stable enrollment of more than 4,000 members through the following methods:

- Members are enrolled and "onboarded" timely with no interruptions in care, as demonstrated by our 5-Star rating for eligibility timeliness.

- Member expectations regarding health plan services are met and exceeded, as shown by our exceptionally low complaint rates for the past five years (2012 rate: 0.08 - a 5-Star rating).

CMS Compliance

- Health Choice has established a comprehensive compliance program, as demonstrated by our 5-Star compliance rating for the categories "Beneficiary Access and Performance Issues" and "Timely Decision on Appeals."

Care Coordination

- Health Choice received maximum scoring for its Model of Care for SNP Target Population or population stratification, organizational structure and roles for case management and care coordination teams, structure, development and deployment of Individualized Care Plans (ICP), and measurable goals to drive performance and outcomes.
- The Health Choice Medication Therapy Management (MTM) program has a 5-Star rating for high risk medications.

Reduced Costs

- Through Medicaid/Medicare alignment and our robust model of care and targeted care coordination, Health Choice has driven lower costs and improved outcomes for the members enrolled in its D-SNP. When comparing 2009 claims for Health Choice aligned duals against the Medicare duals FFS national average, Health Choice duals show higher performance over many key indicators. Health Choice duals: 1) Are admitted at a rate 18.4 per 1,000 less than the Medicare duals FFS national average; 2) Use the Emergency Room (ER) at 26.8 per 1,000 less that of the Medicare duals FFS national average; and 3) Are readmitted (within 30 days) 11% less than FFS Medicare duals national average (7.3% to 19%). These results clearly show that at Health Choice, our model of care and care coordination achieve improved health outcomes through dual SNP alignment, reducing costs for Federal and State taxpayers.

2) Processes Used to Maximize Care Coordination for Arizona Dual Eligibles

Care coordination is an essential component of integration. All of our care coordination processes are integrated across our members and products. We coordinate care for of all our Medicaid/Medicare members, even for Medicare services that are not our responsibility (e.g. un-aligned dual members). Through rich data sources – including inpatient, outpatient and ER notifications and secondary billing information – we coordinate care for unaligned FFS and Medicare Advantage dual members. As CMS claims and Part D data become available, we will incorporate these data sources as well. The table below shows how we use comprehensive processes to maximize appropriate, evidence-based care for all dual eligible members – regardless of whether or not they receive their Medicare benefits from Health Choice:

Care Coordination Process	Health Choice Arizona D-SNP (Health Choice Generations) Member	Another Medicare Advantage Plan Member	Medicare Fee-for-Service Participant
Integrated, Clinical Case Management: *Evidence-based, fully integrated operations across Medicaid and D-SNP services and populations, including a dedicated Clinical Case Manager assigned to each dual member for all chronic conditions*	✓	✓	✓
Analytics: *Leverage real-time clinical and encounter data along with claims data mining and decision support tools to identify and stratify those at highest risk for complications and exacerbations of their current or predicted chronic conditions*	✓	✓	✓
Member Profiles: *Member Profiles established for providers to drive advanced care planning, care coordination and individual-level care support*	✓	✓	✓
Comprehensive ICPs: *Leverage rich sources of data and evidence-based decision-support tools to engage members and providers in the care planning process and assess member support system*	✓	✓	✓
Discharge Planning, Post-discharge, Transition of Care: *Patient-Centered Transitions program and reassessment of patient needs at discharge and post-discharge from acute and subacute facilities*	✓	✓	✓
Behavioral Health Coordination: *Behavioral health / physical health alignment and integration of data for efficient handoffs and ongoing*	✓	✓	✓

coordination between Medicaid/RBHA benefits, Medicare Part D medication therapy and Medicare Part B physician care			
Chronic Care Improvement Plan: *For members with two or more chronic conditions, this program plays an important role in our model for cost savings*	✓	✓	✓
Long-Term Care Coordination: *For members transitioning to Arizona Long Term Care Services (ALTCS), extensive individualized coordination with ALTCS plans to help ensure continuity of care, reduce need for institutional care and maximize appropriate use of home and community-based services*	✓	✓	✓
Medication Therapy Management: *Facilitates patient education, medication reconciliation, nurse monitoring of medication adherence, Medi-sets and provider intervention for possible acute adverse interactions and contra-indications*	✓	✓	✓
Home-based Primary Care Program: *Leverage community primary care providers to render services to frail, elderly and disabled members in their home to ease their access to care*	✓	✓	✓
Inpatient, Outpatient and ER Notifications: *Real-time daily notification to PCPs of inpatient and outpatient admissions and hospital ER visits to prompt outreach for follow-up care*	✓	✓	✓
Non-Emergency Medical Transportation: *Coordinate, schedule and provide transportation to appointments, regardless of primary payer or Medicaid benefit coverage for that service*	✓	✓	✓
Care Navigators: *Health Choice Care Navigators are assigned to individual Medical Health Homes to work collaboratively with physicians and duals. Each member is assigned a dedicated Care Navigator to engage the member and their existing support system, identify and connect member with additional support services, coordinate care for the member and navigate the delivery system.*	✓	✓	✓

3) Processes for Ensuring a Positive Member Experience to Increase Dual Alignment and Retention

To maximize alignment of Medicaid/Medicare enrollment, continuously improve member satisfaction and improve our overall Star rating for "Member Experience with Health Plan," Health Choice uses an array of programs and processes, each applied to all of our dual eligible members, regardless of enrollment type. Operationally, Medicaid and Medicare services are integrated to provide new and current members with a seamless, supportive experience, built on trust and integrity. Operational structures and processes to improve the member experience and maintain alignment, include:

- ***Community and Dual Member Outreach:*** We regularly reach out to Health Choice Arizona members through letters and phone calls to engage them in Medicaid/Medicare benefit alignment. Additionally, outreach teams act as "Promotoras" in the community to educate unaligned duals on the benefits of alignment.
- ***New Member Onboarding Process:*** Interested members are assigned to an Enrollment Representative (broker) for further explanation and enrollment. All brokers representing Health Choice Generations HMO are employees of Health Choice. This enables us to ensure brokers are well-versed in health plan operations, benefit structure, the provider network and policies for both Medicare and AHCCCS. As part of the enrollment process, each broker partners directly with a Retention Specialist to jointly "onboard" the member. The Retention Specialist develops an individualized transition plan to ensure all care is coordinated and there are no gaps or barriers to care during the first 90 days of enrollment. The Retention Specialist place a key role in **connecting with the member** and reaches out often including after the first provider visit claim is received, prescription is filled or any other service is accessed to ensure a positive experience and troubleshoot any issues that arise.
- ***Member Services:*** We provide a single point of contact for each dual eligible member who provides ongoing support services. Support begins with our ***local, Arizona-based*** call center, assisting members with benefit and delivery system education, appointment scheduling and arrangement for non-emergency transportation. A dedicated, single point of contact, called the Duals Member Healthcare Advocate, is assigned to each dual member after their 90-day on-boarding process is complete to ensure a relationship is forged at the individual level and to educate each member on how to access the health plan and benefit structure to optimize member engagement.
- ***Member Education & Engagement****:* Our outreach team brings member welcome events, support groups and health education events directly to dual eligible members in the senior homes where they live throughout Arizona. In

addition, disease-specific health education events, specific to prevalent chronic conditions such as diabetes and COPD, as well as "Medicare 101" classes, will be launched in Q2 2013 to further enhance member engagement.

- ***Delivery System:*** We have established a fully-aligned provider network statewide – across all 15 Arizona counties – for all of our Medicaid and Medicare members. Delivery System Management Teams positioned throughout Arizona onboard and educate participating providers through frequent face-to-face site visits and regularly scheduled Joint Operating Committee (JOC) meetings.
- ***Integrated Benefit Design, Medical Management, and Utilization Management:*** Health Choice has an integrated, individualized clinical program approach focusing on the development of a support system to better serve the complex medical and socio-economic needs of all of our dual eligible members, with particular attention to ensure any existing support system is not supplanted. This approach provides dual members with **one ICP, dedicated Clinical Case Manager and Care Navigator** based on their risk assessment to effectively manage care under both Medicare and Medicaid benefits. Medicaid and Medicare data is fully integrated across our claims, call center and care coordination platforms to ensure smooth processes and a positive member experience. Health Choice will create a single member ID card with a single Member ID number in compliance with CMS and AHCCCS requirements.
- ***Grievances and Appeals:*** Health Choice integrates management of all Medicaid and Medicare grievances and appeals to obtain timely and appropriate resolution of any dual member's dissatisfaction or concerns regarding access to care, coverage determination, plan benefit design, or any other expression of dissatisfaction with the health plan or delivery system. These in turn drive remediation efforts to continuously improve the member experience.
- ***Medical Health Home:*** Our Medical Health Home program provides members with a more integrated care experience, intensive patient education and referral support at both the plan and provider level. The Health Choice Medical Health Home model was developed in collaboration with AHCCCS and is based on the national model for the "Patient-Centered Medical Health Home." For dual eligible members with chronic conditions, we have created and will continue to expand upon condition specific Medical Health Homes, such as diabetes, COPD and asthma. To support each Medical Health Home, we provide data and tools, such as reports reflecting rates in HEDIS quality metric achievement, utilization and health care cost trends. Individual Member Profiles report patient-specific gaps in care, diagnoses, medication history and utilization history to providers. Each Medical Health Home is assigned a dedicated Care Navigator to provide face-to-face, personalized assistance and coordination of care for our members. For certain high-risk members, such as disabled dual eligibles, we give providers the opportunity to use Remote Monitoring technology to better monitor urgent symptoms and treatment progress of these patients. To date, we have established four Medical Health Homes with practice partners, including FQHCs, extending to 19 sites in three GSAs, encompassing special programs focused on complex disease management.
- ***Brand Coordination:*** Our name, branding and member communications is coordinated to minimize confusion among members, to aid retention and enrollment alignment, and show that we are a single, Arizona-based organization accountable to the member across all products.

- ***Supplemental Benefits:*** We provide Health Choice Generations HMO members with critically needed supplemental benefits to improve their overall health and wellness. Specifically, we provide members with comprehensive dental, hearing and vision coverage. This enables members to receive needed care, such as glasses and hearing aids, not available through the standard Medicare or Medicaid benefit packages. By enabling vision correction or the ability to hear, these supplemental benefits improve overall quality of life and subsequently health outcomes for our members.

4) Value-based Strategies to Improve Outcomes, Increase Integration and Enhance Dual Alignment and Retention

Our value-based alignment strategies will increase integration of Medicaid/Medicare in our network and our operations. These models will improve dual eligible member outcomes and increase physician engagement, further enhancing member alignment within existing and planned payment reform programs. ***Table 6.3*** provides the specific implementation schedule for the each of the alignment and payment reform programs we describe below:

- ***Medical Health Home Expansion:*** We are strategically expanding our current Medical Health Home program to reach all of our dual eligible membership. Ideally, we would like to work with providers to enroll 100% of our dual eligible members in a Medical Health Home Program. Unfortunately, factors such as lack of stable living conditions may make this impractical for some members. However, we have developed the capacity to serve a significant number of our dual eligible members in a Medical Health Home, and conduct outreach and program collaboration to homeless shelters to reach as many additional members as possible. Further, we are expanding our Medical Health Home program to serve at least 20% of our unaligned dual eligible population.
- ***Duals Partnership for Quality Care Program:*** This physician-driven, pay-for-quality program is adapted for our dual eligible members and structured to reward evidence-based, patient-centered care. We will expand the program to

include all primary care physicians serving our dual eligible members. Current incentives are tied to:

- Annual comprehensive health and functional assessments and supporting chart documentation – a critical component to anticipate these fragile members changing needs in care.
- HEDIS/Quality measures based on 14 important Star measures. Thresholds based on the Star scale to measure the physician with per member/per month quality bonus based on rating.

- ***Integrated Networks / Physician Pods:*** Hospitals continue to drive the highest costs, however, hospitals have not traditionally been integrated with physician networks to increase efficiency. In 2012, Health Choice developed and piloted an integrated network called Health Choice Preferred, a physician-led organization comprised of more than 330 physicians and three hospitals in GSA12. The network is further broken down into "pods" – physician alignment around an acute care hospital to facilitate specialty and ancillary referral patterns. By aligning dual members' care under both Medicare and AHCCCS benefits with this clinically and financially integrated network, and deploying value-based payment models for meeting quality and outcome targets, hospitals and physicians are fully engaged in improving outcomes and curbing costs. Current program value-based incentives are tied to:
  - Annual comprehensive clinical and functional assessments – a critical component to anticipate these fragile members changing needs in care.
  - HEDIS/Quality measures based on 14 important Star measures. Thresholds like the Star scale to rate each pod, with a per member/per month quality bonus based on performance.
  - Member satisfaction /CAHPS
  - Reduction in overall costs driven by the reduction of unnecessary utilization

  Health Choice will replicate this model throughout Arizona, integrating community physicians and hospitals in geographically appropriate pods where financial incentives are aligned to quality and outcomes measures.

- ***Payment Reform for Preventable Events and Hospital Readmissions:*** In concert with AHCCCS, Health Choice will launch its Payment Reform for Preventable Events and Hospital Readmissions Program. This program will hold hospitals accountable for preventing certain readmissions. Depending on final AHCCCS policy, we will implement this program through reimbursement penalties and/or bonuses. Bonuses would be funded from the 1% shared savings withhold. This program help reduce costs and improve outcomes for all members, including dual eligibles.
- ***Bundled Payment:*** Our current inpatient bundled payment program, which consolidates Medicare and AHCCCS reimbursement for cardiac and orthopaedic episodes, will be expanded to include additional episodes of care common for dual eligibles. Additionally, Health Choice/IASIS was named as a participant in the first phase of the CMMI Bundled Payments for Care Improvement initiative beginning on Jan. 1, 2013.
- ***Statewide Expansion of D-SNP:*** Health Choice has applied for the statewide expansion our D-SNP health plan. In preparation, we have already expanded our provider network to all 15 counties in Arizona, aligned our network to serve both dual eligible and Medicaid-only members, and expanded our care coordination and quality improvement capabilities to ensure readiness.

Table 6.3: Implementation of Value-based Strategies

Strategy	Commitment	Implementation By
Medical Health Home Expansion	Capacity to serve all dual eligible members in Medical Health Home.	50% by December 2013 * 75% by December 2014 100% by December 2015
Duals Partnership for Quality Care Program Expansion	Expand to include all PCPs serving dual eligibles	75% by July 2013 * 100% by April 2014
Integrated Networks / Physician Pods	Replicate model throughout Arizona	Five integrated network / physician pods by January 2015
Payment Reform for Preventable Events and Hospital Readmissions	In concert with AHCCCS, implement payment reform for preventable events and hospital readmissions through reimbursement penalties and/or bonuses.	In concert with AHCCCS, January 2014
Bundled Payment	Expand Bundled Payment to additional episode types common for dual eligibles.	Identify and analyze new episode types by October 2013. Add two or more dual eligible-centric conditions by January 2014.
Statewide Special Needs Plan for Dual Eligibles	Expand D-SNP to all remaining Arizona counties.	January 2014

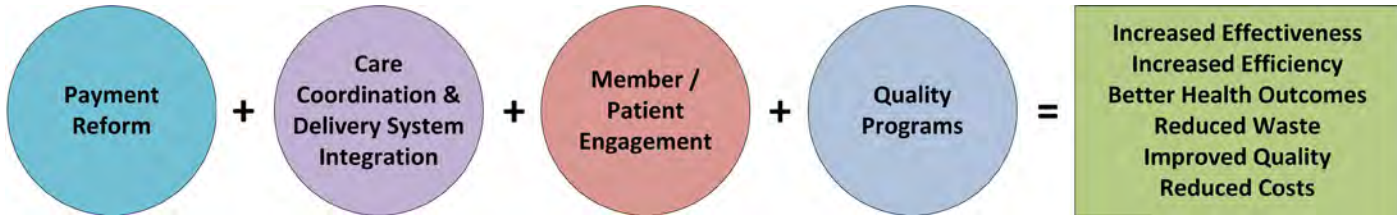
** Capacity based on % of all Health Choice dual eligible members.*

Organization

Q7 Health Choice Arizona agrees with the assessment of the Institute of Medicine and AHCCCS that the health care system in the United States is on an unsustainable path. We recognize the enormous health care expenditures that are wasted as a result of unnecessary services, inefficient care, excess administration, inflated pricing, prevention failures and fraud. Since 1990, Health Choice has operated an AHCCCS managed care organization committed to the delivery and coordination of effective, efficient health care. Based on the audited financial statements for 2011, Health Choice had the lowest administrative cost and the second lowest medical loss ratio of all AHCCCS plans. These results demonstrate our exceptional historical performance, effective programs and operations to continuously reduce waste, increasing the efficiency and effectiveness of care delivery throughout the system. Our success is due to our rigorous strategic planning process, resulting in iterative tactical plans to improve operations and quality of care through more efficient and effective clinical programs, delivery systems, provider reimbursement models, member engagement programs, and analytics and decision support tools for members and providers.

Health Choice Arizona recognizes that physician alignment and partnerships are key elements to carrying out our mission to provide quality, value-driven health care for the underserved. Our primary strategic goal is to continuously improve the effectiveness and efficiency through which care is delivered. ***Figure 7.1*** depicts our strategies to achieve this goal.

Figure 7.1 Core Strategies to Drive Program Efficiency and Improve Outcomes



Below, we describe: 1) Current investments to enhance infrastructure; and 2) Current and future initiatives to increase quality, improve outcomes, reduce waste and lower costs. We identify the stakeholders involved, the timelines for implementation and the expected outcomes.

1) Current Investments to Enhance Infrastructure.

Our approach to preparing for potential membership increases centers on aligning our programmatic and administrative efforts to assist providers in providing the right care, at the right time and in the right setting. Beginning in January 2011, Health Choice implemented the following initiatives to improve our core systems:

Initiative	Description	Stakeholders	Timelines	Outcomes			
				Better health	Reduce waste	Improve quality	Lower costs
Robust, intuitive Care Management Platform	Implemented enterprise Care Radius™ Care Management Platform - to improve care coordination and administrative efficiency	• Members • Providers • Facilities • AHCCCS • CMS	Implemented: 1/11/2012	✓	✓	✓	✓
Scalable communications	Installed new Avaya Phone System to support expanded member and provider communications and reporting capabilities	• Members • Providers • Facilities • AHCCCS • CMS	Implemented: 1/6/2012	✓		✓	
Comprehensive Data Analytics Platform	Develop and implement data warehouse and analytics solutions to integrate robust data sources to risk stratify members to improve care planning efficiencies	• Members • Providers • Facilities • AHCCCS • CMS	Implementation: 7/1/2012 – 10/1/2013	✓	✓	✓	✓

2) Current and Future Initiatives to Increase Quality, Improve Outcomes, Reduce Waste and Lower Costs

Health Choice identified four key strategies, which leverage the functionality enabled by these "best in class" systems, to improve quality, enhance outcomes, reduce waste and contain costs. Each strategy is evidence-based, drawing from recent research that identifies best practices to reduce the human and financial cost of overuse, misuse and underuse of care. Addressing these issues requires a multi-faceted approach: all solutions are necessary, none of them by themselves is sufficient. As identified in Figure 4.1, Health Choice's core strategies focus on:

- **Payment Reform Platform –** Health Choice Arizona will continue to align reimbursement with the clinical performance (quality of care, patient safety, and patient outcomes) and efficiency (cost and operational) of providers.
- **Care Coordination and Delivery System Integration –** Health Choice Arizona has implemented initiatives – and will continue to enhance existing platforms and launch new initiatives – to improve clinical outcomes, increase quality and safety, reduce waste and increase efficiency, and invest in Arizona's care delivery infrastructure.
- **Member / Patient Engagement** – Health Choice Arizona will continue to implement new programs and tools to inform, educate and engage members to participate actively in their health care by encouraging the use of preventive services, participation in care planning, adoption of healthy lifestyle behaviors and self-care management.
- **Quality Programs –** Health Choice Arizona will continue to implement and enhance programs to improve each of our plan's performance measures and quality of care focusing on quality triggers that drive better health outcomes and lower costs

Below, we describe specific future initiatives to increase quality, improve outcomes, reduce waste, and enhance cost containment. We identify the stakeholders involved, the timelines for implementation and the expected outcomes.

- ***Payment Reform Platform:*** The following table describes our efforts to implement value-based payment models beginning with the success of our current Medical Health Home pilot, and scaling and adding additional models to align provider reimbursement with evidence-based measures of quality of care, patient outcomes, patient safety and cost efficiency of care delivery. In addition to these initiatives, if AHCCCS policy results in an "earn back" opportunity based on quality and performance, Health Choice will leverage the 1% shared savings withhold to fund bonus pools to reward effective, efficient providers.

Initiative	Description	Stakeholders	Timelines	Outcomes			
				Better health	Reduce waste	Improve quality	Lower costs
Medical Health Home Program	In partnership with AHCCCS, leverage Medical Health Homes in the delivery system to pilot value-based reimbursement including "access to care" capitation and quality and performance measure gating / requirements for shared savings	• Members • Providers • Provider associations • AHCCCS	Implemented: May 2012 Current, engaged Members: 5,500, 19 Clinics across 3 GSAs	✓	✓	✓	✓
Banner Rapid Clinic, Emergency Room (ER) Triage Program	Leverage the Banner Estrella Rapid Clinic to treat conditions not appropriate for the ER. Shared savings between ER visit and provider clinic visits	• Members • Providers • Facilities • AHCCCS	Implemented May 2012; Looking to expand with Banner, Q2 2013	✓	✓	✓	✓
Payment Reform for Preventable Events (PPE) and Hospital Readmissions	In concert with AHCCCS, implement payment reform for preventable events and hospital readmissions through reimbursement penalties and/or bonuses. Bonuses would be funded from 1% shared savings withhold.	• Members • Providers • Facilities • AHCCCS	January 2014, in concert with AHCCCS add new PPEs as evidence base supports	✓	✓	✓	✓
Bundled Payment	Scale current program (cardiac and orthopaedic) to	• Members	Identify and analyze new	✓	✓	✓	✓

Programs	add additional episode types	• Providers • Facilities	episode types by October 2013. Add two or more dual eligible-centric conditions by January 2014.				
AHCCCS & Duals Partnership for Quality Care Programs	Incentivize providers through bonus payments for comprehensive clinical evaluations, and for achieving performance measures	• Members • Providers	Implemented January 2013, ongoing expansion	✓	✓	✓	✓

- ***Care Coordination and Delivery System Integration:*** Health Choice Arizona has implemented and will launch the following initiatives to improve clinical outcomes, increase quality and safety, reduce waste and inefficiency, and invest in Arizona's care delivery infrastructure.

Initiative	Description	Stakeholders	Timelines	Outcomes			
				Better health	Reduce waste	Improve quality	Lower costs
Management of Pharmacy Benefit Manager (PBM)	Changed PBM to obtain robust analytics and improved drug therapy clinical guidelines, and improve care coordination and clinical case management for members on specialty medication	• Members • Providers • AHCCCS	Implementation: 1/1/2012	✓	✓	✓	✓
Medication Therapy Management (MTM) Program	Engaged PharmMD to operate MTM to better identify and manage members with drug therapy issues	• Members • Providers • AHCCCS	Implementation: 6/1/2011	✓	✓	✓	✓
Management of radiology benefit	Implement MedSolution's hi-tech, cardiac and OB/ultrasound clinical and decision support programs to reduce waste and abuse of these services	• Members • Providers • AHCCCS	Implementation: 6/1/2010	✓	✓	✓	✓
Improve Care Management Programs	Continuously improve complex disease management and care coordination programs to enhance member engagement and improve outcomes.	• Members • Providers • AHCCCS	Transition of Care and Home-based PCP Programs for duals, 1/1/2011; New programs as identified	✓	✓	✓	✓
Medical Health Home Capacity	Expand Medical Health Home capacity. Directly participate in innovative programs to promote new primary care facilities in underserved areas	• Members • Providers • Clinics • Tribal Communities	January 2013 through December 2015	✓	✓	✓	✓
Graduate Medical Education Program Expansion	Utilizing IASIS residency programs, expand PCP and Medical Health Home capacity to improve access to care in underserved areas	• Members • Providers • Facilities • Community Clinics	Implementation July 2013	✓	✓	✓	✓

Medical Health Home Enrollment by Dual Eligibles	Maximize percentage of dual eligible members served by Medical Health Home.	• Members • Providers • Clinics • Tribes • Community organizations	50% by Q4 2013 75% by Q4 2014 100% by Q4 2015	✓	✓	✓	✓
Medical Health Home Enrollment by High-Risk Non-Dual Eligibles	Serve 20% of all non-dual eligibles, based on high-risk characteristics by Medical Health Homes.	• Members • Providers • Tribal communities • Community organizations	50% by July 2013 100% by December 2013	✓	✓	✓	✓
Expanded Medical Health Home Capabilities	Offer payment incentives and technical assistance for Medical Health Homes to expand capabilities (e.g., EHRs, eRX, eLab, care management, referral management).	• Medical Health Homes • Providers • Clinics • Tribal communities	New payment incentives by March 2013 Technical assist program by April 2013	✓	✓	✓	✓
Integrated Networks / Physician Pods Model	Physician alignment around an acute care hospital to facilitate integrated care	• Members • Providers • Hospitals • AHCCCS	Implemented: 1/1/2013. Expand statewide by January 2015	✓	✓	✓	✓
Qualified Health Plan in Health Insurance Exchange (HIX)	To better coordinate benefits for churning members, participate as a Qualified Health Plan in HIX.	• Members • Future HIX Members • Providers	Operate as QHP for CY 2014 and thereafter	✓	✓	✓	✓
Statewide Dual Special Needs Plan Or Dual Demonstration Plan	Expand current D-SNP statewide or participate in Duals Demonstration with AHCCCS.	• AHCCCS • CMS • Dual eligible members in expansion counties	State Wide Duals Network: January 2013 Aligned Duals: January 2014	✓	✓	✓	✓

- ***Member / Patient Engagement:*** Health Choice will implement the following initiatives to advance member/patient engagement and participation in their care – an essential ingredient to improving outcomes, reducing waste and preventing unnecessary care.

Initiative	Description	Stakeholders	Timelines	Outcomes			
				Better health	Reduce waste	Improve quality	Lowers costs
24-hour Nurse Advice Line	Implement 24-hour nurse line to provide members immediate assistance for health concerns and reduce unnecessary ER utilization	• Members • Providers • Hospitals • AHCCCS	Q4 2013	✓	✓	✓	✓
Health & Wellness Program Expansion	Implement expanded wellness programs, including: member incentives for healthy behaviors; health, safety and condition-specific classes; and support groups	• Members • Medical Health Homes • Providers	July 2013	✓	✓	✓	✓

Pain Management Clinic	Implement integrated pain management clinic with IASIS.	• Members • Providers • RHBAs • Pharmacies • Hospitals	January 2014	✓	✓	✓	✓
Member Onboarding	Assign additional retention specialists and establish new member education classes to educate members on access to care.	• Members • Providers • Family • Caregivers	Begin classes June 2013 Expand retention specialists by January 2014	✓	✓	✓	✓
Online and mobile/tablet tools and education resources	Implement social media, leveraging opt-in text messaging and smartphone/tablet apps to improve member communication and education	• Members • Family • Caregivers	Implement portal and social media Q1 2013 Implement mobile and tablet Q4 2014	✓	✓	✓	✓
Enhance Website with Patient Education and Member Portal	Develop member self-education and self-service tools to enable members to actively engage in their own health care.	• Members • Family • Caregivers • Providers	October 2013	✓	✓	✓	✓

- ***Quality Programs:*** Although all of our strategic initiatives drive improvements in quality of care, the following are specific initiatives to hardwire policies and processes to ensure continued quality improvement:

Initiative	Description	Stakeholders	Timelines	Outcomes			
				Better health	Reduce waste	Improve quality	Lowers costs
Quality Accreditation	Secure URAC accreditation for Health Choice Arizona, Health Choice Generations (Duals) and Health Choice Insurance Co. (HIX).	• Members • Providers • AHCCCS • CMS	March 2012: 'In Process' status January 2013: Submitted Application Spring 2013: Onsite Review Summer 2013: Achieve Accreditation	✓	✓	✓	✓
Measure Quality Outcomes of Skilled Nursing Facilities (SNF)	Track and trend acute readmissions from SNFs to hospitals to continually improve the quality of care and outcomes	• Members • Providers • AHCCCS • CMS	March 2013	✓	✓	✓	✓
Improve Performance, HEDIS and Star measures for both Health Choice Arizona and Health Choice Generations	Coordination and collaboration between internal operations, members and providers to leverage internal and external resources to continually improve performance, HEDIS and Stars measures.	• Members • Providers • AHCCCS • CMS	July 2012 – Ongoing	✓	✓	✓	✓

Q8 In today's challenging fiscal environment, it is more important than ever that state and federal taxpayer funds are used for their intended purpose. Addressing fraud and abuse is a key priority nationally, and in Arizona, as the federal government continues to devote additional resources to improve program safeguards and the state legislature advocates for program improvements and novel approaches to address this issue.

Fig. 8.1: Seven Components of the Health Choice Compliance Program:

1. Compliance Officer and Compliance Committee
2. Written Policies and Procedures
3. Effective Training and Education
4. Effective Lines of Communication
5. Internal Auditing and Monitoring
6. Enforcement of Disciplinary Actions
7. Quick Response to Identified Issues

At Health Choice Arizona, our approach to fraud, waste and abuse is constructed around the seven components of an effective compliance program (see ***Figure 8.1***). Our compliance program is the foundation of our pledge to the contract requirements. We also have an experienced team of leaders who ensure the elevation of compliance within the organization.

Our team begins with our Compliance Department consisting of the Medicaid Compliance Officer, Medicare Compliance Officer and Compliance Analysts. The Compliance Officer reports directly to the Health Choice Chief Executive Officer, and chairs the Health Choice Compliance Committee. The Compliance Committee, consisting of both Compliance Officers, the HIPAA Compliance Officer, Chief Executive Officer, Chief Financial Officer, Chief Operating Officer and Chief Medical Officer, reports directly to the Chief Executive Officer of our parent company, IASIS. This structure ensures prompt and thorough responses to potential fraud, waste and abuse and an environment of compliance throughout the organization.

Below, we will describe activities that Health Choice will take to limit, identify, and address fraud and abuse, through: 1) Core program safeguards already in place; 2) Enhancements to strengthen our program; 3) Our efforts to ensure prompt and thorough response to fraud, waste and abuse concerns; and 4) Additional program and process improvements we will implement in the coming year.

1) Core Program Safeguards

It is important to recognize the safeguards already in place because of the maturity of Arizona's Medicaid managed care program. In ***Table 8.2*** below, we describe those core safeguards that we are already performing. This is the springboard from which we have built our Compliance Program.

Table 8.2: Health Choice Core Compliance Safeguards

Provider Focused	Member Focused	Claims Focused	Health Plan Focused
• Require use of contracted network providers. • Require prior authorization for non-contracted provider claims to be paid. • Require providers to be registered with AHCCCS before any payment can be issued. • Process provider discipline and compliance notices from AHCCCS. • Require credentialing and re-credentialing in accordance with State and national standards. • Perform monthly Exclusion verifications. • Verify paid claims. • Fraud, waste and abuse education for providers. Require providers to perform fraud, waste and abuse staff training. • Require providers to perform staff exclusions verifications. • Monthly review of provider billing profiles (including E&M code Stratification)	• Request picture ID to compare against picture on AHCCCS Eligibility site. • Provide education to members. • Publicize and encourage use of fraud, waste and abuse hotline.	• Correct Coding Initiative Edits in claims system. • Integrate claims edits into adjudication system from AHCCCS Encounters and Reference tables. • Medical review before claims are paid for commonly abused services. • Recovery efforts, including recoupments for incorrect payments. • Education of plan and provider billing staff.	• Appointed Compliance Officer, established Compliance Department and Compliance Committee. • Staff education for how to make a referral to the Compliance Officer. • Immediate referral to AHCCCS OIG. • Participating in AHCCCS CONG meetings. • Providing fraud, waste and abuse education to all health plan staff.

Finding new and inventive ways to limit, identify and address fraud and abuse. Despite the rigorous use of our core safeguards, we recognize that more can be done. Health Choice Arizona is committed to working with AHCCCS to aggressively combat and eliminate fraud, waste and abuse within our state's program. Our commitment is evidenced in:

- Active participation with the Arizona Associations of Health Plans' credentialing alliance, which streamlines the credentialing and re-credentialing process for providers. As a result of this initiative, we are able to combine efforts and ensure that no inappropriate providers slip through the cracks due to multiple credentialing processes.
- Engagement with the AHCCCS Compliance Officer Network Group (CONG), where we took a lead role in establishing a network of health plans interested in improving cooperation between the AHCCCS Office of Inspector General (OIG) and the plans relating to fraud and abuse referrals and reporting.
- Participation with AHCCCS in its audit with CMS in 2009 and 2012, where we shared our health plan's best practices with CMS.
- Collaborating with the AHCCCS OIG's Inspector General to educate our staff and raise awareness of fraud, waste and abuse issues.
- Meeting with the OIG on a number of important cases, resulting in process improvements and new policies.
- Our identification of a specific area of care that presented a significant fraud risk to the program. As a result, the OIG has placed new focus on this area and has had success in addressing the issues.
- Financial investment to be a member of the Health Care Compliance Association (HCCA) and to have staff regularly attend several national conferences throughout the year to stay up-to-date with national trends and initiatives.

2) Enhancements to Strengthen Program

While our core safeguards and program design features consistently demonstrate effectiveness, we have enhanced several of the required activities, and added several non-required functions to combat fraud, waste and abuse within our program.

Exclusion verifications: In accordance with Federal Law, we contract with the Wolters Kluwer Sanction Screening Services program, which checks the Office of Inspector General List of Excluded Individuals and Entities (LEIE), the General Services Administration System for Awards Management (SAMS), and other databases to ensure no provider or employee are on these lists. On average, we screen approximately 10,000 unique providers and 2,300 entities per month. In addition to this standard verification, we also:

- Check the databases of any state that has set up its own exclusion list, such as the one Arizona is establishing.
- Check any non-contracted provider who we have in our system as a result of having a claim submitted.
- Check the company for which the providers work.
- Verify a new provider before loading a new non-contracted provider into our system.

Pharmacy verifications: Through our Pharmacy Benefits Manager (PBM), we require that all pharmacies have the ability to do point of sale verification checks. For example, if a prescription was written by a provider who is excluded from federal programs (as verified by the LEIE or SAMS databases), an alert will be generated by the PBM and won't allow the pharmacy to fill the prescription.

Use of notices from AHCCCS: We promptly act on all notices from AHCCCS regarding provider discipline, exclusions and restrictions. Once AHCCCS electronically notifies the health plans of this activity, we employ an established process in which these notices are immediately disseminated to key management for action. Both our Network Operations and Quality Management/Credentialing directors review each notice and evaluate which action needs to be taken by the health plan. Action may include restrictions in our claims processing or prior authorization system, referral to the Quality Management Committee, termination of contract and/or inactivation of the provider file in our system. In 2012, we took action on over 35 notices.

Claims data-mining reports: In addition to a strong upfront claims edit and audit process, our Medical Economics Department has developed a series of standardized claims data reports that are reviewed monthly and evaluated to identify areas of program vulnerability. A full-time analyst focuses on fraud and abuse monitoring, auditing and education, reviews claims data reports, and performs the necessary research and analysis to determine appropriate action. The reports were informed by national trends and common program vulnerabilities, and provide us with the ability to identify patterns, anomalies and outliers for further investigation and review. These reports include, but are not limited to:

- Evaluation and Management Code (E&M) bell curve for PCPs to watch for higher than normal billing of the more complex codes.
- Near duplicate claims to look for different providers billing for the same service.

As a result of our Evaluation & Management (E&M) Code bell curve reports, we identified six unique cases that required provider education on proper coding. In turn, we believe we will save the system approximately $100,000 a year in these cases alone.

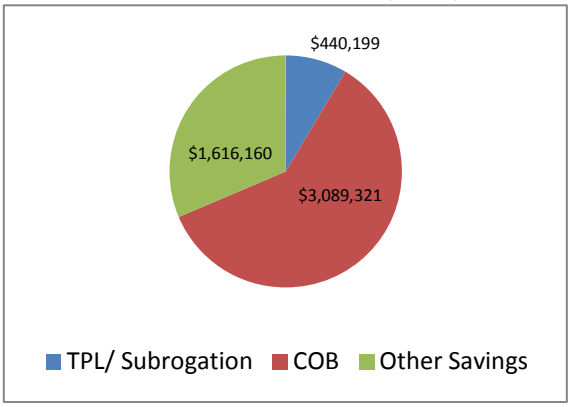
- Multiple E&M on same day to ensure that a provider was not paid for two similar services on the same day.
- New patient E&M code to ensure that new member codes are not being billed more than once every 3 years.
- High number of visits by one PCP in one day to reduce the likelihood that a doctor is not billing for other providers or is actually providing the services billed.

These analyses are shared with the Compliance Committee, and key department leaders, such as the Network, Claims, Medical, and Finance management staff during the monthly Provider Relations Improvement Committee (PRIComm) meetings. This information is leveraged to identify potential program vulnerabilities that could be addressed through program changes. In the first review of these reports we identified claims being billed under the wrong provider and mid-levels being billed under a physician's name and identification number.

Provider Profile Reports: Our comprehensive provider profile compares a single provider's utilization against those of their peers in the same specialty and in the same geographical area. This enables the Compliance team to easily detect over- and under-utilization. For example, we recently identified a provider who was billing only one type of service, such as all high-level E&M codes. Additionally, these profiles stratify not only our members by their complex conditions, but also our providers by their patient mix, billing behavior patterns and panel size. This stratification reporting enables us to prioritize and quickly identify education areas, and fraud or abuse concerns. The Compliance Department analysis of these reports has led to significant program integrity enhancements.

Third-Party Liability and Coordination of Benefits (COB): Our Recoveries Department operates a comprehensive program to avoid other unnecessary and improper expenditures. This program includes third-party liability (e.g. identifying another payer such as auto insurance) and COB (e.g. primary insurance other than Medicaid) efforts. This combined effort saves an average **$3 million** in unnecessary or improper expenditures each quarter. In 2011, we contracted with HMS who is able to recover Medicaid overpayments from the primary insurance carriers that were not previously identified by the member. In the first four months of this contract, we recovered more than **$1,000,000** in overpayments.

Table 8.3: Savings from Third-Party Liability and Coordination of Benefits (COB) Efforts



Claims Edits and Audits of Services: We have integrated several edits for claims into our adjudication system including, but not limited to:

- AHCCCS encounter claims edits and reference tables.
- National Correct Coding Initiatives (NCCI) and surgical bundling.
- Eligibility edits, copayments and benefit limitations, such as physical therapy.
- Provider category of service restrictions.
- Code to place of service validation.
- Authorization requirements including flags for unmatched services to the original request.
- Age and gender restrictions for diagnosis and procedures.
- Triggers for high dollar claims, by report codes, high risk services, and outliers that need medical review.
- Coordination of Benefits (COB).

Our dedicated Claims Audit Department conducts prepayment audit of all claims payments over $2,500, as well as other claims audits such as electronically adjudicated claims, claims processor performance and accuracy to claims rules. The Audit Department also reviews provider fee schedules and other provider demographics before they are loaded into our provider and payment systems. The Audit Department, as well as the Claims Department and Encounter Unit, reports any findings of improperly paid claims to the Recoveries Department for recovery of incorrectly paid claims. This process has identified claims vulnerabilities such as providers consistently billing with non-specific codes (such as those ending in -99) when a more specific code is available, providers coding incorrectly in order to avoid a denial, and unbundling of codes.

*In 2009, Health Choice implemented National Correct Coding Initiatives (NCCI) edits resulting in **$2.5 million** in savings per year.*

We also have a process to verify that a member received the service for which Health Choice Arizona has paid a claim for.

Encounter responses and reconciliations: Another layer of audit is the AHCCCS Encounter process and the AHCCCS Data Validation process. Our Encounters Unit has a success rate of over 95% for the submission of clean claims to AHCCCS, indicating that we are able to prevent improperly coded claims from being paid and passed through to AHCCCS. Annually, AHCCCS performs a Data Validation audit on these encounters. In the most recent audit, for Contract Year 2010, AHCCCS had no significant findings for Health Choice and no sanctions were assessed.

3) Ensuring Prompt and Thorough Response

In addition to the core safeguards we use to prevent, avoid and identify fraud, waste and abuse, we have a program in place to promptly and thoroughly respond. Because fraud, waste and abuse can appear in many different forms, we employ a variety of methods for reviewing and responding, including:

- Training on fraud, waste and abuse for every new employee to be commpleted in the first 30 days of hire, as well as an annual training for all Health Choice staff.
- Focused training on fraud, waste and abuse for specific departments.
- Ensuring that provider network staff is trained to listen for issues of fraud, waste and abuse and report the issues to the Compliance Officer, and also how to train and support the provider offices in their program for fraud, waste and abuse.
- Training for Member Services staff to identify issues of fraud, waste and abuse with members and report the issues to the Compliance Officer, as well as to educate members on how to avoid fraud, waste and abuse.

OIG referrals: Our Compliance staff receives all referrals from health plan staff, members, providers, subcontractors, agencies or the general public. All referrals are immediately logged and reviewed, and then categorized by allegation type and handled accordingly. Issues that cause a loss to the system and require further investigation are immediately referred to the AHCCCS OIG. Health Choice averages about 50 OIG referrals per year.

Prompt Response to Fraud, Waste and Abuse:

- Education and Training
- Identifying and closing operational vulnerabilities
- Referrals to OIG

Provider and member education: Through our experience, we have identified best practices in handling issues that do not meet the qualifications for an OIG referral. In many cases, education and prevention training for both members and providers is the best and most expeditious way of saving program dollars. A significant tool we use to educate providers is our Provider Claims Educator (PCE). The PCE offers general claims and coding education, as well as onsite customized and issue-specific assistance to individual providers. In 2012 our PCE provided onsite training sessions to more than 200 providers. Training is also shared with the full Health Choice network in various ways such as statewide meetings, conference call meetings and electronic distribution. It is also important to note that a comprehensive training effort will be launched to prepare providers for ICD-10 and APR-DRG implementations. In addition to provider education, we also perform frequent member education through our member education tools, such as our newsletters, handbook and website.

Member Lock In: Another significant tool we use is our Member Lock In program. We monitor member behavior, including instances of overutilization and potential fraud, such as members engaging in drug-seeking behavior. Our Medical Services team reviews internal data reports as well as information from our vendor partners, such as the PBM, PharmMD for medication reconciliations and Radiology Benefit Manager (RBM) that show high usages of medications and high numbers of services like High-Tech Radiology and Emergency Room (ER) visits. After analyzing the information, we can address those members who may be over-utilizing services due to a lack of understanding of program rules or who are "doctor shopping" for the purposes of obtaining medically unnecessary prescriptions, we utilize a restriction program that "locks-in" a consumer to an individual physician and/or pharmacy. We have found that this program not only gives the members better health outcomes, but reduces unnecessary pharmacy and ER costs, and eliminates the need for an unnecessary referral to the OIG.

Identify and close vulnerabilities: On a larger scale, we evaluate program expenses to identify waste. Health Choice Arizona has an extensive Medical Economics Department to monitor and understand the utilization and cost trend drivers for medical expenses at a detailed level. This provides us with the ability to react quickly to changes in utilization and costs and develop clinical programs and other initiatives to "bend the health care cost curve." For example, routine analysis in 2009, we found total radiology costs were increasing at a nearly 20% annualized rate for high tech radiology services (MRI, CT, PET scans). This led to the discovery that providers in the network were not consistently following evidenced-based guidelines for these high tech services and other diagnostic radiology procedures and therefore there was abuse of these services. To solve this issue, we partnered with MedSolutions, a Radiology Benefit Manager, to leverage their robust decision support tool enabling physicians to understand and easily follow appropriate clinical guidelines for use of high tech, cardiology and ultrasound diagnostic imaging. By partnering with physicians on a decision support tool

rather than simply implementing a 'gate keeper' model, we were able to garner the buy-in from physicians and subsequently reduce the radiology cost trend from close to 20% down to 2% annually.

4) Program and Process Improvements

We continue to invest in our comprehensive fraud, waste and abuse program to address changes and the nuances of the evolving health care environment. Several program and process improvements will be implemented by October 2013 to further expand our program integrity capacity. These are outlined below:

Participation in statewide HIE: Providers will be able to stop and manage member behaviors when they have access to more complete and timely data. Health Choice Arizona is actively participating with the Health Information Network of Arizona (HINAz) to make the warehouse of clinical data for Arizona a reality. Participation from health plans, facilities and other providers in a statewide HIE will be critical to reduce the complexity of accessing information.

Member / patient empowerment: With the assistance of a member portal, we will give patients more real-time access to their own medical history and allow them to become more responsible for their utilization, as well as provide more transparency to their care. This access will also give them the opportunity to identify and report any suspicious claims of services from providers, supplementing the "verification of paid services" process discussed above. We are also building a member smartphone/tablet app and developing ways to communicate differently through social media and text messaging with members to accelerate our response rate.

Continued operational optimization: We feel that one of the best ways we can identify and improve program integrity is by reducing resource waste and eliminating processes that hold no value to the State of Arizona, our members or providers. As shown in our extremely low administrative costs, we are consistently looking for ways to use our resources to better the overall fiscal performance of the health care system. We recently reduced our need for prior authorization resources by eliminating services from requiring pre-service approval and shifted those to focus on high cost, high utilization member care coordination. As stewards of public funds, we have the duty to continue these efforts. Our compliance program will leverage these lean processes to eliminate barriers to effective detection of fraud and abuse.

Procurement of provider review audit services: To supplement our internal review efforts, we will also contract for an outsourced recovery audit contractor to ensure that providers are billing us for appropriate and documented services.

Implement enhanced provider payment methodologies: In addition to instituting appropriate program integrity safeguards, we have and will continue to implement provider payment methodologies that may serve to reduce the potential for fraud, abuse and waste. Many fraud schemes or instances of abuse can be tied to fee-for-service payment methodologies that may encourage over-utilization and improper billings to enhance reimbursement. By implementing provider reimbursement reforms that serve to better tie reimbursement to outcomes, we believe that we can potentially reduce the program's vulnerability to fraud, abuse and waste. These programs will incent providers to focus on medical outcomes (e.g. reduced ER visits and inpatient admissions) and member satisfaction, instead of utilization. In designing and implementing these expanded reforms, our Compliance Department will carefully evaluate and address potential vulnerabilities within the program design.

Purchase of fraud detection software system and audit services: We are currently negotiating a contract to obtain a specialized software system offered by EDI Watch, designed to provide a robust tool to our Compliance team for the evaluation of claims data to spotlight patterns of suspicious behavior for further review and investigation. This software will enable us to sift through claims data to identify aberrant billing patterns and questionable coding, and to create a more structured review process to determine the best course of action, whether to improve claims edits, perform claims audits, change prior authorization requirements, or update provider education messages. This will allow us to provide the AHCCCS OIG with clear and understandable information from which to build any investigations. We are positioned to execute a contract and implement by Q2 2013.

Inpatient claims validation software: Traditionally, inpatient claims validation efforts have been successfully deployed by payers to retrospectively review inpatient claims, identify medically improbable claims for further review by trained medical staff, and to identify and recover improper payments. In our Medicare line of business, we currently utilize a national software program that validates the billed DRG code on an inpatient claim to ensure that we pay the correct level of care. When Arizona implements APR-DRGs for Medicaid in 2013, we will be poised to expand these efforts to the Medicaid claims review process.

In summary, while many of the existing program design features serve to minimize program vulnerabilities, we have taken numerous steps over and above existing program requirements to address the issue of fraud, waste and abuse within our program. We remain committed to addressing this important issue, devoting additional resources and investing in innovative process improvements to further enhance our efforts in this area.

Q9 Throughout our 22 years of experience as an AHCCCS contractor, Health Choice Arizona has worked to create a transparent, smooth and simple path to provider payment. We have leveraged our provider-centric strategy for claims payment and reimbursement to achieve high provider satisfaction. This guiding philosophy has minimized our provider claims dispute volume, resulting in a high rate of provider retention and consistently low rates of provider appeals, in turn reducing the need for the formal hearing process. Due to our transparent claims adjudication process and focus on adjudicating the claim correctly the first time, without the need for the dispute process or backend recoupments or adjustments, we are recognized by most Arizona providers as their AHCCCS plan of choice, especially in the rural counties of the state.

> ***"[Health Choice has] worked closely with our individual clinics, giving support services to keep our companies aligned as we fulfill our mission to provide care to the underserved populations in all of the northern counties of Arizona. We appreciate Health Choice and their dedication to us and those we serve."***
>
> *Marti Neff, Director of Operations, North Country HealthCare*

We have a clear understanding of the administrative and financial costs that result to the state, providers and health plan, when payment and related issues cannot be resolved early in the claims process. For example, the cost of adjusting an incorrectly processed claim costs five times the amount of processing it correctly the first time. Similarly, processing a claim dispute is four times more costly than an adjustment. We also recognize that efforts to minimize claims disputes and reduce administrative costs are more critical than ever in light of recent fee schedule cuts, anticipated increase of Medicaid members, as well as the potential stress on provider networks resulting from federally-subsidized health care coverage beginning in January 2014. **Reducing the provider "hassle" factor is imperative to ensuring continued provider participation in the AHCCCS program.**

With our continuous quality improvement process, excellent customer service for providers and accurate claims payment history, we are able to keep the claim dispute volume to a minimum. In 2011, we processed more than three million claims. Of that number***, less than one-third of one percent (<0.3%)*** of these claims were disputed, which is down from 0.35% in 2010, as represented in ***Table 9.1*** below. Additionally, we have found that of the claims that are disputed, most were processed correctly. Consequently only 26 % of claims disputes are overturned and our goal is to continue to reduce this rate by refining front end processes. Further, providers requested a hearing for just 8% of the denied disputes demonstrating that we appropriately educate providers and their office staff for the reasons behind the denied dispute (see ***Figure 9.2***). We were able to settle the majority of these requests, before going to hearing, by performing continued outreach to the provider to talk through the reason for our claim adjudication results and subsequent claim dispute decisions. In many cases, the provider agreed with our decision and withdrew their hearing request.

Below, we will: 1) Outline our approach, objectives and management of operations to ensure correct reimbursement and reduce the need for disputes; 2) Identify strategies implemented by Health Choice to outreach to and partner with providers while anticipating global issues by evaluating feedback; and 3) Describe the interventions and strategies pursued by Health Choice to resolve claims disputes without resorting to the hearing process.

1) Approach to Ensuring Proper Claims Reimbursement

Claims adjudication is one of the most important core processes of our health plan. It impacts all areas of plan operations including network management/provider relations, financial management, medical management and contract compliance.

Table 9.1: Year-over-Year Percent Claims Where Dispute Was Filed

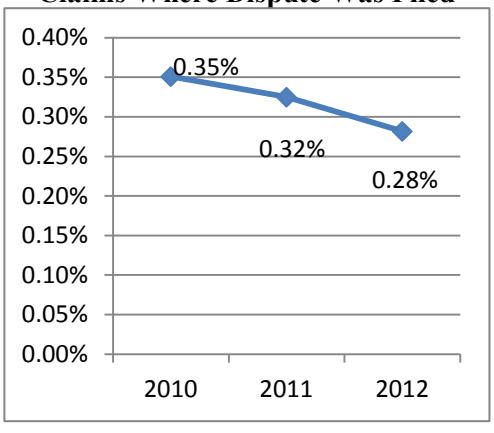
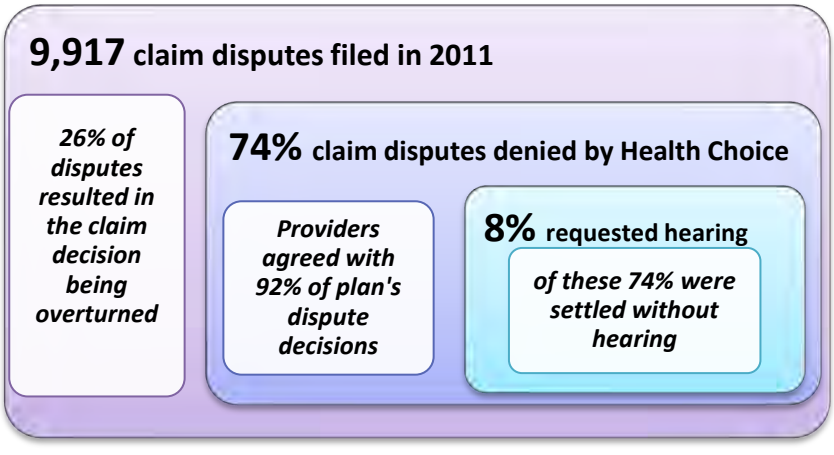


Figure 9.2: Results of Claims Dispute Process



We ensure accurate and timely payment, and minimize the need for providers to utilize the claims dispute process by making the adjudication of claims an internal, local priority and closely managing the claims adjudication process.

Our approach to claims adjudication is based on meeting these key objectives:

- Providing and promoting the use of electronic billing through many methods including direct, clearinghouse, and/or direct data entry.
- Continuously increasing claims auto-adjudication rates to improve accuracy and consistency. Across all claim types we currently process 40% through auto-adjudication and are on track to process **75%** of claims electronically by Oct. 1, 2013.
- Paying claims quickly, accurately and leveraging Electronic Funds Transfer (EFT) and Electronic Remittance Advices (ERA) to increase the speed by which payments are deposited into providers' accounts, and using standard codes to increase providers' understanding of the adjudication result.
- Continuously monitoring and auditing the claims process to ensure accurate and timely payments.
- Continually questioning and evaluating internal processes and legacy decisions to streamline adjudication, including ongoing analysis of provider feedback.
- Submitting encounters to AHCCCS timely and ensuring that all paid and denied claims are reconciled and encountered appropriately. We have an average **96%** successful first pass rate to the AHCCCS mainframe encounters system.

Figure 9.3: Claims Audits

Health Choice Arizona processes more than 2.8 million claims per year.

Routine Claims Audits:
- ✓ *Claims Over $2,500*
- ✓ *Adjudicated Claims*
- ✓ *New Processor*
- ✓ *Auto Adjudication*
- ✓ *Performance*
- ✓ *Fee Schedules*

In addition to meeting and exceeding these best in class claims adjudication objectives, we also ensure the following:

- ***Maintenance and operation of a robust, customized claims processing system:*** Health Choice leverages a specialized software platform for claims adjudication and payment called Med/MC, which has been fully customized to meet all AHCCCS managed care functionality requirements. Med/MC is a versatile system, facilitating flexible programming options and enabling us to leverage claim edits to optimize data integrity, correct coding, cost avoidance, timeliness, as well as enrollment, network and benefit adherence. We have been able to partner with and meet or exceed AHCCCS's expectations for new payment methodology implementations for the past 22 years. In 2005, we were the first plan to certify as ready for the Outpatient Fee Schedule (OPFS) changes. In addition to a robust claims payment process to ensure accurate payments, we continuously monitor and track claims reports to allow us to identify process improvements and opportunities for provider education. This system processes all HIPAA ANSI X12 transactions that are received from clearinghouses, direct from providers (Claims-837P/I/D) and AHCCCS including Eligibility (834), Capitation Payment (820) and generates the Encounters files (837P/I/D and NCPDP). Accepting and processing electronic claims files have been 4010 and now 5010 compliant without provider interruption. Throughout our 22 year history, as described below, we have implemented several best practices in managing our claims processing function.
- ***Use of AHCCCS edits to ensure AHCCCS-specific processing:*** Although we use multiple industry-standard coding tools, such as OptumInsights (formerly Ingenix) Data Files that include all standard medical and dental coding as well as Encoder Pro to confirm the appropriateness and correctness of the services billed, we also utilize the medical coding and provider information supplied by AHCCCS from each Reference file cycle. More specifically, we utilize the data from the Reference ('Refe'), and Provider Profile Records to drive adjudication edit logic. Validation edits, relationship edits, and clinical edits have also been integrated into Med/MC and are now part of the core adjudication logic. We have incorporated the knowledge gained regarding the AHCCCS encounter process during the past 22 years, and we have created a thorough claims processing system that is able to change as rapidly as the health care industry changes, limiting erroneous adjudication, reducing provider "hassle factor" and reducing the need for the dispute and hearing process.
- ***Fee schedules and provider demographic files loaded correctly and refreshed timely:*** Many claims disputes could potentially result from incorrect and untimely adoption of fee schedules and additions or changes to provider demographic files. To minimize these issues, fee schedules and provider information change or ad requests are loaded correctly and refreshed routinely in the claims processing system. Our Claims Audit department routinely performs audits of fee schedules loaded into Med/MC, to ensure accurate payment and reduce the opportunity for disputes. Not only do we continually validate established contracted fee schedules to ensure accuracy, but we also audit fee schedules requests *before* being added to the system. This ensures that incorrect amounts are not being loaded into the system and used by the Claims Department for claims payments.

- ***Claims processing performance and oversight:*** In addition to maintaining a robust claims processing system, we also operate a strong oversight and management process to ensure accurate and timely claims processing. Our Claims Management team has developed comprehensive processes that monitor the claims volume daily, ensure distribution to processors with expertise in a particular area, and provide immediate assistance to the claims processors to avoid lengthy pend times. This tight management is demonstrated by our quarterly Claims Dashboard submitted to AHCCCS.
- ***Claims audit and quality cycle:*** Our Claims Audit Unit, staffed with an Audit Director and a team of highly experienced claims auditors, is dedicated to ensuring the accuracy of claims adjudication. To create a proper audit function with no conflict of interest from within the operation, the Claims Audit Unit reports to the Finance Department. The audits, listed in ***Figure 9.3***, are evaluated and scored by procedural, financial and payment accuracy categories. Their purpose is to review, track, tend and subsequently report on the accuracy of claims payment and claims denial. Audits and audit findings are handled at all levels: claim specific, processor specific, and issue specific. Solutions to audit findings may include adjustment in payment of a claim, overturning of a denial, correction of a payment before the claim is paid, additional auditing of a specific processor, further audit of a particular issue, education to claims staff, or change in claims policy.

The Health Choice Arizona claims operation is based in Arizona. This allows senior claims employees to meet with providers at their offices throughout the state to work through any issues reducing the need for the dispute / hearing process.

All results are reported back to the Claims Director and the Provider Claims Educator (PCE), as well as to the CEO, CFO and COO. The results of claims audits are discussed in the Claims Committee, which is a committee that meets at least every other month and is attended by leadership of Claims, Claims Audit, Compliance, Medical Services, Recoveries and Finance. The committee analyzes the reports and makes recommendations to senior management for process improvements and sets claims policy to ensure payment accuracy. Our years of focus and dedication to timely and accurate claims payment shows in our results as depicted in ***Table 9.4*** below:

Table 9.4: Claims Payment Accuracy

Measure	AHCCCS Standard	Health Choice Standard	Current Performance
Timeliness (% within 30 days)	95.0%	98.0%	99.7%
Daily Inventory 'Days Out'	N/A	17 Days	15 Days
Payment Accuracy	N/A	97.5%	97.7%
Encounter Acceptance	N/A	97.5%	98.3%
ECR Rate	60.0%	70.0%	71.1%
EFT Rate	60.0%	70.0%	72.9%

2) Provider Outreach and Partnership Efforts

We recognize that sometimes a provider may disagree with our claims adjudication decision. To ensure a quick and thorough response to provider inquiries, we also employ targeted and proactive avenues of outreach and partnership tailored to each providers' unique circumstances and particular service delivery environment. Using numerous avenues enhances our ability to minimize the use of the claims dispute process. Additional key components of our provider outreach and partnership efforts include:

- ***Trending of claim adjudication results by provider:*** The Medical Economics Department of Health Choice produces monthly reports tracking denial volumes, by type and by provider, to anticipate billing issues before the provider is even aware. Reports are shared with the providers by the PCE to help the provider fix any billing issues and better understand AHCCCS billing procedures. Claims department leadership also review reports to ensure denials are correct and appropriate. The combination of these efforts allows us to proactively solve claims and billing issues, reducing the provider's need to utilize the dispute and hearing process.
- ***Provider meetings:*** Delivery System Management Team (DSM Team) members are available by phone, email or in person for all contracted providers. DSM Team members take requests for information, complaints and general inquiries, and research any claim, prior authorization or member assignment issues. This greatly reduces the resolution cycle time giving the provider closure and the ability to focus on giving quality care to our membership, and also serves to pre-empt the formal dispute process.
- ***Claims call center:*** Many of the telephonic inquiries, complaints and requests for information received from providers are accepted and resolved within the Claims Call Center operated locally in Arizona under the direction of the Member Services Department. We are able to resolve 98% of inquires during the first call.

- ***Adjustment specialists:*** Adjustment Specialists handle claims requiring complex adjudication and give detailed explanations to providers. These specialists take provider calls regarding claims issues and educate providers on the adjudication methodology of the claim, frequently adjusting the claim while the provider is on the phone.
- ***Post-adjudication analyst:*** Facilities and large provider groups can use the services of a Post-Adjudication Analyst. The Post-Adjudication Analyst works one-on-one with the facility or provider group to perform an in-depth analysis of all outstanding claims on a daily, weekly or monthly basis.
- ***Provider portal:*** Providers requiring the status of their claims or prior authorization requests are also encouraged to utilize the secure Health Choice Provider Portal. The portal employs role-based security utilizing specific provider information to ensure the Electronic Protected Health Information (e-PHI) meets all HIPAA security and privacy laws for the entire AHCCCS network, whether or not they are contracted with Health Choice Arizona.
- ***Comprehensive provider education:*** Accurate claims submission, and our ability to mitigate the claims dispute process, is also directly related to a provider's understanding of claims payment policies. To ensure appropriate training, we offer various opportunities for provider education and training on claims submission protocols and claims processing logic to help providers expedite payment and reduce administrative costs inherent to multiple claims submissions payment. We communicate educational information to our providers in various ways such as: our website, our Provider Manual, blast faxes, letters and statewide training seminars. Our full time PCE, a Certified Professional Coder, develops comprehensive provider trainings at least annually, and provides training in person and/or via dial-in conferencing throughout Arizona. The PCE is also available to meet with providers on specific issues at their request or at the request of their Health Choice Provider Representative. Statewide training topics have included: Coding tips, EPSDT/VFC billing requirements, CLIA rules, modifiers, coding for well visits, understanding the Health Choice Arizona Prior Authorization process, common billing denials, and coordination of benefits.

Dr. Alan Barton's claims denial rate decreased from ***53%*** *to* ***7%*** *after direct claims and coding education from our Provider Claims Educator (PCE).*

Quality improvement cycle: In addition to monitoring and trending our own internal data, and working directly with providers to provide information and education, we have several processes to obtain and resolve provider feedback:

- Call Coding.
- Provider surveys.
- Provider complaint tracking.
- Provider Relations Improvement Committee (PRIComm) meetings.
- Claims Committees.

In our last provider survey, we were pleased to see that more than 40% of providers expressed that they receive excellent customer service from Health Choice staff members and particular departments. We believe that having locally based operations adds to the quality customer service we give our providers. Feedback from providers is documented in our system for trending.

Our call coding process is our system to document all incoming communications (email, fax, phone) from providers. Call coding enables us to track provider needs and eliminate any barriers to navigating our claims processing system. Our provider complaint tracking methodology is based on the call coding process. This allows any Health Choice staff member to take in a complaint and assign it to the appropriate department for resolution ensuring the complaint is acknowledged and answered quickly and appropriately by the right person. The Network Operations Director monitors all outstanding inquiries to ensure responses and solutions are made within 30 days.

Additionally, the PRIComm and Claims Committee are comprised of leaders from various operational departments in order to provide a holistic view of vulnerabilities and possible solutions. Both committees are designed to make the health plan experience better and easier for all providers.

As an example of how these committees operate to improve systems, during summer 2012, through the process of analyzing our internal monitoring systems as described above, we identified a noticeable trend in provider complaints related to the prior authorization process. The PRIComm recommended that a focused review be conducted to identify commonalities of the complaints and to identify meaningful solutions. Some of the implemented solutions included: reducing the services that require prior authorization; communicating to our network about the changes; streamlining the OB authorization process; and enhancing staff training and production flow, including reducing our average time to process a routine prior authorization request from 10 days to four days.

3) Interventions and Strategies to Resolve Disputes Without Resorting to the Hearing Process

Health Choice Arizona has a well-established Claim Dispute Unit that takes in all formal claim disputes. All providers have the right to file a claim dispute, as provided by the Arizona Administrative Code. Our primary goal, and the focus of all of our efforts, is to ensure the fair adjudication of the provider's dispute without having to rely on the hearing process for resolution. In addition to the strategies and process described above that serve to minimize claims disputes, we have developed several strategies and interventions that are specifically targeted at resolving disputes without resorting to the expensive and administratively-burdensome hearing process, including:

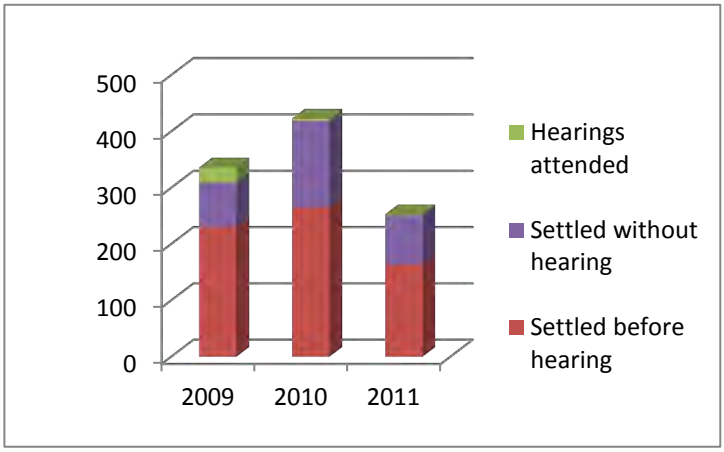
Health Choice Arizona developed and implemented a comprehensive audit process in 2007 to ensure accuracy of claim disputes.

- ***Auditing of disputes:*** We perform audits of our dispute decisions to ensure accuracy of the decision and identify opportunities for process improvement, staff training and policy recommendations. Dispute process measures include: timeliness of acknowledgement letter and decision letter, completeness of file, and appropriate review documentation from the subject matter expert. Additionally, the audit validates that the content of the dispute letter is thorough and the decision is correct. Any decision determined to be incorrect is returned to the coordinator for an amended decision to overturn the denial and approve the provider's request. Files are tracked to ensure timely correction within the department requirements. Coordinators scoring below 90% are provided training. Coordinators scoring 97% or below are subjected to a monitoring process that requires a higher percent of files to be reviewed until the scores return to acceptable levels.
- ***Proactive outreach to resolve outstanding cases:*** In 2009, due to the State's budget cutbacks, we saw the hearing process experience an abupt slow down. Where we were accustomed to hearings being scheduled and resolved in 60-90 days from date of a hearing request, we have seen files wait for as long as three years before being scheduled for hearing. We addressed this change by reaching out to providers to discuss the cases for resolution *without* waiting for the hearing to be scheduled. Dedicated and experienced staff reviewed our hearing files pending for hearing to identify settlement options and pre-empt need for the hearing. We found that most providers were willing to have a discussion with us about an informal resolution. Our approach was to first review high dollar claims and large volumes of disputes with the same provider, and with the same or similar issues. In our first 90 days, we were able to reduce the backlog by 15% and made this part of the routine process after a hearing is filed.We have maintained an average of at least 20% file resolution before AHCCCS has to send a case to the Office of Administrative Hearings.
- ***Additional resources to resolve disputes:*** In 2013, we are adding a full time dedicated Post-Dispute Coordinator who will review all pending hearings and reach out to providers for early resolution. Our goal is to move the 20% success rate to approximately 80% success rate. This Coordinator will interact with all departments of the health plan to determine an appropriate resolution as well as to identify trends.

In summary, Health Choice Arizona has developed a multi-faceted approach, which includes a multitude of policies, processes and intervention, designed to minimize the need for providers to use the claims dispute process by resolving claims disputes without the need to resort to the hearing process. The success of this approach is demonstrated by the decreasing number of claims disputes and the high level of accuracy of our initial claim adjudications as seen in ***Table 9.4***. Moving forward, we will continually evaluate and improve our performance in this area, and make the policy changes and investments necessary to ensure disputes and subsequent hearings are at the lowest levels possible.

Table 9.4: Claims Dispute Trend*

2009 - 2011



**Based on year dispute received.*

Q10 *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*

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

Health Choice Arizona, Inc., acknowledges that it will comply with the stated guidelines and calendar for this process.

Health Choice Arizona, Inc., acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal.

Health CHOICE

Value-driven health care for Arizona communities.

Health Choice Arizona

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