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 - 23

A1: OFFEROR'S BID CHOICE FORM

ACUTE CARE PROGRAM

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

MediSun Community Care, Inc. dba
Blue Cross Blue Shield of Arizona Community Care
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**
- [X] **GSA 12 Maricopa**
- [ ] **GSA 14 Graham, Greenlee, Cochise**

Carol G Smallwood
Authorized Signature

January 24, 2013
Date

Carol G. Smallwood
Print Name

Chief Executive Officer
Title

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

Authorized Signature _____ Date _____

Print Name _____ Title _____

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

B. *ATTESTATION*

Attestation	*Requirement No.*	*Offeror's Page No.*
	1-34	25-29

C. *CAPITATION SUBMISSION*

Capitation	*Requirement No.*	*Offeror's Page No.*
Acute Care Program Capitation Bid Submission Including Actuarial Certification	1	31-34
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	36-39
	2	40

E. *ACUTE CARE NARRATIVE SUBMISSIONS*

Access to Care/Network	*Requirement No.*	*Offeror's Page No.*
	1	42-46
	2	47-51

Program	*Requirement No.*	*Offeror's Page No.*
	3	52-56
	4	57-61
	5	62-66
	6	67-69

Organization	*Requirement No.*	*Offeror's Page No.*
	7	70-74
	8	75-78
	9	79-81
	10	82

F. CRS NARRATIVE SUBMISSIONS

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

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

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

Solicitation Contact Person

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

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

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

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

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

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

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

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

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

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

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

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

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

Late proposals shall not be considered.

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

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

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

OFFER

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

Arizona Transaction (Sales) Privilege Tax License No.: 20909896

Federal Employer Identification No.: 46-1656812

E-Mail Address: Small01@AZBlue.com

MediSun Community Care, Inc. dba
Blue Cross Blue Shield of Arizona Community Care
Company Name

8220 N. 23rd Avenue
Address

Phoenix AZ 85021
City State Zip

For Clarification of this offer, contact:

Name: Carol G. Smallwood

Phone: 602-864-4590

Fax: 602-916-7820

Carol G Smallwood
Signature of Person Authorized to Sign Offer

Carol G. Smallwood
Printed Name

Chief Executive Officer
Title

CERTIFICATION

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

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

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

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

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

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

The bidder certifies that the above referenced organization _X_ 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**	**Signature**
Carol G. Smallwood	January 23, 2013	
Typed Name		**Typed Name**
Carol G. Smallwood		Michael Veit
Title		**Title**
Chief Executive Officer		Contracts and Purchasing Administrator
Name of Company		**Name of Company**
MediSun Community Care, Inc. dba Blue Cross Blue Shield of Arizona Community Care		AHCCCS

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

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

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

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

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

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

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

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 19th day of December, 2012, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature Carol G Smallwood	**Date** Jan. 23, 2013	**Signature**
Typed Name Carol G. Smallwood		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company MediSun Community Care, Inc. dba Blue Cross Blue Shield of Arizona Community Care		**Name of Company** AHCCCS

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

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

This solicitation is amended as follows:

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 4th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature Carol G Smallwood	**Date** Jan.23, 2013	**Signature**
Typed Name Carol G. Smallwood		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company MediSun Community Care, Inc. dba Blue Cross Blue Shield of Arizona Community Care		**Name of Company** AHCCCS

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

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

This solicitation is amended as follows:

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

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

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

Bid component requirements:

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

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

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

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

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

Bid component requirements:

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 10th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature Carol G Smallwood	**Date** Jan. 23, 2013	**Signature**
Typed Name Carol G. Smallwood		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company MediSun Community Care, Inc. dba Blue Cross Blue Shield of Arizona Community Care		**Name of Company** AHCCCS

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

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page 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 Carol G Smallwood	**Date** Jan. 25, 2013	**Signature**
Typed Name Carol G. Smallwood		**Typed Name** Michael Veit
Title Chief Executive Officer		**Title** Contracts and Purchasing Administrator
Name of Company MediSun Community Care, Inc. dba Blue Cross Blue Shield of Arizona Community Care		**Name of Company** AHCCCS

Section G, pages 6-23 have been omitted from this file per Section H-Instructions to Offerors.

"No pages will be withheld with the exception of Section G: Representations and Certifications of Offeror. The Offeror shall not designate any information to be proprietary in nature with the exception of Section G: Representations and Certifications of Offeror."

Section **Page Numbers**

Attestation …….……..…….....25-29

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: MediSun Community Care, Inc. dba Blue Cross Blue Shield of Arizona Community Care certifies the elements attested to in this document are true and it is understood that AHCCCS will rely on this attestation in determination of the award.

Carol G Smallwood — January 24, 2013
Authorized Signature — **Date**

Carol G. Smallwood — Chief Executive Officer
Individual's Printed Name — **Title**

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Capitation Submission……...31-34

January 24, 2013

Actuarial Certification
Medisun Community Care Inc., DBA BCBSAZ Community Care

AHCCCS Acute Care Capitation Bid: GSA 12
October 1, 2013 – September 30, 2014

I, Susan K. Hart, 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 Medisun Community Care Inc., DBA BCBSAZ Community Care (Medisun) to provide a certification of the actuarial soundness of its proposed capitation rates for Acute Care Services in GSA 12 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 sheet 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 12
TANF < 1	$468.58
TANF 1-13	$94.56
TANF 14-44 F	$214.11
TANF 14-44 M	$138.13
TANF 45+	$381.34
SSIW	$150.13
SSIW/O	$748.73
AHCCCS Care	$405.71
Delivery Supp	$5,490.25

Table 2
Administrative Component by Risk Group and GSA

Risk Group	GSA 12
TANF < 1	$37.48
TANF 1-13	$7.56
TANF 14-44 F	$17.12
TANF 14-44 M	$11.05
TANF 45+	$30.50
SSIW	$12.01
SSIW/O	$59.89
AHCCCS Care	$32.45
Delivery Supp	$439.21

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 GSA 12 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 Medisun, and my judgment. In performing my analysis, I relied on data and other information provided by AHCCCS and Medisun. 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 Medisun's provider reimbursement descriptions without audit. My opinion that the rates are actuarially sound is based on the assumption that Medisun's capitated providers and administrative vendors are financially stable and have the financial resources to absorb capitation or fee risk. I did not review the financial resources or medical management abilities of any provider or vendor to confirm their ability to assume financial risk.

The utilization rates and average costs in the attached Bid Template sheet 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 Medisun 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.

Susan K Hart FSA MAAA

Susan K. Hart, FSA, MAAA
January 24, 2013

Acute Care RFP Bid Template - Medisun Community Care Inc., DBA BCBSAZ Community Care

Gross Medical Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$0.00	$0.00	$0.00	$0.00	$0.00	$468.58	$0.00
TANF 1-13	$0.00	$0.00	$0.00	$0.00	$0.00	$94.56	$0.00
TANF 14-44 F	$0.00	$0.00	$0.00	$0.00	$0.00	$214.11	$0.00
TANF 14-44 M	$0.00	$0.00	$0.00	$0.00	$0.00	$138.13	$0.00
TANF 45+	$0.00	$0.00	$0.00	$0.00	$0.00	$381.34	$0.00
SSIW	$0.00	$0.00	$0.00	$0.00	$0.00	$150.13	$0.00
SSIW/O	$0.00	$0.00	$0.00	$0.00	$0.00	$748.73	$0.00
AHCCCS Care	$0.00	$0.00	$0.00	$0.00	$0.00	$405.71	$0.00
Delivery Supp	$0.00	$0.00	$0.00	$0.00	$0.00	$5,490.25	$0.00

Administrative Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$0.00	$0.00	$0.00	$0.00	$0.00	$37.48	$0.00
TANF 1-13	$0.00	$0.00	$0.00	$0.00	$0.00	$7.56	$0.00
TANF 14-44 F	$0.00	$0.00	$0.00	$0.00	$0.00	$17.12	$0.00
TANF 14-44 M	$0.00	$0.00	$0.00	$0.00	$0.00	$11.05	$0.00
TANF 45+	$0.00	$0.00	$0.00	$0.00	$0.00	$30.50	$0.00
SSIW	$0.00	$0.00	$0.00	$0.00	$0.00	$12.01	$0.00
SSIW/O	$0.00	$0.00	$0.00	$0.00	$0.00	$59.89	$0.00
AHCCCS Care	$0.00	$0.00	$0.00	$0.00	$0.00	$32.45	$0.00
Delivery Supp	$0.00	$0.00	$0.00	$0.00	$0.00	$439.21	$0.00

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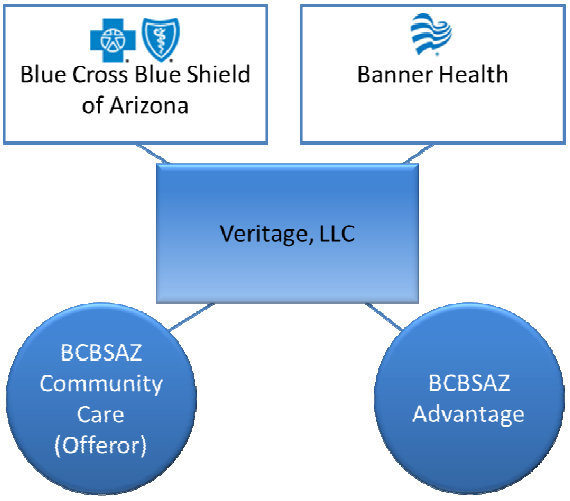
Executive Summary and Disclosure……...36-40

1. Executive Summary

Blue Cross® Blue Shield® of Arizona (BCBSAZ) Community Care is pleased to submit this proposal to the Arizona Health Care Cost Containment System (AHCCCS) for acute care services for Maricopa County (Contract/RFP No. YH14-0001).



Arizona's premier community non-profit providers of health care services and insurance have come together to offer a comprehensive capability that improves the quality of health care, enhances the well-being of our members, and provides affordability for people enrolled in AHCCCS, Medicare, and commercial plans. Called Veritage, this joint venture between Blue Cross Blue Shield of Arizona and Banner Health has created BCBSAZ Community Care, an aligned plan to provide highly coordinated care and services for AHCCCS members no matter where these members seek care in Maricopa County. Most importantly, Community Care can deliver on the promise of excellent patient care and well-being that AHCCCS members deserve.

The RFP speaks to a need for provider networks sensitive to member needs on a community basis. Members must be able to access health care that meets their fundamental medical needs where they live and should be able to develop provider relationships that will be available to meet their long-term needs. By combining two of Arizona's leading health care non-profits, BCBSAZ Community Care can meet these challenges. We offer a foundation of financial stability, access to extensive resources, innovative programs and technology. The Blue Cross Blue Shield of Arizona brand is well known and trusted by Arizonans, and members will be reassured to know they will enjoy the same commitment to an excellent member experience whether they use our AHCCCS, individual, commercial, or Medicare Advantage products.

Blue Cross Blue Shield of Arizona

Serving Arizonans since 1939, Blue Cross Blue Shield of Arizona offers services to over 1.3 million customers. Locally operated, they are the largest insurer of individuals in Arizona and understand how to provide superb member-centric service like that needed for AHCCCS rather than focusing solely on servicing companies and other organizations. Blue Cross Blue Shield of Arizona is the leading plan for providers in Maricopa County with strong existing relationships to leverage.

AHCCCS faces many challenges in the current economic environment and Blue Cross Blue Shield of Arizona has a proven record of providing innovative solutions including the first group health coverage for all federal employees in 1960, the first HMOs in the country in 1972, a Preferred Care PPO product in 1983, a free community health screening program in 1989, and the Walk On! Program to combat childhood obesity in 2006. Blue Cross Blue Shield of Arizona cares deeply about our community and will be a valuable partner to AHCCCS for identifying new solutions.

As populations have grown across Maricopa County, Banner Health and Blue Cross Blue Shield of Arizona have met the communities' needs and increased demands. Banner Health has constructed desperately needed hospitals and free-standing multi-specialty clinics. Blue Cross Blue Shield of Arizona has focused on providing the best value in health insurance by automating processes, streamlining business operations, and implementing continuous quality improvement. Blue Cross Blue Shield of Arizona also partners with physicians to help its members manage complex conditions and maintain healthy lifestyles. Their dedication to Arizonans is infused in the culture of Community Care.

BCBSAZ Community Care is also assembling a first-class, experienced leadership team that includes CEO Carol Smallwood. Ms. Smallwood served as the AHCCCS Acute Care Administrator in 2005 and 2006 and is thoroughly familiar with the AHCCCS member population. Ms. Smallwood has served as CEO of El Paso First Health Plans, Inc. since 2006; providing Medicaid, CHIP, and CHIP Perinatal programs in the State of Texas. She also served as Vice President of Operations for Health Choice Arizona, an AHCCCS managed care organization, from 2002 to 2005. Her diverse and extensive leadership experience will be an essential component to the success of our program.

Our team also includes the national expertise of APS Healthcare (APS), a wholly owned subsidiary of Universal American. For over 15 years, APS has been dedicated to the design and delivery of specialty health services that focus on health improvement to lower costs and improve quality of life. They also provide face-to-face interventions for high-risk members utilizing evidence-based care.

BCBSAZ Community Care is also supported by Hawaii-Mainland Administrators (HMA), an Arizona-based company that has 20 years of experience providing third-party administrative services to multiple AHCCCS plans and offers over 100 collective years of staff AHCCCS experience.

BCBSAZ Community Care is specifically designed to deliver superb care, well-being, and service to AHCCCS members. It is a new value-based model that delivers on a promise of excellence for AHCCCS members. "We have come together to more efficiently and effectively serve expanding markets in the Government sector," said Richard Boals, President and CEO of Blue Cross Blue Shield of Arizona. "By joining together, we're able to offer a comprehensive plan like Community Care with a broad range and distribution of quality services."

Banner Health

Tracing its history back to 1911, Banner Health is Arizona's largest health care provider and one of the largest non-profit hospital systems in the country. Banner has 11 acute-care hospitals and health care facilities in Maricopa County currently caring for over 55,000 inpatient AHCCCS cases annually. Banner offers comprehensive health care services, extensive infrastructure, and a network of over 2,600 affiliated physicians located throughout Maricopa County.

Banner Health is a leader in providing integrated care with a care management infrastructure that leads to high quality outcomes. Banner was recognized in 2012 by Thomson Reuters as one of the Top 5 Large Health Systems in the country for having superior survival rates, better long-term outcomes, better adherence to accepted care protocols and patient safety standards, shorter hospital stays, higher patient satisfaction scores, and fewer patient complications.

Relevant Experience

Blue Cross Blue Shield of Arizona currently serves 23,500 Medicare Advantage, 4,600 Medicare Part D Prescription Drug Plan, and 22,700 Medicare Supplement members. BCBSAZ Advantage has a well-established provider network in Maricopa County that will be augmented as necessary to provide sufficient providers for dual eligible members.

Blue Cross Blue Shield of Arizona also launched BlueAlliance, an innovative health insurance product offering lower premiums by using Banner Health Network's local network of more than 2,600 health care providers in Maricopa County. BlueAlliance is the lowest-priced health plan available in their entire portfolio of small group health plans, while providing an enhanced level of care through a value-based approach that effectively utilizes population health tools.

Banner Health was one of 33 organizations selected nationwide as a Medicare Pioneer Accountable Care Organization (ACO). Banner Health began caring for and managing the health of the 51,000 Medicare members attributed to its ACO effective January 1, 2012. The ACO is a value-based delivery model designed to provide coordinated, high-quality care; chronic disease management; and improve the member experience while lowering costs. While final outcomes from the first year of operation are not yet available, there is clear evidence in year-to-date performance that Banner Health's value-based model can deliver on the promise of high quality care and lower costs, including:

- Anticipated medical cost savings in excess of $10 million
- A 7% reduction in avoidable hospital readmissions
- Significant growth in attributed lives and participating providers in year two (2013)

Through Veritage, Banner Health and Blue Cross Blue Shield of Arizona are convinced that the successful outcomes with the Medicare Pioneer ACO and BCBSAZ Advantage plans can be replicated in a value-based Community Care plan for AHCCCS members. Our belief is founded on a successful record with new value-based models that is unique in its scope in Arizona, and the ongoing stability and high performance of two of Arizona's premier organizations.

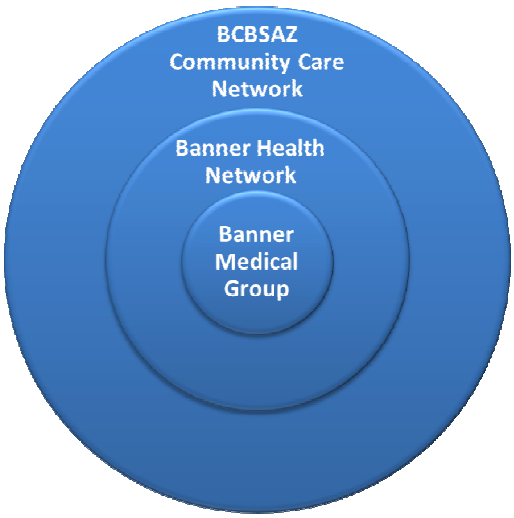
As BCBSAZ Community Care's partner for the delivery of care management services, APS currently provides services to over 11 million consumers spanning 30 Medicaid programs in 22 states in the United States and Puerto Rico. Their relationships include direct contracts with States to manage their Medicaid Fee-for-Service (FFS) programs, providing care management and behavioral healthcare services to 11 health plans, and population health management programs for commercial and other government specialty contracts.

Proposed Approach

We welcome the opportunity to share our deep Arizona experience with the introduction of our services to this new market. Representing a partnership between Arizona's number one health care provider system and number one provider of health care benefits in Arizona, BCBSAZ Community Care offers AHCCCS membership extraordinary access to care. The foundation of our offering is the existing and extensive Banner Health network. Banner Health is the largest provider of acute care services for all AHCCCS plans. Our members can count on a comprehensive network of providers that are geographically convenient and accessible: physicians, RN case managers, pharmacies, home care, hospice, long-term care facilities, surgery centers, web-enabled tools, and 24-hour availability via telephone hotlines. This broad array of medical and health management expertise and wellness resources will be augmented in the coming years with openings of new health centers and clinics.

We will utilize an integrated, multi-disciplinary care model providing tools and interventions to support each member's needs - from those who are just in need of preventive care and health education to those with complex, multi-condition profiles requiring intensive face-to-face case management. As shown in **Figure 1**, BCBSAZ Community Care encompasses a broad community of physicians throughout the service area. APS will provide our care management offerings to all our members to ensure the highest quality outcomes while driving costs lower through efficient resource use. Our network also encompasses the Banner Health network, providers that are aligned with Banner and offer many of the advantages of Banner's integrated care model. At the core of our network is Banner Medical Group, providers employed by Banner Health who utilize all of Banner's resources for integrated care including a system-wide electronic medical record (EMR). The advantage to members who choose to access care in the Banner networks is that we can provide more tightly integrated care as our clinicians and case managers will have access to more comprehensive medical information.

Figure 1. BCBSAZ Community Care Layered Network Approach



Other AHCCCS plans utilize Banner Health on a fee-for-service basis. However, as a full partner in BCBSAZ Community Care, Banner brings access to all their resources including full integration of the Banner Health EMR that dramatically increases efficiency and effectiveness of care. BCBSAZ Community Care members will be treated with a "system of care" rather than a "network of care" where evidence-based medicine and a consistent care delivery model drive better outcomes and reduced costs. No competing health plan can match the integrated tools we will offer as a shared services organization.

Our team is committed to achieving optimal health outcomes for vulnerable populations. We will deliver care management and outreach for all our members with targeted interventions for high-risk, high-cost individuals. We will use a multi-disciplinary Care Team approach that ensures members' medical, behavioral, and social/environmental needs are addressed with the highest caliber of professionalism. Care delivery will be guided by the Care Team and tailored to address needs through enhanced care coordination utilizing and managing a care delivery model focused on Patient Centered Medical Homes (PCMHs).

Subject to compliance with CMS and AHCCCS regulations, targeted efforts will be made during the transition and implementation periods to emphasize to BCBSAZ Community Care dual eligible members and their caregivers the benefits and importance of enrollment in the BCBSAZ Advantage Dual Eligible Special Needs Plan (D-SNP), BCBSAZ Community Advantage.

Added Value

Our team members have led the way for reducing inappropriate emergency room (ER) use with strategies that we will utilize in BCBSAZ Community Care. Through member education, redirection to 24/7 nurse lines, and emphasizing engagement with primary care physicians and PCMHs, we have reduced inappropriate ER use. Banner Health was also involved in a collaborative effort with AHCCCS to provide members a convenient, lower cost, and high quality alternative to the ER.

We have established and fully implemented processes to effectively manage transitions of care (TOC) for members discharged from inpatient settings, nursing facilities, and other settings of care. We will ensure that all members understand the importance of follow-up care and help coordinate all basic needs and support systems. This approach significantly reduces the likelihood of readmissions.

Team member APS brings BCBSAZ Community Care complete medical management services such as utilization management and community-based care service delivery. Their strength is chronic condition management and identifying and serving the most complex members who typically drive a large percentage of costs. APS services will allow us to identify the most impactable members and provide sophisticated care management interventions.

Our proposal narrative outlines a wide variety of programs currently offered by our team members to deliver services that will add value for AHCCCS. Our team provides the following additional benefits for members:

- Numerous primary care physicians who join Banner Medical Group following training and remain in Arizona
- A large array of specialized services (Cardon Children's, Banner MD Anderson Cancer Center, Home Care, Hospice, Alzheimer's institute, etc.) will be available to BCBSAZ Community Care members

Medicare Structure

Blue Cross Blue Shield of Arizona and Banner Health have created Veritage, LLC, a joint venture to provide the BCBSAZ Community Care and BCBSAZ Advantage products. BCBSAZ Community Care itself is a separate corporate entity whose only line of business is to provide services to AHCCCS eligible individuals as specified in *A.R.S. §36-2906.01*. We are also in the process of establishing a D-SNP, BCBSAZ Community Advantage, in Maricopa County. We will complete and file the D-SNP and Duals Demonstration applications for 2014 by February 21, 2013, the CMS submission deadline. Veritage will have the full legal and actual authority to direct, manage, and control the operations of the BCBSAZ Advantage plan and the BCBSAZ Community Care plan, to provide the necessary integration of services for dual eligible members. Our new D-SNP will align with the services provided by BCBSAZ Community Care using integrated policies and procedures and/or teams for the following functional areas:

Network Management **-** Our D-SNP network is the intersection of providers common to both our Community Care and Advantage plans, so it will meet all AHCCCS and CMS credentialing and network access requirements. Members of our D-SNP will receive a provider directory listing participating providers when they enroll. Dedicated BCBSAZ Community Advantage customer service representatives can also assist D-SNP members via a toll-free number. Our Community Care provider relations staff will service all provider education, communication, and network needs.

Member Services **-** D-SNP members can call a dedicated toll-free number to speak with highly trained customer service representatives who will serve as their single point of contact.

Quality Management **-** Quality Management for dual eligible members will be handled though a joint quality committee comprised of the BCBSAZ Community Care and BCBSAZ Advantage Quality departments.

Medical Management **-** Medical Management for dual eligible members will be handled using the same approach used by BCBSAZ Community Care as is outlined in our proposal response.

Corporate Compliance **-** We will utilize an integrated compliance organization for both BCBSAZ Community Care and Advantage that reports to a common Board of Directors. This will include a standing Compliance Committee comprised of the Chief Compliance Officers for each plan to oversee our corporate compliance, allowing for more effective use of resources, aligning our compliance activities, and offering additional opportunities for fraud and abuse initiatives.

Grievance System **-** Members will be able to register any grievances through our website, in writing, or by calling our Community Advantage toll-free number. Our Community Care team will take the lead on investigating and resolving grievances, and will work in coordination with their counterparts at BCBSAZ Advantage.

Branding **-** The name of our proposed D-SNP program, BCBSAZ Community Advantage, evokes the role it plays at the intersection of our BCBSAZ Community Care and BCBSAZ Advantage plans. We will further promote and advertise it to establish the brand as an easily identifiable plan for dual eligible enrollees through our website and enrollment and marketing materials.

2. Moral or Religious Objections

Blue Cross Blue Shield of Arizona Community Care will not exclude any covered services for moral or religious objections.

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Acute Care Narrative Submissions

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1. AHCCCS anticipates that its membership will grow as a result of implementation of the Affordable Care Act (ACA). It is estimated that an additional 180,000 to 430,000 new members will be eligible and enrolled with AHCCCS in the first year of implementation. These growth figures are dependent on decisions made by Governor Brewer and Arizona lawmakers regarding the many options under the ACA. In addition to the increased AHCCCS enrollment, the implementation of the Health Insurance Exchange will increase demand for provider accessibility. What steps will the Offeror take to ensure access to care to support the influx of members? In addition to network management, how will the Offeror ensure its operational and administrative structure is sufficient to efficiently implement all program operations to accommodate the membership growth?

Blue Cross Blue Shield of Arizona Community Care (BCBSAZ Community Care) represents a partnership inclusive of two best-in-class, non-profit Arizona-based organizations – Blue Cross Blue Shield of Arizona and Banner Health – combining to ensure delivery of the highest quality of service and network to AHCCCS members. This partnership will provide unparalleled value to AHCCCS based on the best practices of these two leaders in healthcare innovation for Arizonans. BCBSAZ Community Care and our owner organizations are committed to achieving the highest level of member and provider satisfaction by providing efficient care that will result in superior outcomes to AHCCCS members and overall value to the AHCCCS program.

- ***Experienced Leader in Healthcare Coverage:*** Blue Cross Blue Shield of Arizona has significant experience as a health insurer and currently offers services to over 1.3 million customers in Arizona. The experience, excellent brand reputation, and broad market presence of Blue Cross Blue Shield of Arizona benefits BCBSAZ Community Care when contracting with providers to meet the needs of AHCCCS members.
- ***Largest Healthcare Provider in Arizona:*** Banner Health is one of the nation's largest secular, non-profit healthcare systems. BCBSAZ Community Care and its members will benefit from Banner Health's significant medical services, breadth and depth of clinical programs, ability to create a pipeline of new providers to Arizona through an extensive residency training program, and the ability to nationally recruit clinical talent where needed through Banner Medical Group. Banner Health's provider network will be "embedded" into the fabric of BCBSAZ Community Care.
- ***Neighbors Serving Neighbors:*** Blue Cross Blue Shield of Arizona and Banner Health, through BCBSAZ Community Care, are non-profit, Arizona-based organizations committed to the needs of our neighbors, fellow Arizonans. BCBSAZ Community Care is being offered to the AHCCCS members via a unique partnership that is currently providing high quality services to approximately 24,000 Medicare members in Maricopa County.

Steps to Ensure Access to Care to Support Influx of Members

BCBSAZ Community Care is committed to developing and maintaining a Provider Network Development and Management Plan that ensures services provided in Maricopa County are delivered in a manner designed to facilitate appropriate access to care. Between Blue Cross Blue Shield of Arizona and Banner Health, we have the greatest number of payer and provider relationships with physicians in the Arizona market, relationships that are built on trust and mutual partnerships in a variety of settings. BCBSAZ Community Care is in an unrivaled position to offer a quality network to AHCCCS members. A few of the unique network features that will ensure we meet the needs of expanded enrollment and growth in demand for provider services include:

- ***Integration with Banner Health Network's Quality Acute Care and Specialty Facilities:*** While other AHCCCS plans have access to Banner Health's clinical services, BCBSAZ Community Care members will enjoy the benefits of full integration between the health plan and the delivery system maximizing continuity of care and health information for the benefit of the member. This integrated delivery network includes Banner Health's 11 acute care facilities, a children's hospital, surgery center, health centers including Cardon Children's Medical Center, Behavioral Heath Delivery Capability, Banner MD Anderson Cancer Center, Alzheimer's Institute, Home Care and Hospice.

- ***Investment in Community Network Access:*** Banner Health currently supports over 55,000 AHCCCS inpatient admissions annually and has invested tens of millions of dollars in programs and services in Arizona. Banner Health has constructed hospitals and free standing, multi-specialty clinics to constitute the complete medical homes that families and individuals so desperately need, in the areas most needed. Through integrated information technology, BCBSAZ Community Care members will have unique access to the Banner Health Centers in Buckeye, Peoria, Sun City West, Surprise, Goodyear, Gilbert, Queen Creek, Chandler and Mesa. These health centers are pursing NCQA Level 1 PCMH certification by December 31, 2013.
- ***Banner Health Network – Train, Recruit and Retain:*** Banner Health is currently training 271 residents in 16 programs in Arizona. The creation of Banner Health Network and Banner Medical Group provides practice opportunities for these residents to stay in Arizona and expand the provider base. In addition, this integrated delivery model ensures network stability and the ability to expand the network to meet members' needs even when there are shortages of physicians. In 2012, 174 physicians joined Banner Medical Group, many of them recruited from outside of Arizona.
- ***Blue Cross Blue Shield of Arizona – Commitment to Providers:*** Blue Cross Blue Shield of Arizona is committed to strong relationships with providers and operates the largest network in the State of Arizona, including 97.3% of hospitals and 91.9% of PCPs and specialists in the state**.** Blue Cross Blue Shield of Arizona retains this strong network through its commitment to relationships, scoring over 95% physician satisfaction annually in every survey conducted since 2009. This commitment to providers will be translated to BCBSAZ Community Care.
- ***Banner Health Network:*** BCBSAZ Community Care has a unique relationship with Banner Health Network, an affiliated provider organization that currently serves over 200,000 members in Medicare and Commercial Accountable Care models, including the Center for Medicare and Medicaid Pioneer ACO model with approximately 50,000 members. This organization has already embraced the principles of the Affordable Care Act (ACA) and has demonstrated success in improving the affordability of healthcare.
- ***Care Team Concept:*** Beyond delivering an adequate number of quality providers, BCBSAZ Community Care is designing our delivery model built on the physician-centric Care Team concept to ensure access to many types of providers including physicians, nurse practitioners, physician assistants, social workers, case managers, and other professionals to truly engage members in their health and well-being.
- ***Health Insurance Exchange:*** BCBSAZ Community Care, to the extent permitted by regulations, will participate with Blue Cross Blue Shield of Arizona in the commercial health insurance exchange to ensure the highest level of efficiency for providers and to expand accessibility for those members changing eligibility between commercial and Medicaid status. Due to its relationship with Blue Cross Blue Shield of Arizona - the largest insurer in the Arizona individual insurance market – BCBSAZ Community Care will provide seamless transitions of care to these members.

AHCCCS has outlined specific parameters that define the sufficiency of a provider network. BCBSAZ Community Care has adopted these parameters as our minimum level of network adequacy. We are developing a network of experienced providers to successfully meet the needs of AHCCCS members. We fully expect to exceed these parameters and deliver a network unparalleled in quality and access. Please refer to the GeoAccess map on page 8, which illustrates the providers we already have under contract. We will build on the our base of hospitals, PCPs, specialists, and ancillary providers to establish a provider network that has the capacity and scalability to meet future expansion needs as a result of the ACA, including potential Medicaid enrollment expansion and the impact of the implementation of the Health Insurance Exchange provisions.

BCBSAZ Community Care understands that individuals need access at all times to a broad array of services designed to meet each person's unique cultural needs while simultaneously providing opportunity for choice. In addition to PCPs, OBs and Specialists, we understand the importance of leveraging home- and community-based services that allow members to safely remain in their homes, thereby avoiding costly and unnecessary hospital and skilled nursing facility (SNF) admissions. This understanding is foundational to our network development in Maricopa County.

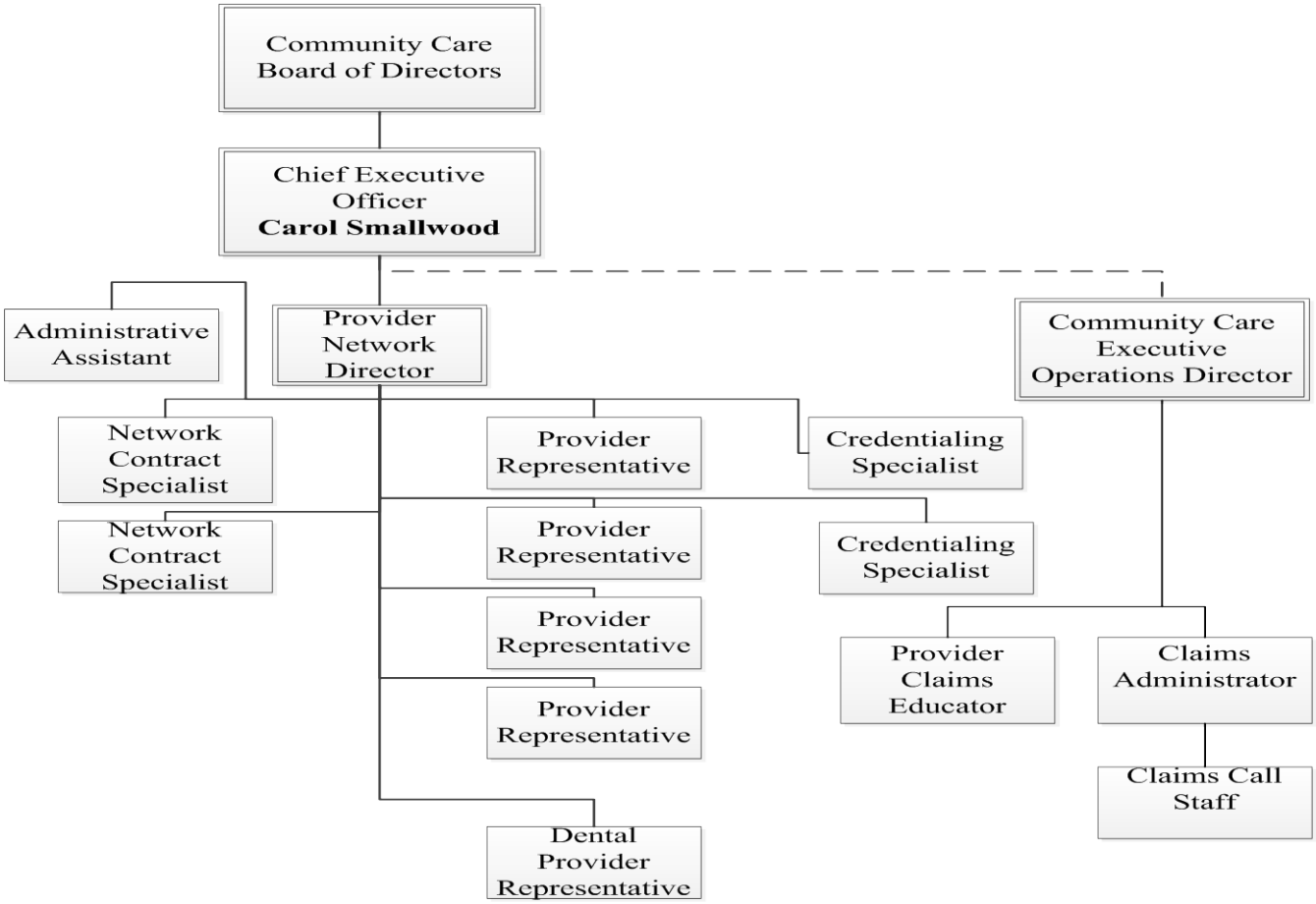
Network Management, Operational and Administrative Structure

BCBSAZ Community Care has already hired and has in place an AHCCCS-experienced leadership team to fulfill the operational administrative structure for this program. We will ensure that network, operational and administrative staff members are in place prior to BCBSAZ Community Care assuming functions in Maricopa County. Our delivery model exceeds the development and management functions outlined in the RFP to enhance member choice and cultural diversity. We have structured our Development and Management Plan not only to accommodate the funding, contracting, and reimbursement methodologies needed to ensure no disruption in care, offer providers 24/7 access to a BCBSAZ Community Care staff member for inquiries, and ensure that providers remain financially solvent; but we are committed to increasing network participation and satisfaction through effective financial and non-financial incentive programs.

BCBSAZ Community Care will have in place a network management team that will fully implement the AHCCCS network management standards contained in the RFP and provide a full complement of professionals to serve the needs of Maricopa County. Under the direction and leadership of Carol Smallwood, Chief Executive Officer, the Provider Network Director will provide guidance and oversight to an integrated BCBSAZ Community Care team of network contract specialists, provider representatives and credentialing specialists. To maximize administrative efficiency, our team also includes a provider claims educator who will work directly with providers and their staff members to ensure a clear understanding of the claims process. Our network management staff will be dedicated to regions and provider types enabling us to maintain close relationships with providers and monitor accessibility. Provider representatives are familiar with out-of-network providers in their assigned regions and have developed relationships with them to facilitate expansion of the network when appropriate. In addition to quarterly provider staff educational and training meetings, staff will visit PCPs and OBs once each quarter and specialists twice each year. Claims service representatives support providers by assisting with claims issues, real-time.

Ms. Smallwood, BCBSAZ Community Care's Chief Executive Officer, has extensive experience in Medicaid health plan and network management. The BCBSAZ Community Care staffing plan for network management is included in **Figure 1** on the following page.

Figure 1: Provider Network Management Department



Accommodating Future Membership Growth

In addition to our network management staff, the BCBSAZ Community Care operational and administrative structure will efficiently implement all program operations to accommodate the membership growth expected due to the ACA. Key performance indicators (KPIs), based on AHCCCS standards in each functional area (e.g., Member Services, Enrollment and PCP Assignment, Provider Claims Disputes, Complaints and Appeals, Claims/Encounters Administration, Prior Authorizations and Notices of Actions, Concurrent Review, Care Management Caseloads) will be monitored both daily and monthly through a management metrics dashboard. This monitoring allows us to accurately forecast staffing needs and to proactively have additional staff in place to accommodate growth. Our established staffing ratios will be monitored and maintained, and through our partner, APS Healthcare (APS), we have access to vast resources to rapidly recruit and hire qualified personnel necessary to accommodate program expansions in scope or enrollment. The reputation and long-standing statewide presence of Blue Cross Blue Shield of Arizona and Banner Health has allowed us to assemble an experienced leadership team and further enables us to attract and retain talent from a deep pool of resources.

BCBSAZ Community Care's network management approach and structure will play a critical role in training and retaining providers, coordinating with stakeholders, managing and facilitating network development activities, and collaborating with internal departments, to build an environment of continuous quality improvement and outcomes.

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

Evaluating and Measuring Network to Ensure Timely Access to Care to Underserved Populations

Network sufficiency is fundamental to quality and access to care. The underlying assumptions of network sufficiency begin with the qualitative understanding that a responsive and innovative network must:

- Be aligned with the principles of the system for all populations, ensuring easy access and convenient location and hours of operation, member choice, and culturally and linguistically appropriate services.
- Sustain a focus on community-based services, peer and natural supports, strengths, and recovery that maximizes the availability of community-based primary care and specialty care access and reduces utilization of emergency services, one-day hospital admissions, hospitalization for preventable medical problems, and hospital-based outpatient surgeries by using lower cost surgery centers when available.
- Meet the systemic needs of families and stakeholders and proactively involve members, families, support systems, and stakeholders in treatment planning.
- Adequately address treatment needs of people with co-occurring diagnoses and concurrent medical conditions.
- Implement best practices and innovative treatment, and monitor leading indicators of change.

Drawing on these qualitative assumptions, we will use the following quantitative measures to drive the ongoing sufficiency of the proposed network to meet or exceed all AHCCCS expectations:

- Current and projected eligible and enrolled members including their demographic characteristics.
- Current and anticipated utilization by service and population type to ensure access to the full continuum of covered services in accordance with AHCCCS requirements.
- AHCCCS required network access standards.
- Availability of culturally and linguistically appropriate services for members and families, routine and crisis, with language translation services as needed.
- Geographic location of providers relative to current and projected eligible individuals and members, with consideration to travel distance and time, physical accessibility, and transportation barriers so that members have an adequate choice of providers such that 90% of our members do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC); and a minimum of one hospital contract in each service district listed in ACOM Draft Policy, Acute Network Standards.
- Member complaints regarding access to care issues.

BCBSAZ Community Care will develop outreach programs that enhance the provider network through education and relationship development, executing the provider oversight requirements of AHCCCS and will execute these requirements with the highest level of courtesy and respect. We will ensure that our members do not endure unreasonable waiting times and that all members have access to care within the time frames outlined in AHCCCS policy.

Member Appointment Availability Review: BCBSAZ Community Care will perform Member Appointment Availability Reviews on a quarterly basis to ensure that statistically significant results can be determined regarding the availability of primary care, specialist, dental, behavioral health, and maternity appointments for all members with additional analysis for underserved populations. The Member Appointment Availability Reviews will address the availability of routine, urgent, and emergent appointments for all members and will include a review of prenatal services during the first, second and third trimesters for all pregnant members and specialized review of prenatal care for high-risk pregnancies. The review process will be monitored by the Provider Network Director and results and action plans will be reported to the Chief Executive Officer.

BCBSAZ Community Care will monitor provider compliance with appointment availability for both new and established members by provider type through statistical measurements, AHCCCS-required quarterly reporting, random calls, and complaint and appeal information. We will use random calling to determine appointment availability, after-hours coverage, and bilingual messaging for providers that are listed in the directory as being bilingual. In addition, we require all PCPs (internal medicine, family practice, general practice, pediatrics, and OB/GYNs acting as a PCP) and specialists to provide or arrange for medical care 24 hours a day, seven days a week. The provider or the designated covering physician or healthcare professional must be available to provide care personally, or to direct members to the most appropriate treatment setting.

In order for members to reach their physician after regular office hours, all contracted PCPs and specialists must have a telephone answering system or service available. Providers who use answering machines for after-hours services are required to include urgent/emergent instructions as the first point of instruction, information on contacting a covering provider, and a telephone number for after-hours physician access. In addition, Banner Health is currently implementing a portal, where electronic appointment scheduling will become available 24 hours a day, seven days a week for many of their providers.

When a provider fails to meet the access and availability standards based on random calls, there will be a follow-up call the next business day. The provider will be informed of the finding, given a corrective action plan, and informed that a follow-up call will be scheduled within 30 days. The provider will be monitored until found to be compliant. Failure to meet access standards may result in disciplinary actions, up to and including termination from the network.

Identifying Deficiencies in the Network

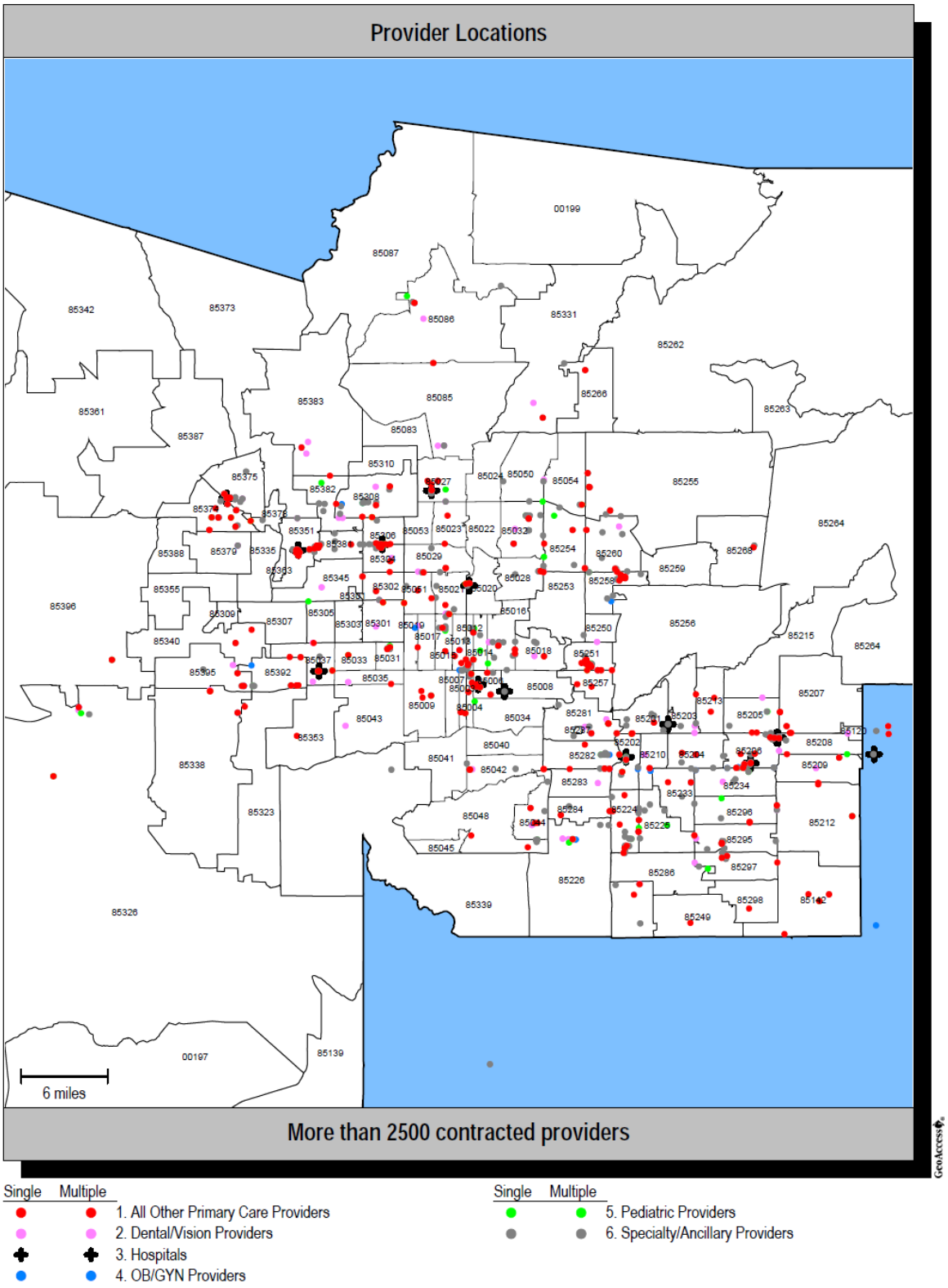
Gaps can and do occur within any provider network. The likelihood of gaps occurring within the robust network of BCBSAZ Community Care providers is greatly diminished by the strength of Banner Health and Blue Cross Blue Shield of Arizona. The partnership and commitment these organizations provide physicians and hospitals will be extended to AHCCCS providers through BCBSAZ Community Care. In addition, we are exercising great care in contracting additional providers of all specialty types across Maricopa County to ensure choice for our membership and to guard against any member traveling unnecessarily from family and support systems to receive appropriate care.

There are locations, like Gila Bend, Black Canyon City, and South Central Maricopa County where the loss of a specific provider type could result in a geographic provider gap. In the event that were to occur, immediate steps will be taken to ensure members in that geographic region have access to care with a similar provider specialty type. We will also work directly with the affected members to provide personalized assistance in making the necessary appointment and gaining timely access to transportation.

We believe that being accountable to members, caregivers, the State of Arizona, and all stakeholders in Maricopa County on the implementation date translates to ensuring that the network not only meets, buts exceeds, the RFP standard that 90% of the members in Maricopa County travel less than 10 miles/15 minutes to visit their PCP, dentist, or pharmacy. We currently have established relationships with most of the providers in Maricopa County and will continue to build upon these relationships should we be awarded the AHCCCS contract.

The GeoAccess map provided in **Figure 2**, demonstrates the network of BCBSAZ Community Care contracted providers that meet the AHCCCS network access requirement that 90% of its members travel less than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC); and a minimum of one hospital contract in each service district listed in ACOM Draft Policy, Acute Network Standards:

Figure 2: GeoAccess Map – Blue Community Care Network as of January 25, 2013



Managing the Network

BCBSAZ Community Care will implement Blue Cross Blue Shield of Arizona's Network Management methodology, including their Participating Provider Communications Plan that assists network providers in understanding administrative policies and procedures. Network Management Department staff will be led by Penny Marshall, a highly experienced Medicaid network management leader, and will provide support for the following key functions:

- Provider network maintenance by negotiating agreements with all provider types.
- Provider contract maintenance, file maintenance, and administration.
- Network accessibility and availability of services.
- Directory of participating providers (online and hardcopy).
- Provider relations program.
- Provider communications.
- Provider complaints, grievances, disputes, feedback, and suggestions.
- Provider education and training.
- Provider satisfaction monitoring.

BCBSAZ Community Care strives to maintain positive provider relations by providing support and sponsorship to organized medicine continuing medical education programs and seminars. We will provide sponsorship for Continuing Medical Education (CME) programs (based on budget approvals) through select professional society/organizations in our community (e.g., American Academy of Pediatrics, Arizona Academy of Family Physician, Arizona Osteopathic Association, American College of Physicians, Arizona Nurse Practitioner Council). We will staff the exhibitor booths at these events to greet the providers on their breaks, distribute information about no-cost educational materials available for use in their practice, information about electronic billing options and electronic funds transfers, and general customer relations support.

Components of the Network Management Plan include new provider orientation packets; a provider web portal; a provider newsletter; the Provider Operating Guide (administrative manual for all provider types); network activity updates and notices; written notices of changes in fee schedules or contracting provisions; and informing providers how to obtain claim, benefit, eligibility, pharmacy tiers, and appeals information.

Ensuring Quality: We will develop quarterly profiles and standard utilization reporting from available data and use statistical techniques to identify program outliers in terms of providers or service types. This analysis will identify best practices, outcomes, inpatient and Emergency Department (ED) use, specialty referrals, use of diagnostics, incorrect coding, member satisfaction and complaints, and total cost of care.

Making Improvements to the Network and Sustaining an Adequate Network

BCBSAZ Community Care will continually strive to improve our network, both in terms of access and quality. As previously discussed, we will provide continual monitoring of the access and adequacy of our network to AHCCCS members to ensure prompt availability of services within a convenient distance that meet or exceed the RFP requirements. In cases where we identify a weakness in our network, our team will recruit additional providers including drawing upon resources from Blue Cross Blue Shield of Arizona and Banner Health. These combined resources have more provider relationships than any healthcare organization in Arizona to positively encourage provider participation with BCBSAZ Community Care. Details about our ability to improve and maintain network adequacy was further discussed in our response to **Question 1**. To improve the quality of our network, we offer several initiatives, such as in-person and online provider training seminars, provider outreach services and provider profiling. We also will promote coordinated care through the implementation of Banner Health's Patient-Centered Medical Home (PCMH) network.

Ongoing outreach to providers, as well as our continued commitment to easing the administrative burden through technology improvement and innovative programs, will ensure that providers are satisfied with BCBSAZ Community

Care. Experience tells us that provider satisfaction is critical to maintaining access for both current and new members. Satisfied providers stay in the network and are less reluctant to take on additional AHCCCS members as patients, and accommodate the needs of current AHCCCS members in a timely manner. The BCBSAZ Community Care Network management strategy will closely mirror the successful approach employed by Blue Cross Blue Shield of Arizona to deliver world class service to providers. In the most recent 2012 physician satisfaction survey, Blue Cross Blue Shield of Arizona scored a 96% overall satisfaction rate among physicians. In their 2012 hospital satisfaction survey, Blue Cross Blue Shield of Arizona scored an overall satisfaction rate of 95%. In addition, Blue Cross Blue Shield of Arizona averaged an appeals and grievance to claims rate of less than 0.12% for the last three years.

3. AHCCCS supports efforts to reward desired care outcomes attained through care coordination and the provision of the best and most appropriate evidence-based care that results in lower costs. How will the Offeror use data and evidence based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies? How will these tools and data be used to implement outcome- and value-oriented payment models? Describe the Offeror's experience and specific results.

BCBSAZ Community Care is committed to achieving optimal health outcomes for all of our enrolled members while containing costs for the most vulnerable. We will provide the most innovative model of care, accessing the capabilities of Banner Health's highly coordinated patient experience, PCMH model and the total health care management and innovative technology of APS. This approach will provide the ultimate in value, member/provider experience, and care outcomes.

Care management, utilization management and outreach are delivered using a Total Health Management (THM) approach which includes wellness and prevention programs to keep members healthy, and provides targeted intensive care management for high-risk members with multiple chronic conditions. We use a member-centered, integrated, multi-disciplinary team (Care Team) that ensures members' medical, behavioral and social/environmental needs are proactively addressed with the highest caliber of member service.

Thus, BCBSAZ Community Care will provide the full spectrum of care management services, however, the continuum of services is held together by the coordination services provided by the PCMH, Banner integrated health system and by the APS field-based care coordination services. The field-based care coordination services provided through APS uses the available data sources and, with that data, produces information that allows our THM program to provide access to the best and most appropriate medical and community-based resources in the THM program. The following narrative is a description of how APS' analytics and technology will maximize BCBSAZ Community Care's coordination of services for the member.

Data and Evidence-Based Decision Support Tools to Maximize Care Coordination for Members, Improve Outcomes, and Create Cost Efficiencies

BCBSAZ Community Care's THM approach is driven by a state-of-the-art Advanced Identification and Stratification Matrix based on several validated models, as well as predictive methodology to determine an individual's acuity level and ranking within these levels. We determine the need for outreach or care management intervention based on clinical triggers which are customized for population needs. We determine member acuity levels ranging from low to high risk to drive the intensity and type of outreach needed. Within each acuity level, we prioritize the interventions based upon individual member needs and impactability (member ability to experience positive healthcare change). Cost of care is also used for acuity ranking. Our technology identifies the total claims costs during the most recent rolling 12 months. The whole population is ranked and assigned a value from 0 to 1, for example, PMPM percentile of 80 would be assigned a value of 0.8). Member complexity also considers the member's total number of chronic conditions and number of providers used.

Data Sources: Historical claims (medical, behavioral and pharmacy), lab, biometrics, electronic medical record (EMR) data, health risk assessment (HRA) and self-reported data.

Identification and Stratification Methodology: Our rules engine objectively assigns each member a risk or "acuity" level (low, moderate, high) and calculates a risk score for ranking within the acuity levels for the entire member population. Rules and algorithms are derived from evidence-based sources and methods including:

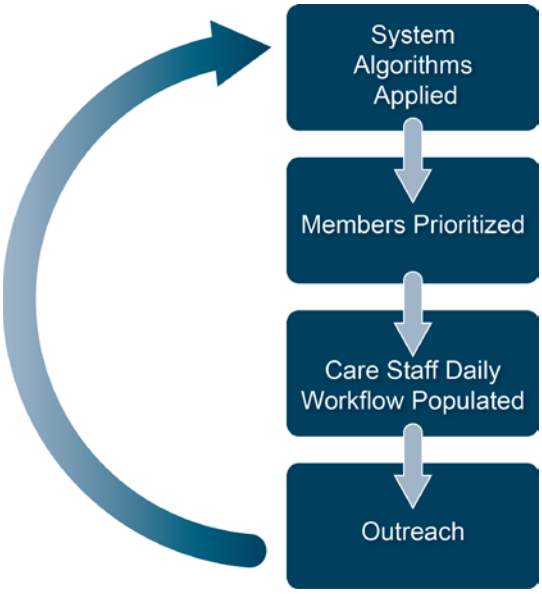
Actuarial risk via the Chronic Illness and Disability Payment System (CDPS). Our technology integrates data from multiple disparate sources to gain a 360-degree view and understanding of each member. These data sources include, but are not limited to, demographic data, CDPS algorithm (an industry proven risk-adjustment tool used to determine the actuarial risk based on their diagnoses) and historical medical costs. This diagnosis-based risk measurement tool produces 30 major disease categories corresponding to body systems or type of diagnosis, further divided into

subcategories by degree of expenditures associated with the diagnosis. The CDPS assigns an initial risk score to each member based on the member's current health risk (concurrent risk score) and the member's predicted program cost (prospective risk score) using demographic and diagnostic characteristics.

Measure Impactability through Access to Care Analyses. We adopted the method to assess members with poor access patterns, which was developed by the New York University Center for Health and Public Service and the Agency for Healthcare Quality and Research known as the Uncoordinated Care Analyses (UCC). It enables us to further evaluate potential issues related to fragmentation of care, as well as socioeconomic and structural barriers that impede access to care. For members with chronic disease who are compliant with the prescribed treatment plan and medically stable, there is little opportunity to impact their care. We do continue to analyze all member claims on a regular basis as part of our thoughtful monitoring to quickly identify individuals whose status has changed and who would benefit from our care management services. Conversely, there are members that use care inappropriately because of health literacy, socioeconomic or structural challenges. For members with multiple, uncontrolled health conditions who inappropriately use resources, we can create individualized solutions that positively impact outcomes.

Care Gap Analysis. The final component of our approach to measure member impactability uses a clinical data mining tool to identify instances of sub-optimal care and care gaps, when compared with evidence-based protocols for chronic diseases. The tool identifies members who lack recommended care for their identified conditions (e.g., a member with diabetes who has not had A1C or LDL-C tests or a member with asthma who is not taking an inhaled corticosteroid). The ability to integrate biometric screening, EMR and HRA data enables us to create more robust scores and "triggers" within the prioritization methodology.

Figure 3: Outreach Prioritization Process



Automated Daily Outreach Prioritization. Member outreach is automated using technology that prioritizes, or "percolates" members daily based on their changeable events. As demonstrated in **Figure 3**, the system identifies members with impactable behaviors and creates a prioritized list of members that is sorted based upon members' uncoordinated care and treatment gap triggers. The system's unique flexibility enables us to modify priority population triggers based on member- or contract-specific needs. This technology produces two important rankings for the population: 1) across all members to ensure those with the most urgent and impactable needs are contacted first; and 2) on a member-specific basis, to ensure that issues are addressed based on priority. Once members are identified as at risk, the system prioritizes them using a weighting process based upon risk assignment and ability to impact care to ensure outreach is made to the highest risk members first. We apply the relative weight using a sliding scale based upon frequency and timeliness of events taking into account the timeliness of triggers and recognizing that a member discharged last week has a higher risk of readmission than a member who was discharged three months ago.

Wellness and Prevention. Members' wellness and prevention needs are identified using our integrated registry software systems. Examples include, but are not limited to: women's health screenings such as cervical and breast cancer screening; appropriate prenatal care, children's needs such as lead screenings, EPSDT, and childhood immunizations; dental, nutrition, physical activity, safety assessment and education.

Care Coordination. Our systems prioritize care management/care coordination services that are designed to support and assist members with accessing healthcare and services to meet their unique individual needs across the care continuum.

Medication Therapy Management. To achieve maximum treatment effect and improve safety, unique individual member pharmacy profiles are compared against key health and safety indicators. This enables us to identify outliers,

such as: members receiving the same medication from more than one physician; members receiving several medications of the same type (polypharmacy); excessive or sub-therapeutic dosing; failure of high-risk members to fill prescriptions in a timely fashion (adherence); and discrepancies between diagnosis and medications prescribed.

Utilization Management. The spectrum of activities include prior authorization, concurrent review, retrospective review, and medical claims review utilizing nationally recognized, evidence-based standards to ensure appropriate use of resources.

Transition of Care (TOC)**.** We use established techniques and processes to effectively and appropriately manage TOC for members who are discharged from all facility-based care setting (i.e., acute, long term acute, skilled facilities). We ensure that they are integrated back to their PCMH and community.

Chronic Disease Management. We manage the traditional chronic conditions (i.e., diabetes, asthma, COPD, CHF, and CAD) via a holistic approach that additionally addresses the members' bio-psychosocial issues. Monitoring, trending and tracking allow us to focus on member education, self-management and managing gaps in care through various interventions. Also, complex members (who have multiple conditions, receive care from multiple providers in different settings, take numerous medications and very frequently have a co-occurring behavioral health condition) would be considered high risk and managed via our intensive care and disease management model.

Maternity Program. This program identifies expectant mothers through a variety of methods including comprehensive claims analysis (i.e., medical, pharmacy, diagnostic, etc.), EMR, successful partnering with physicians, and through case management. Case managers will work with the Maternal Child Health/EPSDT Coordinators to coordinate care for expectant mothers with health conditions. We conduct a number of outreach efforts to enroll members as early as possible in their pregnancy. This program enables us to effectively assess, track, manage and report on each member's clinical status and progress. Additional features of the program include initial risk assessment and stratification, high-risk interventions, and post-partum assessments. The program also includes post-delivery, new mother guidance and scheduled outreach focused on newborn care, appropriate scheduling of well-child visits, that is designed to reduce inappropriate ED usage for newborns. We provide access to a 24/7 nurse advice line to help new mothers with questions related to newborn care and treatment for common childhood illnesses.

Evidence-Based Decision Support Tools and Data Used to Implement Outcome and Value-Oriented Payment Models

We achieve cost savings not by limiting access to care, but through identification, stratification, early intervention, enhanced care coordination, and a focus on community-based services. The most effective way of controlling costs is to ensure appropriate care is provided at the right time, in the right setting, and at the right level of intensity.

Care Coordination Reimbursement for PCPs: Understanding the challenges providers face in managing their practices and staying on top of the ever-evolving healthcare system and rising costs, BCBSAZ Community Care supports incentives to PCPs to provide quality care. Providers designated as PCPs shall be reimbursed for providing care coordination activities and collaboration with our Care Team. Reimbursement for these activities shall begin on October 1, 2013 for physicians or groups with 50 or more paneled members. Specific care coordination activities will be developed and measured in alignment with AHCCCS program goals and shared with network providers prior to October 1, 2013. The goal of the care coordination activities is to ensure members receive high quality and highly efficient care even when current billing mechanisms do not allow the provider to bill for those services. Provider eligibility for this program will be based on meeting quality of care indicators (e.g., HEDIS), satisfaction scores, and other Quality Improvement projects.

Banner Health has additional comprehensive care coordination methodology for Banner Medical Group given the high level of data and clinical integration. The detailed program includes panel size, member acuity, clinical effectiveness, performance metrics, resource utilization, and member satisfaction.

Provider Profiling/Standard Utilization Reports: We develop quarterly profiles and standard utilization reporting from available data and use statistical techniques to identify outliers in terms of providers or service types. This analysis

identifies best practices, outcomes, inpatient and ED use, specialty referrals, use of diagnostics, incorrect coding, member satisfaction and complaints, and total cost of care.

Total Cost of Care Management: A dedicated team performs rigorous ongoing analyses to identify categories of cost, drivers of cost, and unexpected variability to ensure adherence to budget, creation of mitigating interventions, and appropriate utilization of resources.

Quality Improvement Processes: There is a well-designed process, staffed with qualified individuals and fully implemented system-wide quality improvement plan that continuously monitors, trends and tracks information to improve care outcomes, improve member and provider satisfaction, and lower medical spend. Information will be used for identification of improvement opportunities, selecting quality improvement projects, and measuring clinical effectiveness.

Quality and Clinical Effectiveness Committee: We will have an established quality program that is the foundation for all quality activities conducted throughout the health plan. This program monitors the quality and appropriateness of care and services delivered to members based on community, regulatory, internal and national standards. The program consists of established policies, procedures and activities that support the organization's vision and mission, as well as meet contractual requirements. A component of this program is the work plan that includes specific objectives designed to demonstrate how we will monitor the care and services delivered to our members. BCBSAZ Community Care uses specific measurable indicators, benchmarks and methodologies to determine if improvements in the delivery of care and service have been achieved. The BCBSAZ Community Care Board of Directors (BOD) has ultimate authority and responsibility for the program's quality and integrity. Oversight of the program is delegated to the Chief Medical Officer (CMO) by the BOD through the Chief Executive Officer (CEO). The CMO, with input from all functional areas, is responsible for ensuring all program components are relevant to BCBSAZ Community Care membership and carried out in accordance with BCBSAZ Community Care policies and procedures.

Experience and Specific Results

APS Healthcare Care Management Services: As BCBSAZ Community Care's partner for the delivery of care management services, APS currently provides services to over 11 million members in 30 Medicaid programs and 22 states in the U.S. and Puerto Rico. Their relationships include direct contracts with states to manage their Medicaid Fee-for-Service (FFS) programs; providing care management and behavioral healthcare services to 11 health plans; and total health management programs for commercial and other government specialty contracts.

Below we have listed examples of successful interventions that have resulted in significant improved care outcomes:

Example of Telephonic and Community-Based Coordination: Pennsylvania Enhanced Primary Care Case Management and Disease Management: APS provides telephonic and community-based care coordination services including scheduling PCP appointments, appointment reminders calls and assistance with scheduling transportation. Over the first 18 months of operations, APS outreached to 175,000 members regarding a general health assessment; assisted more than 27,000 members to coordinate dental services; and answered more than 270,000 in-bound member calls. They provide targeted education and support to empower participants with self-care skills to better manage chronic conditions. This education is provided telephonically as well as face-to-face with an increased concentration on in-person interaction focusing on high-risk members.

Example of THM program: Wyoming Healthy Together Total Population Health Management Program: APS provided the State of Wyoming Department of Health a THM program for its Medicaid members - Healthy Together. APS delivered a comprehensive array of services to a population of 84,000 members. The program served as a portal of entry for members into the healthcare system, offering member identification for those at risk, risk stratification into population tiers, and appropriate interventions based on stratification. APS facilitated healthy behaviors and self-management of illness. Outcomes and accomplishments of the program include:

- DMAA award recipient for Best Government Disease Management Program.

- Independent validation by Milliman Consultants showed a 25% reduction in Medicaid inpatient hospital utilization, 11% reduction in ED visits for members with asthma, $12.7 million in annual cost avoidance.
- A reduction of over 38 admissions per 1,000 and an estimated cost savings of approximately $20 million from 2010 to 2011.
- Reduction in average length of stay (ALOS) for Psychiatric Residential Treatment Facility services from 2010 to 2011 contributed to over $1 million in cost savings.
- Realized ED cost avoidance for non-trauma visits from 2010 -2011 contributed to over $1.2 million in savings.

Example of Maternity Care Management for Quality Outcomes: APS has provided a maternity management program since 1993. This program works collaboratively with physicians and expectant mothers to assure healthy outcomes through high-risk identification, intervention, education, and coaching on healthy lifestyle choices. BCBSAZ Community Care will work to implement this successful maternity program for AHCCCS members. This program has been able to achieve savings for members through effective support of at-risk individuals, and thus avoiding the high costs associated with pre-term deliveries. **Table 1** below shows APS maternity management outcomes as compared to the national average for Medicaid members.

Table 1: Outcomes Compared to National Average

Deliveries	APS Maternity Management	National Average
Prenatal Care-First Trimester	91.2%	83.4%
Full-Term	92.5%	87.9%
Pre-Term	7.5%	12.1%
Cesarean Sections	25%	26.1%

Banner Health Experience with Hospital to Home Transition: We believe that a large portion of preventable re-admissions will be avoided if members are connected promptly after discharge with their PCP. We use case managers working within the Banner Health Network physician practices and throughout the BCBSAZ Community Care network, and have three goals for reducing readmissions: ensure members understand their physician's care plan; assist members' availability of their prescribed medications; and assist in securing follow-up medical attention they need to keep their conditions under control.

This successful Care Management model ensures that members receive well-coordinated care that helps them live healthier, more productive lives while keeping the cost of medicine affordable. This model has been employed by BCBSAZ Community Care partner, Banner Health, and resulted in savings that were realized from fewer ED visits, a reduction in ALOS, and lower readmissions. For example, in 2012, the ALOS for the organization was 3.81 days. This number represents an overall 7.52% improvement in ALOS or a total of 66,986 total potential saved days across the 11 hospitals that participated in the strategic initiative.

The Banner Health program employs embedded case managers that telephone members within 48 hours after discharge to assess their status, review their care plan and medications, and confirm or make follow-up appointments to engage the members in their own care. Case managers ask the member questions about their understanding of their care and any problems that would prevent the follow through of the discharge plan. They then proactively provide assistance with issues that would put the members at risk, such as access to pharmacies and reliable transportation to appointments. As part of this program, most at-risk - Adult Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN) and Childhood Asthma members will have an appointment scheduled within three days with a provider prior to discharge, as well as post-hospitalization symptom and medication management.

4. Mr. Andrews is a member in your plan and is extremely overweight and spends long periods in bed due to ill health and complete exhaustion. He has no family. He cannot walk 100 feet without resting. His medical diagnosis is COPD and he has a chronic cardiac condition following two heart attacks and stent insertions. When he becomes short of breath, he becomes very anxious and calls 911 to take him to the ER. He has been to the ER 12 times in the last six months. His PCP has referred him to the health plan for disease management. Please describe how the Offeror would address the needs of Mr. Andrews. Describe what systemic processes the Offeror will use to improve health care outcomes for members with one or more chronic illnesses.

Addressing the Needs of Mr. Andrews

Mr. Andrews' multiple chronic conditions and frequent ED use would have identified him as a candidate for our Care Management program and he would have been assigned to a case manager before excessive ED visits would have occurred. This program integrates community-based, targeted and intensive case management with telephonic case management and meaningful, data-driven provider outreach as well as prevention programs to keep members healthy. We use a member-centered, integrated, multi-disciplinary team (Care Team) that ensures members' medical, behavioral and social/environmental needs are proactively addressed and with the highest caliber of member service. The program, which addresses the complex combination of chronic physical and behavioral health conditions for adults and children, has proven successful because of its holistic and member-centered approach. Just as importantly, it also addresses the individual environment and socioeconomic factors that influence the member's healthcare and well-being, such as reliable transportation, medical home/PCP coordination, housing issues, and social support system.

Since there is a high likelihood that Mr. Andrews is not compliant and not an active participant in his care, we will use such techniques as Motivational Interviewing, culturally appropriate content, and easily understood language for member engagement. Motivational Interviewing is defined as a collaborative, member-centered form of guiding to elicit and strengthen motivation for change, and is based on collaboration between the case manager and the member; evoking or drawing out the member's ideas about change; and emphasizing the autonomy of the member. The strategies employed include using open-ended questions, affirmations, reflections and summaries. The expected outcome is to engage individuals who are disinterested and or resistant to change to become motivated, an active participant in their own care, and stop undesired actions that are detrimental to member's health and well-being.

The next step after enrollment into this program would include the development of a comprehensive plan of care that will address all of Mr. Andrews' healthcare and social needs. He would be assigned to a BCBSAZ Community Care case manager who will maintain frequent telephonic and in-person contact with him. The plan of care will include a COPD action plan specifically providing him with the knowledge to recognize changes in his condition early, and self-management tools that will enable him to manage his medication, self-monitor and escalate his condition changes to his Care Team (with the creation of an acute action plan) and set goals, by defining roles and responsibility, establishing timelines and the date of next contact, and obtaining feedback to ensure understanding and agreement. Mr. Andrews' plan of care will cover at a minimum: an assessment of living conditions, activities of daily living, functional status, evaluation of existing and potential social support systems, identification of barriers to accessing care, medication management treatment, education on COPD, CAD, proper nutrition and weight management, exercise and physical activity, home care management, behavioral health evaluation, and assessment of need for biometric monitoring. The action plan will be prioritized to manage his COPD, cardiac and morbid obesity at the most appropriate level of care.

Following completion of the plan of care, we will share it with his PCP and will obtain his/her input. In particular, we will discuss the need for specialist referrals to pulmonary, cardiology, a nutritionist and weight management program, and behavioral healthcare to ensure that all his chronic conditions are managed appropriately. We will support Mr. Andrews' plan of care through continued education and messaging and relaying the importance of treatment by his medical home, particularly in this case where Mr. Andrews requires routine follow-up and frequent plan of care monitoring for his chronic conditions and linking him to available community-based outreach services and

coordination with his specialists. The case manager will help coordinate new appointments and will accompany him to his PCP appointment.

One of the distinct features of our care management program is that for specific cases such as Mr. Andrews, his case manager would conduct an in-home visit to assess his personal economic, living, social and healthcare needs and coordinate services and resources – from basic needs to complex healthcare issues. In addition, these programs are supported by web-based coaching and/or face-to-face counseling. Our case manager will be instrumental in managing Mr. Andrew's obesity, which may also be a contributing factor to his shortness of breath. The case manager will make program referrals based on his motivation level and availability/accessibility of weight management via meeting locations, online tools and self-management resources. The case manager will make calls to Mr. Andrews to assess his weight loss progress, encourage and motivate him to continue participation, and re-iterate the importance of exercise and proper nutrition. The case manager also tracks if there is a change in his diagnosis or pharmacy utilization during the weight loss process. The importance of this valued relationship is evidenced by member feedback and actual weight loss results.

The PCP and the case manager will collaborate to identify, evaluate and refer to behavioral health providers through the use of validated behavioral health screening instruments. By using valid and scientifically proven screening tools, PCPs can detect underlying depression and/or anxiety early and make appropriate referrals to a behavioral health provider. Working with Mr. Andrews' PCP, we would perform a depression/anxiety screening and if appropriate, will coordinate with the Regional Behavioral Health Authority (RBHA), and assist him to find the resources necessary to treat his condition.

In an effort to reduce Mr. Andrews' inappropriate use of the ED, we use proven, highly effective member education with effective care management that augments the services provided by PCMHs. To support Mr. Andrews' concerns, we will offer 24/7 access to nurses to answer health questions, help him determine the urgency of his situation and advise if his condition warrants an ED visit. The Nurse Line is staffed with Registered Nurses (RNs) that can provide Mr. Andrews with information that may help him avoid going to the ED, act as entry point to the care management services after hours (e.g., disease management, etc.) based upon his specific needs, as well as connect him to the other health information resources (audio, web, telephonic, etc). If Mr. Andrews experienced shortness of breath and began feeling anxious he could speak with an RN at any time, day or night. The RN would advise and assist Mr. Andrews with making the appropriate healthcare decisions. The RN would document all information and his dedicated case manager would contact him the next business day for follow-up. One of the best features of the Nurse Line is that the RN would also be able to provide Mr. Andrews with an appointment with his PCP.

For all of our members with chronic conditions such as Mr. Andrews, BCBSAZ Community Care will implement an ED diversion initiative that uses personalized interventions that provide opportunities for one-on-one education about the appropriate use of ED services. Our risk identification and stratification software performs daily prioritization of members to identify those who need outreach by our case managers. The prioritization will be based on an analysis of members' historical claims data using algorithms developed and validated by New York University's Center for Health and Public Service Research. We will also use clinical data mining tools to identify instances of sub-optimal clinical care when compared with evidence-based protocols for chronic disease, as gaps in care frequently drive ED use. Interventions by the case manager may include meeting the member in the ED to support their discharge plans, or within two business days after the event to address specific needs, such as securing appointments with the PCP, identifying a PCMH, or resolving transportation issues that result in ED use. BCBSAZ Community Care will also supply PCPs with a list of their high ED utilizers and support their efforts to educate their patients on the appropriate use of the ED.

These efforts will be supplemented by real-time interaction at the point of care in cooperation with the provider ED facility. Banner Health has also implemented an ED diversion program that performs triage when AHCCCS members arrive at the ED with non-urgent issues (i.e., cough and cold symptoms) and provides suitable alternative primary care options. Because of our integrated approach, BCBSAZ Community Care will be able to capitalize on this, as we will have an "early warning system" when one of our members presents to a Banner ED. We will not have to wait for a

claim submission to be alerted to an inappropriate use of the ED. Our case managers will contact those members early enough to have a meaningful impact on behavior.

In summary, Mr. Andrews will be provided with appropriate health and disease education, access to care in the most appropriate level of care setting, a comprehensive (physical, behavioral, nutritional, social support) evaluation and action plan with appropriate home health services and monitoring, Nurse Line access, and close follow up of his status by his PCP and case manager. His multiple chronic conditions will be well managed as evidenced by reduced ED visits, increased medication compliance, PCP, specialist and case manager appointment completion, weight loss achievement, active participation and compliance with his care plan, improved functional status, and becoming an active member of his community. **Error! Not a valid bookmark self-reference.Table 2** outlines our approach compared to traditional models.

Table 2: BCBSAZ Community Care Total Health Management Model

Conventional DM Model	BCBSAZ Community Care Total Health Management Model
Strictly medical approach	Multi-dimensional, integrated medical and behavioral approach addressing social issues, structural needs and high-risk symptoms and behaviors and provide linkages with PCP and specialist, community support services that may or may not be related to covered benefits; assistance and access for social support or community agencies
Single disease-focused	Member-focused, applying coordination of services and care based upon the member's hierarchy of needs
Identification and stratification of high-risk members with single and multiple chronic conditions	Identification of members through analysis of lab, pharmacy, biometric, HRA, EMR data, as well as current impactable conditions
Limited to educational interventions	Comprehensive approach addressing member's basic and complex needs – social, clinical and educational interventions that enable members to self-manage their chronic conditions and seek appropriate care by being able to identify early warning symptoms
Delivery model: Telephonic	Delivery model: Community-based engagement (with members and providers) and intervention as well as telephonic coordination based on members' needs
Monthly or quarterly stratification using claims	Patent-pending technology which applies criteria and member-specific algorithms to prioritize members daily within acuity levels based on urgency, impactable opportunities and completed outreach activities
Multiple IT systems	Single technology platform that integrates disparate data sources, including (but not limited to) claims, EMR, HRA, biometric, utilization, diagnostic, and pharmacy data to drive workflow, produce a single web-based Plan of Care, and deliver integrated cost and quality reports
Provider engagement via telephone and mail	Providers receive meaningful and actionable information through methods that best fit their preference and workflow: telephone, mail, in-person visits and online Provider Portal. Tools and staff enable providers to obtain access to members' clinical history and gaps in care. Support for care management interventions also provided in-person and telephonically

Systemic Processes BCBSAZ Community Care Will Use to Improve Healthcare Outcomes for Members with Chronic Illnesses

Comprehensive Systems of Care: BCBSAZ Community Care will use a systematic approach to manage the full spectrum of physical, behavioral and social issues which include, but are not limited to, application of bio-psychosocial care, and employment of effective tools to engage members to modify their behavior such as motivational interviewing, coaching, and persistence with those resistant members. We will use multiple methods of

outreach based on member preference (email, text, web, US mail, telephonic, face-to-face) and conduct frequent telephonic and direct meetings with the members. We will assist with discharge planning and follow-up within two business days after the event to address specific needs, such as securing appointments with the PCP and identifying a PCMH, coordination of care, and resolving transportation issues. Proactive use of information systems and technology will identify members in need of intervention, using evidence-based guidelines and tools and disease management programs for the most prevalent conditions. We will work closely with and support PCPs: provide a list of their high ED utilizers; support their patient education efforts; exchange most up-to-date contact information; assist when members have not seen their PCP or when they are unable to reach their patients; provide access to, availability and direct involvement of the BCBSAZ Community Care medical director; and conduct robust medical management activities to ensure efficient and appropriate use of resources.

Daily Data Mining to Identify Members at Risk of Hospital Admission: For all of our members with chronic conditions such as Mr. Andrews, BCBSAZ Community Care will implement an ED diversion initiative using personalized interventions that provide opportunities for one-on-one education about the appropriate use of ED services. Our risk identification and stratification software performs daily prioritization of members to identify those who need outreach by our case managers. The prioritization will be based on an analysis of members' historical claims data, using algorithms developed and validated by New York University's Center for Health and Public Service Research. We will also use clinical data mining tools to identify instances of sub-optimal clinical care when compared with evidence-based protocols for chronic disease as gaps in care frequently drive ED use.

Prioritized Workflows Direct Outreach to the Most "Impactable": The system prioritizes member outreach efforts based upon individual member needs and "impactability." For example, a member has several chronic conditions and is in need of a liver transplantation. He is on the organ transplantation waiting list and is taking daily measures to manage his chronic conditions, with support from the Care Team, as needed, to ensure that issues related to transportation, medications, and follow-up appointments are attended. Though high risk with potential for hospital admission in the future, the member is currently receiving all support available. Comparing this case with another high-risk member with poorly controlled chronic conditions and not receiving care from PCP. This member is more impactable than the first member, and therefore is prioritized. The Care Team outreaches and engages the member to secure an accessible medical home, and ensure creation and compliance to a plan of care.

Patient-Centered Medical Home (PCMH): BCBSAZ Community Care would ensure that Mr. Andrews and all AHCCCS members have an identified, accessible medical home that provides comprehensive and coordinated care. A PCMH is a multi-disciplinary, integrated and culturally competent healthcare delivery that provides comprehensive and continuous medical care to individuals with the goal of obtaining maximized health outcomes. PCMH is designed to provide better access to healthcare, increase satisfaction with care, improve health, and reduce healthcare costs. Essential components of PCMH include care coordination, use of health information technology, and appropriately trained staff practicing at the top of their license.

Through integration with the Banner Health Medical Home and through the existing relationships with Maricopa Integrated Healthcare District, District Medical Group and Bayless Behavioral Solutions, we can provide medical home services for large populations of ethnically diverse membership. Medical literature shows that medical homes can reduce healthcare disparities and enhance care outcomes through improved access and better coordinated care. For those members who prefer to be assigned to their PCP, their assigned PCP will serve as a medical home. For members in outlying areas of Maricopa County, transportation is especially important. BCBSAZ Community Care will assist those members with coordinating transportation to ensure members have access to care.

The BCBSAZ Community Care community-based approach to care management is developed to address the needs of all members. Case managers visit and collaborate with high-volume providers to meet directly with members and may also schedule time in non-clinical settings and member residences. To promote medication adherence, particularly among persons who reside in these more remote areas and/or those with limited mobility, we identify pharmacies that will automatically deliver prescription refills so that the member has consistent access to medication therapy.

Keeping the medical home engaged and productive is vital to the success of the medical home. Data from multiple sources such as EMR, biometrics, HRA, claims, lab and pharmacy are used by our analytic system to generate a comprehensive risk score for each member. This process stratifies the members based on indicators of uncoordinated care such as ED and inpatient utilization, gaps in care, poor medication adherence, and readmissions to inpatient care. We then use this prioritized listing of members for outreach to both members and their medical homes. We provide member and practice profiles to PCPs that help identify gaps in care, and member rosters that identify members with specific chronic diseases, highlighting services that may have not been scheduled and/or delivered. This approach arms medical homes with actionable information that offices can use to identify and prioritize needs. At the same time, we work directly with members to coordinate care for medical and other needs, and help them develop self-management skills. This analysis approach results in a process of continuous surveillance that drives workflow on a daily basis for coordinated care and holistic strategies to solve problems and strengthen engagement with the medical home.

5. George Robertson, a 29 year old AHCCCS member, was involved in a motor vehicle accident on March 1, 2012. After immediate stabilization at the scene, George was rushed to the Arizona General Hospital and treated in the emergency room as a trauma patient. George sustained multiple injuries including a fractured femur, internal bleeding, and trauma to the sternum. After surgery to resolve the internal bleeding, and internal fixation of the fractured femur, George was transferred to the hospital floor. George has been an AHCCCS member for five years. George has a history of substance abuse which may have been a contributing factor in the accident. George is in active substance abuse treatment with a Regional Behavioral Health Authority provider but is not consistent in participating in treatment. After 21 days in the hospital, George is discharged home. George lives alone in a run-down apartment complex in Phoenix. George must navigate two flights of stairs to reach his apartment. Four weeks after discharge, George was found by a maintenance worker at the bottom of the stairs. Paramedics were called and George was rushed to the emergency room. George was diagnosed with a head injury, later determined to be a traumatic brain injury, and broken ribs that were sustained from the fall down a flight of stairs. George was found to be in possession of illegal substances by the paramedics, resulting in police involvement at the hospital. After an additional four day inpatient stay, George is transitioned by the hospital Social Worker to a skilled nursing facility that specializes in TBI patients. The skilled nursing facility is not a contracted provider. Describe what processes would be used to coordinate care for George as he moves through the continuum of care related to these documented health issues. What does the Offeror see as the greatest setback risks/challenges for George and how will the Offeror proactively address these concerns?

BCBSAZ Community Care employs a THM approach to our care management processes that is comprehensive and integrated across the entire continuum of care. In the case of Mr. Robertson, these approaches would include, but are not limited to: integration and coordination with RBHA, concurrent review, discharge planning, non-par management (out-of-network care), social and behavioral health (substance abuse), development of a plan of care, telephonic and face-to-face care management including motivational interviewing techniques, a lock-in program, hospital-to-home transition, and other transitions of care.

Processes to Coordinate Care through the Continuum of Care

BCBSAZ Community Care's medical management process and facility contract elements include requirements for timely notification of admissions. This allows us to conduct concurrent review using recognized industry standards throughout the entire length of stay, with proper discharge planning starting at the time of admission.

There were several issues that were not managed appropriately during Mr. Robertson's initial stay. The opportunities for improvement include adequate rehabilitation, appropriate level of care, ongoing substance abuse, safety issues, adequate social support, and coordination of care with the member's PCP, substance abuse provider (RBHA) and the health plan.

If BCBSAZ Community Care had been Mr. Robertson's health plan, through our comprehensive THM approach, we would have already been aware of the substance abuse issue and would have initiated care coordination with his RBHA. When notified of the initial admission, we would initiate care coordination with his PCP, the RBHA and other care providers. For cases like Mr. Robertson, our case manager would seek a bio-psychosocial assessment and offer an immediate psychiatric evaluation in coordination with the RBHA. Also during this initial assessment, we would have identified and contacted his PCP and the RBHA case manager to obtain a better understanding of his history and situation. Once the initial needs assessment was completed, our case manager would meet with him to provide support and convey the importance of aftercare via follow-up counseling on substance abuse services and utilizing other in-network providers. Following the assessment, a comprehensive plan of care would be generated that addresses his post-acute medical care, rehabilitation services and psychosocial services. The plan of care specifically calls for coordination of efforts between BCBSAZ Community Care and RBHA case managers. The BCBSAZ Community Care medical director would engage the PCP and RBHA medical director in a three-way call to address and manage all physical and behavioral health issues.

Members with chronic and ongoing substance abuse are more inclined to resist change and are less likely to be motivated to engage as an active participant in their own care. One of the methodologies used to manage such situations is Motivational Interviewing that is defined as a collaborative, member-centered form of guidance to elicit and strengthen motivation for change. Motivational Interviewing is based on collaboration between the case manager and the member; evoking or drawing out the member's ideas about change; and emphasizing the autonomy of the member. The strategies employed include using open-ended questions, affirmations, reflections, and summaries.

BCBSAZ Community Care recognizes that Mr. Robertson underwent open reduction and internal fixation (ORIF) surgery and experienced a 21-day LOS. We have a robust concurrent review process that follows the member from admission through discharge. We would apply evidence-based standards of care to ensure his level of care during his inpatient stay was appropriate and that he received evaluation for functional status, environmental safety at home, and family and social support. However, if Mr. Robertson refused transfer to an SNF, our case manager would determine whether his support structure (family or friends) could provide temporary alternative living with appropriate supervision during his recovery. We would also assist him in making other housing arrangements or using other community-based services, as necessary. If Mr. Robertson did not have a medical home or PCP, BCBSAZ Community Care would help him identify one and coordinate services for substance abuse with his RBHA provider. We believe that promoting a PCMH and working with members to maintain their medical home relationship is essential in promoting adherence to treatment and prevention plans.

Unfortunately, after his initial discharge, Mr. Robertson sustained a traumatic brain injury (TBI), and was discharged to a non-contracted SNF after only four days of inpatient care. Again, there are several opportunities for improvement including adequate rehabilitation, coordination of care with his health plan, use of non-contracted providers and potential ongoing substance abuse. BCBSAZ Community Care has effective processes in place to prevent complications and proactively manage these uncoordinated activities from occurring**.**

The ultimate goal for Mr. Robertson in both admissions is successful integration into the community. Therefore, the BCBSAZ Community Care case manager would develop an integrated care plan to manage his medical stability, level of dependency (activities of daily living), safety, clinical rehabilitation, assistance with self-care and mobility, and social support systems. We would address Mr. Robertson's care by providing and facilitating the following processes and interventions:

Acute and post-acute medical care: Continuous and ongoing concurrent review and strong discharge planning ensures delivery of optimal care at the most appropriate care setting. Our program includes an integrated Transition of Care (TOC) through each phase of his recovery, including medication reconciliation and timely follow-up care with his PCP. We would help assess the need for the Arizona Long Term Care System (ALTCS) for ongoing placement services. We would also determine if the involvement of a physician, with expertise in providing care in extended care facilities, would be appropriate for improving care and reducing the probability of readmission.

BCBSAZ Community Care has fully established and implemented processes to effectively and appropriately manage TOC for members who are discharged from inpatient settings, extended care facilities and other settings of care. We ensure that all members understand the importance of follow-up care and that all basic needs and medical support systems are coordinated. Our approach provides improved care coordination for members upon admission and reduces the likelihood of readmissions. The following summarizes our approach to managing TOC.

- Plans of Care — A comprehensive and dynamic plan of care would be maintained in the care management system and shared with the member's PCP that would address the full spectrum of needed interventions for the member (medical, behavioral, social).
- Follow Up — The Care Team follows up with the provider and the member post-discharge to ensure that the member makes it to his follow-up appointments and receives the services necessary for their recovery.

- Medication Information — All medications are listed in our care management system; a reconciled listing would be sent to providers, and members.
- Hand-Offs Between Settings — Direct and close coordination between facilities and community-based providers to ensure consistent understanding of member status and follow-up via robust clinical record and plan of care sharing.

Rehabilitation services: We would obtain an evaluation by a physical medicine specialist to verify whether he would benefit from rehabilitation services. If so, we would address physical, functional and cognitive deficits, and the appropriate delivery setting. Standardized tools would be used to document progress and transition to the next level of care.

Substance abuse: If proven to be an ongoing issue, Mr. Robertson would be encouraged to enroll into a substance abuse treatment program upon successful completion of rehabilitation. This service may be provided in the inpatient or community-based setting, and BCBSAZ Community Care would require coordination of services with all providers.

Psychosocial services: TBI survivors usually have ongoing psychological issues that require evaluation and ongoing counseling. The case manager would work with RBHA and community providers to ensure adequate services are delivered and would follow up with the member as needed.

Vocational and skills building services: We recognize that cognitive rehabilitation requires close collaboration between the AHCCCS plan and the RBHA team because there may be grayness between the covered services under each plan. For example, cognitive deficits with associated behavioral and emotional disturbances (outbursts, disruptive behavior, depression, irritability, etc.) would be covered under the RBHA and require vocational and skills building services to remedy the deficits. BCBSAZ Community Care would work closely with the RBHA case manager to provide referrals for Mr. Robertson to community resources, like those found within ADES Division of Employment and Rehabilitation Services, to support his recovery.

***Appropriate housing and placement*:** Mr. Robertson required placement in an environment that provided safety and needed supervision while maintaining his independence and autonomy. Depending upon his functional status, his options include, but are not limited to: living independently, living with family members or friends, or living in a group home. The critical element is availability of trained and qualified caregivers. The case manager would identify all social support systems, community resources, funding sources, and coordinate with providers to create an individualized solution for Mr. Robertson.

Vocational rehabilitation services: The case manager would assist Mr. Robertson in connecting with Arizona Vocational Services in Maricopa County (https://www.azdes.gov/rehabilitation_services) to provide vocational rehabilitation to achieve increased independence and/or gainful employment through the provision of comprehensive rehabilitative and employment support services in a partnership with all stakeholders.

***Other support services*:** BCBSAZ Community Care would assist with referrals to local/regional advocacy organizations to help locate local support groups and other resources.

Patient-Centered Medical Home (PCMH): If Mr. Robertson does not have a medical home, BCBSAZ Community Care would help him identify one. Mr. Robertson's complex condition would be best managed by a multidisciplinary, integrated Care Team to improve adherence to treatment and prevention plans.

Follow-up Care after Hospitalization Experience

An example of the types of programs our team has pioneered to improve outcomes across the continuum of care is APS' FUH7 program to improve follow-up after hospitalization for a mental illness within seven days. Medical literature indicates that availability of follow-up care within seven days of discharge from hospitalization for mental illness is a strong predictor of reduction in hospital readmissions. Facility treatment stabilizes individuals with acute behavioral conditions, but timely and appropriate continued care is needed to maintain and extend improvement

outside the hospital. The period immediately following discharge is recognized as a time of increased vulnerability. Ensuring continuity of care by increasing compliance to outpatient follow-up care helps detect early post-hospitalization medication problems and provides continuing support that improves treatment outcomes and reduces healthcare costs.

APS takes a focused approach to managing the post discharge transition of care by applying a combined utilization management and case management set of strategies to behavioral health programs across the country. Performance is measured against industry benchmarks to determine if ambulatory follow-up appointments are being accessed by individuals discharged from a hospitalization. The Healthcare Effectiveness Data and Information Set (HEDIS) includes "Effectiveness of Care" measures established by the National Committee for Quality Assurance (NCQA) that allow external benchmarking of engagement rates for FUH7.

Using these strategies, we strongly support the members' transition to the home or work environment and help ensure that gains made during hospitalization are not lost. Through this program, the compliance rate for Hawaii Medicaid members increased from a monthly mean of 47% to 78% (HEDIS 90th percentile) with breakthrough change. The compliance rate increased beyond the 90th percentile in Wyoming via incremental change.

Greatest Setback Risks/Challenges and Proactively Addressing These Concerns

Mr. Robertson presents a number of risks and challenges due to the multi-faceted nature of his case. The BCBSAZ Community Care team's complex care management approach would ensure that all his co-morbid conditions are addressed and that continuity is provided as he moves through the various phases of his treatment plan. **Table 3** below lists risks and challenges associated with Mr. Robertson and how BCBSAZ Community Care would address them had he been our member.

Table 3: Setback Risks/Challenges and Mitigation Strategies

Risks and Challenges	Mitigations
Insufficient or Non-existent Discharge Planning	Mr. Robertson was released following his accident without an acceptable discharge plan; we would conduct concurrent review and discharge planning throughout his entire course of treatment. We would identify suitable housing consistent with his injuries, caregiver supervision, and appropriate care and treatment following discharge. Appropriate discharge planning may have avoided Mr. Robertson's subsequent admission following his fall. We would directly discuss these issues with the attending physician and hospital medical director to prevent future recurrences.
Lack of Coordination with PCP/Medical Home	BCBSAZ Community Care would support Mr. Robertson's care plan through continued education and messaging and relay the importance of treatment by his medical home, particularly in this case where Mr. Robertson requires routine follow up and frequent care plan monitoring for his chronic conditions.
Post-TBI deficits involving, thought process, memory, decision making, emotion control, speech, ambulation, and decreased sight or hearing acuity.	The case manager would ensure continuity of care with PCP and medical home, RBHA, neurologist, physical medicine, other specialists as needed (such as endocrinologist), and home health to provide ongoing, multidisciplinary, coordinated medical, behavioral and cognitive rehabilitation, psychological services, educational services, vocational services, and recreational services. The case manager would evaluate if Mr. Robertson's support structure (family, friends, and place of worship) could provide temporary living with supervision arrangements during his recovery. Ongoing counseling would be provided to help manage the effects of TBI.
Medication Non-Compliance, Prescription and Illicit Drug Abuse, and/or Doctor Shopping	BCBSAZ Community Care would coordinate with RBHA to establish a treatment and rehabilitation plan and monitor compliance. An experienced case manager with superb Motivational Interviewing skills would be assigned. Due to Mr. Robertson's issues with both substance abuse and chronic pain resulting from his injuries, we

Risks and Challenges	Mitigations
	would monitor him for any potential prescription drug abuse. We would coordinate with his PCP and RBHA, and consider utilizing a Lock-In Program using an automated surveillance tool to discriminate between types and level of abusive behavior exhibited, that would give a preliminary recommendation for the type of intervention indicated. This program reviews paid pharmacy claims and generates three scores for each member by performing multiple comparisons of the dates of service, days' supply, physician and pharmacy claims within a therapeutic class. Therapeutic classes include opioids, benzodiazepines/sedative hypnotics, stimulants, skeletal muscle relaxants, and barbiturates. This data would be analyzed to generate scores for the likelihood of abuse. The "shopping score" quantifies the severity of overutilization by calculating number of overlapping days' supply of drugs from same therapeutic class obtained from multiple physicians and pharmacies. The "duplicate score" indicates the acuity of overutilization by calculating number of episodes of drugs from the same therapeutic class obtained from different physicians and pharmacies on the same day. These scores, along with number of physicians and pharmacies providing the controlled substances, are used to generate preliminary recommendations for selection of profiles for manual review, intervention and treatment.
Mr. Robertson's degree of engagement in treatment and rehabilitation	Provision of member-focused care and placement in a recovery environment-focused facility. His case manager would contact and visit him on a regular basis, and if possible, would accompany him to his PCP and specialist visits. If he is placed in an alternative residential setting, his case manager would coordinate with the facility staff to ensure continuation of the needed services, and compliance with care plan.
Safe Housing	It is very likely that Mr. Robertson would not return to his previous residence as the existing situation is unsafe for him. If Mr. Robertson did not have a full recovery, then the paramount issue is to place him in a safe and caring environment that allows him to reside in his community and continue to receive appropriate services. Placement with family, friends or in a group home with expertise with TBI would be required. Ongoing supervision at home or adult day care would also be needed. Care settings would also require availability of trained individuals to administer medication and manage potential complications.
Lack of adequate community based resources	Case managers familiar with local community and available resources identify available resources (housing, vocational, educational) not commonly known, and employ perceptive solutions to facilitate provision of benefits for TBI survivors.
Transition of Care	A very high percentage of members discharged from an acute care setting are readmitted to the hospital in less than 30 days. In order to avoid preventable readmissions BCBSAZ Community Care team has a well-established transition of care program which uses case managers positioned within the Banner Health Network physician practices and throughout the BCBSAZ Community Care network, and has three goals for reducing readmissions: • Ensure members understand physician's care plan • Assist members' availability to their prescribed medications • Assist in securing follow-up medical attention needed to keep their conditions under control

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

Experience in Medicare Advantage and/or Medicare Special Needs Plans (SNPs)

BCBSAZ Community Care was formed from two of the most trusted Arizona-based healthcare brands brought together to provide AHCCCS members with a best-in-class healthcare experience: Blue Cross Blue Shield of Arizona and Banner Health. Blue Cross Blue Shield of Arizona brings 75 years of experience servicing over 1.3 million customers in Arizona, mostly in Maricopa County. Banner Health's network currently serves over 55,000 AHCCCS inpatient cases annually. As a valued partner to the health plan, APS Healthcare will provide overall medical management including comprehensive care management, member services, healthcare analytics bringing innovative technology, over 20 years of Medicaid field-based care management, and behavioral health experience to the program.

BCBSAZ Advantage (formerly Banner MediSun) is also equally owned by Blue Cross Blue Shield of Arizona and Banner Health and has been contracted with CMS to provide Medicare Advantage products and services within the Maricopa County service area for over 10 years. It has received a "4 STAR" quality rating from CMS and has historic member disenrollment rates of less than 5%. With an expected 2013 enrollment exceeding 24,000 Medicare members, plan enrollment has increased by 35% since 2010. The health plan operated a successful Chronic Care SNP (C-SNP) for members with qualifying cardiac diagnoses including congestive heart failure (CHF), coronary artery disease (CAD), and Acute Hypertension until 2011. Members participating in the C-SNP were assigned a primary cardiac specialist to oversee all aspects of their cardiology management in close coordination with the member's chosen PCP. Specialty clinics were developed specifically around anticoagulant therapy and use, aggressive management of CAD, and anti-hypertensive therapy management. Significant outcomes included decreased facility readmissions, stabilization of disease progression, and increased member satisfaction by those participating in the program.

APS, through its parent company Universal American (UAM), has offered a broad array of health insurance and managed care products and services since 2001, primarily to the growing Medicare population. UAM's principal health insurance product for the senior market is Medicare Advantage (including Medicaid members who are dual eligible). UAM subsidiaries operate Medicare Advantage plans in 36 states, 17 of which are coordinated care plans. These plans currently provide Medicare services to over 160,000 members, including approximately 30,000 dual eligible members. UAM has also operated SelectCare of Oklahoma, an Institutional SNP (I-SNP), since 2005 where they have seen significant reductions in avoidable hospitalizations and readmissions. They have been able to proactively identify and initiate preventative measures to improve the quality of care for members through the use of mid-level practitioners. APS provides care coordination services for UAMs Medicare plans.

Processes to Enhance and Maximize Care Coordination and Improve the Member Experience for Members Served for Both Medicare and Medicaid Services and for Members Only Served for Medicaid

BCBSAZ Advantage is forming a Dual Eligible SNP (D-SNP), Blue Community Advantage, in Maricopa County that will maximize care coordination and improve the member experience for those members served for both Medicare and Medicaid in the Blue Cross Blue Shield of Arizona family of health plans. BCBSAZ Advantage and BCBSAZ Community Care will provide a non-fragmented member experience by implementing a consistent administrative and care management platform through APS to include member services, utilization and care management, and healthcare analytics. To maximize efficiency, we will use a Compliance Committee co-chaired by the Chief Compliance Officers from both BCBSAZ Community Care and BCBSAZ Advantage. The committee will allow for more effective use of resources, align our compliance activities, and offer additional opportunities for fraud and abuse initiatives.

In order to ensure that members enrolled in both our Medicare Advantage and AHCCCS Medicaid plans fully understand the benefits that they are entitled to, we will provide them with a toll-free number in their enrollment materials that directs them to specially trained customer service representatives that are knowledgeable on the benefits of both plans and how they work together. These representatives will become our dual members' single point of contact and assist them in locating participating providers, navigating the sometimes confusing rules and authorization requirements, and ensuring that any questions or complaints are answered in a comprehensive manner.

To effectively integrate care for dual-eligible BCBSAZ Community Care members served by another Medicare Advantage plan, our Care Team will work closely with other Medicare Advantage plans to coordinate care, services, and benefits through warm transfers between plans, care coordination through clinician-to-clinician interactions, and benefit coordination.

Regardless of a dual-eligible member's Medicare plan, BCBSAZ Community Care will provide a consistent care management experience that has been developed in line with the CMS Model of Care guidelines. We recognize that dual eligible members are typically more complex medically, are more likely to report they are in fair or poor health, and also require additional, non-medical services for assistance with activities of daily living. Optimal treatment for this population does not deal solely with symptomatology; it requires a comprehensive approach that balances the unique circumstances of the member with the resources available from the healthcare, social, familial, and community environment in which they belong. To accomplish this balance, our community-based care management program will feature the following:

- Interactive, member-centered treatment planning that views the member in the context of the local community, individual long term care and treatment needs, and ability to access and use services.
- Local, community-based case manager support to conduct in person assessments, assist with provider appointment, and act as an advocate for the member.
- Comprehensive assessment of the member's health status and needs and development of an Integrated Care and Service Plan (ICSP) for every member.
- Encouragement and support of the member's use of a medical home.
- Access to broad range of services, including healthcare, long-term care, behavioral health, social, educational, financial, and Home and Community-Based Services (HCBS) so individuals have access to the right services in the optimal setting.
- Inclusion of family members, caregivers, and providers in the development and execution of the plan of care
- Innovative, evidence-based models of care.

BCBSAZ Community Care will seamlessly facilitate all prior authorization and utilization management activities using our care management system, CareConnection®, that is fully HIPAA-compliant and easily configured to handle the AHCCCS program. The platform is a web-enabled system that integrates eligibility and authorization data into a member-centered record for comprehensive reporting, transparent management and prioritized development to gain efficiencies in utilization review. This web-based application minimizes the administrative burden for the reviewers and the providers. We will also furnish the competencies necessary to maintain integrated care, behavioral health services, long-term services and supports (LTSS), and use of HCBS.

Patient-Centered Delivery Model: We have outlined a framework of care management and service coordination that includes comprehensive identification of dual-eligible members, uniform assessments, plans of care and care management, and service coordination that takes into consideration the unique needs of the dual-eligible member. These specific mechanisms support a patient-centered delivery model and include the following:

- ***Assessments.*** The treatment planning begins with an assessment which may be initially conducted telephonically and for those needing a more intensive evaluation, a face-to-face contact with the member and others involved in the member's treatment. The assessment addresses the member's strengths, preferences, abilities, needs, and other current and historical data regarding the member's family, social support, cultural influences and medical status including psychiatric illness, employment, education, abuse and neglect issues,

and activities of daily living. This process also includes a risk assessment, substance abuse assessment, annual medication review, educational/vocational scale and the member's strength inventory. Assessments embody practices set by The Council for Quality and Leadership and the Human Service Research Institute for examining the quality of member-centered services and supports.

- ***Integrated Care and Services Plans (ICSP).*** The ICSP is an auto-generated, member approved, member-centered plan available electronically to the Care Team as well as members and their families. It captures all clinical, behavioral, long-term support services, and HCBS a member receives or needs. It is used for ongoing stratification and prioritization of outreach to members most in need.
- ***Care Management and Service Coordination.*** Individualized care management of all clinical, behavioral, and long term care needs and coordination of HCBS.
- ***ICSP Tracking and Reporting.*** Mechanism for the care plan that allows us to ensure members plans are being followed, and identification of providers falling outside of best practice guidelines.

Strategies to Increase and Maintain Aligned Medicaid and Medicare Enrollment

Because dual eligibles often have extensive care needs, the benefits of identifying and moving enrollment into a coordinated care environment are significant for both member well being and AHCCCS. Dual eligibles, who tend to have chronic health conditions and rely on services from numerous healthcare providers, could have their lives simplified and health outcomes improved through a more coordinated approach. In addition, AHCCCS will benefit through better management and reduced costs. Many dual eligibles have multiple chronic conditions and complex health, behavioral and long-term services and supports needs. Many want to retain their current providers and direct their own care. Aligning members in Medicare and Medicaid will allow for enhanced member experience through integrated health plan services and care management.

BCBSAZ Community Care has several key strategies to increase and maintain enrollment in our aligned AHCCCS and D-SNP health plans. We will identify any member of either of our Medicare Advantage or AHCCCS plans that is eligible for enrollment in our aligned Blue Community Advantage (D-SNP) plan. We will outreach to such members with information and education regarding the benefits of enrolling in an aligned health plan for a fully integrated health plan experience. All outreach to members will be in compliance with applicable CMS and AHCCCS requirements.

Members are introduced to the program through a comprehensive communications campaign that generates program awareness and helps increase participation. Our goal is to surround members with support - whether they are high risk and in need of care management or simply need assistance with daily living tasks to help remain in the home. We believe the relationship between the member and case manager is the most effective tool we have to encourage member participation. We understand the importance of helping members to understand their risk, and communicate this status directly to the member and/or the caregiver either face-to-face or by telephone. Our case managers are trained to communicate so that we can convey appropriate information about the program to members.

We will also utilize an integrated Quality Committee that will track all member feedback. The tracking, reporting, and analysis of feedback will be coordinated through the Quality Improvement Program (QIP). The feedback will allow us to make improvements to health plan benefits and operations that meet the members' needs as permissible by AHCCCS and CMS.

7. The health care system in the United States is currently on an unsustainable path. The projected growth of Medicare and Medicaid based on demographics and historical trends result in public programs that consume an excessive portion of the U.S. Gross Domestic Product. There have been numerous studies that document that while having some of the highest costs in the world, the U.S. health care system based on some measures does not have the best outcomes. Recently the Institute of Medicine (IOM) released a report titled Best Care at Lower Cost that estimated $750 billion nationally is "wasted". This includes $210 billion in unnecessary services, $130 billion in inefficient care - $190 billion in excess administration - $105 billion in inflated prices - $55 billion in prevention failures and $75 billion in fraud. The same IOM study also identified various strategies that should be pursued to improve care and lower costs. As one of the single largest payers in the state of Arizona, AHCCCS has an important role to play in helping to move the health care system to a more sustainable model that improves outcomes. As a participant in the AHCCCS program, provide specific initiatives and efforts your organization will pursue to deal with "waste" that exists within the existing system and improve outcomes. Provide specific information describing the initiatives that would be pursued to improve quality and enhance cost containment including but not limited to the stakeholders involved, the timelines for implementation and the desired outcomes.

BCBSAZ Community Care is committed to promoting programs designed to contain the increasing costs of healthcare while also improving the quality of care and access available to our members. Initiatives that increase the quality of care also tend to reduce the cost of healthcare by eliminating inefficient, extended, and more intensive treatment. BCBSAZ Community Care combines the practices of three leaders in providing high quality care and reducing inefficient and unnecessary services - Blue Cross Blue Shield of Arizona, Banner Health, and APS. Our integrated approach will combine sophisticated technology and evidence-based clinical algorithms to analyze retrospective claims data and identify providers whose practices fall outside of recommended best practices. We will share clinical data with providers about their panel via a web portal, and follow-up with peer-to-peer educational inventions and actionable feedback. Our initiatives will focus on:

- Increasing the use of best practices supported by evidence-based guidelines.
- Enhancing member safety and quality of care.
- Promoting appropriate coordination and integration of care for members accessing multiple providers.
- Sharing informed, actionable feedback with providers to improve the health outcomes of their members.
- Identifying under-utilization or over-utilization of services and medication management.

Specific Initiatives and Efforts to Deal with "Waste" Within the Existing System and Improve Outcomes

For the remainder of this section, we outline our initiatives to address each of the categories of waste outlined in the Institute of Medicine report. The stakeholders for every initiative include AHCCCS, members, providers, and BCBSAZ Community Care either through direct participation in the initiative, or indirectly through improved outcomes, cost savings, and/or increased satisfaction.

Unnecessary Services - Care rooted in outmoded habits, driven by providers' preferences rather than scientific findings, members lacking proper understanding of the best way to receive care, or something other than provision of optimal care for a member.

Initiative: *Reducing Avoidable Admissions and Readmissions*

Unnecessary readmissions will be controlled through proactive discharge and aftercare planning before a member leaves the inpatient setting. Equipping members with access to and coordination with resources and natural supports helps members to step down to lower levels of care and avoid ED visits and/or readmission to the inpatient setting. Additional procedures to effectively control avoidable hospital admissions include daily data mining to identify members at risk for hospital admission and prioritized workflows and direct outreach to those most "impactable."

We will manage chronically ill and post-acute members to ensure at-risk members are managed in the most medically appropriate venue. We will couple a transitional and chronic care program with the dedicated support of Banner Health and partnering hospitals to provide care management and support to those members who require it.

Members receiving care at Banner Health hospitals will also benefit from their readmission reduction initiative that assesses for risk of readmission, provides auto-notifications to PCPs, provides medication reconciliation at all transitions, and performs follow-up calls within 48 hours of discharge. Additional services are provided for moderate and high-risk members such as creating continuum of care plans. When readmissions do occur, they analyze the case and look for new lessons learned to integrate into their program.

Timeline and Desired Outcomes
This initiative will be available immediately at plan startup. The results will be reduced costs and improved outcomes by ensuring appropriate monitoring and care is provided so avoidable admissions and readmissions are reduced.

Initiative: *Evidence Based Controls*

Our evidence based controls initiative will:

- Implement programs such as educational campaigns and prior authorizations to reduce the use of procedures and treatments that are scientifically proven to be ineffective.
- Provide care alerts to notify physicians of potential omissions in care such as drug-to-drug interactions.
- Use provider report cards and our PCP Incentive Program to encourage the use of best practices.

Timeline and Desired Outcomes
These initiatives will be available at plan startup. They will improve member outcomes and reduce the use of wasteful treatment options. For example, in 2012 Banner Health had an initiative in their EDs to reduce the use of CT scans for atraumatic headache care and it a substantial reduction was achieved.

Initiative: *Drug Utilization Review*

Banner Health has implemented drug utilization reviews for their affiliated physicians. Member prescription records are analyzed for potential drug interactions, duplicative medications, and signs of abuse of addictive substances. If the system flags suspicious or concerning prescriptions, the physician is notified by letter.

Timeline and Desired Outcomes
This is an ongoing initiative by Banner Health, and through our PBM will be immediately available for BCBSAZ Community Care providers at plan start up. Over 2,000 interventions per quarter are currently being sent to providers.

Inefficient Care - Inefficient care includes poor execution or lack of widespread adoption of best practices, such as effective preventive care practices or member safety best practices. Delivery failures can result in member injuries, poor clinical outcomes, and higher costs. This may also occur when members experience care that is fragmented and disjointed or performed at sub-optimal locations.

Initiative: *Reduce Inappropriate ED Utilization*

BCBSAZ Community Care will implement an innovative solution to ensuring appropriate usage of EDs that has proven highly effective in other states by combining member and provider education with effective care management that augments the services provided by PCMHs. To support member concerns, we will offer 24-hour access to nurses to answer health questions, help members determine the urgency of situations and advise if they warrant an ED visit, and provide assistance obtaining appointments with PCPs.

Another important aspect of the initiative will be personalized interventions that provide opportunities for one-on-one education about the appropriate use of ED services for both members and providers. Our risk identification/ stratification software will perform daily prioritization of members to identify those who need outreach by our case managers. The prioritization will be based on an analysis of members' historical claims data using algorithms developed and validated by New York University's Center for Health and Public Service Research. We will also

utilize proprietary clinical data mining tools to identify instances of sub-optimal clinical care when compared with evidence-based protocols for chronic disease as gaps in care frequently drive ED usage. Interventions by the case manager may include meeting the member in the ED to support their discharge plans, or within two business days after the event to address specific needs, such as securing appointments with the PCP, identifying a PCMH, or resolving transportation issues that result in ED use. BCBSAZ Community Care will also supply PCPs with a list of their members who are high ED utilizers and support the PCP's efforts to educate members on appropriate ED utilization.

These efforts will be supplemented by real-time interaction at the occurrence of the event in cooperation with the provider facility. Banner Health-affiliated EDs have also implemented an ED diversion program that performs triage in the ED and reroutes inappropriate cases to suitable alternative primary care options. BCBSAZ Community Care will work closely with the Banner Health ED diversion program for our members who present in one of their facilities.

Timeline and Desired Outcomes
This initiative will be available immediately and will reduce ED utilization with an accompanying reduction in costs. The success of our approach has been validated by team member APS. For example, APS implemented this approach for the Pennsylvania Medicaid ACCESS Plus program and experienced 39.9 ED visits per 1,000 members as opposed to 72.4 per 1,000 experienced by the Medicaid members managed by the MCOs for the same period.

Initiative: *Patient Centered Medical Homes (PCMH)*

BCBSAZ Community Care will strongly encourage the use of PCMHs by our members. Our team members, particularly Banner Health, are leaders in the use of PCMHs where each member has his or her own PCP leading teams to take accountability for the comprehensive care of that member using protocols and evidence-based practice guidelines. This coordinated approach reduces wasteful duplication of services, decreases the probability that important treatment steps will slip through the cracks, and provides better outcomes by providing the PCP with a better understanding of the member's overall healthcare needs.

Timeline and Desired Outcomes
PCMHs are widely implemented throughout our Banner Health network, as well as within our BCBSAZ Community Care Network. Banner Health's PCMHs are scheduled to receive their NCQA Level 1 certification by the end of 2013. The desired outcomes for PCMHs include better member outcomes and reduced cost from elimination of inefficient care.

Initiative: *PCP Incentive Program*

BCBSAZ Community Care will use an incentive program in which providers designated as PCPs are eligible for reimbursement for providing care coordination activities. Specific activities that will be measured will be developed and sent to providers prior to the initiative start date. If, after one year, a provider does not meet the care coordination activity measurements then all or a portion of the reimbursement may be discontinued.

Timeline and Desired Outcomes
Reimbursement for care coordination activities shall begin on October 1, 2013 for physicians or groups with 50 or more paneled members. The goal of these activities will be to ensure members receive high quality and efficient care.

Excess Administration - Waste that occurs due to inefficient or flawed rules and bureaucratic procedures. These costs may also occur when providers do not effectively use new technology to streamline their administrative operations.

Initiative: *Using Technology to Streamline Care*

BCBSAZ Community Care will use a care management information system called CareConnection® from our team member, APS, that integrates utilization, diagnostic, and pharmacy data to drive workflow, house assessments, produce a single, web-based plan of care, and deliver integrated cost and quality reports. The system will run a stratification algorithm daily to identify high-risk members who need outreach and intervention. Our Care Team will use this platform to reach out to members based on the members' individual changing needs. CareConnection recommends the most appropriate interventions for each member based upon identified rules and triggers and the

multi-disciplinary Care Team staff will apply the appropriate level of resources on the highest priority members to engage them in the appropriate service and apply selective interventions.

In addition to APS' CareConnection, Banner Health offers a nationally recognized suite of tools that includes an electronic medical record (EMR) and computerized provider order entry system that will be used to serve BCBSAZ Community Care members utilizing Banner physicians and facilities. These tools will be fully integrated with APS' CareConnection on day one of implementation.

An EMR provides comprehensive member information at the point of decision making, allowing for more informed decisions. Electronic orders are transmitted instantaneously for action so diagnostic tests can be scheduled more quickly and results delivered more promptly, and integrated care alerts prompt the user if an order goes against evidence-based practices. The elimination of handwriting reduces errors.

CareConnection also offers providers access to various member data and content through a secure provider portal feature. Providers will have the capability, with the member's permission, to view, modify, and approve the member's recommended POC. Additionally, the provider and case manager can share member self-reported information and other pertinent facts in a HIPAA-compliant and secure manner. For example, the provider can view the member's prescription history and fully understand the extent to which prescriptions are filled and utilized.

Timeline and Desired Outcomes

CareConnection and Banner Health's EMR are already implemented. Using these platforms will increase communication between BCBSAZ Community Care staff and providers to better coordinate care for the member.

Initiative: *Prior Authorizations*

We recognize that requiring prior authorization for treatment is typically an administrative burden on providers. In order to minimize this burden, BCBSAZ Community Care will have a short, manageable list of items that require prior authorization and will allow prior authorization requests to be submitted via the Provider Portal. The list will contain only those items that are subject to fraud or abuse or that evidence-based guidelines indicate are being greatly over utilized.

Timeline and Desired Outcomes

Our reasonable prior authorization list will be implemented at plan startup and adjusted on an ongoing basis. Our use of a manageable prior authorization list will reduce provider administrative costs with a secondary benefit to BCBSAZ Community Care and AHCCCS of increased provider retention from minimizing administrative frustration.

Inflated Prices - Waste that occurs when the price of a service exceeds the actual cost of production plus a reasonable profit. For example, magnetic resonance imaging and computed tomography scans are several times more expensive in the United States than in other countries due to lack of transparency and competitive markets.

Initiative: *Negotiated Prices*

An effective approach to managing health care costs is to negotiate reasonable prices with providers. As the largest commercial insurer in Arizona, Blue Cross Blue Shield of Arizona has unparalleled understanding of market conditions to effectively negotiate the best prices. The Blue Cross Blue Shield of Arizona name is trusted by local physicians who know they can count on us for prompt payment and fewer hassles, and BCBSAZ Community Care is also committed to this philosophy. Banner Health, as one of the largest provider of AHCCCS services, is also committed to managing costs and keeping rates reasonable.

Timeline and Desired Outcomes

The negotiated prices are already being implemented with our provider contracts. These prices will ensure that AHCCCS funds are not being wasted on inflated prices.

Initiative: *Provider Profiling*

The intent of provider profiling is to identify best practices, improve care outcomes, enhance member and provider experience, deliver effective network management, and to create value for all stakeholders. BCBSAZ Community Care

will use provider profiles for quality management initiatives such as adherence to evidence-based guidelines, determination of efficiency and effectiveness of care delivery, and for quality improvement projects. In addition, provider profiling will assist BCBSAZ Community Care in identifying program outliers (above or below two standard deviations) for certain utilization measures such as under- and over-utilization of resources, high admission or readmission rates, incorrect billing practices, and excessive medical spend. Our profiling will incorporate elements such as member panel characteristics (e.g., case mix adjustment), provider distribution, and coverage limitations to prevent generation of inaccurate information and execution of wrong interventions. BCBSAZ Community Care will develop comprehensive quarterly profiles from all available data using valid statistical methodologies.

The profiles will be presented to the Clinical Effectiveness Committee and Network Management Committee for review and action, and will also be shared with network providers and other stakeholders as appropriate. BCBSAZ Community Care may use the provider profiling reports to reward providers who have demonstrated better care outcomes and higher satisfaction with preferential member assignment, when feasible and appropriate.

Timeline and Desired Outcomes

The provider profiling initiative will begin immediately upon contract startup, with the results becoming available in the third quarter as the profiles require at least six months of claims data to be meaningful. Provider profiling will greatly curtail overbilling and reduce program costs.

Prevention Failures - Diseases or injuries that could have been avoided with suitable preventive care.

Initiative: *Increasing Use of Preventive Care*

BCBSAZ Community Care realizes that a key element to controlling escalating healthcare costs lies in the increased application of prevention. We will provide required AHCCCS services to include early detection, screening, treatment, and primary prevention for hypertension, elevated cholesterol, colon cancer, sexually transmitted diseases, tuberculosis, HIV/AIDS, breast cancer, cervical cancer; and prostate cancer as well as other preventable and impactable diagnoses. Our program will include a number of web-based tools and educational content designed to increase preventive care that will be accessible to members 24 hours a day.

- **Health Risk Assessment (HRA):** The HRA takes 10 to 15 minutes to complete and interactively integrates medical risks, laboratory values, and biometrics with lifestyle, mental health, and injury prevention. HRA variables include; age, gender, ethnicity, personal and family health history, medications, allergies, biometric test history, nutrition, physical activity, readiness to change, substance use, mental health, and injury risks.
- **Preventive Care Plan:** Highly personalized, culturally sensitive, and easy-to-understand preventive care plans are delivered to members for interactive participation. Evidence-based best practice guidelines and ethnicity-based predictive modeling are used for accuracy and culturally appropriate presentations. Members receive recommendations for disease prevention, healthy lifestyles, self-care, and injury prevention, along with their risk evaluations for: coronary artery disease, diabetes, high blood pressure, stroke, obesity, depression, asthma, colon cancer, breast cancer, cervical cancer, prostate cancer, and testicular cancer.
- **Outreach and Education:** Outreach will be provided by our Care Teams, via mailings, and through our website; providing reminders and education about the importance of preventive measures such as flu shots.

Timeline and Desired Outcomes

Our preventive care initiatives are ready to be implemented at plan startup and will reduce the incidence and severity of diseases and injuries, lowering overall healthcare expenditures.

Fraud - In addition to fake medical bills and scams, this category includes the cost of additional inspections and regulations to catch wrongdoing.

The BCBSAZ Community Care team recognizes that fraud and abuse in the healthcare system has an enormous adverse impact on healthcare quality and safety, while also imposing higher costs on consumers, employers, and taxpayers. As will be further described in our response to **Question 8**, we will empower multiple teams and departments to collaborate on robust activities to detect, prevent, and correct fraud and abuse activities.

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

BCBSAZ Community Care will implement an aggressive Fraud, Waste, and Abuse (FWA) program within our Compliance Program that complies with all Federal, State, and CMS requirements including 42 CFR 438.608, and all RFP requirements including those specified in Number 62, Section D1. This program will provide a corporate-wide, anti-FWA strategic philosophy and vision, as well as tactical processes that will allow us to effectively detect, correct, and prevent FWA. We will immediately notify (within 10 business days of discovery) the AHCCCS Office of Inspector General (OIG) regarding any suspected fraud or abuse in writing by completing the confidential AHCCCS Referral for Preliminary Investigation form. This will include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, contractors, or subcontractors.

Additional Activities to Limit, Identify, and Address Fraud and Abuse

Beyond the required compliance programs, BCBSAZ Community Care will execute FWA initiatives that are built upon the methodologies used by our team members and industry best practices to ensure that AHCCCS funds are used in the way that they are intended, without waste or abuse.

Initiatives relevant to **limiting** fraud and abuse include:

Member Lock-in Program - The BCBSAZ Community Care Team will monitor, investigate, and assess member use of medical services to prevent unsafe practices or inappropriate use of resources such as overutilization or duplication of services, ED use for primary care, abuse of prescription drugs and controlled substances, and use of multiple drugs with the potential for negative interactions. Identified members will be assigned a case manager to assist them with addressing issues causing the unsafe or inappropriate use of resources and may be locked-in to a pharmacy, a primary care provider, or both.

We will use an automated surveillance tool to discriminate between the types and level of abusive behavior exhibited. It will review six months of paid pharmacy claims and generate FWA scores for each member by performing multiple comparisons of the dates of service, days' supply, physician, and pharmacy for drug claims from within a therapeutic class. It will analyze the likelihood that the member is "doctor shopping" drugs from the same therapeutic class or forging prescriptions. Utilizing the integrated EMR at our Banner Health facilities, we will have advanced warning of inappropriate ED utilization even before claims are submitted.

When evaluating candidates for lock-in due to suspected abuse of ED services, we will consider the number of ED visits, number of ED facilities visited, average number of days between visits, ratio of outpatient visits to ED visits, and number of non-emergent ED visits.

If a problematic member is identified, these automated analyses will recommend that our staff either perform a lock-in or send a warning letter and educational material to the member. Our Care Team staff will review the records based on the recommendation and determine the final action. In an initial evaluation, the automated system correctly classified 95.3% of the recommendations.

Pre-pay Edit Review - Our claims system will perform claims edits based on configurable rules that look for improper coding on claims before they are paid. It will also perform additional front-end reviews for specific members, providers, and codes that have demonstrated problems in the past.

BCBSAZ Community Care will also monitor sanction lists and the National Practitioner Database on a monthly basis. The Credentialing Committee may, at its discretion, order appropriate action up to terminating the provider from the network if the provider is found to be out of compliance with program credentialing requirements. Additionally, if we become aware of (through notification by AHCCCS or any other source) that a provider (in- or out-of-network) has been excluded from providing service or is subject to any other state-imposed provider restriction, we will configure the claims systems to flag any claim submitted by the restricted/excluded provider causing the claim to be denied.

Initiatives relevant to **identifying** fraud and abuse include:

Claims Fraud Detection Software – BCBSAZ Community Care will use a comprehensive claims fraud detection software suite that incorporates pre-payment and post-payment analytics and provider profiling. The software suite will identify erroneous payments "in-stream". The system will also audit claims for outliers and send high-dollar claims to our Medical Director for review and approval.

Our claims fraud detection software removes unnecessary costs by identifying claim aberrancies and catching potentially fraudulent, wasteful, or abusive claims early in the claim lifecycle, including pre-payment. With algorithm and statistical based predictive analytics and proprietary fraud detection rules; the solution reduces the amount of false positives, minimizes costs, and improves detection capabilities. Other highlights of this solution include:

- Multiple fraud identification tactics detect aberrant claims:
  - Consistent data mining systems flag qualified cases for investigation
  - Custom rules and alerts driven by member-specific workflow and payment policies
  - Checks new claims against current and historical claims to prevent duplicate claims, even similar services that are coded differently
  - Looks for misrepresented services or products provided (such as up-coding), medically unnecessary services (e.g., CMS Medically Unlikely Edits), unbundled services, and billing for costs unrelated to covered member care
- Operates throughout the claim lifecycle:
  - Pre-adjudication
  - Post-adjudication/pre-payment
  - Post-payment (retrospective)
  - Automation augments manual processes for greater accuracy and efficiencies

Tasks Force Meetings and Seminars - BCBSAZ Community Care and/or Blue Cross Blue Shield of Arizona FWA personnel will regularly attend task force meetings and seminars from organizations such as the National Association of Drug Diversion Investigators (NADDI) and the International Association of Special Investigation Units (IASIU) to stay current on the latest FWA schemes. We will share the information learned at these meetings between our organizations. This will allow us to continually update our automated and manual FWA detection processes. BCBSAZ Community Care will also become a corporate member of the National Healthcare Anti-Fraud Association (NHCAA) and our FWA staff will attend their meetings and training courses to earn continuing education credits, obtain industry certifications, and expand their knowledge of schemes and trends.

Blue Cross and Blue Shield Association FWA Program - As an independent licensee of the Blue Cross and Blue Shield Association, BCBSAZ Community Care will have access to all plan alerts - instances and patterns of fraud that are detected are reported by all Blue Cross and Blue Shield licensees throughout the country.

Initiatives relevant to **addressing** fraud and abuse include:

Special Investigation Unit (SIU) - The BCBSAZ Community Care SIU will detect and investigate instances of suspected insurance fraud, including performing analyses of claim files and interviewing involved parties. We will publish an anonymous, toll-free FWA hotline in training materials, on web pages, on printed communications, and EOP/EOBs. The hotline will allow callers to leave messages 24-hours a day and the SIU will check the line daily.

The SIU will investigate any internal or external referrals of any incident, complaint, or discovery of potential FWA. All leads will be tracked and recorded, allegations documented, and due diligence performed. The SIU will pursue resolution unless requested otherwise by regulatory or law enforcement bodies, and will enforce corrective action as deemed appropriate for each detected offense.

The SIU will also be responsible for the content of the FWA training for employees and subcontractors. This training - taken at the time of hire/contract and no less than annually thereafter - will cover regulations, laws, program requirements, FWA indicators, trends and schemes, whistleblower protections, and other individual rights and

responsibilities regarding suspected or known FWA. They will also provide quarterly FWA training for providers.

Active Enforcement - In order to deter and prevent ongoing patterns of fraud and abuse, BCBSAZ Community Care will refer all instances of suspected fraud to AHCCCS and any other appropriate agency along with a detailed report of our findings.

Provider Training - Many providers respond well to outreach and education when approached for repeated claims issues. Often the providers did not understand the correct way to code for specific items, or they may have been unaware that their coder was billing too aggressively. We always strive to resolve issues agreeably to keep well-meaning providers in the network.

BCBSAZ Community Care will also implement an initiative that has been very successful for Blue Cross Blue Shield of Arizona at providing an integrated approach to **limiting, identifying, and addressing** fraud and abuse:

Focused Provider Review Committee - BCBSAZ Community Care will establish a multidisciplinary management committee for focused provider reviews. The committee will be chaired by the BCBSAZ Community Care Medical Director and members will include management level decision makers from Health Services, Network Management, Compliance, and Customer Service. The committee's mission will be to develop, promote, and maintain a strategy for overseeing providers referred by internal and/or external sources or identified by the SIU for evaluation of billing, coding, or utilization issues. The committee will determine what action(s) will be taken based on review and investigation results. Such actions may include, but are not limited to:

- Approve performance benchmarks and thresholds that will be used to measure success of the provider corrective action plans
- Recommend changes to current reporting, system configuration, processes, and policies to enforce appropriate billing and reimbursement
- Report unresolved and ongoing issues to AHCCCS and appropriate external provider governing bodies
- Make recommendations to the Credentialing Committee regarding appropriate provider contracting actions
- Understand impacts of the recommended action plans to minimize impact to the customer experience
- Develop review strategies for providers identified for focused review, including criteria for placing a provider on focused claim review, monitoring a provider while on focused review, and removing a provider from focused review once desired results are achieved
- Create and implement customized corrective action plans that include pre-monitoring, communication, education, and post monitoring

Experience Using These Methods and Examples of Successful Application

Blue Cross Blue Shield of Arizona Focused Provider Review Committee: The Focused Provider Review Committee of our partner Blue Cross Blue Shield of Arizona recently applied data analysis, provider and member education, and prepay edits with medical records review to save its members and groups over $2 million on a single case.

- Analysis and Claims Review: The Blue Cross Blue Shield of Arizona SIU team identified high utilizing internal medicine physicians through reports run from its claims data warehouse and identified an outlier. Reviewing the data during the investigation indicated that 90% of the physician's members' claims included the same diagnosis along with a similar pattern of treatment. A sample of medical records was requested to better determine the physician's practice. Sampled claims were reviewed by both a nurse reviewer and a medical director, and the conclusion was that services billed were upcoded and/or not medically necessary. Findings were brought to the Focused Provider Review Committee which implemented a full prepay edit review of the provider's claims. The full review found the same pattern identified within the sample of records. Claims that did not support either medical necessity and/or did not support the codes billed were denied prior to payment (over $1 million).
- Provider Communications: Along with the record review, Blue Cross Blue Shield of Arizona discussed with, wrote to, and fully educated the provider on the issues. The provider, however, continued the practice of

upcoding and billing for medically unnecessary services and was terminated from the network. The provider edit for medical review remains in place for the now out-of-network provider (additional savings projected of over $1 million). Education was also provided, in general, to all providers via a regularly published on-line provider newsletter informing and reminding the provider community of the medical necessity criteria in order to have the particular services covered.

- Member Communications: Blue Cross Blue Shield of Arizona also educated its members who were directly impacted by the claims denials even though they were not responsible for payment. This was a focused education only for those members who had received the services to help them with their decision of whether to continue receiving treatment.
- Government, Group and Law Enforcement Notifications: Blue Cross Blue Shield of Arizona sent notifications of this provider's practice to the appropriate Government and provider governing bodies, including the Arizona Department of Insurance, to ensure that other Government programs and private self-funded customers were able to review and determine whether they had a similar issue with this provider's billing.

Wisconsin Lock-in Program**:** Team member APS developed and administered the Wisconsin Lock-in program to facilitate coordination of healthcare services provided to members who abused or misused Medicaid benefits by seeking duplicate or medically unnecessary services. Many of these members had significant medical conditions in addition to being addicted to controlled substance medications. Healthcare coordination improves the quality of care and reduces unnecessary physician and pharmacy utilization while ensuring reasonable access to necessary Medicaid services. Lock-in candidate referrals were received from providers and pharmacies and through automated surveillance methods. If enrollment was warranted (final determination made by the Medical Director), they oversaw the coordination of care for the next 24 months by monitoring claims payments, tracking lock-in physicians and pharmacies and their referrals, responding to provider and recipient inquiries, and making changes in the assigned providers. One month before recipients are scheduled for release from the lock-in, paid pharmacy claims are reviewed for compliance.

The physician response rate to the alert letters was 71% with 87% of physicians rating the information received as very useful or useful. Cost benefit analysis demonstrated that the program saved $5.38 per dollar spent. This analysis also demonstrated a 24% decrease in drug expenditures, a 21% decrease in hospitalizations, and a 26% decrease in ED visits for lock-in participants. Review of Diagnosis Related Groups for recipient pre- and post-intervention did not show substantive differences in reasons for hospital admissions pre- and post-intervention. These findings indicate that the program did not appear to cause an increase in illness post-intervention.

Hawaii-Mainland Administrators (HMA) Claims Auditing: HMA, the BCBSAZ Community Care team member responsible for identifying potential FWA based on claims data, is an Arizona-based company that has 100 years of collective staff experience providing third-party administrative services to multiple AHCCCS plans. Their FWA prevention methodology is customized for each contract based upon contract preferences.

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

BCBSAZ Community Care is built on the collective experience of Blue Cross Blue Shield of Arizona and Banner Health. Their best practices have been combined to build the foundation of our claims payment, claims complaint handling, and claims dispute processes. Blue Cross Blue Shield of Arizona is one of the largest buyers of healthcare services in Arizona. Banner Health, with their ownership of medical facilities and Banner Medical Group employing over 900 providers, brings our team a thorough appreciation of the billing process from providers' viewpoints. Combining these perspectives, we understand the issues that lead to partial (e.g., National Correct Coding Initiative edits, not covered services line items, national drug code invalid) and whole claim denials (e.g., third party liability, member not eligible, non-covered service, service not prior authorized), as well as the cash flow issues that providers face and their desire to have fast claims payment and complaint resolution.

Our solution will combine the best of our technology, policies and procedures, oversight and management, daily reporting, and staff and provider education. Tying all the pieces together is our senior management team that collectively has over 100 years of healthcare experience, including 71 collective years of experience with AHCCCS.

Ongoing Processes and Strategies to Minimize the Need for Providers to Utilize the Claims Dispute Process to Obtain Proper Reimbursement

The best way to minimize the need for providers to utilize the claims dispute process is to ensure that providers are paid quickly and accurately and much of our focus is on achieving this goal. When an inquiry is made that may lead to a complaint, we will make reasonable efforts to negotiate solutions in order to minimize disputes. Our overall approach will include the following elements:

Accurate Provider Database: The leading cause of automated claims payment errors are inaccuracies in the provider database. The process for adding newly credentialed and contracted providers, removing terminated or suspended providers, updating the provider's contact information, updating credentialing information, and reinstating providers previously removed from the directory involves a coordinated approach and workflow processes between the credentialing staff and the provider file maintenance staff. We will use established Blue Cross Blue Shield of Arizona procedures for loading and maintaining the provider files, regularly tracking and monitoring metrics to ensure provider file maintenance is completed in a timely and accurate manner. The quality department will regularly review the provider file metric results and provide recommendations for quality improvements. Blue Cross Blue Shield of Arizona metrics for 2012 reflect 100% of provider file maintenance items were completed within 8 business days and over 92% were completed without error. Additionally, Blue Cross Blue Shield of Arizona was recognized in 2012 by the Blue Cross Blue Shield (BCBS) Association as their #1 BCBS processing site for provider data quality.

Claims System: In today's marketplace, an efficient, flexible, reliable, and fully integrated claims payment process and system is crucial to the management of all aspects of a program. BCBSAZ Community Care Team members are experienced in processing claims in accordance with Federal and State laws and regulations and the requirements set forth in the RFP. Through an efficient and innovative claims processing system operated by HMA, we can process and pay claims quickly and accurately. In 2011, the claims processing accuracy was 99% and the procedural accuracy was also 99%. HMA brings to the BCBSAZ Community Care Team over 100 years of collective staff experience providing third-party administrative services to multiple AHCCCS plans.

To ensure that claims are processed accurately, and to minimize provider claims disputes, we will complete a detailed benefits configuration matrix. The benefit matrix fully documents how each procedure code is processed and includes any authorization requirements and/or units. We will import AHCCCS files including eligibility files, fee schedules, covered services codes, covered code relationships, and coordination of benefits (COB).

The BCBSAZ Community Care testing and production environments are housed in independent testing and production databases. We are creating test plans using (1) a member test bed of known profiles, supplemented as needed by additions or variations to those profiles, and (2) a test case library of known and common scenarios for both positive and negative results, and which are also supplemented by customized variations for new or unique situations reflected from the approved benefit matrix. Our claims, contracting, and medical management business units will participate throughout the testing cycle to ensure collaboration among member, technical, and business units with the end result of acceptable levels of confidence and successful transition to production.

Prior Authorization Process: To reduce provider administrative burdens, BCBSAZ Community Care will use a clearly defined prior authorization policy that only requires a reasonable number of services to receive prior authorization. The services that require prior authorization are there to protect members and ensure that the right care is provided in the right setting. Not requiring prior authorization for an excessive number of services reduces the administrative burden on provider staff, and generally leads to greater network participation with higher satisfaction.

The 24/7 secure provider portal on our care management platform allows providers to examine member eligibility and submit prior authorization requests. We have designed the portal to be easy to use to encourage 100% online submission of prior authorizations, allowing us to respond efficiently and timely. Providers can also contact their network representative and request a denied claims exception for certain circumstance (e.g., change in billing or front office staff, clearinghouse issues). Providers may ask us to waive timeliness requirements and consider overturning certain denied claims. Our CEO will approve reasonable requests and network representatives will educate and assist the provider's office staff to ensure the issues do not occur again.

Provider Education and Communication: BCBSAZ Community Care network contract specialists, provider representatives, credentialing specialists, and a provider claims educator will be available to take care of provider questions and issues quickly and educate providers and their staff in understanding the administrative policies and procedures of the BCBSAZ Community Care program including prior authorizations. Our operational system has an established process to identify, track, monitor, and address complaints and concerns received verbally, electronically, or in writing in our tracking system.

We will use the First Call Resolution (FCR) initiative as a way to better handle customer issues and to provide the best possible customer service. FCR means that our customer service representative will work to resolve matters during the initial phone call, elevating the call to progressively higher levels of authority as necessary - avoiding additional phone calls, emails, or letters that could potentially frustrate the customer. In addition to driving customer satisfaction and encouraging customer loyalty, this initiative also supports cost containment and improved efficiency.

As an affiliate of the Blue Cross and Blue Shield Association, BCBSAZ Community Care will participate in the Member Touchpoint Measures (MTM) program. The MTM program assesses service performance by monitoring enrollment processing, inquiry resolution, claim adjudication, and FCR. We will perform ongoing tracking and monitoring of these metrics to assure service responsiveness to customers. We will also track and monitor other phone accessibility metrics such as average speed to answer and abandoned rate and regularly report results to the Quality department.

Every quarter, our network management staff will conduct provider educational sessions to update provider office staff on changes in requirements, regulations, and contracts that will affect their claims.

Claims Staff Training: The goal of our initial claims staff training is to ensure all claims staff members have sufficient knowledge of our claims system in order to process claims timely and accurately. Our training program ensures that our claims staff members receive current information on policies and procedures and remain updated on issues that affect program performance. This includes new Federal and State initiatives as well as information regarding the routine flow of information among BCBSAZ Community Care, AHCCCS, and other vendor partners.

BCBSAZ Community Care has a training department that includes a full array of general and function-specific curriculum delivered via multiple channels including classroom settings, online learning tools, and on-the-job training.

The claims training program is structured by claim type and includes testing on each element of employee responsibility. Trainees must score 90% or higher to proceed from the classroom training to the on-the-job training phase of claims training which includes 100% quality control (QC) and a ramped approach to productivity. Before graduating from the training program, new processors must achieve 95% QC during the on-the-job training phase. Topics included in the claims training program include:

- Corporate Compliance Plan and Code of Conduct.
- Fraud, Waste, and Abuse.
- HIPAA and Protected Health Information (PHI).
- Claim Lifetime Overview.
- Claims Form Fields and Review (HCFA1500, UB04).
- Claims Systems Training.
- Claim Types (e.g., Inpatient, Outpatient, Acute Care, Home Health, Hospice, etc.).
- Member Liability and Benefits.
- Policies and Procedures.

Claims staff will also have to attend an annual refresher training program as well as periodic training for new or updated policies and procedures.

Oversight: Our compliance personnel will perform ongoing monitoring of claims issues, providing daily, monthly, and quarterly reports. Reports will include timeliness, accuracy, complaint review, metrics, and staff productivity. If the reports identify areas of deficiencies, for instance if staff performance does not meet AHCCCS program standards, we will create and implement corrective action plans to address the issues. Additional initiatives will include utilization of claims staff, provider surveys, and compilations of the top reasons for calls from providers that will be fed into our quality improvement program.

As part of our standard operations, we will track and trend complaints and resolution to identify areas for improvement at the program level as well as on an individual staff basis. We will monitor and analyze claims disputes on a monthly basis by the BCBSAZ Community Care Complaints and Appeals Committee comprised of the CEO, CMO, CFO, CCO, Executive Director of Operations, Operations/Member Services Director, and the Provider Network Director. For claims disputes, this committee will identify processes within the health plan that are causing claims disputes (e.g., system configuration, provider contract loading, claims processing). Once identified, we will fix the issue and readjudicate effected provider claims.

We will also identify individual provider billing trends and if certain billing practices cause multiple claims denials that lead to complaints, provider representatives will educate the provider's staff in order to ensure they understand the billing errors.

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

We recognize providers as the backbone of our service delivery and work collaboratively to ensure the most effective services for members are delivered with minimal administrative burden to the provider. When a complaint from a provider does reach the claims dispute process, our staff will continue to work with the provider, treating them with professionalism and courtesy to address the issue.

Our primary intervention with providers will be close communication with the provider. For example, for complex claims, our network management staff will meet face-to-face with the provider to review the claim and the claims file. Our Medical Director will be involved with the process as appropriate for questions concerning medical necessity. We will clearly explain how and why we performed any edits or denied the claim to assist them with resubmission. If, during the review, we determine that we are incorrect, we will admit the fault and correct the mistake.

Additionally, over 900 providers in our network are part of Banner Medical Group, employed by BCBSAZ Community Care partner Banner Health. Banner Health is committed to working internally to resolve any claims disputes with Banner Medical Group employed providers before they reach the hearing process.

10. Information Technology (IT) Systems Demonstration

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

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

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

--Guidelines
--10-day Calendar
--User Guides and Manuals

These mock scenarios will begin on Tuesday, January 29, 2013. For this Submission Requirement, the Offeror shall provide written acknowledgement as follows:

BCBSAZ Community Care acknowledges that its participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No.10.

BCBSAZ Community Care acknowledges that it will comply with the stated guidelines and calendar for this process.

BCBSAZ Community Care acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal.