Response to

**Acute Care / Children's Rehabilitative Services (CRS)**

**Solicitation No.: YH14-0001**

Presented to

**Arizona Health Care Cost Containment System (AHCCCS)**

Submitted by

**Southwest Catholic Health Network Corporation**
**dba Mercy Care Plan**

**Due Date: January 28, 2013 at 3:00 P.M. Arizona Time**

# A. General Matters

## EXHIBIT A: OFFEROR'S CHECKLIST

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

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

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

### *A. GENERAL MATTERS*

| ***Subject:*** | ***Page Number Reference*** | ***Offeror's Page No.*** |
|---|---|---|
| Offeror's Checklist *(This Exhibit)* | Exhibit A | 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 | 5a - 5f |
| Completion of all items in Section G: Representations and Certifications of Offeror | Section G | 6 - 31 |

### *A1: OFFEROR'S BID CHOICE FORM*

**ACUTE CARE PROGRAM**

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

Southwest Catholic Health Network Corporation
dba Mercy Care Plan
**Offeror's Name**

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

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

Authorized Signature — Date: 1-15-13

Mark Fisher — Print Name

President and Chief Executive Officer — Title

**CHILDREN'S REHABILITATIVE PROGRAM**

☑ Checking this box indicates the Offeror is bidding on the ***Children's Rehabilitative Program***.

| | |
|---|---|
| Authorized Signature | 1-15-13<br>Date |
| Mark Fisher<br>Print Name | President and Chief Executive Officer<br>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 | 33 |

## C. *CAPITATION SUBMISSION*

| Capitation | *Requirement No.* | *Offeror's Page No.* |
|---|---|---|
| | | |
| Acute Care Program Capitation Bid Submission Including Actuarial Certification | 1 | 39 |
| CRS Program Capitation Bid Submission Including Actuarial Attestation | 2 | 47 |

## *D. EXECUTIVE SUMMARY AND DISCLOSURE*

| Executive Summary and Disclosure | *Requirement No.* | *Offeror's Page No.* |
|---|---|---|
| | | |
| | 1 | 55 |
| | 2 | 59 |

## E. *ACUTE CARE NARRATIVE SUBMISSIONS*

| Access to Care/Network | *Requirement No.* | *Offeror's Page No.* |
|---|---|---|
| | | |
| | 1 | 63 |
| | 2 | 68 |

| Program | *Requirement No.* | *Offeror's Page No.* |
|---|---|---|
| | | |
| | 3 | 74 |
| | 4 | 79 |
| | 5 | 84 |
| | 6 | 89 |

| Organization | *Requirement No.* | *Offeror's Page No.* |
|---|---|---|
| | | |
| | 7 | 95 |
| | 8 | 100 |
| | 9 | 105 |
| | 10 | 110 |

## *F. CRS NARRATIVE SUBMISSIONS*

| Access to Care/Network - CRS | *Requirement No.* | *Offeror's Page No.* |
|---|---|---|
| | | |
| | 11 | 113 |

| Program - CRS | *Requirement No.* | *Offeror's Page No.* |
|---|---|---|
| | | |
| | 12 | 119 |
| | 13 | 124 |
| | 14 | 129 |

| Organization - CRS | *Requirement No.* | *Offeror's Page No.* |
|---|---|---|
| | | |
| | 15 | 135 |

**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.:

Not Applicable

Federal Employer Identification No.:

86-0527381

E-Mail Address: mark.fisher@aetna.com

Southwest Catholic Health Network Corporation dba Mercy Care Plan

Company Name

4350 E. Cotton Center Blvd., Bldg. D

Address

| Phoenix | AZ | 85040 |
|---|---|---|
| City | State | Zip |

For Clarification of this offer, contact:

Name: Mark Fisher

Phone: 602-453-6027

Fax: 602-263-2098

Signature of Person Authorized to Sign Offer

Mark Fisher

Printed Name

President and Chief Executive Officer

Title

**CERTIFICATION**

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

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

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

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

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

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

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

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

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

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

Michael Veit, as AHCCCS Contracting Officer and not personally

| | SOLICITATION AMENDMENT | AHCCCS |
|---|---|---|
| | Solicitation No.: **RFP YH14-0001**<br>Amendment No. **1 (One)**<br>Solicitation Due Date: **January 28, 2013**<br>**3:00 PM (Arizona Time)** | Arizona Health Care Cost Containment System<br>701 East Jefferson, MD 5700<br>Phoenix, Arizona 85034<br>Meggan Harley<br>Contracts and Purchasing Section<br>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**<br>1/7/2013 | **Signature** |
| **Typed Name**<br>Mark Fisher | | **Typed Name**<br>Michael Veit |
| **Title**<br>President and Chief Executive Officer | | **Title**<br>Contracts and Purchasing Administrator |
| **Name of Company**<br>Southwest Catholic Health Network Corporation<br>dba Mercy Care Plan | | **Name of Company**<br>AHCCCS |

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

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

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

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

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

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

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

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

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

| Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment. | | This Solicitation Amendment is hereby executed this the 19th day of December, 2012, in Phoenix, Arizona. |
|---|---|---|
| **OFFEROR** | | **AHCCCS** |
| **Signature** | **Date**<br>1/7/2013 | **Signature** |
| **Typed Name**<br>Mark Fisher | | **Typed Name**<br>Michael Veit |
| **Title**<br>President and Chief Executive Officer | | **Title**<br>Contracts and Purchasing Administrator |
| **Name of Company**<br>Southwest Catholic Health Network Corporation<br>dba Mercy Care Plan | | **Name of Company**<br>AHCCCS |

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

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

This solicitation is amended as follows:

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

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

| Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment. | | This Solicitation Amendment is hereby executed this the 4th day of January, 2013, in Phoenix, Arizona. |
|---|---|---|
| **OFFEROR** | | **AHCCCS** |
| **Signature** | **Date**<br>1/7/2013 | **Signature** |
| **Typed Name**<br>Mark Fisher | | **Typed Name**<br>Michael Veit |
| **Title**<br>President and Chief Executive Officer | | **Title**<br>Contracts and Purchasing Administrator |
| **Name of Company**<br>Southwest Catholic Health Network Corporation<br>dba Mercy Care Plan | | **Name of Company**<br>AHCCCS |

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

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

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

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

Bid component requirements:

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

| Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment. | | This Solicitation Amendment is hereby executed this the 10th day of January, 2013, in Phoenix, Arizona. |
|---|---|---|
| **OFFEROR** | | **AHCCCS** |
| **Signature** | **Date** 1-15-13 | **Signature** |
| **Typed Name** Mark Fisher | | **Typed Name** Michael Veit |
| **Title** President and Chief Executive Officer | | **Title** Contracts and Purchasing Administrator |
| **Name of Company** Southwest Catholic Health Network Corporation dba Mercy Care Plan | | **Name of Company** AHCCCS |

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

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

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

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

AHCCCS Response:

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

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

| OFFEROR | | AHCCCS |
|---|---|---|
| **Signature** | **Date** 1/25/2013 | **Signature** |
| **Typed Name**<br>Mark Fisher | | **Typed Name**<br>Michael Veit |
| **Title**<br>President and Chief Executive Officer | | **Title**<br>Contracts and Purchasing Administrator |
| **Name of Company**<br>Southwest Catholic Health Network Corporation<br>dba Mercy Care Plan | | **Name of Company**<br>AHCCCS |

Mercy Care Plan

# Section G:
# Representations and Certifications of Offeror

(This section is proprietary and has been submitted to AHCCCS as a separate file as instructed in Amendment 2)

# B. Attestation

# B. ATTESTATION

## Table of Contents

**Exhibit C: Attestation Form** ..... **33**

## 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<br>*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<br>*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<br>*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<br>*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<br>*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<br>*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<br>*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<br>*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.<br>*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<br>*RFP, Section D, Paragraph 16, Staff Requirements and Support Services* |
| 11. ☑ | Maintain system upgrade and conversion processes which include appropriate planning and implementation standards<br>*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<br>*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<br>*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<br>*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<br>*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]<br>*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<br>*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<br>*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<br>*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<br>*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<br>*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<br>*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<br>*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<br>*AMPM Chapter 310F* |
| 25. ☑ | A process to analyze utilization data and use the results to implement medical management changes to improve outcomes and experience<br>*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<br>*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<br>*RFP, Section D, Paragraph 12, Behavioral Health Services; AMPM Chapters 400 and 1000* |
| ***Access to Care***<br>***(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<br>*RFP, Section D, Paragraph 27, Network Development* |
| 29. ☑<br>***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<br>*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<br>*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<br>*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.*<br>*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.*<br>*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.<br>*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:** Southwest Catholic Health Network Corporation dba Mercy Care Plan certifies the elements attested to in this document are true and it is understood that AHCCCS will rely on this attestation in determination of the award.

**Authorized Signature** **Date** 1/7/2013

Mark Fisher President and Chief Executive Officer

**Individual's Printed Name** **Title**

# C. Capitation

Mercy Care Plan

# C. CAPITATION

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Mercy Care Plan

# Acute Care Program Capitation Bid Submission

*(Submission Requirement No. 1)*

**Acute Care RFP Bid Template - Mercy Care Plan**

Gross Medical Component by Risk Group and GSA

| Risk Group | GSA 2 | GSA 4 | GSA 6 | GSA 8 | GSA 10 | GSA 12 | GSA 14 |
|---|---|---|---|---|---|---|---|
| TANF < 1 | $408.45 | $430.94 | $434.42 | $0.00 | $441.52 | $479.00 | $415.51 |
| TANF 1-13 | $86.32 | $93.71 | $101.23 | $0.00 | $78.22 | $94.29 | $88.42 |
| TANF 14-44 F | $184.90 | $227.61 | $269.36 | $0.00 | $192.22 | $214.27 | $221.57 |
| TANF 14-44 M | $104.61 | $158.88 | $172.61 | $0.00 | $119.27 | $139.95 | $149.81 |
| TANF 45+ | $292.93 | $381.79 | $393.12 | $0.00 | $324.88 | $382.11 | $362.68 |
| SSIW | $156.55 | $105.75 | $97.78 | $0.00 | $112.83 | $150.00 | $132.23 |
| SSIW/O | $813.30 | $868.38 | $867.74 | $0.00 | $724.09 | $758.82 | $842.73 |
| AHCCCS Care | $334.40 | $404.20 | $429.93 | $0.00 | $308.63 | $400.44 | $368.40 |
| Delivery Supp | $4,710.22 | $5,239.57 | $5,253.68 | $0.00 | $5,249.24 | $5,539.57 | $5,125.39 |

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 | $30.63 | $32.32 | $30.41 | $0.00 | $30.91 | $33.53 | $29.09 |
| TANF 1-13 | $6.47 | $7.03 | $7.09 | $0.00 | $5.48 | $6.60 | $6.19 |
| TANF 14-44 F | $13.87 | $17.07 | $18.86 | $0.00 | $13.46 | $15.00 | $15.51 |
| TANF 14-44 M | $7.85 | $11.92 | $12.08 | $0.00 | $8.35 | $9.80 | $10.49 |
| TANF 45+ | $21.97 | $28.63 | $27.52 | $0.00 | $22.74 | $26.75 | $25.39 |
| SSIW | $11.74 | $7.93 | $6.84 | $0.00 | $7.90 | $10.50 | $9.26 |
| SSIW/O | $61.00 | $65.13 | $60.74 | $0.00 | $50.69 | $53.12 | $58.99 |
| AHCCCS Care | $25.08 | $30.32 | $30.10 | $0.00 | $21.60 | $28.03 | $25.79 |
| Delivery Supp | $353.27 | $392.97 | $367.76 | $0.00 | $367.45 | $387.77 | $358.78 |

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Mercy Care Plan

# Acute Care Program - Actuarial Certification

# Mercy Care Plan

**Solicitation Number: YH14-0001**

**Acute Care Program Capitation Rate Attestation**

***Contract Year: October 2013 –September 2014***

**Background**

The purpose of this capitation rate attestation is to certify that the proposed gross medical claims expense and administrative expense loads were developed following the guidance provided by CMS in accordance with 42 CFR 438.6(c). CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

**Intended Use**

This document is intended solely for use by the Arizona Health Care Cost Containment System (AHCCCS) in the evaluation of Mercy Care Plan's proposal response for solicitation #YH14-0001. The projections and assumptions described within must be viewed in aggregate and should not be reviewed independent of the other projections and assumptions contained herein.

**Base Experience Data**

AHCCCS provided three and one half years of detailed Acute Care Program encounter data and financial records of the current contract holders. The encounter data included claims for full contract years ending in 2009, 2010 and 2011 and the first six months of contract year ending in 2012. The financial statements were also included for fiscal years ending in 2011.

In our evaluation of the encounter data, we found the data to be credible and representative of the population to be covered.

We blended the encounter data from contract years ending in 2010 and 2011 to establish the base data set. We blended the two years using a credibility formula based on the member months from each fiscal year. 100% credibility for the most recent contract year was given to rate cells that had over 240,000 member months. For those rate cells with member months less than 240,000, the credibility formula was as follows:

| Square root of [most current contract year member months / (most current contract year member months + first prior contract year member months)] |
|---|

A table with the credibility given to the most current contract year's data for each rate cell by GSA is shown as Table I in the Appendix.

**Claim Trend**

We continually analyze the change in historical medical costs for all our lines of business controlling for known changes to benefits, provider reimbursement, membership mix, and risk profile. We also analyze and review published literature from consultants, federal government agencies and state government agencies.

We are using an overall trend assumption of 2.8%; 2.1% for utilization per 1,000 and 0.7% for unit cost. The number of months between the base period and contract period, Oct 2013 through Sept 2014, is 36 months. Therefore the trend factor applied to the base experience period claims is 1.088 (1.028 ^ (36/12)).

This trend assumption is quite reasonable. Mercy Care Plan has been experiencing claims trend between 2% and 3% since early 2010.

The average trend assumptions for each rate cell and GSA are included as Table II in the Appendix.

**Claim Adjustments**

Adjustments to the base period claims are made when there is a known change that has occurred or will occur between the end of the base experience period and the contract period. These can take the form of changes to covered benefits, elimination of covered benefits, changes to provider reimbursement, changes in the acuity of the current and future enrollees and/or contracting with providers to establish a network.

*Provider Reimbursement*

In April 2011 and October 2011, the state of Arizona reduced the state fee schedule by 5%. The rate reductions were also incorporated by Mercy Care Plan. The fee schedule decreases have been incorporated into the future claims projections.

*Benefit Changes*

There were a number of small benefit changes that occurred during the base period or shortly after. In our analysis, the benefit that was most substantial was the change from unlimited inpatient hospital days to a limit of 25 days per contract year. We reviewed the benefit change values that were presented by AHCCCS in their rate development documentation. In our review we determined that the benefit changes they incorporated were reasonable. Therefore, we incorporated their values for the changes in benefits during the first prior, base period and prior to the upcoming contract year.

*Managed Care Savings*

The Acute Care Program has been managed by managed care organizations since 1982. In our estimate, there is no substantial managed care savings opportunity an MCO could achieve beyond what the current carriers have already achieved.

**Positioning of Gross Medical Claims Expense within the Rate Range**

Per the bid instructions, bidders are required to bid the gross medical claims expense within the rate range provided by AHCCCS. Bids outside the range will be scored zero. Therefore, all the gross medical expenses in this bid are within the rate range. The placement within the range for each rate cell and GSA is included as Table III in the Appendix; 0% = bottom of the rate range, 100% = top of the rate range.

**Administrative Expense Load**

The administrative expense load for GSAs 6, 10, 12 and 14 is set to 7.0% of the gross medical claims expense. The administrative expense load for GSAs 2 and 4 is set to 7.5% of the gross medical claims expense. The load is applied uniformly to all rate cells in each GSA.

**Profit Margin Load**

Per the bid instructions, the profit margin load will be 1.0% of the gross medical expense, but should not be included as part of the RFP bids. The profit margin load will be applied by AHCCCS when the final rates are determined.

**Premium Tax Load**

Per the bid instructions, the premium tax load will be 2.0% of the gross capitation rate, but should not be included as part of the RFP bids. The premium tax load will be applied by AHCCCS when the final rates are determined.

**Deviation of projected future events and actual outcomes**

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

# Actuarial Certification

I, Jason Strandquist, am an employee of Schaller Anderson, an Aetna Company and a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I have examined the encounter data, financial records, assumptions and methods used to develop the gross medical claims expense and administrative expense loads proposed by Mercy Care Plan for the Acute Care Program contract. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

In developing the assessment, I relied upon the encounter data and financial records provided by AHCCCS. I have accepted the data without audit and have relied upon AHCCCS for the accuracy of the data.

In my opinion, the gross medical claims expense and administrative expense loads for solicitation number YH14-0001 are actuarially sound for the purposes of 42 CFR 438.6(c), according to the following criteria:

1. The proposal has been developed in accordance with generally accepted actuarial principles and in accordance with Actuarial Standards of Practice Nos. 5, 23, 25, 26 and 41, and
2. The proposal is appropriate for the populations to be covered and the services to be provided under the contract

_____ January 22, 2013

**Jason Strandquist**, FSA, MAAA **Date**
Director, Actuarial Services
Schaller Anderson, an Aetna Company
(602) 659-1759

## Appendix

**Table I: Current Period Credibility Weighting**

| Ratecell | GSA_2 | GSA_4 | GSA_6 | GSA_10 | GSA_12 | GSA_14 |
|---|---|---|---|---|---|---|
| SSI w/ Med | 72.1% | 72.2% | 71.8% | 72.0% | 100.0% | 71.5% |
| SSI w/o Med | 71.6% | 71.6% | 71.4% | 72.0% | 100.0% | 71.6% |
| TANF < 1 | 70.6% | 69.2% | 68.6% | 69.6% | 100.0% | 69.2% |
| TANF 1-13 | 70.0% | 100.0% | 70.0% | 100.0% | 100.0% | 70.4% |
| TANF 14-44 F | 70.7% | 70.5% | 70.7% | 100.0% | 100.0% | 71.0% |
| TANF 14-44 M | 70.3% | 70.5% | 70.7% | 70.7% | 100.0% | 70.7% |
| TANF 45+ | 71.1% | 71.2% | 71.5% | 71.3% | 72.0% | 70.6% |
| AHCCCS Care | 71.4% | 71.2% | 71.1% | 100.0% | 100.0% | 71.8% |
| Maternity Kicker | 75.0% | 75.0% | 75.0% | 75.0% | 75.0% | 75.0% |

**Table II: Average Annual Claim Trend**

| Ratecell | GSA_2 | GSA_4 | GSA_6 | GSA_10 | GSA_12 | GSA_14 |
|---|---|---|---|---|---|---|
| SSI w/ Med | 5.5% | 2.3% | 2.0% | 2.3% | 4.0% | 3.4% |
| SSI w/o Med | 1.9% | 6.0% | 3.7% | 0.1% | 3.1% | 1.5% |
| TANF < 1 | 2.8% | -0.9% | 3.7% | 3.1% | 2.3% | -0.4% |
| TANF 1-13 | 2.7% | 1.3% | 2.5% | 0.9% | 1.7% | 2.3% |
| TANF 14-44 F | 3.2% | 0.7% | 3.7% | 3.1% | 2.5% | 2.3% |
| TANF 14-44 M | 2.3% | 3.2% | 5.9% | 4.4% | 2.9% | 6.2% |
| TANF 45+ | 2.5% | 5.7% | 4.9% | 3.5% | 4.2% | 5.6% |
| TWG | 1.2% | 3.5% | 2.0% | 0.7% | 3.7% | 1.9% |
| Maternity Kicker | 2.7% | 2.7% | 2.7% | 2.7% | 4.0% | 3.2% |

**Table III: Placement within Gross Medical Expense Range**

| Ratecell | GSA_2 | GSA_4 | GSA_6 | GSA_10 | GSA_12 | GSA_14 |
|---|---|---|---|---|---|---|
| SSI w/ Med | 75% | 75% | 25% | 49% | 49% | 75% |
| SSI w/o Med | 75% | 75% | 25% | 50% | 50% | 75% |
| TANF < 1 | 75% | 75% | 25% | 50% | 50% | 75% |
| TANF 1-13 | 75% | 75% | 25% | 48% | 48% | 75% |
| TANF 14-44 F | 75% | 75% | 25% | 49% | 49% | 75% |
| TANF 14-44 M | 75% | 75% | 25% | 49% | 49% | 75% |
| TANF 45+ | 75% | 75% | 25% | 50% | 50% | 75% |
| TWG | 75% | 75% | 25% | 50% | 50% | 75% |
| Maternity Kicker | 75% | 75% | 25% | 50% | 50% | 75% |

Mercy Care Plan

# CRS Program Capitation Bid Submission

*(Submission Requirement No. 2)*

| CRS RFP Bid Template |
| --- |
| Enter Offeror's Name |
| Mercy Care Plan |
| |
| Enter Administrative Expenses PMPM |
| $44.39 |
| |
| This bid represents the average CYE14 administrative expenditure for all CRS members in any of the four coverage types. All bids must be provided as a per-member-per-month (PMPM) amount. Bids above $60.00 PMPM will receive zero points in competitive scoring. |

Mercy Care Plan

# CRS Program - Actuarial Attestation

# Mercy Care Pan

**Solicitation Number: YH14-0001**

**CRS Capitation Rate Attestation**

***Contract Year: October 2013 –September 2014***

**Background**

The purpose of this capitation rate attestation is to certify that the proposed capitation rates for the Children's Rehabilitative Services (CRS) contract were developed following the guidance provided by CMS in accordance with 42 CFR 438.6(c). CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

**Intended Use**

This document is intended solely for use by the Arizona Health Care Cost Containment System (AHCCCS) in the evaluation of Mercy Care Pan's proposal response for solicitation number YH14-0001. The projections and assumptions described within must be viewed in aggregate and should not be reviewed independent of the other projections and assumptions contained herein.

**Base Experience Data**

AHCCCS provided three and one half years of detailed CRS encounter data and financial records of the current contract holders. The encounter data included claims for full contract years ending in 2009, 2010 and 2011 and the first six months of contract year ending in 2012. The financial statements were also included for fiscal years ending in 2011.

In our evaluation of the CRS encounter data, we found the data to be credible and representative of the population to be covered.

We blended the encounter data from contract years ending in 2010 and 2011 to establish the base data set. We blended the two years using a credibility formula based on the member months from each fiscal year. The credibility formula was as follows:

| |
|---|
| Square root of [most current contract year member months / (most current contract year member months + first prior contract year member months)] |

The credibility given to the most current experience period is 72%.

**Claim Trend**

We continually analyze the change in historical medical costs for all our lines of business controlling for known changes to benefits, provider reimbursement, membership mix, and risk profile. We also analyze and review published literature from consultants, federal government agencies and state government agencies.

We are using an overall trend assumption of 1.0%; 1.0% for utilization per 1,000 and 0.0% for unit cost. The number of months between the base period and contract period, Oct 2013 through Sept 2014, is 36 months. Therefore the trend factor applied to the base experience period claims is 1.03 (1.01 ^ (36/12)).

**Claim Adjustments**

Adjustments to the base period claims are made when there is a known change that has occurred or will occur between the end of the base experience period and the contract period. These can take the form of changes to covered benefits, elimination of covered benefits, changes to provider reimbursement, changes in the acuity of the current and future enrollees and/or contracting with providers to establish a network.

*Provider Reimbursement*

In April 2011 and October 2011, the state of Arizona reduced the state fee schedule by 5%. The rate reductions were also incorporated by Mercy Care Plan. The fee schedule decreases have been incorporated into the future claims projections.

*Benefit Changes*

There were a number of small benefit changes that occurred during the base period or shortly after. In our analysis, the benefit that was most substantial was the change from unlimited inpatient hospital days to a limit of 25 days per contract year. We reviewed the benefit change values that were presented by AHCCCS in their rate development documentation. In our review we determined that the benefit changes they incorporated were reasonable. Therefore, we incorporated their values for the changes in benefits during the first prior, base period and prior to the upcoming contract year.

*Managed Care Savings*

The CRS Program has been managed by managed care organizations for quite a long time. In our estimate, there is no substantial managed care savings opportunity an MCO could achieve beyond what the current carriers have already achieved.

**Administrative Expense Load**

The administrative expense load for the CRS contract is set to 8.0% of the capitation rates. In our evaluation, an 8.0% load will be adequate to cover the additional cost to manage the entire CRS program. Based on the membership distribution percentages provided by AHCCCS, the projected average capitation rate is $554.91 pmpm; 8.0% of $554.91 pmpm is $44.39 pmpm.

**Profit Margin Load**

Per the bid instructions, the profit margin load will be 1.0% of the gross medical expense, and was not included as part of the capitation rates. The profit margin load will be applied by AHCCCS when the final rates are determined.

**Premium Tax Load**

Per the bid instructions, the premium tax load will be 2.0% of the gross capitation rate, and was not included as part of the capitation rates. The premium tax load will be applied by AHCCCS when the final rates are determined.

**Deviation of projected future events and actual outcomes**

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

# Actuarial Certification

I, Jason Strandquist, am an employee of Schaller Anderson, an Aetna Company and a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I have examined the encounter data, financial records, assumptions and methods used to develop the gross medical claims expense and administrative expense loads proposed by Mercy Care Plan for the Children's Rehabilitative Services contract. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

In developing the assessment, I relied upon the encounter data and financial records provided by AHCCCS. I have accepted the data without audit and have relied upon AHCCCS for the accuracy of the data.

In my opinion, the capitation rates proposed for solicitation number YH14-0001 are actuarially sound for the purposes of 42 CFR 438.6(c), according to the following criteria:

1. The proposal has been developed in accordance with generally accepted actuarial principles and in accordance with Actuarial Standards of Practice Nos. 5, 23, 25, 26 and 41, and
2. The proposal is appropriate for the populations to be covered and the services to be provided under the contract

_____ January 22, 2013

**Jason Strandquist**, FSA, MAAA **Date**
Director, Actuarial Services
Schaller Anderson, an Aetna Company
(602) 659-1759

# D. Executive Summary and Disclosure

Mercy Care Plan

# D. EXECUTIVE SUMMARY AND DISCLOSURE

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**Q1: Executive Summary: The Offeror must provide an Executive Summary that includes an overview of the organization and its relevant experience, a high-level description of its proposed approach to meeting contract requirements and a discussion of how it will bring added value to the program. In the final portion of the Executive Summary, the Offeror must describe how it will meet the requirements specified in Section I, Exhibit D, Medicare Requirements, Section 2. The Executive Summary will not be scored, but may be used in whole or part by AHCCCS in public communications, following contract awards. (4 page limit)**

## Organization Experience

Southwest Catholic Health Network Corporation, dba Mercy Care Plan (MCP), a not-for-profit, locally owned and operated company, has strong roots in Arizona. One of the first AHCCCS health plans, MCP was formed as a mission-based entity in 1985 to serve Medicaid members in Arizona through an AHCCCS contract by two Arizona-based provider organizations: Carondelet Health Network (a ministry of Ascension Health) and St. Joseph's Hospital and Medical Center (a Dignity Health member). Today, we continue to work closely with AHCCCS, as we have throughout our 27-year history, to develop and deliver programs and services that improve clinical outcomes and member satisfaction while reducing unnecessary costs.

MCP has consistently supported AHCCCS in its mission to provide comprehensive, quality healthcare to those in need. As one of the largest AHCCCS contractors, we deliver services to more than 330,000 members through the Acute Care, ALTCS, DDD, Mercy Healthcare Group and Medicare Advantage Dual Special Needs Plan (D-SNP) programs. MCP currently manages the Acute Care services for approximately 25 percent of the CRS enrolled population and manages medical services for more than 9,200 developmentally disabled members in Arizona. We also serve more than 17,300 dual eligible members through Mercy Care Advantage (MCA), our Medicare Advantage Dual Special Needs Plan. It is our understanding that we are one of the largest Dual SNPs in the country.

MCP is supported by the national administrative, clinical and technological resources available through our administrative subcontractor, Schaller Anderson, LLC (Schaller), which is now owned by Aetna Inc. (Aetna). Aetna, a publicly traded corporation and a Fortune 500 company, is one of the country's oldest and largest healthcare companies. Established in 1853, Aetna has more than 150 years of successful healthcare experience and is one of the nation's leading diversified healthcare benefits companies, serving 36.4 million people and employing nearly 34,000 people in 116 offices nationwide.

Schaller Anderson, also based in Arizona, has proven experience in successfully serving Medicaid populations throughout the nation under an integrated managed care model and is the core of Aetna's Medicaid business unit. Aetna Medicaid affiliates currently own or administer Medicaid benefits for Aged, Blind and Disabled, special needs, TANF, and SCHIP populations for more than 1.2 million members in 12 states, including Arizona, California, Delaware, Florida, Illinois, Maryland, Missouri, New Hampshire, New York, Pennsylvania, Texas and Virginia.

## Approach to Meeting Contract Requirements

MCP proposes to provide member-centered, innovative managed care for Acute, CRS, and Dual SNP members across the state. Our approach to transform the system, built upon our long-standing history of service delivery, is consistent with AHCCCS' mission: *Reaching across Arizona to provide comprehensive quality health care to those in need while shaping tomorrow's managed health care from today's experience, quality and innovation*.

**Acute Care Program:** MCP proposes to provide acute care services in 13 Arizona counties. We have experience in managing successful expansion implementations and have the resources available to accomplish this expansion in a timely and cohesive manner, with minimal disruption to the member and provider community. We will utilize our proven methodologies for delivering high quality care through our medical and quality management programs. We will coordinate, manage and provide acute care services to members while coordinating members' behavioral health services as delivered through the Regional Behavioral Health Authorities (RBHAs). We are already well established in Arizona and have significant experience expanding into new counties. Utilizing our successful methodologies for completing start-up activities, we will maintain ongoing clinical and operational staffing in meeting the needs of increased membership. MCP is committed to supporting AHCCCS programs and members and has in place the organizational, operational, medical and administrative systems capable of transforming healthcare in Arizona.

**CRS Program:** Our proposal is designed to improve the quality of life and achieve better outcomes for Arizona children with special healthcare needs. To achieve these goals, MCP will use its member-centered, family-friendly case management program, data sharing mechanisms and tools to improve care coordination and promote information sharing between CRS, acute and behavioral health providers. These strategies will facilitate greater participation and collaboration in the creation of a common service plan. We will also use our management processes to continuously streamline systems to improve efficiencies and reduce the "hassle factor" for healthcare providers. We have in place the organizational, operational, managerial and administrative systems capable of fulfilling all CRS contract requirements. Additionally, MCP will invest – well above and beyond what is required by the RFP – in the development of an Ombudsman/Client Advocate function that will engage stakeholders from across the State in every facet of the CRS program.

## MCP Value Adds

MCP's approach to service delivery is a proven model that adds value for the members we serve, the providers, and the entire system. As we design our clinical, operational, and administrative systems, we seek to add value and system transformation that results in enhanced member outcomes, improved quality of care, and system efficiencies. Our model of care adds value to the service delivery system through:

**Offering a Superior Model of Care.** MCP's model of care matches members with the resources they need to improve their health status and to sustain those improvements over time. We offer members choices in where they receive care, and work to engage them and their families in all aspects of care – assessment, care planning, and selecting service providers. MCP has a sophisticated predictive modeling tool that allows proactive identification of high risk members who may benefit from an increased level of care coordination, service and support. Through our model of care, members have access to the right services, at the right time, improving their ability to manage their health symptoms in appropriate settings, thereby improving health outcomes and reducing system costs.

**Innovative Care Coordination.** MCP will proactively remove the possibility of duplication of services and gaps in services through our comprehensive care coordination model. *Our model of care relies upon high touch service coordination and communication among treatment team members as well as technological solutions that ease providers' administrative burdens.* This infrastructure is designed to empower providers and members, and to optimize the collaborative aspects of our integrated care model.

**Mercy Care Plan is known for the quality of our programs. For example, for the period ending September 30, 2010, MCP scored highest among all AHCCCS-contracted health plans on the AHCCCS Quality Management Performance Measures.**

**Advanced Technology:** MCP employs advanced technologies, including member and provider web portals, to share information in a timely manner to identify real-time gaps in care; to identify preventive screening needs; to expedite prior authorization decisions; and to make evidence-based practice guidelines available to providers. *As a value-add to our members and providers, we provide actionable health information to each participant of the member's clinical team through our innovative reporting systems.* MCP's technology infrastructure makes it easier for providers to support members with complex medical conditions.

**A Strong Quality Focus:** Quality management is a core competency for MCP. Our quality management systems and structures employ routine and comprehensive monitoring and oversight systems that result in improved member care, service delivery system enhancements, and excellent member outcomes. MCP's quality management program has consistently met and exceeded all AHCCCS requirements as measured through the annual Operational and Financial Review. *Our commitment to quality adds significant value to the service delivery system for acute and CRS members.*

**MCP currently serves more than 45,000 members in our innovative patient centered medical homes with a focus on whole person health through our collaboration with the RBHA providers in Maricopa and Pima counties.**

**Innovative Programs and Services:** MCP is committed to providing creative, innovative programs, services and care that promote each member's strengths and recognizes that a whole health and member-centered approach is integral to quality, safe, cost-effective services. Our vision is to deliver services that will promote hope, recovery and wellness in every aspect of the member experience – from engagement to treatment, service delivery, and customer service. Through our patient centered medical homes, members receive access to a quality-driven interdisciplinary and clinician-led team approach that puts members at the center of all decisions and eliminates care fragmentation. *We currently serve more than 45,000 members in our innovative patient centered medical homes with a focus on whole person health through our collaboration with the RBHA providers in Maricopa and Pima counties.*

**Continuous Learning:** MCP is engaged in promoting a continuously learning healthcare system that: 1) involves members, clinicians and communities in building a productive healthcare environment; 2) adapts and improves as information becomes available; 3) delivers reliable clinical knowledge to members and their providers to engage them in their care; and 4) creates a collaborative environment where healthcare policy innovations can flourish. We are dedicated to building a sustainable healthcare system through implementing program innovation and best practices on an ongoing basis and by continuously developing mechanisms to reduce administrative cost and improve program efficiency. Our approach to integrating continuous improvement within our daily health plan operations incorporates the Institute of Medicine's (IOM) recommendations for strategies to improve care, reduce costs, and enhance member outcomes. Our member-centered, innovative approach to service delivery exceeds AHCCCS standards and brings added value to the service delivery system.

**Local Presence:** As a locally-based, provider-sponsored plan, MCP has close connections to the communities it serves. Arizona is home to more than 1,000 MCP staff members. As MCP expands into additional counties, jobs created by our expansion will remain in Arizona. Because our staff live in the local communities, we are keenly aware of the strengths and needs of the community, as well as the needs of our members. *As a value-add*, *our local presence allows members the opportunity to engage with us in person.* Our Arizona-based Member Services Department allows members to meet with us and have their concerns addressed face-to-face, allowing us to establish connections with our members and engage them in their healthcare.

**Our "Member First" Philosophy:** In following MCP's mission of caring for the poor and underserved population, our staff furthers this mission throughout their daily work. MCP improves each member's healthcare experience by providing member-focused care that empowers and supports the member as he/she moves through the healthcare system. We assist the member in navigating the healthcare system each step of the way. *As a result of our "member first" philosophy, only one percent of MCP members select another health plan when they have the opportunity*.

**Ombudsman/Client Advocate:** To fully support system transformation, MCP will create the Office of the Ombudsman (OOO) to provide CRS members and stakeholders with a strong voice throughout our organization, as well as within their own communities. The Ombudsman will be based in Phoenix and will be supported by a regionalized communications function that will work in tandem with the OOO to accomplish vigorous outreach to both members and all stakeholders involved in the CRS Program. In this response, we have identified key facets of the CRS system that must be addressed and describe how, through our investment - well above and beyond what is required by the RFP - in the Ombudsman/Client Advocate function, we have designed an approach that will engage stakeholders at the forefront of the process of transforming the CRS system to achieve the desired outcomes.

**Partnership with Providers:** As a provider-sponsored plan, MCP understands our providers' requirements and their essential role in the delivery of healthcare services to our members. We will continue to foster a collegial relationship with all providers, including Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, Rural Health Clinics (RHCs), T/RBHAs and Multispecialty Interdisciplinary Clinics (MSICs). *Our collaboration with providers is an added value to the service delivery system in that it enables us to work with them at every level to improve the quality of care and reduce unnecessary costs.*

**A Comprehensive Provider Network:** MCP works cooperatively with a wide range of community primary and specialty care providers, local hospitals and their affiliated providers, FQHCs, and community mental health agencies. We will build upon our current network to develop a viable network, including contracting with MSICs capable of providing all covered services (regardless of type) to all Acute Care and CRS members in urban and rural areas of Arizona. Our programs are designed to achieve optimal care coordination and collaboration among all providers.

**Collaboration between all Stakeholders:** Over its long history of providing care to members in Arizona, MCP has forged positive relationships with community stakeholders, all other AHCCCS health plans and T/RBHAs. We will continue to support a collaborative environment by engaging all stakeholders to address quality and cost issues, streamline administrative and produce improved clinical outcomes. For example, we will work with other health plans to implement mechanisms and tools to improve data sharing in a cohesive and standardized manner that support both members and providers.

MCP will further collaborate with AHCCCS to transform the system by reducing program complexity, improving care coordination and chronic care management, reducing administrative burdens, leveraging joint purchasing power, and reducing unnecessary administrative and healthcare costs. *We will continue to add value to each program we serve, recognizing the unique needs of members, including those with special healthcare needs or chronic conditions.*

## Compliance with Medicare Requirements

MCP currently serves 17 percent of the total number of Medicaid/Medicare fully-aligned members across the country through Mercy Care Advantage, our Medicare Advantage Dual SNP. Based on our experience, we know that the alignment/integration of Medicaid/Medicare will achieve greater cost savings for AHCCCS and better outcomes and satisfaction for our members. MCP will meet all requirements specified in Section I, Exhibit D, Medicare Requirements, Section 2 of the Request for Proposal, employing our experience, superior model of care, innovative technology, partnership with providers and collaborative approach to working with all stakeholders.

MCP is prepared and compliant with application requirements under the Dual Demonstration (Dual Eligible Financial Alignment Initiative Capitated Model) should the state decide to pursue this avenue as a means of automatically enrolling dual eligible members. MCP has been involved with AHCCCS over the course of several months in investigating the evolving dual demonstration opportunity being offered by CMS and has participated in AHCCCS' information gathering and sharing meetings, stakeholder engagement events, and other opportunities to contribute knowledge and constructive thought to the unfolding potential opportunity for increased dual eligible integration presented by the Dual Demonstration. As a result, MCP is prepared to participate in either the Dual SNP environment or the Dual Demonstration environment.

MCP will build on our existing and proven integrated care models that focus on dual eligible members and comply with all Medicare policies and procedures. We have measurable administrative and clinical policies, procedures, and processes that allow us to effectively coordinate care for dual eligible members. Our policies, procedures and processes meet all Medicare demonstration requirements as required by CMS and the state.

MCP's Medicare Model of Care (MOC) for dual eligibles is well-developed and has a demonstrated track record of removing barriers to care and administering Medicare-Medicaid benefits in an integrated way. Consistent with this model, our processes will be seamless to the member. MCP's MOC was recently recognized for its positive impact on member outcomes in a study conducted by Avalere Health in July (2012). The Avalere study concluded, "Mercy Care's model of care is successful in keeping people out of the hospital and in lowering readmissions relative to fee-for-service." The study also presented data to demonstrate that MCP's care coordination model for dual eligibles results in higher use of preventive/ambulatory services, and lower rates of inpatient utilization (Avalere, 2012).

In summary, MCP brings the power and passion of a locally-based, provider-sponsored health plan. For over 26 years, families and individuals have trusted our health plans to provide care for members with complex needs. We have earned this trust and appreciation through our commitment to the members we serve. For decades, we have lived our mission and values through our dedication to service delivery, our roots in the community, and the unwavering commitment to quality care. We will apply the lessons learned from our extensive experience to transform the service delivery system, developing innovative approaches to delivering high quality healthcare services.

**Q2: Moral or Religious Objections: The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may propose a solution not already contemplated by this Contract to allow members to access the services. The Contractor must identify solutions pertinent to the Acute Care Program and the CRS Program if submitting proposals for both. AHCCCS does not intend to offer the services on a fee-for-service basis to the Contractor's enrollees. The proposal must be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.**

Southwest Catholic Health Network Corporation, d.b.a. Mercy Care Plan (MCP), is a not-for-profit company. Since 1985, MCP has been a locally owned and operated health plan in Arizona. MCP is sponsored by Dignity Health, d.b.a. St. Joseph's Hospital and Medical Center, and Carondelet Health Network, a ministry of Ascension Health. The Board of MCP is comprised of representatives from Dignity Health and Carondelet Health Network. MCP subcontracts the management of all administrative services to Schaller Anderson, LLC (Schaller Anderson), an Aetna company.

MCP was formed as a mission-based entity in 1985 to serve Medicaid members in Arizona through an AHCCCS contract. MCP was one of the first AHCCCS health plans. Today, we work as closely with AHCCCS as we have for the past 27 years. We provide services to all AHCCCS programs, including serving over 17,300 AHCCCS members through a dual eligible Special Needs Plan.

MCP's sponsors, Carondelet Health Network and Dignity Health, have been serving the healthcare needs of Arizonans since before Arizona was a state. The Sisters of St. Joseph of Carondelet opened Arizona's first hospital, St. Mary's Hospital, in 1880. In addition to St. Mary's Hospital, Carondelet sites in Tucson today include St. Joseph's Hospital, the Cerelle Center for Mammography and Carondelet Imaging Services Central. As southern Arizona's premier health services provider, Carondelet currently serves more than 1.3 million Arizona residents. The Sisters of Mercy opened St. Joseph's Hospital and Medical Center in Phoenix in 1895 and today, it is part of Dignity Health, the nation's fifth largest hospital provider, employing more than 60,000 caregivers in Arizona, California, and Nevada.

Federal law mandates that state Medicaid agencies provide coverage for family planning services. Some of these services are in conflict with traditional Catholic values and social teachings. MCP has religious and moral objections to providing the family planning services listed in the AMPM Section 420. MCP's special corporate member holds a separate contract with Schaller Anderson, MCP's contract administrator, to administer all family planning services that MCP objects to for religious or moral reasons. This is a continuation of an arrangement implemented in 2002 that was approved by AHCCCS. Any payments due to Schaller Anderson for the activities defined in their contract, including administering family planning services and other benefits, will be MCP's responsibility.

In accordance with A.R.S. 36-2907(A)(8), MCP's election does not disqualify MCP from delivering all other covered health and medical services and MCP elects Schaller Anderson for administrative family planning and certain OB/GYN services. Therefore, all covered and medically necessary services will be available to AHCCCS' members through the Acute Care and CRS programs.

# E. Narrative Submissions

Mercy Care Plan

# E. NARRATIVE SUBMISSIONS

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Mercy Care Plan

# Acute Care Narrative Submissions

Mercy Care Plan

# Access to Care/Network

## Q1: MCP's Readiness for ACA-Driven Membership Expansion

Since 1985 Mercy Care Plan (MCP) has consistently delivered high quality, accessible, and cost effective services to AHCCCS members. As a contractor for all AHCCCS programs (e.g. Acute Care, DDD and ALTCS), as well as Healthcare Group and Medicare Advantage Dual Special Needs Plan (MA-DSNP), we know that the Affordable Care Act (ACA) will impact all aspects of Arizona's healthcare system. We fully support the governor's decision to expand Arizona's Medicaid program to include individuals eligible through the ACA. MCP recognizes that the expansion of Medicaid and the implementation of Health Insurance Exchanges will place new demands on Arizona's healthcare system. MCP is committed to taking the necessary actions to facilitate access to all covered services for members enrolled as a result of the ACA. Our approach to managing the ACA expansion will reduce disruption to the overall healthcare system, avoid unnecessary costs, improve members' continuity of care, and increase our ability to be responsive to members when they join MCP.

MCP has the experience to align our provider network, systems, operations and administrative processes to accept, transition, and manage ACA-driven membership. MCP successfully managed the membership increases from the two other major AHCCCS enrollment expansions. We maintained access to care and high quality services for the growth during the 1998 CHIP-driven expansion and also during the Proposition 204-driven expansion in 2000. In 2009 MCP successfully managed a single year increase in Acute Care membership of more than 12 percent (34,500 members). MCP also successfully managed the transition of ALTCS members in 2005 in Maricopa County when the incumbent contractor ended its contract, and again in 2011 when we expanded our ALTCS contract in Pima County. In 2006, we implemented our MA-DSNP, enrolling 13,000 dual eligible members. Throughout the course of each expansion, we successfully increased our administrative, operational, and network capacity in a manner that served all our members while maintaining the highest quality of care.

Additionally, MCP's administrative subcontractor, Schaller Anderson, LLC (Schaller), has experience managing enrollment expansions. In 2007, Schaller was purchased by Aetna, Inc. (Aetna). Aetna, one of the largest and most respected healthcare companies in the nation, has made and will continue to make its industry leading technology, administrative, and operational support available to MCP. MCP's preparation for ACA-driven membership growth includes leveraging our local experience and Aetna's national expertise to enhance our capacity to serve members enrolled through the ACA.

MCP understands that in addition to a significant increase in numbers of members, the members who will be newly enrolled may have unmet and even unrecognized healthcare needs. To verify our capacity to manage the upcoming membership growth and the needs of the individual members, we implemented a systematic approach to evaluate the readiness of our network, administrative, and operational capabilities. Under the direction of MCP's Board, our Chief Operating Officer (COO) led a health plan-wide assessment of our operational and administrative structure and provider network in order to identify any potential problems and needed adjustments to reinforce our infrastructure. Our conclusion was that we have a sound and responsive operational, administrative and network structure that is capable of supporting successful ACA-driven membership growth.

### Steps MCP Has Taken and Will Take to Ensure Access to Care to Support the Influx of Members

#### *Preparing the Network*

In preparation for increased membership due to ACA, we evaluated the capacity of our network to determine the most effective strategies for increasing our network capacity. We identified three interrelated approaches to make sure our network has the ability to absorb the membership growth, including: 1) expanding our health homes; 2) increasing participation with FQHC and FQHC look-alikes (referred to as FQHCs); and 3) strengthening our existing network by both increasing growth among existing providers' capacity and by adding new providers.

Expand Health Homes: MCP has continued to develop health home models to provide integrated care to members with complex needs. We anticipate that many of the first members to enroll with us as a result of the ACA will have unmet needs, resulting in increased service utilization and requiring close coordination of care. To facilitate access to care for members with multi-faceted needs, we will continue to expand health home services in 2013 through strategic contracting and infrastructure support. We will provide consultation and technical assistance to providers who are

interested in being recognized as a health home and will also offer financial incentives and assistance with data analysis and reporting. MCP currently has over 45,000 members who see a PCP within a health home practice. This was achieved during implementation of our health home models between 2011 and 2012.

Increase participation with FQHCs and FQHC look-alikes: We have established contracts with every FQHC and FQHC-look alike in the state, as well as multiple Rural Health Clinics, as these providers are known for their work in serving underserved and diverse populations. MCP will continue its work with FQHCs to assist them in becoming health homes. We have actively engaged in discussions with the Alliance of Community Health Centers and will launch new pilot health home programs with all or some of the Community Health Centers. For example, Marana Community Health Center will help serve our members in Pima County through their new health home program. MCP will continue to strengthen our relationships with these and other providers to expand the availability and accessibility of services to accommodate our current membership as well as the expansion group.

Strengthen our existing network: MCP has a robust provider network that affords our members with timely access to high quality services. We will expand the existing capacity by offering providers incentives for extending their office hours to include night and weekend appointments. We will further strengthen our network by actively seeking out providers who are not in our network but who have the capacity to serve our members and work to establish their participation in our network. Because our Board is comprised of provider representatives, we also have credibility in the provider community, which facilitates our ability to engage providers. In preparation for the ACA-driven membership expansion we implemented a letter of intent (LOI) campaign. Over a four month period we were able to secure 1,769 LOIs representing 3,550 providers across Arizona who are willing to participate in MCP's geographic expansion and MCP's support for membership expansion. MCP will continue to monitor, assess, and implement our time proven activities to strengthen and sustain our network as the ACA and insurance exchanges are fully implemented.

MCP will further strengthen our network by leveraging the existing relationships we have with Accountable Care Organizations (ACO), including those of our sponsors. The ability to serve members through ACOs affords our members access to additional provider organizations with the capacity and willingness to provide services. We will utilize these relationships to expand our existing network to serve additional members enrolled through the ACA. There are three approaches our sponsors have taken, and will continue to take in their unwavering support of MCP's ability to increase access to care. All of these efforts will lead to increased capacity in our networks. These are to: 1) facilitate relationships with physicians/groups that have admitting privileges to their hospitals to encourage them to either contract with MCP or increase the MCP members included in their practices; 2) expand MCP's member-centered health home[1] program by increasing member capacity and/or adding new practices; and 3) support MCP's efforts to have physicians enhance access to care by increasing the number of practices employing physician extenders, promoting practices offering extended hours, and encouraging practices to adopt flexible appointment scheduling systems. The value of our sponsors' commitment to MCP and our Arizona Medicaid and Medicare members and providers cannot be over emphasized. For example, when MCP started its member-centered health home program, our sponsors committed their expertise, skills, clinics, healthcare units and practices. As a result of our sponsors' commitment, MCP has a responsive health home program that will be a valuable asset in accommodating ACA-driven membership growth.

Throughout the expansion, we will continually assess our network development approach and make adjustments to our strategy as necessary. Our local professional provider relations team knows the provider communities and will be ready to timely and accurately add, train, and retain providers.

## Ensuring a Sufficient Operational and Administrative Structure

In addition to evaluating the adequacy of our network, MCP conducted a review of our infrastructure and management processes to better position MCP operationally to accommodate anticipated ACA related membership growth. The ACA membership growth will be challenging, but we have been planning for some time to have our technology systems, staff, operations, and programs ready to support these new members. We describe below how our operational and administrative structure will be ready to meet these increased membership demands.

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1The Kaiser Family Foundation defines health home as person-centered systems of care that facilitates access to and coordination of the full array of primary and acute physical and behavioral health services and long-term community-based services and supports.

**Medical Management:** Our Quality Management and Utilization Management (QM/UM) Committee, chaired by our CMO, and including committee members who are local community physicians, representatives of Arizona hospital leadership, senior FQHC executives, and others is leading the analysis of our Medical Management program to confirm our preparedness for the upcoming expansion. Three of our integrated medical management systems will be critical in our capability for this: 1) predictive modeling 2) utilization management (UM); 3) case management (CM). These systems work together and share information to improve member outcomes, facilitate care coordination and reduce duplication of services. MCP uses data from medical and pharmacy claims as well as information from health risk appraisals performed by the member to develop sophisticated analysis that identify members at highest risk for poor outcomes or high utilization. This information is used to identify and implement actions that will improve member outcomes. The primary system used to notify Case Managers of this data is CaseTrakker®Dynamo. This system is scalable to meet membership growth and is available 24/7. New employees will receive training through a fully documented program that uses classroom instruction, and computer-based and self-paced approaches. MCP has reduced the demand on providers and increased our capacity to accept the additional volume of prior authorizations (PAs) that may be realized with membership growth by implementing actions to reduce the number of services that require PA. In 2013 we will further enhance our PA processes by increasing automation through our web-based Auto Authorization tool. We have also assessed adequacy of our clinical practice guidelines to address the needs of the ACA-driven membership and at this time we have determined that our current guidelines will meet future demands. We will continue to assess our evidence-based clinical practice guidelines. Our case management approach was designed to be expandable and adaptable to meet a wide variety of needs in diverse populations with varying demographic and health characteristics. Our ability to efficiently and effectively identify high-risk members through our member-centered outreach and predictive modeling techniques will allow us to scale our case management program to the needs of the membership. Our capacity to efficiently hire case managers further supports our scalability, as described below.

**Quality Management:** Our Quality Management and Utilization Management (QM/UM) Committee, chaired by our CMO, is responsible for assessing the Quality Management (QM) program's readiness for membership expansion. As evidence by our results on AHCCCS minimum performance standard measures and from evaluations by independent reviewers, quality is an MCP core competency. In preparing for enrollment growth our QM team, under the direction of our CMO, led a review of every large scale member transition into and out of MCP. Using continuous process improvement protocols we applied the results of this analysis and subsequent root cause analysis of any identified gaps in the process to develop new policies, procedures and tools. MCP implemented a new electronic tool that automates the input and retrieval of data points and creates notifications of high-risk or complex member need. This tool then identifies services that could be potential gaps in care, so that during transition, members who may require prior authorization overrides, medications or any other special needs, such as out of network transitions, receive services without interruption while services within the network are being coordinated.

We are also actively engaged in performing a Plan-Do-Study-Act cycle with the goal of increasing our ability to efficiently and effectively identify at-risk members by increasing the completion rate of the Health Risk Questionnaire by new members. This will increase our capacity to identify and stratify members based on their self-reported health risk data before claim data is available. This will improve our ability to serve members who have not previously had access to care or are new to MCP and therefore have no claims history. This project will be completed by the second quarter of 2013. Our QM team will focus attention on two critical elements of the member experience that will be very important to successful transition of members during ACA-driven membership expansion. These factors will be continuity of care, and accessibility of covered services. During the implementation process the QM team will monitor complaints and grievances from members and providers to determine if there are specific concerns or trends that require immediate attention. Our basic QM structure is solid and scalable. Based on MCP's experience with previous expansions, Schaller's experience with implementing multiple Medicaid health plans, and the new processes described above, we are confident that our QM system and team is prepared to meet the demands of this membership increase.

**Operations and Administration:** We evaluated our eligibility, claims, encounter and reporting operations to determine if improvements or enhancements are needed to support ACA-driven membership growth. As a result we have determined that each system can be scaled up to meet increase demand without negative impact on turnaround times, effectiveness or efficiency. For example, we confirmed that MCP has a fully compliant and responsive process and system for accepting, processing, applying (including reconciliation of eligibility spans), and reconciling and reporting HIPAA 834 (daily and monthly) eligibility and HIPAA 820 capitation transitions. Evaluation of our claims and

encounter system revealed that it has the necessary capabilities to process the increase in claims and encounters that we anticipate will accompany the expansion. Schaller provides MCP with a fully functioning and responsive computer and support systems (information and telecommunications) that are scalable and flexible. Schaller's established policies and procedures, including business continuity, disaster recovery, and management protocols provide an environment and structure that support growth and facilitate efficient and effective operations. The foundation of our system is a redundant, high speed Local Area Network (LAN) and Wide Area Network (WAN), and clusters of servers. Schaller's system infrastructure, consisting exclusively of Cisco routers, switches, and firewalls provides maximum latitude in configurations. Core business applications run on a cluster of Hewlett Packard ProLiant DL 380/580 servers. Schaller is able to add servers to the cluster to increase performance vertically, and its servers can accept increases in RAM and processing power to grow horizontally. This scalability allows systems to match any escalation in demand associated with the enrollment growth, while at the same time maintaining system uptime and performance.

Our evaluation determined the need to continue improving our Electronic Data Interchange (EDI) and electronic funds transfer (EFT) rates. MCP's Vice President of Health Plan Operations is leading an effort to increase our EDI and EFT rates. A project plan is being developed and we expect to launch these efforts in the third quarter of 2013 and will focus on EDI and EFT during provider recruitment efforts.

As part of our readiness review we evaluated our customer service call center, member material distribution capacity, member outreach capabilities, cultural competency, and employee hiring, training and retention systems to assess our ability to meet the needs of current and future membership. We utilize our Avaya phone system and work force management software that is capable of forecasting call volume to determine appropriate staffing needed to meet service level requirements. We determined our customer service call center, member materials, and member outreach systems are scalable to meet membership expansion demands. In terms of cultural competency, we determined that our current cultural competency program supports our understanding of implications of the ACA on "health literacy"[2] and our review of ACA literature. We have adopted a full CLAS-based cultural competency program that reinforces cultural and linguistic programs.

MCP's evaluation of our Human Resources/Talent Acquisition (HR/TA) process revealed that HR/TA was scalable to support the need for additional employees as a result of the expansion. We use Schaller's HR/TA to recruit, hire, and retain qualified staff. Schaller works closely with Aetna's national HR/TA team. This process successfully utilizes recruiters from across the country to identify, recruit, and hire talent. For example, during a shortened implementation period for our ALTCS expansion in Pima County, we hired 80 case managers through the use of job fairs and recruiting approaches, in time to meet all contractual requirements. We will use the same techniques to recruit staff for the ACA-driven membership growth. In preparation for Medicaid expansion, our HR/TA has developed a streamlined process to screen all candidates for employment to be in compliance with all Federal, State, and Schaller criteria. This process reduces the time needed to perform a complete review of each candidate allowing us to hire large numbers of qualified staff in a relatively short period of time.

**Compliance:** Our COO included compliance as part of our ACA review. Educating new members about fraud and abuse and Coordination of Benefits/Third-Party Liability (COB/TPL) is important to enhance responsiveness to and compliance with Federal and State regulations. Based on our review we will augment our member materials to emphasize the member's role regarding fraud and abuse and COB/TPL.

**Health Information Technology (HIT):** As a result of our assessment of our HIT program, we will continue enhancing our data management, sharing and reporting processes. Our assessment will help us design systems to achieve the next level in clinical outcomes reporting. Our HIT systems and approaches that will be enhanced to support ACA-driven membership include but are not limited to: 1) CaseTrakker™Dynamo, which shares critical data, such as care plans and utilization, between MCP and providers, 2) MercyOneSource, which provides enhancements in provider and member access to the member's care plan, secure messaging, member can view and update their own profile, 3) iNexx, a solution that supports connectivity between providers regardless of organizational boundaries or technological

2 See Somers, Stephen; Mahadevan, Roopa; *Health Literacy Implications of the Affordable Care Act (ACA);* Center for Health Care Strategies, Inc., Presentation to the Institute of Medicine's Roundtable on Health Literacy; November 10, 2010.

sophistication, and 4) ProREPORT, which supports access to provider-specific reports on care coordination and outcomes. These HIT systems promote data sharing with providers and members, reduce administrative burdens, and increase connectivity between providers.

## Steps Above and Beyond Administrative, Operational and Network Improvements

To further evaluate our capacity to support the ACA expansion, we reviewed the capabilities available to us through Schaller and our sponsors. Through this process, we identified the strengths and resources described below.

**Sponsor Commitment to Serving our Members:** Our sponsors, Carondelet Health Network (a Ministry of Ascension Health) and St. Joseph's Hospital and Medical Center (a member of Dignity Health), are part of two of the nation's largest Catholic hospital systems and are among the most respected hospital systems in Arizona. Their leadership and commitment to serving the needs of the community is recognized throughout Arizona, and their dedication has been and will continue to be applied to make sure that MCP meets or exceeds AHCCCS' standards. Our sponsors have first-hand knowledge of Arizona's healthcare issues and they are committed to providing meaningful solutions, including ongoing support of graduate medical education, initiating clinical integration activities, and developing Accountable Care Organizations.

**Record of Healthcare Leadership and Strong Local Presence:** MCP is in a perfect position to support ACA-driven membership growth because of our first-hand knowledge of Arizona's health care concerns, positive relationship with providers and history of leading efforts to improve quality of care and reduce costs. Our senior staff serves on the Boards of more than fifteen Arizona healthcare organizations or committees. In addition, MCP's Chief Executive Officer (CEO), as the president of the Arizona Association of Health Plans (AzAHP), has led the adoption of AzAHP Credentialing Alliance (a centralized credentials verification system to streamline the credentialing and recredentialing process) to reduce providers' and health plans' administrative cost. Efforts such as these will enhance our ability to quickly and efficiently add providers to our network without undue administrative burden and cost. Our leadership will continue to collaborate with local organizations and stakeholders to develop innovative and effective solutions to any and all system challenges that may arise as a result of the ACA expansion.

## Support of a Leading Health Management Company

**Experience:** Schaller has more than 26 years of Arizona and national Medicaid and Medicare managed care experience. Schaller is an Arizona company that was originally formed by two of the first senior executives of AHCCCS. Nationally, Schaller and its affiliates administer benefits for 1.2 million Medicaid members in 12 states. One of the hallmarks of Schaller's experience is its capability and capacity to deliver Medicaid and Medicare managed care to diverse and high-risk members. CMS and the states of Ohio and Illinois, recognizing its outstanding programs and experience, recently awarded two of Schaller's affiliated health plans dual demonstration contracts. Schaller has the administrative systems, member-centered protocols and operational experience and expertise to meet the needs of new ACA-driven membership. Schaller has almost one thousand employees who are exclusively dedicated to MCP. These employees are all Arizona based and all administrative functions are performed in Arizona. We anticipate that this Arizona workforce will grow larger with ACA-driven enrollment expansion.

**Implementation Capacity:** Schaller has successfully implemented complex Medicaid and Medicare programs under a number of different arrangements and requirements. For instance, Schaller implemented a state-wide Medicaid program in Delaware for 90,000 members in sixty days. Schaller also implemented three (3) Medicaid health plans in three (3) different states in a single year - an ACO in Virginia, a management services agreement in Texas and a managed long term care program in New York. Each of these implementations was complex and included development of new comprehensive networks and highly customized medical management programs, member and provider training, claim and encounter administration, and fully functional computer system.

**Schaller's scalable and flexible technology infrastructure:** Schaller provides MCP with a fully functioning and responsive technology and support system. Schaller's technology and support systems are scalable and flexible. This scalability allows systems to match any escalation in demand associated with sudden membership growth, while at the same time maintaining system uptime and performance.

**Q2: Describe how the offeror evaluates and measures its network to ensure timely access to care to underserved populations, identify deficiencies, manage, improve and sustain an adequate network.**

Mercy Care Plan (MCP) uses a coordinated and proactive approach in monitoring our network to verify timely access to care. This network adequacy evaluation is a company-wide effort that considers all covered services and has a special focus on proactively identifying potential deficiencies and on verifying timely access to care for underserved populations. Under the direction of the Chief Operating Officer, MCP's Directors of Network Development and Contracting and Provider Services facilitate network monitoring and management activities, coordinate with other internal departments that participate in the process, and share feedback within the organization. We use information gathered during these activities to continuously improve our network and sustain those improvements. Our process for this is described below.

## Evaluating and Measuring the Network and Identifying Potential Deficiencies

As a means of providing multidisciplinary oversight of our network adequacy, MCP developed a Contract Committee that meets on a weekly basis. Formal analyses are also conducted quarterly (or more often, as needed) using numerous cross-functional monitoring tools to proactively identify potential deficiencies in our network. We compare outcomes from our monitoring activities against AHCCCS' accessibility and availability standards in addition to other measures of network adequacy. Trends data, gathered over time, are used along with the above steps to evaluate network adequacy. We also review these outcomes within and across geographic areas and provider types to determine if there are potential deficiencies in the network and to identify improvement areas. Our main monitoring tools include:

- Monitoring Service Rates across Underserved Populations: Using a variety of avenues, we continuously evaluate the network to identify any deficiencies that could affect members from underserved populations. These avenues include monitoring provider referral patterns, reviewing quality of care concerns related to access to care, and gathering feedback from our Medical Management (e.g., concurrent review, prior authorization, quality management, and case management) and Member Services staff who are in constant communication with members. Through these activities, we are able to identify opportunities to improve timely access to care for underserved populations. Some examples of these initiatives include:
  - We have established contracts with every FQHC and FQHC-look alike in the state, as well as multiple Rural Health Clinics, as these providers are known for their work in serving underserved and diverse populations.
  - MCP has supported health home development by providing financial, technological, data-based, and promotional support for practices that work with underserved populations (such as St. Elizabeth's Health Center, Catholic Community Services). These practices are well-positioned to outreach to underserved populations and increase our network capacity.
  - As a result of feedback from our Member Services staff, we identified that there were transportation barriers for our Somali-speaking members. To meet this need, we contracted with Midnimo, a Somali-speaking transportation provider in Maricopa County. During Plan Year ending Sept. 30, 2012, Midnimo provided 12,395 trips to Maricopa's Somali population. By adding this provider to our network, we improved our ability to deliver services to our Somali members.
  - We analyzed data about adolescent well-care visits and identified some disparities across racial and ethnic groups. To address this, we reached out to providers and members with educational and other incentive-based programs. As a result of these efforts, the number of Native American adolescents receiving an annual well-care visit increased from 27.7 percent to 40.5 percent over a three (3) year period. We will continue our work to increase the access to care for this (and all other) underserved population.
  - MCP is a leader in AHCCCS' Cultural Competency Collaboration, which works tirelessly to improve providers' abilities to deliver culturally competent care by hosting conferences, bringing in nationally recognized speakers, and holding forums for education and the exchange of ideas with multiple stakeholders. In addition, MCP provides orientation to its providers regarding the delivery of culturally competent care when the provider first joins the network and annually thereafter.

  In all these activities and more, MCP provides timely access to care for all members, including those from underserved populations. As a result of our commitment to collaboratively identify deficiencies in the network, manage the network, and make improvements when necessary we have and will continue to sustain our current network and are well-positioned to expand as both Medicaid and geographic expansion opportunities arise.

- GeoAccess Analysis: We use GeoAccess software, the industry standard, for evaluating and measuring the adequacy of our provider network. The data we gather from this is member-specific and includes their location, age, gender, language preference, race, and ethnicity. This is paired with provider-specific data that includes provider specialty, location, and language capabilities. We use these data sets to best evaluate network adequacy and identify opportunities to strategically expand the network in a manner that will meet the needs of our members. GeoAccess reports are reviewed quarterly and as part of any potential network expansion. The GeoAccess reports are also used to ascertain compliance with AHCCCS' accessibility and availability standards related to PCPs and specialists
- Appointment Availability Surveys: Provider Services Representatives (PSRs) perform appointment availability surveys on a monthly basis for high volume PCPs (e.g., ≥ 500 members), quarterly for OB/GYNs and other PCPs, and twice per year for specialists and dentists. Overall, 99.8 percent of our combined PCPs, specialists, and dentists, and 100 percent of our OB/GYNs meet AHCCCS' appointment availability standards for routine services. For urgent services, 99.8 percent of our combined PCPs, specialists, and dentists meet appointment availability standards. For emergent services, 94.8 percent of our combined PCPs, specialists, and dentists meet appointment availability standards. For appointment waiting times, 99.1 percent of our combined PCPs, specialists, maternity providers and dentists are compliant with AHCCCS standards.

Where providers fail to meet standards, follow-up appointments are conducted with the PSR to review their results. If a provider is unable to correct their performance, we may implement additional actions up to and including panel closure, referral restrictions, and termination from the network.

- Analysis of Member Grievances: Member grievances data is also used to monitor the accessibility of services. This information serves to identify opportunities to initiate service improvement and corrective actions. Results from our analysis show that the availability and accessibility of transportation services, primarily due to no-show or late taxi services, represent a significant portion of our member grievances. Only 3 percent of availability/accessibility grievances were for non-transportation services. To address the transportation grievances, MCP reviewed the data and identified two transportation providers with complaint rates higher than their peers and placed these transportation providers on corrective action plans. As a result of this corrective action plan process, we successfully reduced member grievances regarding transportation.
- Member and Provider Satisfaction Survey Data: MCP conducts annual member and provider satisfaction surveys to assess areas that are working well and identify opportunities for improvement. The results are an important way for MCP to take the pulse of our members and providers relative to the accessibility and availability of provider appointments. Data show that satisfaction scores are high and outperform the benchmark score for other AHCCCS health plans. Results from the accessibility categories of the 2012 HEDIS®/CAHPS®[1] member satisfaction surveys reveal that MCP received satisfaction scores as follows:

– Getting needed care composite: 79.3 percent for adult and 82.9 percent for child

– Getting care quickly composite: 80.3 percent for adult and 88.3 percent for child

On the 2012 Provider Satisfaction Survey, overall provider satisfaction increased from 75.5 percent in 2011 to 78.1 percent in 2012. MCP's score of 78.1 percent was higher than all other Medicaid/Medicare HMOs participating in this survey. Other Medicaid/Medicare HMOs scored 75.4 percent.

- Services Provided by Out-of-Network Providers: We continually assesses the use of out-of-network services to verify that our network contains adequate an number and type of providers. We use a report that identifies non-contracted providers who have delivered services more than 25 times to our members. This report is reviewed by a multi-disciplinary team on a quarterly basis to identify network gaps and recruitment opportunities.
- Member-to-PCP Ratio: In addition to MCP's monthly provider accessibility surveys as described above, MCP uses AHCCCS' quarterly "Greater than 1,800 Member Report" as part of our monitoring of network adequacy. When this report identifies a practice that has exceeded the threshold, we implement additional provider accessibility surveys in order to ensure adequate PCP accessibility for MCP members.

1 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- Network Loss: MCP monitors key indicators such as licensure reports, Medicaid sanction status, insurance status, complaints, provider requests for advance payments, etc., in order to identify the potential for the loss of contracted providers. MCP has also established a process for responding to any loss of a provider. In these instances, we work with AHCCCS, members, and providers to facilitate continuity of care and minimize impact to members. We coordinate a seamless transfer of the member and their medical records to a contracted provider. In the event of a natural disaster or other unanticipated provider network loss, we have an established Disaster Recovery Plan and Business Continuity Plan that is maintained, tested, and managed by our Compliance and Operations Departments. Additionally, our Quality Improvement Committee (QIC) oversees compliance with AHCCCS and CMS quality improvement strategies and advises the CMO and the COO on quality improvement strategies pertaining to providers and members.
- Monitoring of Quality of Care and Contract Compliance: In the event that MCP identifies, through any avenue, that a provider is unable to deliver an adequate quality of care or is not willing to comply with terms of the contract, we have protocols to terminate the provider's contract. MCP's administrative and committee structure facilitates early and rapid communication of these events to ensure timely action.
- PCP Change Requests: MCP monitors the requests we receive from members for PCP changes. We review these to determine if there are concerns that may indicate an inadequacy for an underserved population.

An example of how the above multidisciplinary input has led to network improvements is shown in our expansion of home health services providers in Maricopa and Pima counties during 2012. Front line concurrent review nurses and case managers who were caring for vulnerable members identified the need for home health providers who could provide specialty lines of therapy to assist members with particular neurological and cardiovascular needs. This data, along with the interactions led by cross functional collaborative efforts, was used to drive our network expansion.

In addition to evaluating the network, MCP has used provider feedback as an opportunity to create process improvements aimed at addressing issues of importance to providers. Based on feedback, we re-designed our Provider Services Department in 2009 to place a greater focus on individual provider needs. This resulted in dedicated staff for network development and contracting, project management, regulatory and internal reporting, and operations in order to assist with higher level claim research projects. Additionally, our PSRs keep in close contact with all our providers, encouraging them to discuss any issues of individual concern with the goal of resolving these issues as they occur.

## Managing the Network

MCP uses the above statistical data to manage the quality and adequacy of our provider network. Our approach is to identify, analyze, and implement actions based on this information. In addition to this, we also use feedback from MCP departments that is captured through our daily activities, workgroups, and formal committee structures.

### *Daily Activities*

Our staff routinely works cross-functionally to identify and resolve accessibility issues that require immediate intervention. For example, a need to improve accessibility or availability of care may be identified during routine activities by our Medical Management, Quality Management, or Member Services teams. When this occurs, our staff immediately contact Provider Services to resolve the issue to improve access to care. Resolutions employed may include approving referrals to non-contracted providers, granting provisional credentials, or transporting a member to a provider outside of the member's community to address the their immediate needs These events are then tracked and monitored by our Contracts Committee.

### *Work Groups*

Workgroups include Managers, Directors, and staff from multiple departments who review real-time data and trended data, resolve issues, and escalate concerns to senior management and formal committees for further direction. Key work groups that are involved in managing the network include:

- Member Grievances: Member Services, Provider Services, Quality Management, and other staff meet weekly to address escalated member-initiated concerns regarding providers. The Provider Services Department (or Quality Management for quality of care concerns) meets with providers and report feedback at weekly meetings. In addition to real-time follow up, MCP produces a monthly grievance report that the Provider Services Department reviews to identify any further network intervention opportunities.

- Member Appeals: These personnel meet weekly to review member appeals and provider claims disputes, including trended data. This group researches claims issues down to their root cause which may include an incorrect provider claim submission, a provider add/load issue, or a system set up issue.
- Operational Meetings: Meetings are designed to prioritize and implement strategies surrounding contract implementation, network adequacy and quality, claims payment and problem resolution. For example, if a performance measure related to accessing care (such as a drop in well-child visits) is identified, this committee would evaluate the applicable data and recommend an action plan.

***Committees***

Our staff-level work groups share findings and activities through MCP's formal cross-functional committee structure. Our committees make recommendations regarding managing the provider network, communicate provider issues and action plans to Executive team decision makers, and implement actions through workgroups or other means. Major MCP committees involved in access to care are:

- Quality Improvement Committee (QIC): Oversees compliance with AHCCCS and CMS quality improvement strategies and advises the CMO and the COO on quality improvement strategies pertaining to providers and members. The QIC meets every two weeks.
- UM/MM Committee: Assesses utilization patterns, reports, and other data to assess a wide range of activity including provider-specific and facility-specific trends. The UM/MM Committee meets monthly.
- Contracts Committee: Reviews multiple sources of data as described above in addition to all Letters of Intent and Letters of Agreement in a multi-disciplinary venue to verify network adequacy. The Contracts Committee meets weekly.
- Strategy and Business Development Council: Discusses business strategy and prepares action plans that improve the organization, including the provider network. The Strategy and Business Development Council meets quarterly.
- Member Advisory Council: Comprised of members and supported by MCP Member Services, Quality Management and Provider Services, the Council reviews MCP activities, member communications, program interventions, and general services for our members. The Member Advisory Council meets quarterly.
- Joint Operating Committees: Provider Services and staff from other MCP departments hold Joint Operating Committee meetings with hospitals, FQHCs, skilled nursing facilities, and ancillary providers on a regular basis. The Joint Operating Committee meets monthly in most situations, but no less frequently than quarterly.

## Improving and Sustaining the Network

The information obtained from the above processes helps us verify that the network is sufficient. We use it to identify gaps and take immediate steps so that our members' care is not compromised. We use the outcomes of these analytical efforts to proactively enhance our network and avoid future gaps by implementing the following actions:

- Continuously monitor multiple data sources to identify providers who are new graduates, new to the area, or are expanding their practice. To help identify these providers, MCP works with provider associations, medical schools, advocacy groups, and other providers for referrals regarding recruitment.
- Contact providers who had previously closed their panels, since, in many cases, providers had only intended to close panels temporarily. Our PSRs discuss the possibility of re-opening these panels with providers during individual site visits.
- Offer an after-hours care program for our members through PCPs who have agreed to provide non-emergent care outside of regular physician office hours.
- Provide focused education or require corrective actions with providers who fail to meet accessibility or after-hours requirements, or for whom we have received complaints.
- Offer providers a variety of technological tools designed to make interacting with MCP administratively easy, in turn allowing providers to focus on increased access to care.

MCP also implements various ongoing initiatives to improve access to care and to avoid disruptions. Our robust and stable network allows MCP to focus on initiatives such as the expansion of health homes, enhancing access to care in rural underserved areas, and workforce development. We communicate initiatives and provide education to providers through our Provider Services Program which helps us achieve and sustain improvements in the network.

### *Health Homes*

During 2012, MCP continued to develop a variety of health home models for integrated care throughout our service areas, and currently serve over 45,000 members. Our health home models take advantage of new practices, collaboration, and new technologies, providing increased access to care and coordination with community services. We provide support through enhanced access to case management services, data reporting and analysis, and financial incentives for aligned quality improvement measures. We also assist through the provision of technology (such as electronic health records (EHRs) and provider portal reports/real-time health records in order to create virtual health homes among providers in rural areas. In addition, best practices are shared among health homes to assist in developing stronger care management strategies and technological solutions. We have monitored the success of this health home program through various measures.

We will continue to expand health home services in 2013 through strategic contracting and infrastructure support. MCP has also worked with FQHCs on the health home initiative and has been actively engaged in strategy discussions with the Alliance of Community Health Centers throughout 2012. MCP and the Alliance will launch two pilot programs with all or some of the Community Health Centers, with both pilots strengthening the health home capabilities. With this agreement, a full range of new technology will provide the Centers with integrated clinical, utilization, and financial reporting capabilities. This will, in turn, provide each member's care team with the ability to preview details about the member's health care experience, including emergency department and hospital utilization and any gaps in care. MCP will also conduct a pilot program with Marana Community Health Center to serve our dual eligible members in Pima County.

### *Relationship Development in Rural Areas*

In order to enhance access to care for the underserved populations, we work with providers who specialize in serving these members, such as FQHCs and RHCs, and have long-standing contractual relationships with them throughout the state. We will continue to strengthen our relationships with these providers and partner with them by offering health home programs, where appropriate, and technological assistance, as conditions allow, to help these providers focus on providing access to care and accommodating individual members' needs. Also, in anticipation of overall service area expansion and Medicaid enrollment expansion, MCP has developed relationships with providers outside of our current service areas to increase our network capacity.

### *Support of GME and Workforce Development*

MCP helps develop the workforce by supporting partnerships with Graduate Medical Education programs, medical schools, and local network provider councils. This has proven to be a key strategy for addressing network service gaps. MCP has worked with St. Joseph's Hospital and Medical Center's residency program to fill network gaps when identified. We plan to work even more closely with partners such as Creighton University School of Medicine, Midwestern University, Maricopa Integrated Health Systems (MIHS) and District Medical Group, St. Joseph's Medical Group, Arizona School of Dentistry, and Phoenix Children's Hospital to identify specialty and geographic needs. Through these efforts, we will able to further encourage the development of physician capacity through GME programs. Additionally, we will offer financial incentives to programs and individuals that assist in filling network gaps through placement efforts.

### *Provider Services*

MCP works closely with the provider community to understand their needs and to provide tools to continuously support them. Providers enjoy working with MCP and, as a result, we have experienced a strong, stable network over time as measured by the various monitoring tools described above. It is a top priority for MCP to sustain an adequate network as we expand across geographic areas and increase our membership. A key component of our stability is our focus on providing ongoing support and education for our providers. We offer high-touch provider communication and a variety of technologically advanced tools to make interacting with MCP an administratively friendly process. Our process has been successful in achieving and sustaining a network that meets the required accessability and availability standards, receives high scores on appointment availability surveys, earns high provider and member satisfaction survey scores, and that experiences a low amount of amount grievances. We will monitor our network on an ongoing basis to verify that we are continuing to sustain our network adequacy.

Mercy Care Plan

# Program

**Q3: Describe the Offeror's experience working with providers and stakeholders to maximize care coordination, improve outcomes, and create cost efficiencies using tools and data to obtain specific results.**

## MCP: Board-driven Commitment to Better Outcomes

Mercy Care Plan's (MCP's) Board of Directors has made it an organizational priority to achieve better outcomes through care coordination and the provision of the best and most appropriate evidence-based care. This commitment to better care is based on the Board's belief that improving health care delivery and elevating the health of the population is the only sustainable healthcare strategy that will also result in lower costs for the State. To achieve this goal, MCP uses data and evidence-based decision support tools to maximize care coordination for members, to improve outcomes, and create cost efficiencies. We make these tools available both within all departments of MCP and to all stakeholders, including providers and members.

## MCP's Approach To Care Coordination

The Integrated Care Management (ICM) program is our approach to care coordination. Through ICM, we recognize the member's needs and provide an individualized, patient-centered, bio-psycho-social model of care. ICM targets high volume utilizers with chronic disease(s); special needs; complex care concerns; and/or those who use multiple providers and care settings. Our staff have the training and expertise necessary to provide the appropriate level of care. Members who need intensive support have a Registered Nurse or Licensed Behavioral Health (BH) professional as their case manager. ICM is supported by MCP's policies and procedures, staff training, desktop support, and data analytics.

MCP's commitment to ICM is embedded in the culture of the organization and is operationalized in our policies, procedures, and staff training. Our ICM policies, procedures, and staff training cover eligibility and enrollment, member consent for ICM services, documentation for establishing and recording member care plans, member confidentiality, rights and responsibilities, data and reporting, quality improvement, and quality assurance. These efforts also guide care coordination among all providers involved with the member's care, case load limits, referrals, case closure protocols, and case management staff qualifications, structure, and supervision.

Case management staff receive training on the proper use of guidelines based on nationally accepted and evidence-based clinical practices that help members be more informed about their health conditions and the required follow-up. Members receive, as appropriate, training in managing their care, using available technology to facilitate health and wellness, and other measures they may take to promote their own health, including their responsibility to comply with prescribed treatments or regimens. Training emphasizes that member care plans focus on achieving member wellness (to the greatest degree possible) and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. Care plans also assist the member in identifying appropriate providers and facilities through the symptom to provider pathway, as well as throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner. MCP staff are also trained to identify opportunities and provide care coordination for members who have multiple complaints regarding services or the AHCCCS program, or habitually contact governmental entities for assistance, including AHCCCS. These members, regardless of whether they meet clinical criteria, are enrolled in MCP's case management program.

### *Examples of Decision Support tools and Data Analytics for Case Managers and Program Directors*

MCP's Case Managers use **CaseTrakker™ Dynamo**, which is a tool that supports member assessment, care planning, and service coordination. The application's workflow rules prompt event-driven actions to support member and provider compliance with evidence-based clinical practice guidelines. Automated escalation alerts inform the care team of upcoming or overdue assessments and the audit report feature supports compliance with evidence-based clinical practice guidelines. The workflow processes used within CaseTrakker™Dynamo have been designed to help utilize and document use of evidence-based practices such as motivational interviewing in the care for people with multiple co-morbid chronic diseases and have been adapted for use specifically in Medicaid populations by clinical experts within MCP's administrative subcontractor, Schaller Anderson.

Another evidence-based tool to manage care and reduce cost is our **ActiveHealth® CareEngine® System** – a claims-based clinical support system that includes an automatic message generator called Care Considerations. The system analyzes a member's claims data (medical and pharmacy), clinical data, and laboratory results, and compares the results to accepted evidence-based clinical rules. It identifies member-specific ways to optimize care and sends evidence-based recommendations or "Care Considerations" for use by Care Coordinators and providers alike. CareEngine can also send

test results, provider recommendations, and "Wellness Considerations" to members and their Care Coordinator, which allows the member to focus on prevention and wellness issues (e.g., EPSDT visits, mammograms, and other screenings). At the heart of this health management and clinical decision-support tool is the patented and innovative platform that is designed to help integrate data from different sources and make it more accessible and usable. CareEngine was developed to collect and analyze massive volumes of data on a daily basis (including medical claims, pharmacy, and lab data) and match it with the latest and most advanced clinical standards. As a result, CareEngine can provide customers with tools to help continually identify gaps in care at an individual level. Once these issues are identified, send clinical alerts to the individual and/or the physician. The decision support tools are based on more than 1,500 monitored events and more than 5,000 clinical rules that are derived from nationally accepted clinical guidelines and are continuously managed by a team of over 30 board-certified physicians, pharmacists, and registered nurses.

Two other key tools used by the case management staff for informing members about evidence-based care are **Krames On-Demand** and **Milliman Chronic Care Guidelines**. These support the education of members with chronic diseases and can be integrated into the member's care plan.

Our **Predictive Modeling Tool** supports care coordination by using data from several sources, including our Actuarial Services Data Base, and transforming the data into markers. These markers are used to stratify each member, reflecting both the member's level of risk and improvement potential. This supports placing the member in the right care coordination level. In addition, members and providers who meet rule-based criteria for interventions can be identified. This criteria-based adoption feedback enables us to improve providers' use of evidence based guidelines and to work with members to improve care outcomes and reduce costs.

Our **Consolidated Outreach and Risk Evaluation (CORE)** report is based on Medicaid inpatient risk prediction and includes Emergency Department (ED) use. The resulting inpatient and ED models provide member specific scores, indicating the likelihood the member will visit the ED or experience an inpatient admission in the next 12 months.

Our **General Risk Model** collects data from member demographics, medical claims, pharmacy claims, eligibility records, call tracking systems, and care management systems. The data yields information about diagnoses, medical and surgical procedures, diagnostic tests and procedures, prescribed medications, functional status, utilization service levels, and issues with access to needed services. A profile of this information is available to the Care Coordinator and UM staff to view the member's 12 month history profile on a single page and allows the Care Coordinator to drill down from the profile to the claim level as needed.

Our **Inpatient Census Tool** is a dynamic application that provides UM staff with up-to-date information about members who are currently receiving inpatient care. The tool provides concise information for prioritizing actions and managing the concurrent review process. It further allows staff to quickly identify areas of care that need immediate attention, such as identifying new hospital admissions and members who have exceeded the average length of stay.

## Extending Decision Support Tools to MCP Stakeholders Helps Everyone Work Effectively as a Team

As mentioned previously, the information available to Case Managers and others within Mercy Care Plan is also available to providers. Both **CaseTrakker™ Dynamo** and **ActiveHealth's CareEngine® System** have methods and processes to passively or actively push the information to members and front-line providers.

We also utilize a number of other decision support tools that help providers have better information that helps them deliver better, more evidenced-based care and to be more administratively efficient. These tools help MCP providers provide the most appropriate care in the most cost-efficient way possible. These tools include the following:

**MercyOneSource** is a secure HIPAA-compliant web portal designed to foster communication and facilitate access to a variety of data in numerous ways. It synchronizes data on a daily basis with QNXT™ through data extract and load processes. Through MercyOneSource, providers are able to perform various functions, including member eligibility verification, panel roster review, searchable provider list, claim status search, remittance advice search, and search for and submit prior authorizations.

**ProPAT** is an application on our secure web portal that allows our providers to review specific prior authorization (PA) requirements. Using ProPAT, providers are able to enter up to six CPT/HCPCS codes and receive a response as to whether the code(s) is valid, expired, and/or covered. It also provides PA exception information. In 2013, we will

implement **Auto-Authorization,** which will enable providers to submit prior authorization (PA) requests online, where they are reviewed against nationally accepted, evidence-based guidelines and then approved, denied, or referred for additional review within minutes. This initiative will assist providers by streamlining administration and expedite PA decisions.

**Epocrates®** is available on our website and gives providers an evidence-based drug formulary/reference guide to use at the time of treatment. It assists providers in reducing medication errors by presenting up-to-date references to accurate drug dosing data and alerting them of potential drug interaction errors. It also provides clinical alerts from the FDA and the CDC.

Another approach MCP will use to improve access to care, decrease medication errors, and reduce cost is **e-prescribing**. It will enable physicians to have access to tools that support eligibility verification, Preferred Drug List confirmation, medication history alerts and prescription routing.

**iNexx** is a secure downloadable platform offered free of charge to providers that supports movement of data across Health Information Exchanges. iNexx connects every member of the integrated care team in a secure environment, regardless of organizational boundaries and technological sophistication, so that data can be shared across providers to improve care coordination. iNexx includes viewing capability for paper-based practices and supports making referrals between providers connected to the iNexx platform. iNexx also allows a provider to store and modify member information. The software can integrate with the provider's existing electronic medical record program to form a secure communication grid for sharing care coordination data and related tasks online. iNexx establishes a unique, ad-hoc health information exchange specific to each individual provider and the data that is needed to be exchanged to assure greater continuity of care.

## MCP's Experience and Specific Results of Implementing Outcome and Value-Oriented Payment Models

### *Patient Centered Medical Home/Health Home (PCMH)*

MCP launched several PCMH/Health Home programs, including ones with each of our sponsor organizations, Dignity Health and Carondelet Health Network. The Dignity Health PCMH program is located at St. Joseph's Hospital and Medical Center in Phoenix. This program has implemented numerous activities to improve accessability and quality of health care, including open access scheduling, expanded service hours into the evenings and weekends, and improved care coordination. Care coordination was improved both by hiring a dedicated care navigator to track member engagement and improve access to health care services and by embedding a MCP Case Manager, who works collaboratively with the care navigator and others on the care team to address MCP members identified as being high risk/high cost. The program includes P4P and non-financial incentives to encourage providers to improve AHCCCS performance measure outcomes and to implement innovative ways to reduce avoidable ED utilization. Our PCMH model embodies all components of MCP's Value-Oriented Payment (VOP) model. These include the care management fee, enhanced fee schedule, payment for attainment of NCQA Level 3 PCMH certification, and use of Pay for Performance (P4P) incentives targeted at historically underutilized services.

Our decision support tools were critical to the implementation and outcomes of this PCMH. For example, we utilized our predictive modeling tools, consolidated outreach and risk evaluation, general risk models, and clinical data from Care Considerations and Wellness Considerations to create a comprehensive "Provider Profiles". These profiles gave the PCMH leadership, practice managers and clinicians a ready made patient registry to assist the practice in identifying members at highest risk for poor outcomes, and with gaps in care against clinical guidelines and who needed outreach. MCP's PCMH coordinator provided significant support to the practice that helped them become expert users of these tools. CaseTrakker™Dynamo was used by the embedded Case Manager to prompt event-driven actions and to support member and provider compliance using evidence based clinical practice guidelines.

**Dignity Health PCMH Results**

| Performance Measure | Trend to Baseline |
|---|---|
| **IP admits/k** | -10% |
| **ED visits/k** | -6% |
| **Rx PMPM** | -5% |
| **Medical cost PMPM** | -4% |

We took the initial experience of VOP implementation at Dignity Health and extended it to cover a total of 15 different clinical practices serving over 45,000 members. These members are from all of our contacted

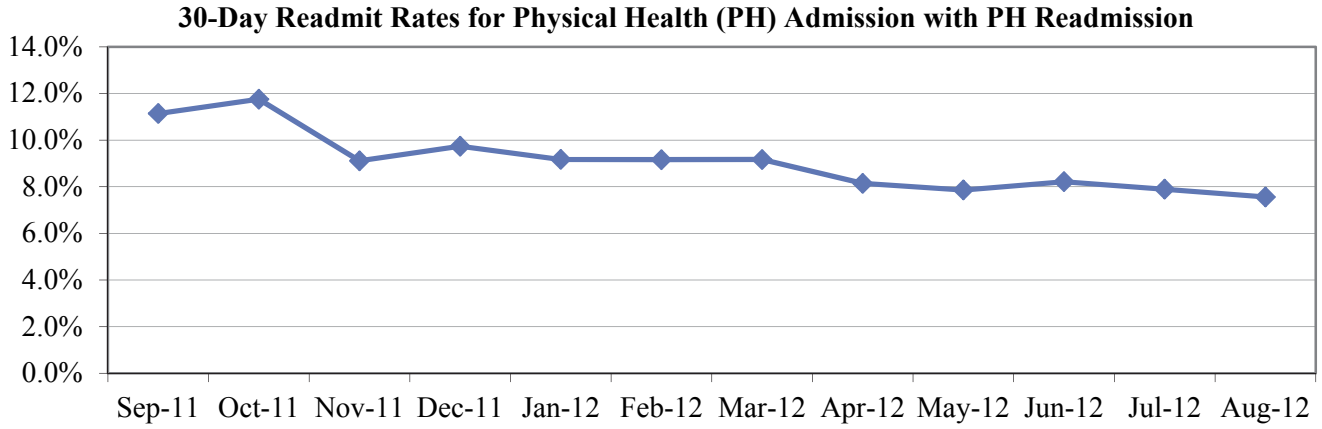
populations. Our efforts have resulted in decreased emergency department and hospital utilization, and reduced prescription drug costs for members cared for through the PCMH model. In the table to the right we report key measures of performance experienced after implementation of our PCMH model. Compared to the baseline, we saw reductions in pharmacy and medical costs and emergency department and inpatient admissions.

In Southern Arizona, MCP and Carondelet Medical Group (CMG) implemented a PCMH model targeted at meeting the needs of members with diabetes using community navigators, self-management tools and education, community based nursing, telehealth technology, and community partnerships all supported by both our VOP model and our decision support tools. Specific aims of the project include early management and control of the disease. Stratification of members with the highest health needs is one example of applying our decision support tools in this project. MCP's decision support tools and the information they convey helped CMG providers apply evidence based practices customized to the member's specific needs. MCP's VOP model supported this project by providing additional funding in the form of a care management fee, enhanced fee schedule, and P4P incentives targeted to achievement of specific diabetes performance measures. CMG further sought and was awarded a technology grant that allowed for purchase and implementation of tele-monitoring equipment. CMG and MCP are working with university based health services researchers to analyze the data being gathered in this program using the most rigorous scientific methods. In 2013, we will use the results of this evaluation to guide further disease-specific interventions as well as identify the proper role of telemedicine technologies in these VOP models.

### *Improving Outcomes and Creating Cost Efficiencies*

Our decision support tools have been critical to our ability to achieve population level outcomes for common and important health care conditions that contribute significantly to the cost of Medicaid programs. Our ability to use data and measure outcomes has been used and will be used to create opportunities to not only improve care, but develop VOP models that benefit all AHCCCS members.

While hospital readmissions have many potential causes, poor coordination of care and incomplete sharing of patient data among inpatient and outpatient providers at the time of discharge is known to be among some of the most critical contributors to unnecessary readmissions. MCP used features available in CaseTrakker™ Dynamo and Inpatient Census Tool to identify members at highest risk for unnecessary readmission. MCP Concurrent Review Nurses and Case Managers then enhanced their communication with the hospital-based care team and made high-touch outreach to the member's outpatient care team. We also identified issues that contributed to unnecessary readmissions, including overly restrictive PA requirements for durable medical equipment and home health nursing. As a result, we removed and/or implemented more streamlined methods to get needed services to the member. Our tools such as MercyOneSource and ProPAT are available to providers to assist in implementation of these streamlined administrative processes. Providers used these tools to know instantly what services required PA and, if needed, electronically submit data to support their requests with the minimum of administrative burden. Our efforts to improve care coordination and facilitate appropriate sharing of data between inpatient and outpatient providers at the time of discharge resulted in a decrease in MCP's monthly readmission rate, which dropped from 12 percent to less than 8 percent. This represents a 30 percent relative reduction in hospital readmission rates among MCP Acute Care members in one year. As evidence that the improvements we saw were not just a result of AHCCCS's implementation of the 25 bed day limit, we saw continued improvement throughout the year and across a wide range of members including those with Medicare and Medicaid primary benefits. We also saw improvements across multiple different hospital systems. For those hospitals that did not see improvement, we used our data to help them implement more effective processes, as shown in the chart on the following page.




As this initiative was implemented, MCP's concurrent review nurses used the Inpatient Census Tool and a newly developed tracking report to ensure that hospital discharge planning activities were completed safely and without regard to the 25 bed day limit. During this time we closely monitored data from our grievance and appeals system and tracked quality of care concerns to identify any unintended adverse impact on members. Our management techniques to prepare the network and our staff for the implementation of the 25 bed day limit policy and the use of data to indicate potential quality or service problems and measure outcomes resulted in cost reductions with no reduction in quality. We will apply the same management principals that were successful in implementing this policy to future initiatives.

Another example of our management processes to develop, implement, and monitor VOP initiatives is evident in our use of data to drive effective yet sustainable contracting mechanisms with our provider network. Our efficient operations and positive provider relationships, combined with our sophisticated data analysis, allow us to leverage our purchasing power into cost containment initiatives. MCP's ability to analyze unit cost, quality, and outcomes data and to develop and deploy sophisticated contracting mechanisms, such as full risk capitation and the securing of volume discounts, distinguishes us as leaders in the fight against inflated prices and allows us to reward providers who deliver excellent or outstanding quality and value.

Since 1985, MCP has been capturing and analyzing data on prior authorization, concurrent review, hospital admission and re-admission, patterns of ED use (by members and providers), member and provider satisfaction (survey) data and other clinical data. We know that applied data analysis is crucial to improve outcomes and develop effective VOP models. This knowledge and experience has allowed us to establish outcome- and value-oriented payment approaches that have resulted in outcomes that matter to members and to the health system as a whole. We will use our experience and expertise in working with PCPs, FQHCs, and other providers to expand initiatives like we have discussed in this response. Our enduring and solid working relationships with local stakeholders and experience applying VOP models will set the stage for improving outcomes and reducing costs for a broader segment of the AHCCCS membership.

**Q4: Describe how the Offeror would address the needs of Mr. Andrews and what systemic processes the Offeror will use to improve health care outcomes for members with one or more chronic illnesses.**

Mercy Care Plan (MCP) has comprehensive interdepartmental and multidisciplinary processes that systemically address the identification of member needs (especially those with chronic and co-morbid conditions). We have developed a system-wide approach to interventions, the evaluation of interventions and outcome reporting, and the re-evaluation or modifications of interventions based on outcomes. These processes include monitoring and evaluating member outcomes for disease or chronic care management programs, utilizing predictive modeling, and modifying the predictive modeling based upon system-wide utilization data for members with a single or multiple chronic illnesses. Through this modification we 1) identify high-risk/high-cost members, 2) perform outcome monitoring using evidence-based medical guidelines for chronic illness, 3) implement performance improvement projects at plan level (and involve providers in those projects), 4) apply case management strategies to those with the highest need, 5) implement patient-centered health homes to improve the delivery of healthcare, and 6) identify and resolve gaps in care at both the population and member level.

MCP recently demonstrated how evaluating specific member-based outcomes can affect the approach to Chronic Care Management (CCM) for all MCP members with a chronic condition(s). We conducted a data analysis of outcomes of specific members enrolled in our CCM program. The CCM program's goals are to provide education about the disease process and about the tools available to self-manage in accordance with evidence-based clinical guidelines and as measured by member outcomes. Member outcomes were defined as a decrease in the use of emergency rooms and inpatient stays with an increase in primary care provider (PCP) visits. The data was analyzed to determine if enrollment in a CCM program has a statistically significant impact on member outcomes. Data for each participating member, categorized by CCM enrollment type (Chronic Obstructive Pulmonary Disease (COPD), Cardiac, Diabetes and Asthma), was reviewed comparing the 6 months prior to enrollment in the CCM program against the 3, 6, and 12 month intervals post-discharge from the CCM program. While some outcomes did improve after the member was in the CCM program, the improvement was not statistically significant. This same methodology was used to evaluate members enrolled in case management where a holistic approach to intervening with the member was used. The Case Manager's (CM's) interventions included addressing member's basic needs and educating them on the chronic condition (or co-morbid management of multiple conditions) using motivational interviewing. Our initial outcome findings on these members demonstrate a statistically significant improvement in all outcomes.

As a result of these findings, MCP will enroll members in case management when a disease or chronic care management referral is received. This example of taking specific member needs by condition and aggregating them in the whole to drive change is an example of how MCP is using member data to drive systemic process changes. We use the Plan-Do-Study-Act performance improvement model to continuously improve these processes.

We recognize that every member is unique. Each member faces different struggles with multiple bio-psycho-social issues. We have designed our Integrated Care Management (ICM) case management program to address these unique and varied needs. Our ICM program is built around the member's needs and provides an individualized, holistic, member-centered, and bio-psycho-social model of care with an emphasis on maximizing the member's ability to achieve self-management and to engage in personal health education. The model of care includes care coordination and specific disease management interventions based upon disease-specific evidence-based clinical guidelines. During a recent CMS review of our Model of Care (MOC), which guides our case management program for our highly vulnerable and frail dual eligible members, the reviewer commented that our MOC was "superior" and among the most sophisticated that they had seen.

**Mr. Andrews: Referral Into ICM Program Incorporating Disease/Chronic Care Management Tools:** Mr. Andrews' PCP has used one of the many ways a member can be referred to our ICM program. MCP has various methods of identifying and referring members that can benefit from case management support. These include: a) our predictive modeling tool that analyzes acute care and pharmacy claims data based upon MCP's experience or historical data from another health plan, while incorporating clinical and demographic data, to identify members with certain diagnoses or co-morbidities who would benefit from ICM, b) identification of diagnoses or risk factors through the member health risk questionnaire, c) member or caregiver self-referral, d) referral from a community stakeholder (such as a PCP, as in Mr. Andrews' case), or e) an internal referral from one of MCP's departments, such as prior authorization, concurrent review, quality management, or member services.

Once a referral from the PCP is received, a triage nurse will complete a comprehensive review and will determine which level of case management would most benefit the member. Some of the data elements the triage nurse will review are the information gathered by providers (including the member's medical record), member utilization data, our predictive modeling tool, and member responses to the health risk questionnaire. In MCP's ICM program, members are risk stratified into intensive, supportive, or low risk based upon several factors. Members with the following characteristics are likely to benefit from intensive case management: three or more emergency department (ED) or inpatient hospital visits, multiple specialist visits, need for increased care coordination and integration of services (this member may benefit from a medical home), complicated social factors (such as lack of family and peer support), inadequate housing, poor understanding of their diseases and conditions, and poor self-management skills. Other members may require a less intensive level of case management, known as supportive case management. Members likely to do well in a supportive case management model include those with less complicated utilization patterns, lower risk scores, or less complicated social factors. As a member's condition changes, our system will trigger a re-evaluation, and if appropriate, change the level of case management. Low risk members require assistance with navigating the healthcare system.

In this instance, Mr. Andrews will be placed in intensive case management, as his needs are highly complex, and require a licensed professional to case manage his Individualized Care Plan (ICP).

**Determination of Mr. Andrews' Needs and ICP Development:** Upon referral, MCP's CM will begin identifying his individualized needs and ability to manage his chronic conditions. Our process will be to prioritize Mr. Andrews' needs according to risk factors and based upon his personal goals in order to develop an ICP. Cultivating a member-centered plan of care will help to determine the level and type of case management services that he will benefit from most. Our CMs have the skill and training to coordinate care for each member. The CM will then contact him to complete a comprehensive case management assessment and applicable disease-specific assessments. As part of the assessment process, the CM conducts a review of available benefits and community resources to explore any additional opportunities to meet the member's needs.

Mr. Andrews will be an active participant in his care so that he is invested in making progress and feels empowered to make appropriate changes. The CM and Mr. Andrews will develop an ICP to address the problems identified from the completed assessments, along with interventions to help him meet his goals. Mr. Andrews' ICP is a living document and will be updated and modified based upon any changes in his needs and goals. His PCP will be actively involved in developing the ICP. Once established, this ICP is shared with Mr. Andrews, his PCP, and all members of his care team.

Through interviews and ongoing conversations with Mr. Andrews and his PCP, the CM will identify the initial priority of issues associated with his recovery, health, overall wellbeing and autonomy, with a focus on supporting Mr. Andrews to live in the most appropriate and least restrictive care setting. If his condition warrants, the CM may conduct the interview in his home. Further details of how we will address these issues as a part of his ICP within our ICM model are detailed below.

**Identifying and employing the most effective intensity of evidence-based, plan-covered systems and services:** By facilitating access to a continuum of services based on the intensity and complexity of his needs, both Mr. Andrews and his CM will collaborate to identify the highest priority issues, Mr. Andrews' goals, and activities that will help him reach those goals. The information obtained from this interview will be used in evaluating his outcomes-driven ICP. The ICP will focus on a range of interventions to address Mr. Andrews' goals, including, but not limited to: education, communication, coordination, service, and community resource facilitation, as well as advocacy. The CM will follow up on all implemented interventions, including referrals to a community organization (along with services and/or equipment ordered by a provider) to verify that he has received the intended services.

**Behavioral engagement for change:** The CM, who acts as a single point of contact, will strive to engage Mr. Andrews in a plan that addresses his critical physical, behavioral and social needs to promote resiliency, recovery, and optimal self-management, which is a critical component to the care plan. Using motivational interviewing techniques, the CM will work to motivate him to make critical changes in persistent patterns of behavior and assume greater responsibility for his health, both of which are critical to improving adherence and achieving positive outcomes.

**Teaming with the member and care providers to implement the plan and enhance care outcomes:** All members of Mr. Andrews' care team will work together as an interdisciplinary team to combine core competencies in physical and behavioral health (BH) within a systems framework in order to manage his bio-psycho-social complexity. The CM will communicate on a regular basis with him, his PCP and other specialty providers to assess changes in the ICP priorities

and interventions associated with his recovery, health and well-being. As the ICP is updated, new copies will be shared with the member and the care team. The CM has the option to arrange for a case staffing with Mr. Andrews' care team. In addition, if he is not reaching his goals as initially planned, a formal interdisciplinary team case conference will be convened at the health plan level to provide additional input and direction to assist the care team's work with him. These participants include a MCP Medical Director, Pharmacist, Psychiatrist, BH Coordinator, and Mr. Andrews' CM. Mr. Andrews will be invited to attend, along with any friends, caregivers, or other natural supports he requests and all members of his care team.

**Ongoing CM issue identification, interventions and outcomes:** The CM's focus will be on coordinating and integrating fragmented services into a system of care that addresses Mr. Andrews' individual needs within his community. The CM will act as a conduit to support him in receiving the most integrated, beneficial, timely and cost-effective care possible. The CM will conduct a disease-specific assessment to see that he is receiving appropriate care for his COPD and chronic cardiac conditions. The CM will also assess lifestyle-related concerns, including weight management/obesity topics, his inactivity, fatigue, and anxiety. The CM will work with him to prioritize issues and act on interventions. Throughout the case management process, the CM will work closely with Mr. Andrews, providing him with needed disease management education using evidence-based clinical practice guidelines, training in self-care to assure follow-up for his chronic conditions and lifestyle-related concerns, and any required follow-up care. Mr. Andrews' roles and responsibilities in his treatment will be emphasized to assist him in achieving wellness and autonomy to the greatest degree possible. The CM will continuously employ motivational interviewing techniques to assist Mr. Andrews in making positive healthcare decisions. If through any of our performance measurement systems, gaps in care are identified, this concern will be communicated to Mr. Andrews and his care team. This will help Mr. Andrews identify preventive care measures that can be taken to improve his overall health status. The priorities, issues and interventions are listed in detail below.

***Issue #1: COPD: Shortness of breath. Member calls 911 and is taken to the Emergency Department (ED)***

Long and short term goals: Mr. Andrews will safely and effectively manage his COPD, identifying early warning signs of exacerbation and the appropriate intervention based on these signs. When appropriate, he will call his providers if he feels his condition is worsening. He will verbalize accurate self-care management of his COPD. His care will be appropriately coordinated among all his providers. Mr. Andrews will verbalize when it is appropriate to call 911 versus when he can call his providers first.

Interventions: The CM will complete the following:

1. Review Mr. Andrews' current medications and adherence to treatments (e.g., use of inhalers, peak flow meter and spacer). This intervention applies across all disease/chronic conditions. Reconcile all medications being prescribed by Mr. Andrews' providers (including ED providers) to ensure that there are no duplications or drug-drug interactions. This intervention applies across all disease/chronic conditions.
2. Obtain copies of the ED visits to see whether a cardio-pulmonary decompensation occurred that increased his anxiety (confirming the ED visits were appropriate), or whether his symptoms were related instead to anxiety. If the findings are related to cardio-pulmonary decompensation, then the CM will coordinate with Mr. Andrews' PCP/specialist to adjust the treatment plan and address his unstable medical condition. Should the ED documentation reveal only findings of increased anxiety related to his chronic health condition, then the CM will coordinate with the PCP to implement the necessary steps identified under Issue #2.
3. Work with PCP to see that Mr. Andrews is being seen by appropriate specialists (e.g., pulmonologist and cardiologist) per chronic care guidelines. Obtain any equipment as needed to manage COPD or other diagnosis.
4. Review primary care utilization with Mr. Andrews and his PCP, and evaluate the need to possibly increase PCP follow-up.
5. Review Mr. Andrews' most recent pulmonary function testing with PCP and/or specialist. If it needs to be updated or additional testing is needed, work with PCP/specialist to arrange. The CM will provide follow up as indicated.
6. Provide disease management education related to COPD, including signs and symptoms of chronic condition and appropriate actions to take when symptoms escalate, including early warning signs of exacerbation. In collaboration with PCP/specialists. Review environmental triggers and actions to take to mitigate these specific triggers. Include education on appropriate nutrition and self-care, which will be reflected in a self-management plan as part of the care plan. Continuously evaluate his health literacy and comprehension level and adjust education materials appropriately.

7. Work with the PCP to encourage Mr. Andrews to try calling his PCP when clinically appropriate before calling 911. Also work with the PCP to see if Mr. Andrews can be seen for same day appointments.
8. Assess if a different PCP model would be more appropriate for Mr. Andrews. Examples include a health home (as it will have extended hours and additional care coordination) or an in-home visitation model (as it will have other potential advantages for increasing Mr. Andrews' access to a PCP).
9. Refer Mr. Andrews to COPD support groups if he is willing and able to attend. Assist and follow up as indicated.
10. If he does not have an updated flu or pneumonia vaccine, the CM will coordinate with his PCP to arrange these. The CM will follow up as indicated. This intervention applies across all disease and chronic care conditions.
11. If Mr. Andrews is a smoker, provide him with education on the importance of not smoking and refer him to the Arizona Smokers' Helpline (ASHline). The CM will coordinate the referral as necessary and follow up as indicated in order for Mr. Andrews to obtain ASHline services and pharmacy support. This intervention applies across all disease and chronic care conditions.
12. Given that he can only walk 100 feet without resting, develop a transportation plan to assist Mr. Andrews so that he is able to attend appointments. Follow up as indicated.
13. Assist Mr. Andrews with completing Advanced Directives if they are not currently in place.
14. Determine if Mr. Andrews is eligible for any other benefits such as Medicare, ALTCS, or community resources. Begin application processes with his approval. Follow up as indicated. If determined eligible for either program, the CM will collaborate with the health plan transition team and the accepting CM to transition care. Also determine if Mr. Andrews has any other benefits to be coordinated (such as VA or Tribal).

***Issue #2: Anxiety (Could be completely related to shortness of breath, or, given the high correlation of anxiety and depression to COPD, Mr. Andrews could have an anxiety/depression diagnosis as well)***

Short and long term goals: Mr. Andrews will be able to self-manage anxiety symptoms as they arise. The cause of his anxiety will be accurately identified. If a diagnosis of anxiety is made, it will be treated by the appropriate provider(s).

Interventions:

1. If, after the CM conducts a comprehensive bio-psycho-social assessment and review of medical records and triggers to his anxiety or has a diagnosis of depression, it is determined that Mr. Andrews has BH needs, the CM will coordinate appropriate follow-up with his PCP and Mr. Andrews. Using the screening tools from the AHCCCS Tool Kit for the Management of Adult Anxiety and Adult Depression from the AHCCCS Tool Kit, the PCP will conduct further screening and evaluation of potential anxiety and/or depression. If the PCP diagnoses anxiety/depression, they will determine if a referral to the Regional Behavioral Health Authority (RBHA) for possible counseling, psychotropic medication, and/or other appropriate BH services is needed, or if the PCP will provide medication management for the treatment of anxiety/depression. If PCP determines that Mr. Andrews should be referred to the RBHA, the CM will assist Mr. Andrews with the referral to the RBHA and will follow up with him and the RBHA to confirm he is being provided BH services in a timely manner.
2. In collaboration with Mr. Andrews, the CM will work to appropriately share information related to his diagnosis with other members of his care team.
3. The CM will collaborate with the MCP Behavioral Health Coordinator if there are any barriers to Mr. Andrews receiving timely BH services.
4. The CM will coordinate with the PCP in transitioning Mr. Andrews to the RBHA provider. This includes confirming the PCP sent all applicable records to the RBHA (such as the reason for the referral), diagnostic information, medical history, medication history, and all current prescriptions.
5. If Mr. Andrews is placed on psychotropic medication(s) as a bridge to his first BH appointment, the CM will make sure he does not run out of his prescribed medication prior to his first appointment with the Behavioral Health Medical Professional (BHMP).
6. The CM will also assist Mr. Andrews with arranging transportation that is provided by MCP to the initial RBHA provider appointment.

***Issue #3: Cardiovascular Disease: Two heart attacks and stent insertions***

Short and long term goals: Mr. Andrews will safely and effectively manage his cardiac conditions. Mr. Andrews will verbalize the importance of taking the appropriate steps to control his blood pressure and lipid levels. Mr. Andrews will also verbalize dietary options to reduce cardiovascular risk and appropriate management of medications.

Interventions (in addition to the interventions around Mr. Andrews' COPD and the cross over interventions :

1. Establish a self-management plan that provides Mr. Andrews with chronic care/cardiac disease management education related to his chronic conditions, including signs and symptoms of possible problems and appropriate actions to take when symptoms escalate. The CM will educate about blood pressure control and importance of taking prescribed medication, emphasize the importance of lipid management (such as obtaining prescribed lab(s) and complying with prescribed medications), and determine if telemonitoring is appropriate to monitor blood pressure or other conditions, as available and appropriate. The CM will also consider the appropriateness of emergency call devices or technologies. The CM will follow up as indicated.
2. If Mr. Andrews' PCP and specialists prescribe anticoagulants for him, the CM will work with him to reinforce the proper use and monitoring of these medications. The CM will follow up to ensure appropriate blood work is obtained in a timely manner and will problem solve to reduce barriers that prevent appropriate monitoring.
3. The CM will collaborate with providers to see if cardiac rehabilitation is appropriate.
4. The CM will educate Mr. Andrews about the benefits of attending a cardiac support group and will assist Mr. Andrews with a referral at his discretion. CM will also follow up as indicated.
5. The CM will encourage Mr. Andrews to continue physical therapy and follow provider recommendations regarding movement and exercise.

***Issue # 4: Obesity (weight management, fatigue, and decreased activity level)***

Short and long term goals: Mr. Andrews will obtain a BMI < 37 and experience a decrease in fatigue and an increase in activity level. He will be able to ambulate at least 300 feet and obtain independence in ADLs.

Interventions:

1. Discuss with PCP the possible need for a home safety evaluation to assess his home situation, as well as need for physical therapy/occupational therapy (PT/OT) to address identified mobility issues. If appropriate, the CM will do an in-home assessment. The CM will provide follow up as indicated.
2. Encourage Mr. Andrews to follow physical therapy and provider recommendations regarding movement and exercise. The CM will continually monitor his adherence to treatment and provider recommendations, as well as provide any necessary education and motivational strategies to assist him.
3. Assist Mr. Andrews in obtaining any DME (e.g., oxygen, wheelchair, shower chair, assistive devices) ordered by his providers and discuss with PCP any equipment that may be needed, but has not yet been ordered to increase self-care activities. The CM will follow up as indicated.
4. Refer Mr. Andrews to the Senior Adult Independent Living (S.A.I.L.) program for assistance with homemaking and the delivery of more nutritionally sound meals. The CM will follow up as indicated.
5. Work with providers to determine if a referral for Mr. Andrews to nutritional counseling related to diagnosis of COPD and cardiac conditions, as well as his identified weight issues is indicated. Follow up as appropriate. Stress adherence to a proper diet.

***Issue #5: Social Isolation***

Short and long term goals: Mr. Andrews will increase social interactions with others. Mr. Andrews will verbalize one intervention which will help decrease his social isolation.

Interventions:

1. The CM will explore with Mr. Andrews if there are any friends or perhaps estranged family members he would feel comfortable reaching out to. The CM will also assist him with this process or engage his BH provider (if he has one) to help him work through this process as needed.
2. With Mr. Andrews' permission, the CM will investigate community resources in his local area to see what is available.
    a. Look up resources on the Community Information and Referral website.
    b. Find out what activities local community centers, churches, or other organizations provide that could help meet Mr. Andrews' needs.
    c. See if community organizations offer "shut-in" or companion visits for those who are homebound.
    d. Follow up on all referrals as indicated.

**Q5: Describe what processes the Offeror will use to coordinate care for Mr. Robertson, as he moves through the continuum of care and how the Offeror will address the greatest setback risks/challenges for Mr. Robertson?**

Mercy Care Plan (MCP) has successfully supported members who have sustained traumatic injuries and who may also have multiple bio-psycho-social issues. Our success starts with the early identification of members who could benefit from case management. The key to early identification is having multiple referral channels. These referral channels include: a) our predictive modeling tool that analyzes acute care and pharmacy claims data, along with other clinical and demographic data to identify members with certain diagnosis or co-morbidities who would benefit from our Integrated Care Management (ICM), b) identification of diagnoses or risk factors through the member health risk questionnaire, c) member or caregiver self-referral, d) referral from a community stakeholder, e) PCP or other provider referral, or f) an internal referral from one of MCP departments, such as prior authorization, concurrent review, quality management, or member services.

## Concurrent Review

Mr. Robertson was likely identified during our concurrent review process. During this process, information regarding facility discharges is received daily via incoming faxes to our ProFax system. Utilization management staff sorts this information as it arrives and distribute it to the assigned Concurrent Review Nurse (CRN). The CRN reviews medical records to assess for medical necessity, level of care, appropriateness of care, and to begin discharge planning activities on day one. During the initial inpatient stay related to the motor vehicle accident and subsequent treatment for trauma and post-surgical care, the discharge plan will have identified challenges and solutions for a safe discharge to home. Since the first discharge resulted in negative outcomes, upon the second admission a referral would be made to our Quality Management (QM) department as a potential Quality of Care (QOC) concern for review which is described further on in this response. Mr. Robertson's second hospitalization and admission to the Skilled Nursing Facility (SNF) would also have triggered a concurrent review and active participation in the discharge planning process. The CRN uses clinical care guidelines that are evidence-based to determine appropriateness of ongoing services. Additionally, prior to each discharge, they identify challenges and solutions to help improve the chances of successful transitions to the community and work to avoid a readmission. In Mr. Robertson's case, the first issue facing us is to see whether the SNF, which is not currently in MCP's network, has the capability of appropriately providing services to a member with a Traumatic Brain Injury (TBI).

### *Issue #1: Assess the SNF's TBI treatment capability*

While hospital discharge staff identified the non-contracted facility as TBI capable, our CRN specifically assesses experience associated with TBI rehabilitation. If the facility has an experienced staff and the capabilities necessary to rehabilitate a member with TBI, then Mr. Robertson would remain at that facility with the CRN following the member's medical need. The facility's non-contracted status would also trigger initiation of a single case agreement (SCA), provided they have an AHCCCS provider identification number. If they do not have an AHCCCS provider identification number, our provider services department would coordinate with the facility to help them apply. If a provider identification number cannot be obtained, Mr. Robertson would need to be transferred to a network facility that could meet his needs. If our assessment shows that information was incorrect and the SNF does not have experience in dealing with the skilled care needs of members with TBI, our CRN will work with the member, facility, treating physicians, and specialists to transition Mr. Robertson to a SNFs which does specialize in treating members with TBI. The CRN continues to monitor the medical necessity of the member at the SNF level of care while simultaneously working on a safe discharge plan that will be implemented when the member is able to have his needs met at a lower level of care. The plan will include the historical information about how this member has previously failed to have a safe discharge. The plan would also take into consideration a review of all clinical progress notes, therapy, and social worker assessments, and would identify any needs for durable medical equipment and skilled nursing services as part of the discharge plan to the lower level of care. The major challenge for this transition is whether the member has the functional capacity and necessary supports to be able continue living independently at home or whether there may be a need to identify alternate residential settings to assure that ongoing needs are adequately met.

## Case Management Assignment and Assessment

The CRN would involve case management immediately so the member could be followed up on post-discharge by the MCP Integrated Care Management (ICM) program. Given Mr. Robertson's specific complex bio-psycho-social issues, he would be identified as needing intensive care management from our ICM Program. This level supports the most

complex and high-risk members who need individualized, relationship-based case management plan in order to positively impact their health status and enable them to manage their own health most effectively. Our ICM triage nurse will select a Case Manager (CM) with experience in managing members with these types of challenges.

Once assigned, the CM will complete a comprehensive, holistic assessment that reviews Mr. Robertson's strengths, barriers, preferences, goals, and addresses the full range of bio-psycho-social issues impacting his health. All CMs are trained in the technique of motivational interviewing, which is used to help engage Mr. Robertson in identifying any underlying issues driving any roadblocks to his recovery. During the assessment process, the CM obtains Mr. Robertson's medical records and any behavioral health records available from the Regional Behavioral Health Authority (RBHA) in order to review previous care and issues and to create a background or baseline for him. The Integrated Care Plan (ICP) is utilized for documenting issues, interventions and outcomes. The CM will identify whether or not the member has provided consent for review of any substance abuse treatment/records. As part of this comprehensive assessment, Mr. Robertson, his family, PCP, and other providers will also be interviewed by our CM, as appropriate, to gather information necessary to assist in identifying the root causes that are driving Mr. Robertson's current health issues and any critical barriers to improvement.

## Care Plan Development

After the assessment is completed, the CM (in collaboration with Mr. Robertson and his entire care team) will develop the ICP. The ICP will reflect Mr. Robertson's strengths, various preferences, and goals. Our care planning features a living, iterative process that continuously tracks and revises his plan in response to his progress toward his goals. As the care plan is updated, new copies are shared with the member and the care team.

Throughout the case management process, member engagement strategies (such as motivational interviewing) will be used to assist Mr. Robertson in identifying his highest priority issues, goals that are important to him, and the agreed upon activities to reach those goals. The CM will also provide him with a detailed description of available services and community resources that will assist him in meeting his goals and will provide education on how to be autonomous in these activities, to the extent possible. This will allow Mr. Robertson to then make informed choices as to services and resources needed to achieve his goals in a timely and cost-effective manner, and to encourage his responsibility for compliance with the identified treatment or support.

Throughout Mr. Robertson's involvement in case management, the CM will provide timely follow-up on services or equipment ordered by a provider, along with referrals to community organizations. The CM will confirm that services are received and, through continuously employing motivational interviewing, will help Mr. Robertson explore any reasons for not following through on treatment, taking into account the level of brain injury sustained.

Should issues arise in the development of the care plan or throughout the ICM process that prevent Mr. Robertson from meeting his goals, the CM may request the assistance of the MCP Interdisciplinary Team (IDT) case conference meeting. An IDT is a formal interdisciplinary team case conference to provide additional input and direction to assist the care team's work with a member. These participants include a MCP Medical Director, Pharmacist, Psychiatrist, BH Coordinator, and the member's CM. The member is invited to attend, along with any family members, caregiver, or other natural supports they request. In addition, all participants of the member's care team are invited.

## Case Management

The greatest setback risks/challenges now facing Mr. Robertson's recovery, health, and well-being, as well as the steps we will proactively take to address them are described below.

### *Issue #2: Traumatic Brain Injury*

Long Term Goals: Mr. Robertson will reach maximum improvement and will function at the highest level possible. Mr. Robertson will be able to independently perform as many self-care activities as possible, given the level of injury that is sustained.

Short Term Goals: Mr. Robertson's functional level will be adequately diagnosed. Mr. Robertson will participate in his recovery and will remain motivated to reach therapy goals. He will comply with recommended treatment to the extent that his impairment level will allow. He and his family/caregiver or support system will have a basic understanding of TBI and the level of Mr. Robertson's injury and the impact on his abilities.

Interventions: The CM will do the following:

- Engage the SNF staff to track physical and cognitive rehabilitation results, including adherence with timelines and activities listed on Mr. Robertson's rehabilitation plan with specific attention to needed services, such as physical and/or occupational therapy. The CM will follow up with any Physical Therapy/Occupational Therapy (PT/OT) to address any fall-risk issues and interventions needed to mitigate that risk. Ongoing neuropsychological testing results will contribute to assessing progress. The CM will follow-up as indicated.
- Work with the care team to provide education applicable to Mr. Robertson's level of brain injury, including available resources, signs and symptoms of problems, when to call the doctor, and management of seizure activity, if applicable. The CM will follow-up as indicated.
- Work with providers to reconcile all medications being prescribed for Mr. Robertson. Along with medical providers, the CM will assist in educating Mr. Robertson regarding his medications and how they interact with each other and other substances. Provide general medication management teaching, including maintenance of a medication list, and information on how to take the medications and obtain refills. Utilize the data agreement with the RBHA provider for sharing of pharmacy data. The CM will follow-up as indicated.
- Continuously evaluate Mr. Robertson's health literacy and comprehension level and adjust education materials appropriately.
- Coordinate laboratory monitoring of blood levels if anticonvulsants are being used. The CM will follow-up as indicated.
- Assess if a different PCP model would be more appropriate for Mr. Robertson. Examples include a health home (as it will have extended hours and additional care coordination), an integrated BH and PH health home available through the patient centered health home agreements with RHBA providers such as People of Color, Mountain Health and Wellness, St. Joseph's Family Medicine, and Southwest Behavioral Health, or an in-home visitation model (as it will have other potential advantages for increasing Mr. Robertson's access to a PCP).
- The CM will assist Mr. Robertson with completing Advanced Directives if they are not currently in place.
- If Mr. Robertson has no family and the cognitive limitation resulting from his TBI diagnosis is at a level that suggests a need for a public fiduciary referral, seek a court appointed guardian. This will include completing necessary referral paperwork and follow-up.
- Assure that Mr. Robertson is provided any necessary training in self-care and other measures that may be needed to support and promote his own health and preventive care.
- Coordinate communication among all stakeholders, including providing case management contact information so that the participants in his care know how to contact the CM should the need arise. The CM will provide Mr. Robertson and/or his caretaker/family member(s) with this information as well.
- Work with Mr. Robertson and his care providers to constructively address any cognitive issues. The CM will also break down tasks into simple steps and, in conjunction with physical or occupational therapy, work to develop visual aides to assist with memory loss. Examples of this include reminder calendars, note-taking devices, memory books, and cueing.
- Determine if Mr. Robertson is eligible for any other benefits such as Medicare, ALTCS, or community resources. The CM will begin application process with Mr. Robertson's approval and follow up as indicated. If he is determined to be eligible for either program, the CM will collaborate with the health plan transition team and the accepting CM in order to transition care. Also, the CM will determine if Mr. Robertson has any further benefits to be coordinated (such as VA or Tribal).

***Issue #3: Substance abuse/behavioral health***

Long Term Goals: Mr. Robertson will complete prescribed substance abuse (SA) treatment and will remain substance-free as a result. He will safely take prescribed medications and will sustain no adverse medication outcomes.

Short Term Goals: Mr. Robertson will comply with prescribed treatments regarding behavioral health issues. He will verbalize the factors that motivate him to comply with SA treatment.

Interventions: The CM will do the following:

- Contact Mr. Robertson's RBHA provider to see that SA concerns are addressed while recovering from TBI. He may have new SA programming needs due to his recent head injury and previous trauma. The CM will forward neuropsychological testing to the RBHA provider to assist in updates to his BH treatment plan. They will also coordinate and communicate with the RBHA provider to achieve successful transition for Mr. Robertson's transition

to an alternate setting following TBI rehabilitation. The CM will continue to coordinate with the RBHA provider as changes occur.

- The CM will continue to coordinate with the RBHA provider as changes occur.
- The CM will coordinate with Mr. Robertson's providers, including his current RBHA provider, to address any identified new behavioral health needs due to Mr. Robertson's change in health status. Mr. Robertson may require an evaluation from a Behavioral Health Medical Professional (BHMP), as well as additional counseling and other behavioral health services, to address any newly developed behavioral health sequelae as a result of his brain injury. The CM will also verify that Mr. Robertson's medical records, including any completed neuropsychological testing, have been forwarded to the RBHA provider in a timely manner. The RBHA provider may need to change his SA treatment programming to accommodate any cognitive impairments resulting from the brain injury.
- Along with medical providers, assist with the provision of education regarding medications used to treat TBI and how they interact with current medications and/or other substances.
- The CM will continuously employ motivational interviewing techniques to assist Mr. Robertson with recognizing the factors that motivate him to avoid substances.

***Issue #4: Transition to home or a residential environment- ensuring safe housing***

Long Term Goals: Mr. Robertson will reside in the least restrictive and safest living environment that includes opportunities for access to providers, community services, and transportation as determined by his level of functional and cognitive skills.

Short Term Goals: Mr. Robertson will be re-integrated into the community as soon as possible. He will transition to the most appropriate residential living environment. He will also receive education related to TBI and connections to providers and community services as outlined in his plan of care.

Interventions: Our CRN and CM would collaborate to identify and coordinate activities related to Mr. Robertson's discharge needs. The CRN and CM will:

- Identify a safe living environment that is easy for him to enter, leave, and move around in via collaboration with Mr. Robertson and the nursing facility. If necessary, they will work with Mr. Robertson to identify a ground floor apartment or alternate setting. Prior to discharge from the nursing facility, the CM will consult with provider to see if a home safety evaluation is needed to assess the environment to which he will be discharged and any potential interventions that can be implemented to ameliorate any identified safety concerns.
- The CM will contact Mr. Robertson upon discharge to assess his current health status and if he was able to obtain prescribed medication. The CM will also work with RBHA to identify any drug-drug interactions using the data sharing agreement for pharmacy data. They will review the pharmacy claims system to confirm medication fills. The CM will address any barriers and will continue follow-up as needed.
- Coordinate any outpatient PT/OT that is ordered by the provider upon discharge and follow up appropriately. They will conduct ongoing evaluation to determine need for assistance with activities of daily living, laundry, housekeeping, shopping, cooking, etc.
- Assist Mr. Robertson with obtaining any durable medical equipment (such as walkers, canes, crutches, wheelchairs, and bathroom aids) and home modifications that may be needed upon discharge and will follow up appropriately.
- Engage stakeholders by coordinating communication, delivery and/or appointments for transportation vendor from home or residential setting. Identify the safest method of transportation according to his condition.
- Encourage Mr. Robertson's PCP to participate in and support all aspects of his recovery, including SA objectives.
- Coordinate with the RBHA provider to see that the SA treatment program has integrated drug review and works in conjunction with any pain management initiatives/providers and home healthcare.
- Identify any accommodations Mr. Robertson may need, such as family/caregiver support and training (if applicable).
- Identify and assist Mr. Robertson with engaging in community programs that would assist him, which may include: Meals on Wheels, the Senior Adult Independent Living (S.A.I.L.) Program (to address any ADL or IADL needs), and Brain Injury Alliance of AZ (a TBI support group), vocational rehabilitation, and/or any available day programs that may meet his current needs. The CM will assist with an ALTCS referral if needed. The CM will also provide follow-up on all services and resources as indicated.
- In the event that Mr. Robertson exhibits functional and/or cognitive impairments that prevent him from living alone, our CRN will work with him, his family/caregiver, and providers to identify and transition him to a TBI-assisted living home. This will provide him with the rehabilitation, coping, social, and AD and IADL support he needs to

maximize his recovery with emphasis on his cognitive function. As a result of our extensive existing TBI home network that is generally used by our ALTCS program, we have the capacity to meet Mr. Robertson's needs should his situation indicate under these contracts.

- Coordinate appointments for any need identified by his PCP for specialists (for example, neurologist or physiatrist). The CM will follow-up as needed.
- Communicate and close any identified gaps in care and make these available to Mr. Robertson's interdisciplinary care team
- Reinforce all education provided regarding signs of problems and when to call the doctor.
- In collaboration with therapists, provide education on exercise recommendations as approved by provider

***Issue #5: Psycho-social Challenges/Risks (Police involvement associated with Mr. Robertson's substance possession, possible loss of income, and potential inability for Mr. Robertson to care for himself)***

Long Term Goals: To assure that any potential transitions between MCP and the Court and Legal System are safe and effective in maintaining Mr. Robertson's recovery.

Short Term Goals: To prepare Mr. Robertson and his care team and family for potential transition from MCP to the Court and Legal System.

Interventions: Our CM will work with the care team to begin preparation for a potential transition.

## Quality Management

All MCP personnel having contact with members or providers receive initial and ongoing training regarding the appropriate identification and handling of quality of care (QOC) and/or service concerns. In Mr. Robertson's case, upon receipt of the referral from the concurrent review nurse, the QM nurse review team, operating under the direction of the Chief Medical Officer (CMO), will be responsible for identification, research, evaluation, intervention, and resolution of any QOC concerns. When appropriate, QOC concerns are raised and discussed at the peer review executive session of our QM/UM Committee. Specific to Mr. Robertson's case, our QM Nurse Review Team will initiate the following (these steps may vary as issues are identified):

1. Conduct an initial assessment of the severity of the quality of care issue and prioritize actions needed to resolve immediate care needs.
2. Refer or report the issue to appropriate regulatory agencies such as AHCCCS, Adult Protective Services, or the Arizona Department of Health Services as indicated.
3. Request and review all records associated with this case. These include hospital, medical providers, internal records such as case management, concurrent review and pharmacy records.
4. Review the QM confidential database to identify any trends related to the providers.
5. Send letters of inquiry if further information is required after the initial review of the records received.
6. Conduct a quantitative and qualitative analysis of the research which may include a root cause analysis to determine if there were systems failures that contributed to the negative outcome for Mr. Robertson. Examples of system failures could include issues with coordination of care and discharge planning deficiencies, or support systems that were not implemented.
7. Present summary of findings to Medical Director for review and further recommendations. If there are no further recommendations and a quality of care issue is identified, a level of severity will be assigned.
8. Request a corrective action plan based on substantiated findings, including any internal findings that require corrective action from MCP.
9. Review all corrective action plans for thoroughness to verify that the action plan is directed at reducing or eliminating the likelihood of the issue reoccurring. Approval or denial will be based on review.
10. Request evidence of implementation of corrective action and schedule a follow-up audit when appropriate.
11. Submit the case to an executive session of the QM/UM peer review committee for additional recommendations as appropriate.
12. Add QOC issues to the confidential database for tracking and trending.

Every substantiated QOC issue identified requires a corrective action plan. This may include education/training/technical assistance, changes in processes, structures, and forms, follow-up monitoring and evaluation of improvement, informal counseling, and termination of affiliation.

**Q6: Describe the Offeror's experience in Medicare Advantage and/or Medicare Special Needs Plans and what processes will be utilized to maximize care coordination and improve member experience to maintain aligned enrollment.**

## Medicare Advantage (MA) and Medicare Special Needs Plans (SNP) Experience

Since 2006 Mercy Care Plan (MCP) has provided high quality, responsive, cost effective, and culturally competent care to dual eligibles through our Mercy Care Advantage (MCA) SNP. Our dual eligibles have complex bio-psycho-social needs and require effective management to improve their quality of life and outcomes. Our experience in administering Medicare and Medicaid benefits to dual eligibles demonstrates our commitment, knowledge, and expertise in working with this vulnerable population.

Results of the 2012 MCA CAHPS®[1] survey indicated high member satisfaction with MCA with an 88.0 overall plan satisfaction rating. This is the highest rating received by any MA health plan in our market area and surpasses both the state and national averages for MA contracts. In addition, the same CAHPS® survey found MCA members to be more willing to recommend their plan (MCA) for prescription drug coverage than members of any other plan. Our rating of 3.61 out of 4.0 was both the leading score of all Medicare Advantage Part D contracts in our market area and was "significantly higher" than the national and state averages for this question. Providers continued to rate MCP/MCA higher than all other Medicaid/Medicare HMOs.

MCA serves more than 17,300 dual eligibles, the vast majority of which are fully aligned. MCP also has experience managing non-aligned dual eligibles in all other AHCCCS programs. Significantly, MCP has provided full scope Long Term Care services through our Arizona Long Term Cere Services (ALTCS) contract, which currently serves more than 11,600 members (85 percent of these members are dual eligibles and many of those are non-aligned.) Regardless of alignment, our programs provide an excellent member experience. Our ALTCS program has become the plan of choice in each of the geographies we serve, as demonstrated by the proportion of members selecting a plan who select MCP as their plan. From this experience, MCA has emerged as a national leader in coordinating care for members served by both Medicare and Medicaid, whether aligned or non-aligned.

**MCA serves nearly**
**1 out of every 6**
**fully-aligned dual eligibles in the United States.**[2]

## MCA Outperforms Fee-For-Service (FFS) Medicare in National Avalere Study

AHCCCS Director Tom Betlach's recent testimony before the Senate Finance Committee in Washington, D.C. cited the "Analysis of Care Coordination Outcomes" study of MCP completed by Avalere Health in 2012. The study was a comparison of the dual eligibles managed by MCA as compared to a national sample of dual eligible beneficiaries in FFS. The analysis demonstrated that our model effectively avoids utilization of unnecessary services and inefficient care, by virtue of improved management of 1) inpatient utilization (measured by hospital days, discharges and length of stay); 2) Emergency Department utilization (ED); and 3) all-cause readmissions. The study also demonstrates that we enhance and improve member experience by driving 4) improved access to preventive/ambulatory health services through our emphasis on members' relationships with their PCP and other means. The increases in access to preventive and ambulatory health services demonstrate that our system of coordinating care effectively removes barriers to care and simplifies

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

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

- Avalere Health 2012, *MCA versus FFS dual eligibles*

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] Note: There are 100,000 aligned duals nationally per AHCCCS's "Arizona Overview" slide in the *AHCCCS Medicare/Medicaid Duals Discussion* slide deck (February 2012, p. 10).

the experience of accessing appropriate services for this vulnerable population.

This is just one example of how MCP, through the MCA SNP, has demonstrated substantial experience in improving quality, service, and cost for dual eligibles.

## National Organization Experience/Support

MCP's administrator, Schaller Anderson, LLC (Schaller Anderson), is owned by Aetna Inc. (Aetna). Aetna is one of the country's largest and most respected healthcare companies. Aetna began offering plan-sponsored Medicare Advantage HMO plans in May 1986 and Medicare Advantage PPO health plans in January 2003. Sponsored Medicare Advantage Prescription Drug Plans (PDPs) were initially offered in January 2006. Aetna currently provides Medicare benefits to 1,134,219 members and their Medicare plans consistently average 3.5 in the CMS Star ratings.

Aetna has the following accreditation designations for its Medicare Advantage plans:

- All 34 Medicare Advantage PPO plans have achieved PPO Medicare Advantage deemed status from NCQA – this is based upon the review of standards approved by Centers for Medicare and Medicaid Services (CMS)
- 20 of Aetna's Medicare plans hold Excellent Accreditation designation
- 14 of Aetna's Medicare plans hold Commendable Accreditation designation

MCA's affiliation with Aetna has enabled MCA to leverage Aetna's Medicare experience in specific, helpful ways such as employing Medicare compliance best practices, internal audit support, and claims payment methodology expertise.

In addition, Schaller Anderson's Aetna affiliates were recently awarded contracts (by the states of Ohio and Illinois) to be a health plan for their state/CMS dual demonstration programs, which Schaller Anderson will administer. The contract awards demonstrate Schaller Anderson's commitment to developing programs and managing plans for dual eligibles.

## Maximizing Care Coordination and Improving Member Experience

MCA's highly regarded Model of Care (MOC) applies best in class processes to maximize care coordination and enhance member experience. Recently, CMS performed an onsite policy, procedure, and outcome review comparable to an AHCCCS Operational and Financial Review (OFR). At the exit conference, the CMS reviewers commented that our MOC was in the "superior" category and among the most highly ranked and sophisticated they had ever reviewed. MCA designed the MOC to engage and empower members to be independent, to guide care coordination and delivery of care, to improve quality of life and clinical outcomes, and to reduce unnecessary costs. Our MOC focuses on a member's strengths, preferences, and needs in order to support the member in accessing medically necessary covered services, as well as support services available from other community resources.

One of the key tenets of our care coordination approach is the move from disease focus to member focus. Our experience in working with this vulnerable population of dual eligibles, including seniors and adults with disabilities, has shown us that providing access to critical non-medical support services benefits members in a variety of ways. Among these are that Members are better able to move toward self-sufficiency in the management of their care, remain in the least restrictive community setting, and have access to the right service, at the right time, with the right level of care.

Early in the care coordination process a holistic assessment is conducted to identify physical, behavioral, and social risks and to determine the member's individual goals. The Case Manager (CM) and the member develop a care plan that is key to arranging services which assist the member in meeting their goals. The member and their family and/or representative are an integral part of the care planning process.

MCA improves each member's healthcare experience by providing member-focused care that empowers and supports the member as they move through the healthcare system. MCA assists the member in navigating the healthcare system by employing the following strategies:

- Evaluate every member for physical, behavioral, and social risks to their current and future health
- Determine the members' individual goals
- Develop a care plan to assist the member in meeting their goals

- Identify and employ the most effective evidence-based services at the right time and right level of care
- Facilitate access to a continuum of services based on the intensity and complexity of each member's needs
- Engage the member holistically using a single point of contact in a manner that addresses their physical, behavioral, and social needs and promotes resiliency, recovery, and optimal self-management
- Team with the member, their families/representatives, and care providers to enhance care outcomes
- Work as an interdisciplinary team with core competencies in physical and behavioral health
- Identify the member's needs and through the supplemental benefit, influence the member's access to benefits
- Coordinate and integrate fragmented healthcare services into a cohesive system of care that is more capable of addressing each member's needs

Our processes are supported by sophisticated Health Information Technology (HIT) systems that provide an enterprise-wide web-based care management application. MCA's CMs, members, and providers all use these systems, thus creating transparent and consistent information about the member's care episodes. We store and retrieve member assessment results, claims data, authorizations, member individualized care plans, and Care Coordinator documentation. Our CMs are empowered because they are able to electronically review members' clinical profiles, facilitate care between providers, develop, share, and review members' individualized care plans, monitor members' medical and pharmacy usage patterns for appropriate use of services, and evaluate members' health outcomes.

Moreover, our applications trigger care coordination alerts (e.g., service gaps, medication issues) and other pre-defined reminders (e.g., reassessment needed, reminder call to schedule prevention screening), all of which are designed to assist CMs to coordinate and manage member care. Our integrated HIT provides our care teams and leadership with access to population-level information, including member/provider cost and utilization trends. MCA reviews this information to:

- Identify members who have under, over, and/or inappropriately utilized health services including ED services, hospital admissions, and prescribed medications
- Identify members who may lack appropriate access to medically necessary services or could benefit from education about how to utilize the healthcare system
- Target education to PCPs who do not appear to be following recommended clinical practice guidelines or who need to more effectively outreach to their assigned members and facilitate better management of the member's care
- Assist in supporting other internal operations, such as concurrent review decisions, member appeals, and fraud and abuse detection
- Push information through Provider Profiles to our health homes in a manner that empowers the provider to improve the healthcare delivery system and achieve measurable outcomes.

MCA's systems and processes have resulted in demonstrable results in the management of Arizona's dual eligible population, including higher quality of care and greater cost savings. MCA provides members with educational materials and support services necessary for the member to reach a better understanding of their chronic condition, and the health interventions related to the member care plan. Additionally, cultural competency is integrated throughout our organization and reinforced through the use of training and education opportunities for staff, providers, and members.

## Improving Member Experience for Non-Aligned Members

MCP always places the member first. Regardless of whether the member's Medicaid/Medicare coverage is aligned through MCP/MCA, only has Medicaid coverage with MCP, or only has Medicare coverage with MCA, we work to achieve a positive experience for the member at each interaction. We will coordinate care and services to meet the member's needs. Our staff identifies services required and works with providers to coordinate and deliver all medically necessary services in a timely manner at the appropriate level of care. MCP/MCA coordinates care with other health plans, CMs, RHBAs, and any local community resources. We make sure that non-aligned members are not caught between two systems.

When we receive a Prior Authorization (PA) request for a non-aligned member, we coordinate care through our PA and Utilization Management staff to make certain that the member receives the right care, at the right level of care, and at the right time. We coordinate payments through claims administration and conduct "pay and chase" activities when

needed. This means that if we are unable to coordinate care with another health plan in real time, we provide the necessary care and conduct follow-up activities with the responsible health plan to receive payment for authorized services on the back end.

To give an example of MCP's approach to managing non-aligned dual eligible members, we describe the case of "John". John is a 25-year-old with a history of a heart transplant prior to MCP Acute Care AHCCCS enrollment, in addition to depression, anxiety, obesity, and history of stroke post-transplant. John's primary insurance is Medicare and is provided by another plan. John enrolled with MCP four months ago. John was identified by our Transplant Coordinator when MCP received the transplant-related medication report and noted that this member was previously unknown to the transplant coordination team. The Transplant Coordinator reached out to the prescriber, known to the team as one of our heart transplant physicians at the University Medical Center (UMC) Transplant center. The Transplant Coordinator updated the records with the UMC heart transplant coordinator, educating the UMC coordinator how to check AHCCCS eligibility, member health plan assignment, and PA requirements, including letting the transplant center know that there is no PA required for part B medications when MCP is secondary. The Transplant Coordinator identified additional concerns and referred John to case management. MCP's CM contacted John and completed a comprehensive assessment. The CM used motivational interviewing techniques to explore John's underlying strengths, preferences, goals and barriers. The CM developed a contact at John's Medicare plan and included this person in the care coordination plan so that if the Medicare or MCP Acute Care plans' receive authorization requests, simultaneous and coordinated decisions can be made assuring the member gets the medically necessary services in a timely manner, regardless of payor. The CM also provided appropriate education regarding necessary medical care and cardiac follow-up required for his conditions. The CM developed a coordinated care plan with John, his primary provider, and the transplant team, including the MCP Transplant Coordinator. The plan included his issues of anxiety, depression, obesity, and healthy weight management, along with a plan to increase his activity level. In addition, the CM assisted John with obtaining specialty medications by expediting the PA process, developing a plan for when some of John's medications will no longer be covered under his Part B plan but will be moved to Part D coverage. The CM also worked with the team to help John obtain coverage of over the counter medications that were medically necessary to prevent John from relapsing or suffering adverse outcomes from his transplant. This was done through John's MCP benefit as these drugs are not a Medicare covered. The CM provided a single point of contact for the member and provider to expedite any coverage issues by staying in close contact with the providers involved. The CM then coordinated his transplant follow-up care with the transplant center in Tucson and arranged for John's travel and lodging. The CM's efforts to coordinate care with both Medicaid and Medicare providers involved in John's care resulted in the member accessing appropriate services to meet his needs.

## Increasing and Maintaining Aligned Medicaid/Medicare Enrollment

We have a track record of success in increasing and maintaining aligned enrollment. Our experience includes the passive enrollment to introduce SNPs to Arizona in 2006 and more recently in achieving a successful expansion and retention of largely dual eligible ALTCS membership in Pima County. MCA is proficient at educating members and providers about MCA benefits. We have experience in managing large volume member transitions that will help us in a passive enrollment process. We are also experts at improving the member experience through care coordination and we offer a robust benefits package that will be attractive to members in a competitive enrollment situation. Our local presence, vigorous member outreach, and strong relationships with providers are assets in increasing and maintaining dual alignment in either situation. In the following sections we describe some of our alignment strategies in more detail.

### *An Unsurpassed Member Experience*

First and foremost, we drive member choice by providing an unsurpassed member experience for our dual eligibles, as demonstrated by our market leading overall CAHPS® plan rating scores. MCA employs a variety of strategies that have proven successful in achieving a high number of aligned Medicaid/Medicare members. This alignment/integration of Medicaid/Medicare will drive better outcomes, improve member satisfaction, and help achieve greater cost savings for AHCCCS. Among the ways we enhance our members' experience are:

- Reinvest MCA's gains from operational efficiencies into more generous member supplemental benefits including dental, vision, podiatry, chiropractic, health and wellness benefits, Independent Living Program, and Van Go Active Steps™

- Operate a 24/7 specialized member services call center support to meet our members' needs, whether to understand their benefits, locate a provider, access pharmacy benefits, or receive any other desired support
- Maintain a Single Point of Contact with MCP for both Medicare and Medicaid programs through our Arizona-based Member Services Department. Members can access MCP via phone (602-263-3000/800-624-3879) and via our website (www.mercycareplan.com)
- Have a local office that can provide face-to-face member services department assistance
- Provide culturally competent systems, driven by fully cross-trained staff at every level who possess awareness of how to effectively interact with this vulnerable population and to navigate both Medicare and Medicaid systems
- Have our CMs coordinate care and advocate for the member
- Coordinate Medicaid/Medicare/third party payor claims payments, thus insulating members from this complicated and frustrating activity
- Handle enrollment/eligibility coordination for the member including single PCP assignment for both programs
- Implement awareness campaigns to improve health literacy and reduce health disparities

***Personalized, Member Friendly Medicare Sales and Retention***

Additionally, Medicare sales and retention staff are focused on meeting members' needs. Our first goal is to achieve and maintain alignment for each dual eligible member. Our member retention unit proactively outreaches to members, reviewing the advantages of alignment for dual eligibles and assisting members with eligibility/enrollment. Each member is assigned a Personal Care Specialist (PCS) who assists the potential member with obtaining information and services. The PCS will outreach to dual eligibles, explaining the value proposition of having aligned Medicaid/Medicare coverage. If a potential member wishes to become aligned, a Medicare Sales Representative follows up with the member to complete all necessary paperwork. The PCS will also follow up to answer questions and make sure that the member's needs are being met. Our PCS and Specialized Member Services Teams help members navigate the system, working door-to-door and person-to-person to introduce members to the benefits of alignment. Our Medicare Sales and Retention staff uses these same member-centered activities to retain alignment within MCA.

***Meaningful Provider Relationships***

Provider relationships, which are essential to having a consistent and high quality network, are also important to the success of our alignment strategies. As a provider-sponsored and locally-owned plan operating for many years in Arizona, MCA has staff located throughout the state that services our providers' needs. We conduct continuous provider outreach, education, and support through our local PSRs. We work with providers to successfully develop health home models and we focus on issues that matter most to providers: evidence-based clinical guidelines, low administrative costs, streamlined PA, timely/accurate claims payments, and opportunities for growth. It is our experience that providers, who are supported by a cooperative health plan like MCA, translate that positive experience into patient education about the benefits of alignment and engagement with a plan such as MCA.

## Flexibility in Supporting AHCCCS's Medicaid/Medicare Alignment Policy

MCP will meet all Medicare Demonstration participation requirements as dictated by CMS and the State including approval of a Medicare Demonstration specific application, approval of a formulary consistent with Part D requirements, approval of a Medication Therapy Management Program (MTMP), and approval of a unified model of care.

We understand that AHCCCS has several options available to guide alignment within the state. We are committed to working with AHCCCS for a successful and mutually beneficial program for the purpose of increasing dual eligible alignment within the state. We will fully cooperate with, assist, and support AHCCCS in any way we can to develop a care management and coordination process to align Medicare and Medicaid enrollment. We will continue to make certain that Medicaid is always the payor of last resort and that the member will never be "caught in the cracks" between the two programs.

MCA is extremely flexible and is firmly aligned with AHCCCS's goals for Medicaid/Medicare members. We will continue to support AHCCCS in any approach it may choose to achieve these goals.

Mercy Care Plan

# Organization

**Q7: Describe what strategies the Offeror will pursue to improve care, enhance quality, eliminate waste, and lower costs. Describe the initiatives that will be pursued to involve stakeholders and reach desired outcomes.**

Mercy Care Plan (MCP) recognizes that waste in healthcare is a significant threat to the sustainability of our healthcare system, which contributes greatly to high cost and to poor outcomes. We are committed to identifying and addressing waste in healthcare in order to improve quality and enhance cost containment. For the purposes of this response, we define "waste" using the Institute of Medicine's (IOM) categories of unnecessary services, inefficient care, excess administration, inflated prices, prevention failures, and fraud. In addition to descriptions of specific initiatives, we will identify the stakeholders involved, the timelines for implementation, and the desired outcomes of these efforts.

## Eliminating Unnecessary Services

To eliminate waste within the system, it is imperative to identify and manage unnecessary services. Unnecessary services includes: a) overuse (beyond evidence-established levels); b) discretionary use beyond benchmarks; c) unnecessary choice of higher-cost services.

Services that are performed beyond evidence-established levels, with poor discretion, or with unnecessarily higher cost options do not improve the quality of care delivered. In fact, they may worsen quality by leading to further needless services, complications, and poor patient experience. To reduce these services, MCP will continuously enhance our ability to assure the appropriate application of evidence-based clinical practice guidelines.

MCP has an excellent track record of assuring proper application of nationally accepted evidence-based clinical practice guidelines through medical necessity review criteria, prior authorization criteria, practice guidelines, and new technology evaluation review. As evidence, we cite our near perfect (99 percent) Inter-rater Reliability Scores against the nationally accepted Milliman testing criteria and our outstanding record of sustained decisions during secondary reviews by Independent Review Entities and administrative hearings under both Medicaid and Medicare. Building on our outstanding experience, we will further eliminate unnecessary services by implementing the following initiatives:

- **Optimize Prior Authorization –** We will make all evidence-based clinical practice guideline criteria readily accessible to all network providers through our website using our **Auto Authorization tool**. The tool's real time feedback enhances the provider's ability to apply the right clinical decisions. For example, an MCP provider considering an MRI for a member with low back pain will be presented with the evidence-based criteria (Milliman Care Guidelines) for appropriate imaging. In this example, if imaging is appropriate, the authorization for the service is made immediately available. This has the effect of aligning clinical decision support with prior authorization review and therefore promotes appropriate imaging to achieve the best diagnostic results for the member at the appropriate time.
  - Timeline: Q3, 2013
  - Stakeholders: Providers
  - Expected Outcome: This in turn will help directly prevent overuse, discretion beyond benchmarks, and the choice of unnecessarily higher cost services.
- **Making Comparative Effectiveness Information Accessible** - MCP is the first and only Medicaid and Medicare health plan in Arizona partnering with the **Agency for Healthcare Research and Quality's Effective HealthCare Program.** This partnership provides information that will translate comparative effectiveness research into useful formats for patients and their doctors to make better care decisions. This information will be readily accessible to our members and providers through MCP's website. To promote the availability of this information, we will develop and distribute training and materials for providers and members.
  - Timeline: Partnership initiated Q3, 2012, Implementation Q2, 2013
  - Stakeholders: AHCCCS, physician associations, clinicians, and members
  - Expected Outcome: This effort will improve the quality of healthcare and promote evidence-based decision making by providers at the point of service and will avoid unnecessary service requests.

## Improving Inefficient Care

Inefficient care is one of the main causes of excessive cost in the healthcare system, especially for members with complex healthcare needs. To eliminate waste within the system it is imperative that MCP reduces inefficient care.

Inefficient care includes: a) mistakes (errors and preventable complications); b) care fragmentation; c) unnecessary use of higher-cost providers; d) operational inefficiencies at care delivery sites.

MCP has an excellent track record of eliminating system waste by reducing inefficient care. We will continue to collaborate with clinical practices by promoting innovative payment strategies that encourage providers to deliver cost effective and high quality care. MCP has an exceptional history of successful work with providers in bringing innovation and best practices to improve the delivery of care. Proof of our ability to improve the efficiency of care includes our performance on single measures of efficiency, such as meeting timeliness of PCP appointment standards, and our success at meeting the AHCCCS Minimum Performance Standards.

The "Analysis of Care Coordination Outcomes" study of Mercy Care Plan completed by Avalere Health in 2012 was a comparison of the dual eligibles managed by Mercy Care Advantage (MCA), our Medicare Advantage Dual Special Needs Plan, as compared to a national sample of dual eligible beneficiaries in fee-for-service. The analysis demonstrated that our model effectively avoids utilization of unnecessary services and inefficient care, by virtue of improved management of (1) inpatient utilization (measured by hospital days, discharges and length of stay); (2) Emergency Department utilization (ED); and (3) all-cause readmissions. The study also demonstrates that we enhance and improve member experience by driving (4) improved access to preventive/ambulatory health services through our emphasis on members' relationships with their PCPs and other means. MCA has achieved the following results: three percent increase in the use of preventive services, 43 percent lower hospital days/1000, 19 percent lower average length of stay, 9 percent lower ED visit rate, and 21 percent lower readmission rate. Additionally, our health home pilots have been expanded to cover more than 45,000 members. Building on this experience, we will further reduce inefficient care by implementing the following initiatives:

- **PCMH/Health Home membership expansion**: MCP has a management initiative to identify and work closely with providers and provider groups that want to achieve health home status. We will identify participating providers who have already achieved NCQA or URAC health home status and encourage them to become health homes for MCP members. We will also provide consultation and technical assistance to providers who have not yet achieved NCQA or URAC health home status, but who are interested in developing the necessary programs to achieve health home status. Participating providers that achieve health home status with MCP are provided enhanced access to financial incentives, panel assignments, and assistance with data reporting and analysis for their members. We also support them with availability of case management services, as well as best practices that are shared to assist in developing stronger care management strategies and technological solutions.
  - Timeline: Ongoing, with expansion of existing and new health homes.
  - Stakeholders: Practices including FQHCs and FQHC look-alikes.
  - Expected Outcome: Our experience demonstrates the reduction of inefficient care, such as the use of the Emergency Department (7 percent reduction), Inpatient Admissions/Readmissions (20 percent reduction), and pharmacy expenditures (32 percent reduction). Additionally, our model simultaneously maintains or improves utilization of PCP and preventive care visits and access to clinical performance measures, such as laboratory testing and immunizations. Our model creates incentives for providers to eliminate care fragmentation, avoid unnecessary use of inefficient services such as ED, and improve operational efficiencies in their practice.
- **Reducing Care Fragmentation Through Continuous and Focused Innovation**: MCP will continue to work with Recovery Innovations, St. Joseph's Medical Group, and Creighton University School of Medicine-- all stakeholders representing behavioral health, physical health and medical education leaders to implement patient centered health care home (PCHCH) models. Our PCHCH models go beyond the previously mentioned PCMH to support integration of the behavioral health system to seamlessly coexist with the physical health system. PCHCH models decrease fragmentation by creating a bridge between behavioral health recovery and resilience services and preventive medical care. Members receive access to a quality-driven, interdisciplinary, clinician-led team approach to coordinating and delivering care that puts members at the center of all decisions and eliminates care fragmentation. We have also begun to work with the Arizona Chapter of the American Academy of Pediatrics, Best Care for Kids, to improve care for children with asthma. We will apply lessons learned from our diabetes specific and behavioral and physical health specific programs to future clinical practice redesign projects to meet specific complex needs like childhood asthma whose health outcomes and costs are most vulnerable to the failings of a fragmented healthcare system.
  - Timeline: Ongoing

- Stakeholders: Physical and behavioral healthcare advocates, community providers, professional associations, medical education leaders, and disease specific advocacy groups
- Expected Outcome: Increases access to care that integrates physical health, behavioral health, and supportive community and social services, making certain that members with complex conditions receive the right care in the right setting at the right time.

- **Deploying Innovative Technologies such as iNexx:** Our health information technology enables organizations and providers to share information and collaborate to provide care. Providers can collaborate and coordinate care over a secure network even when they use different electronic medical record systems. The use of iNexx supports providers in achieving meaningful use of health information technology in a rapid and cost effective manner. Physicians and staff in a practice can choose specific applications that fit their clinical workflow. iNexx technology can be rapidly distributed into clinical settings, create ad-hoc health information exchanges (HIEs) supporting patient centered care, establish new real-time provider interfaces, and allows users in the clinical setting to install third party applications specific to their workflow needs.
  - Timeline: Currently deployed in a pilot status, with further implementations in 2013 and beyond
  - Stakeholders: Information Technology Professionals, PCP's, Specialist and Hospital Systems, Laboratory Providers, and Software Development Groups
  - Expected Outcome: Reductions of operational inefficiencies and reductions of preventable complications that result from poor communication and inadequate information. As a result of having information from other providers, there will be a reduction of duplicated services (e.g. imaging and laboratory testing). More providers will utilize electronic medical records and share near real time clinical information.

## Reducing Excess Administration

To eliminate waste within the system, it is imperative to reduce excess administration. Reducing excess administration includes: a) Insurance paperwork costs beyond benchmarks; b) Insurers' administrative inefficiencies; and c) Inefficiencies due to care documentation requirements.

Excessive administrative burden adversely affects the value of healthcare by adding costs in the form of administrative procedures, actions, or requirements that do not increase service delivery or quality. The resulting cost, without an increase in quality, worsens value. MCP will continuously identify ways to reduce administrative burden in ways that streamline and improve the provider's experience in working with the plan.

Mercy Care Plan has an excellent track record of reducing administrative burden of healthcare as evidenced in a greater than 20 percent reduction in the number of services that require prior authorization and significant reduction in claims disputes over the last five (5) years. We will further eliminate unnecessary services through:

- Our **Auto Authorization** tool, mentioned previously, will also allow prior authorization approvals at the time of request on most if not all requests that meet criteria.
  - Timeline: Summer 2013
  - Stakeholders: Providers
  - Expected Outcome: Providers will have a reduction of 20 percent in the number of services that require prior authorization. Prior authorization requests meeting review criteria will be approved at the time of request, improving efficiencies in scheduling and reducing the administrative burden on the provider's office staff
- **ProPAT**: this Prior Authorization (PA) requirement search tool enables providers submitting PA requests online to search PA requirements by individual or by multiple CPT/HCPCS codes simultaneously. It also allows them to review PA requirements by specific procedures or service groups and to receive immediate, detailed Yes/No information concerning PA requirements
  - Timeline: Ongoing with continuous updates to keep constant with coding practices
  - Stakeholders: Providers
  - Expected Outcome: This tool will give providers at the point of service the decision support information they need to understand prior authorization requirements for any and all procedures. Providers in turn will help providers communicate and schedule procedures, reducing the need for scheduling and other administrative burdens.

- **Our Claims Dispute Resolution Process:** In 2009, MCP established a continuous process improvement initiative to identify and address the critical factors that result in provider claim disputes and state fair hearings. As of October 2012, MCP has seen a 71 percent reduction in the annual number of provider disputes, and an 89 percent decrease in provider state fair hearing requests since this continuous process improvement initiative began. We continuously monitor, adapt, and improve our process in order to remain effective and to reduce administrative burden.
  - Timeline: Ongoing to further reduce the number claim disputes and state fair hearings
  - Stakeholders: Providers, members, AHCCCS, Office of Administrative Hearings
  - Expected outcome: Further reduction of the number of claim disputes and state fair hearings, increased provider satisfaction
- **Managing inflated prices:** To eliminate waste within the system it is imperative to manage inflated prices. Managing inflated prices includes: a) Service prices beyond competitive benchmarks; and b) Product prices beyond competitive benchmarks.

  MCP recognizes its vital role in contributing to unit cost containment in the AHCCCS system by employing effective yet sustainable contracting mechanisms with its provider network. Our efficient operations and positive provider relationships allow us to leverage our purchasing power into cost containment initiatives. We designed the initiatives to focus on the greatest return on investment for our members, providers and stakeholders. To identify the best opportunities for service price improvement, MCP uses increasingly sophisticated health information technology that allows us to factor in increasingly complex information to allow us to better identify best sources of quality and the sources of cost in the healthcare delivery system. Our ability to analyze unit cost, quality, and outcomes data and to develop and deploy sophisticated contracting mechanisms (such as full risk capitation and the securing of volume discounts) distinguishes us as leaders in the fight against inflated prices and allows us to reward providers who deliver outstanding quality and value.
  - Timeline: Ongoing
  - Stakeholders: AHCCCS, Taxpayers, Providers, Members
  - Expected Outcome: Meet and exceed pricing at competitive benchmarks

## Minimizing Prevention Failures

To eliminate waste within the system it is imperative to minimize prevention failures. Minimizing prevention failures includes: a) primary prevention; b) secondary prevention; c) tertiary prevention.

While potentially adding short term costs, prevention services can result in long term cost reductions which are necessary for sustainability in the healthcare system. Missed opportunities to implement effective prevention services reflect one of the current healthcare system's greatest failings. However, as shown in the Avalere study, MCP has been effective at increasing access to preventive and ambulatory services, especially in vulnerable populations. We are continuing to build off of our history of success with the following:

- **Using Decision Support technologies such as ActiveHealth® Care Considerations for members and providers:** This system integrates medical and pharmacy claims data and laboratory results within member-centered records that are then compared to over 1,500 evidence-based clinical rules and related algorithms. It then identifies member specific opportunities to optimize care and communicates evidence-based treatment recommendations to providers. MCP will continue to implement enhancements. For example, ActiveHealth® has the capacity to support personal health record capabilities in 2014, where members will have easier access to evidence-based prevention recommendations. Our provider relations staff trains all providers on use of our technologies and act as a single point of contact when additional support is needed. These Care Considerations are available to and used by MCP providers, Case Managers and Care Coordinators.
  - Timeline: Implemented 2008 and ongoing with enhancements as available
  - Stakeholders: Members, Providers
  - Expected Outcome: Members will be more engaged in prevention services and increase their access to cost effective and proven primary, secondary, and tertiary prevention activities.

- **Targeting meaningful Pay for Performance (P4P) to increase underutilized services**: MCP continues to use provider Pay-for-Performance programs to improve the percentage of members receiving recommended procedures, including screenings. Providers and facilities respond favorably to the program by increasing the delivery of preventive services and the documented completion of these services.
  - Timeline: Ongoing
  - Stakeholders: AHCCCS, providers in Value Oriented Payment (VOP) models and the members they serve, taxpayers
  - Expected Outcome: Increased outreach and delivery of preventive services to members with the most prevalent and costly conditions such as diabetes, heart disease, and cancer who are underutilizing such services

## Identifying and Eliminating Fraud

To eliminate waste within the system, it is imperative to identify and eliminate fraud. This includes all sources of fraud including: a) payers; b) providers; and c) members.

MCP takes seriously the responsibility to identify and eliminate fraud, waste and abuse from every portion of the healthcare sector. Our culture of compliance and our systems and processes are designed to recognize fraud, waste and abuse from wherever they come. We deploy technology and processes and train and encourage employees, providers, and members to limit, identify, and address fraud, waste and abuse well beyond the standard regulatory requirements.

- **Enhanced Fraud, Waste and Abuse Program**: MCP has established a full-time Fraud Waste and Abuse Coordinator position to lead a comprehensive program that improves our ability to identify, report, and prevent fraud. This new program combines the use of technology and data mining to identify trends and patterns of potential fraudulent activities. We use a full array of sophisticated data and data mining techniques to systematically identify areas of concern. We train Medical Management, Prior Authorization, and Utilization Review staff to function as a first line of defense. In addition to provider training, MCP gives information to PCPs that helps them provide more appropriate care and reduce wasteful duplication of services. MCP also empowers members to recognize, prevent, and report suspected fraud and abuse. We also provide members with education to recognize and prevent fraud, waste and abuse, such as how to report fraud and abuse and the use of a hotline (1-800-338-6361) to report their concerns.
  - Timeline: Ongoing
  - Stakeholders: AHCCCS, MCP employees, Providers, Members, Taxpayers
  - Expected Outcome: Enhance the identification of fraud across all sources of healthcare

**Q8: Describe what additional activities included in the required Offeror's compliance program that will limit, identify, and address fraud and abuse using methods and including examples of a successful application.**

Mercy Care Plan (MCP) does now and will continue to exceed the requirements as outlined in AHCCCS' policies and the requirements in this RFP to limit, identify and address fraud, waste and abuse.

## Our Culture of Compliance

MCP has a zero tolerance policy with respect to fraud, waste and abuse. Our approach is firmly rooted in our organizational culture, in which compliance is a core competency for all employees.

This culture begins with our Board of Directors (the Board). The Board's Audit and Compliance Committee is responsible and accountable for the Compliance Program. The Audit and Compliance Committee is composed of Board members, along with key MCP executives. These committee members' skill sets span across Regulatory, Internal Audit, Finance, Operations, and Healthcare Law arenas. Our Audit and Compliance Committee chairperson reports all compliance issues to the Board at each meeting of the Board of Directors and also to the appropriate subcommittees. Additionally, the Audit and Compliance Committee is responsible for verifying that proper financial controls are in place and compliance activities are effective. Thus, at the highest levels of the organization, MCP's Board structure exceeds the requirements for oversight and accountability for compliance. Additionally, MCP is supported by our administrative subcontractor, Schaller Anderson, LLC (Schaller), which is owned by Aetna, Inc. (Aetna). MCP has full access to the investigative, administrative and technological expertise of Aetna's Special Investigations Unit (SIU).

## Our Above and Beyond Commitment of Plan Resources to Limit, Identify and Address Fraud and Abuse

### *MCP Fraud Waste and Abuse Coordinator*

We have taken the unprecedented step of creating an internal position to support fraud and abuse detection and prevention. This position, the Fraud, Waste and Abuse (FWA) Coordinator, is staffed by an individual who has a combination of Information Technology (IT)/Structured Query Language (SQL) server skills, a business intelligence background, training on healthcare business practices and a clear understanding of Federal/State laws and regulations that focus on fraud, waste and abuse issues. This individual, who is located at MCP's Arizona headquarters, is focused exclusively on detecting fraud, waste and abuse through the use of advanced analytics in an SQL environment to uncover developing trends and schemes.

The FWA Coordinator proactively performs intensive analysis of claims data to uncover billing anomalies. The FWA Coordinator also extracts and reviews claims payment tracking and trending reports, claims edits, audits, and provider billing patterns as indicators of potential fraud and abuse. Information gathered by the FWA Coordinator is then used to detect aberrant provider billing behavior, prompting additional analysis and investigation. The FWA Coordinator attends the Operational and Appeals meetings held weekly to identify issues that could signal fraud, waste or abuse, and can pull data to aid in identification. Due to this constant vigilance of report monitoring, data extraction, and seeking out signs of potential fraud, waste or abuse, our FWA Coordinator is an effective mechanism for early detection. If questionable activities are identified, MCP's FWA Coordinator will work in conjunction with MCP's Provider Services and Compliance departments to address the questionable behavior(s) through provider education and outreach. If MCP discovers, or becomes aware, that an incident of potential/suspected fraud and abuse has occurred, our internal Policies and Procedures (P&Ps) mandate that we report the incident to AHCCCS and to other regulatory agencies (e.g., Medicare Drug Integrity Contractor [MEDIC]) within 10 business days of discovery. The FWA Coordinator also reports any identified issues that may indicate a Quality of Care concern or potential harm to a member to MCP's Quality Management Department for further investigation.

The FWA Coordinator position is also responsible for:

- Chairing and directing the monthly FWA Committee meeting. The FWA Committee includes representatives of the Aetna SIU Team, the Compliance Team, the Chief Medical Officer (CMO), the Medical Director, the Dental Director, other physicians as needed, and the Health Plan Operations Director. This high level, cross-departmental assembly functions as a bridge to corporate governance, providing information to executive management and the Board of Directors, and assures that all levels of the organization participate in MCP detection and prevention efforts.

- Providing system-wide, in-depth analysis of anomaly queries. This includes liaising with internal work units such as the SIU (to investigate the local impact from cases of national prominence), the Grievance and Appeals Team (to review cases for possible fraud trends), and Provider Services to analyze billing issues/trends and provide educational opportunities for providers.

## A Special Investigations Unit to Support MCP

In addition to the Arizona-based FWA Coordinator, MCP brings unparalleled support from the national level, through the activities of the Aetna SIU. The SIU identifies, investigates, and reports fraud and abuse violations by providers, subcontractors, employees, and members.. With a total staff of approximately 100 individuals, the SIU is comprised of highly skilled well-trained, experienced, full-time investigators, field fraud (claims) analysts, a Medical Director, a full-time, dedicated information technology team, as well as supporting management and administrative staff. One investigative team within the SIU is specifically dedicated to Medicaid investigations. Aetna also has dedicated an SIU Coordinator (SIUC) specifically for Arizona. The SIU's primary responsibility is to apply specialized tools that identify potential healthcare fraud, waste or abuse and to investigate accordingly. Working together with MCP's CMO and staff, the SIU is a coordinated anti-fraud team. Upon identification of fraud, waste and/or abuse, our SIU Coordinator immediately reports potential fraud and abuse issues to the AHCCCS Office of the Inspector General (OIG) as well as other regulatory and law enforcement agencies as required. The SIU processes an average of 2,400 cases per year. The following list provides information about the individuals within our SIU and the approach it takes.

- SIU Hotline -- The SIU maintains a toll-free 24-hour hotline (1-800-338-6361).
- Case Referrals – The SIU receives case referrals from law enforcement (Federal or State) and State regulatory agencies, State Medicaid agencies, Departments of Insurance, as well as from customer service/claims personnel and other sources. The SIU's internal web-based Health Care Fraud Referral application provides an easy–to-use electronic referral submission tool that allows employees and business associates to refer suspected healthcare fraud directly to the SIU.
- IBM Fraud and Abuse Management System (FAMS) – FAMS is the primary proactive detection tool used by the SIU. Aetna is the health industry leader in the use of FAMS and an IBM development partner for FAMS. The SIU has built more than sixty (60) specialty fraud and abuse models and has applied these models to more than 1.1 million providers. FAMS models provider behavior and identifies provider outliers based on elements chosen from a library of over 8,000 discrete measures, or custom measures built by the SIU technology staff. Providers are profiled by peer group, specialty, product, geography, etc.
- Screening all Aetna SIU cases (including Commercial and Medicare) for potential Medicaid fraud and abuse - This screening system leverages our knowledge of provider practices across claims transactions much broader than Medicaid alone, and helps us to identify suspicious activity before a provider files a Medicaid claim.
- Leveraging data – SIU investigators leverage available data using web-based reporting and analysis tools developed for their use by our SIU information technology unit.
- Provider Watch – An alert placed on a provider's file that directs workflow, routing, and review of provider billings that have an elevated fraud risk. Provider "smart flags" can be placed once allegations of inappropriate billing have been investigated. The SIU provides ongoing national training initiatives for claims processors, underwriters, and other field personnel. Training is delivered via web-based technology. Training consists of fraud awareness, detection, and reporting, state reporting mandates, SIU provider flags, and other issues.
- When allegations of inappropriate billing have been substantiated and approved by AHCCCS, MCP pursues recovery with healthcare providers. Recoveries identified by the SIU for MCP were slightly more than $13.9 million, as of November 2012.
- Upon completion of the initial investigation, the SIU investigator will report the findings to the Compliance Manager to review for completeness and accuracy of the data. The Compliance Manager then forwards the information to the appropriate State agency, and in addition, submits, on a quarterly basis, a summary of our cost avoidance/recovery activity as specified in the AHCCCS Program Integrity Reporting Guide. During the first three quarters of 2012, MCP reported sixteen (16) cases to the AHCCCS OIG for investigation.

**Above and beyond all contractual requirements, MCP, with the help of the Special Investigations Unit, recovered $13.9 million from inappropriate billing in 2012.**

- Scheduling reviews of provider specific services - Each quarter, the SIU audits fresh paid claims data for provider types that have previously been identified as at risk for fraud and abuse. As a new initiative, starting in January 2013, all Durable Medical Equipment (DME), Home Health, Ambulance, Allergy, and PCP (Family Practice/General Practice) providers will undergo a focused intensive review of their claims activity to identify any trends or potential instances of fraud and abuse.
- Implementing a "Boots on the Ground" program - This program enables MCP to assist regulatory agencies in their recoupment efforts. MCP's SIU personnel are available to support the OIG's investigative staff to perform routine provider site visits to verify activity, collect medical records, and review claims activity on behalf of AHCCCS.

## Implementing Audits

Mercy Care, for its Medicare line of business, uses external Recovery Audit Contractors (RACs) to conduct retrospective reviews of inpatient claims to spot potential cases of over payment or other inefficiencies, due to lack of medical necessity, inappropriate coding, or other billing irregularities. Our information indicates that we are at the forefront of health plans' use of RAC audit techniques to discourage inefficiency and educate providers regarding correct utilization patterns and billing practices. MCP's use of RACs will encourage hospitals to put into place processes and practices that will result in billing practices that are more in line with established medical criteria and evidence based guidelines.

## Engaging Technology, Employees, Providers and Members to Limit, Identify, and Address Fraud and Abuse

Above and beyond the standard regulatory requirements, we engage technology, employees, providers, and members to limit, identify, and address fraud and abuse. We deploy innovative technologies:

- Specialized claim edit processes:
  - Pending claims for analyst or medical review for high profile members or providers. Proprietary enhancements to CCI, MUE and other editing by ClaimCheck®. ClaimCheck® provides alternate code replacements when one procedure code specifies a "single" procedure and there is a second procedure code for "multiple" procedures. For example, when the single procedure 44110 is submitted more than once with the same date of service, ClaimCheck® adds the multiple procedure 44111 and does not recommend separate reimbursement for procedure 44110. ClaimCheck® also provides an alternate code replacement when one procedure specifies "unilateral" and there is another procedure for "bilateral" performance of the same procedure. When the unilateral procedure 54860 is submitted more than once with the same date of service, ClaimCheck® adds the bilateral procedure 54861 for reimbursement. MCP ClaimCheck® savings for 2012 was $5,296,485.
  - iHealth editing that also brings proprietary enhancements for editing with special emphasis on drug and DME equipment. iHealth looks for appropriate or inappropriate infusion coding combinations, diagnoses that support specific treatment for infusions/chemotherapy, and appropriate DME billing across providers. iHealth also supports MCP to identify potential fraud, waste and abuse. For example, iHealth tracks all professional claims paid by MCP and provides data for providers that bill modifier 25 or 59 in excess and other claim information for excessive services. Reports are provided quarterly, and reviewed by the FWA Coordinator, Compliance Officer and SIU team to determine if additional data is need or if services should be audited. (MCP iHealth editing savings for 2012 was $852,467.
  - Verification of receipt of paid services audits. Targeted reviews of chart notes for claims submitted are performed based on the triggers above. Coordination between the Quality Management team and the SIU to pull medical records to determine if the services billed were performed by the provider for the member, and to support use of modifiers. This provides an opportunity to not only identify fraud, waste or abuse, but to also review for potential quality of care gaps within our provider network.
  - Corporate audit services' periodic and routine internal random audit reports. Independent review by the Corporate Audit department provides an external review of claims data against regulatory requirements, provider contracts, and standard billing practices. By conducting targeted audits of claims to look for specific billing problems and standard statistically valid audits of all claims, they also help to identify fraud, waste and abuse issues.
  - Policy Application Management (PAM). PAM is a McKesson product that integrates with ClaimCheck® and our processing system. The application supports custom editing by provider, by code, by diagnosis, by gender, by age

to apply maximum unit reductions or other editing. PAM will be implemented in 2013 by MCP to reduce the need for analyst review and will allow us to provide custom limitations based on trends or new information.

***We engage our employees:***

- Medical management, prior authorization, and utilization review oversight activities provide a first line of defense to limit fraud or abuse. Through these, services that have been identified as high-cost or at risk for fraud are reviewed and approved for medical necessity (examples include report codes, high cost DME and medications, duplication, overuse of service, and procedure up-coding or unbundling). Claims submitted for services that are flagged for medical review will not be paid without an authorization.
- Front line employee resources, including employees from Member Services, Case Management, Provider Services, Quality Management, and Prior Authorization provide education and redirection for appropriate billing and level of care.
- Member appeals that are denied reinforce system editing or medical review decisions and further limit or reduce ongoing inappropriate billing or member/provider behavior. Trends are shared with Provider Services to educate providers or Member Services to educate members and to avoid future appeals and claims denials.
- MCP employees are expected to comply with the provisions of our compliance program and complete initial and ongoing mandatory training sessions. We require that all staff, as a condition of employment, conduct themselves in a way that meets Federal and State standards, as well as the contractual requirements of the contract. Each employee is responsible for immediately reporting any suspected or known fraud and abuse violations to MCP's Compliance Officer, the FWA Coordinator, or another manager or supervisor within the organization.
- The compliance training program includes new employee training, additional departmental-specific training related to employees' assigned duties and unit functions, a mandatory annual refresher course for all employees, and ad hoc training as issues are identified. Upon completion of training, MCP employees acknowledge their understanding of training goals and adherence to our compliance program requirements. The Compliance Department maintains attendance and participation records in accordance with AHCCCS record retention standards. The MCP Compliance Officer confirms that MCP employees continuously receive updated, accurate, and timely compliance information. This includes providing both Medicare and Medicaid fraud and abuse information through policy and procedure updates, posting on the company intranet site, and through our internal email and electronic folder system. The Compliance Department provides an annual mandatory Business Conduct and Integrity training, issues frequent email blasts updating compliance fraud and abuse policies (seven email blasts during Q2 and Q3 of 2012), and provides fraud and abuse updates at the Audit and Compliance committee and other management level team meetings. In addition, the MCP Claims Educator proactively disseminates information to both claims and provider services staff regarding watched providers and fraud and abuse issues.
- Increasing the monitoring of appropriate Coordination of Benefits (COB) and Third Party Liability (TPL): MCP employees are empowered to identify potential COB opportunities through information received from: 1) AHCCCS, 2) Health Management Systems (HMS), 3) internal staff, including case managers, 4) members, 5) claims, and 6) Explanation of Benefits (EOB) reports. Once MCP verifies the member's Other Insurance (OI), we move to the secondary payer position and adjudicate the claim in accordance with our COB protocols. When a claim is received without an EOB attached and the member's eligibility record identifies OI, we deny the claim. MCP's internal training department provides training to all staff with exposure to claims and encounter in order to help identify and report COB and TPL opportunities. In 2012, MCP reported cost savings of $72,648,918 for COB savings in addition to more than $160 million reported for claim editing.

  **In 2012, MCP reported cost savings of:**

  **•$72,648,918**
  **for COB savings**

  **•More than $160 million**
  **for claim editing**

  – Intensive pre-payment auditing- MCP's Claims Audit Department conducts a series of pre-payment audits including: 1) a one percent random sample of system-adjudicated claims, 2) a two percent random sample of all analyst-adjudicated claims, and 3) 100 percent of all claims with billed charges over $50,000. When pre-payment errors are discovered during these audits, claims are pended for analysis and adjusted as required for final

adjudication. If our audit identifies a provider billing issue, the information is forwarded to Provider Services staff for provider outreach and education as necessary.

***We engage our providers and subcontractors in a way that supports appropriate care and that limits, identifies, and addresses fraud, waste and abuse:***

- The initiation of Patient Centered Medical Homes and Patient Centered Health Care Homes in 2012 for members receiving pain management services goes above and beyond to limit fraud, waste and abuse. This population has been identified through reporting to be higher utilizers of Emergency Department (ED) and specialist services. MCP provides reports to the PCPs for these members that show each member's services across all providers to allow the PCP to better manage the member's care and reduce the number of ED visits.
- Our Member Pharmacy Restriction Program limits the amount of prescription medication that a member can receive from multiple pharmacies. We then engage Interdisciplinary Teams, Case Management, and our providers to find member-centered solutions that limit abuse by members with these complex problems.
- The provider network is and will continue to be educated about fraud, waste and abuse through a variety of mechanisms. Upon contracting with MCP, the Provider Services representative schedules an orientation with the provider and their office staff to go over the fraud, waste and abuse reporting requirements. Education on fraud, waste and abuse is also delivered to the provider network through the Provider Manual and the MCP website. Each newly contracted provider receives a Provider Manual; any updates to this manual are disseminated to the network incorporating program changes. Examples of provider fraud are included, such as up-coding, billing for services not provided, and submitting false encounter data. The documentation will include identification of the source for reporting suspected cases through the use of the hotline and indicate the responsibility of the provider and office staff to report all cases of suspected fraud and abuse. Periodic articles will be produced in the quarterly provider newsletters to further communicate information on fraud and abuse.
- MCP's contracted Pharmacy Benefits Manager (PBM) requires screening all claims for potential Medicaid fraud and abuse. The PBM provides claim information requested by the SIU and other MCP representatives investigating potential instances of fraud, waste and abuse. The PBM provides regular reports to MCP about the PBM's independent activities to prevent fraud, waste and abuse. The PBM's fraud and abuse prevention program includes, at a minimum, measures to detect, prevent and correct instances of fraud, waste and abuse by members, participating pharmacies, pharmacists, prescribers and subcontractors and any affiliate of the PBM providing any portion of the services. The PBM also cooperates with MCP's SIU, including providing information requested by the FWA Coordinator and other representatives of MCP who are investigating potential instances of fraud, waste and abuse.

***We engage our members***

Under the direction of the Compliance Officer, MCP empowers members to recognize, prevent, and report suspected fraud, waste and abuse. Members are provided fraud, waste and abuse education, such as how to report fraud and abuse and how to use the SIU or MCP fraud hotlines to report alleged fraud, waste and abuse. This education also emphasizes the member' responsibility to report fraud, waste and abuse. We train providers, Case Managers, and Care Coordinators, as well as other personnel, to recognize potential fraud and abuse flags, such as services not provided or services provided but not medically necessary. These personnel have frequent, direct contact with members, and are the primary source for educating members and families/caregivers regarding the process for reporting potential fraud and abuse. We require members to report all potential cases to Member Services or by calling the SIU or MCP fraud hotlines.. We also give our members information regarding fraud and abuse through our Member Handbook. Periodic articles on fraud, waste and abuse prevention are also provided to members through quarterly member newsletters.

***Tying It All Together-Above and Beyond the Requirements***

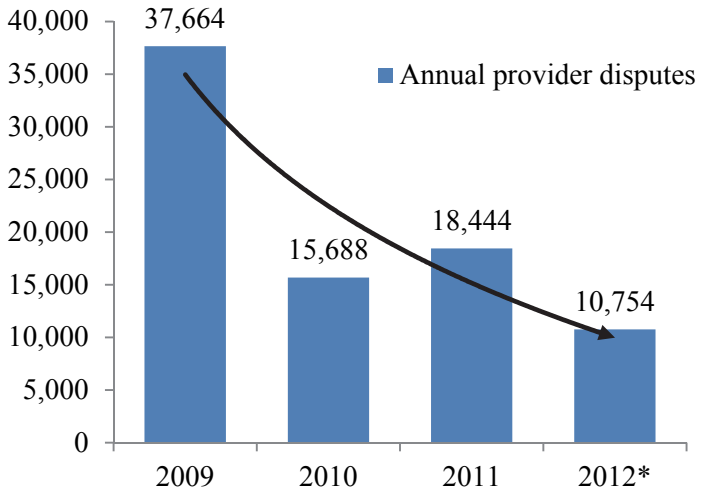
As seen in our Board-driven culture of compliance, the allocation of resources in the form of the full-time FWA Coordinator, our use of a large SIU, and our engaging and empowering everyone who has any opportunity to limit identify or address abuse, MCP has and will continue to go above and beyond to meet and exceed our responsibility to manage the State's healthcare resources.

**Q9: 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.**

As a provider-sponsored and locally managed health plan, Mercy Care Plan (MCP) understands the complexity of the claims adjudication process. Our claims adjudication and provider claims disputes strategy is to empower our staff to resolve claims disputes so the state fair hearing process can be avoided. Our objective for our claims adjudication process is to establish long-term partnerships with providers by optimizing claims adjudication activities, and as a result, increasing provider satisfaction while reducing their claims disputes and state fair hearings.

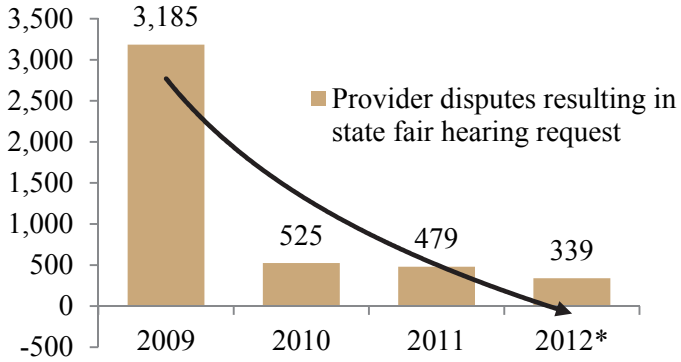
Our claims adjudication system eliminates wasteful and excessive administration enabling providers to focus more of their energy on the delivery of care. These improvements are supported by our claims adjudication and dispute policies, the effectiveness of our structured workflows, and the strength of our technology infrastructure. We also advocate direct and frequent communication with providers in order to quickly identify and effectively resolve claims administration issues. Our compliance with state and federal statutes and regulations, along with our transparent approach to sharing our administrative policies and procedures, helps providers understand our claims adjudication procedures and dispute resolution requirements.

**Table 1: MCP success in reducing provider disputes**




*As of 10/2012

**Table 2:**
**MCP Success in Reducing State Fair Hearing Requests**




*As of 10/2012

## Mercy Care Plan continues to significantly reduce the number of provider disputes and state fair hearing requests

In 2009, MCP established a continuous process improvement initiative to identify and address the critical factors that result in provider claims disputes and state fair hearings. As of October 2012, of all MCP claims processed (n ~ 4.9m), only 0.2 percent resulted in a claims dispute, and only 0.01 percent of these same processed claims resulted in a provider state fair hearing request. This ongoing collaborative effort, which includes the AHCCCS administrative team and local providers, has produced positive results for:

- Reducing the number of new provider disputes (Table 1)
- Reducing the backlog of existing provider disputes
- Decreasing the frequency of state fair hearings originating from MCP contracted providers (Table 2)
- Positively impacting the proportion of auto-adjudicated claims processed by MCP

**As of October 2012, MCP has seen a 71% reduction in the annual number of provider disputes, and an 89% decrease in provider state fair hearing requests since this continuous process improvement initiative began in 2009.**

## Reducing Claims Disputes through Continuous Process Improvements

### *Executive engagement and interdepartmental problem solving*

MCP's Executive Council includes the executive leadership representatives from all MCP departments. This Council meets regularly to discuss business strategy and prepare action plans designed to improve organizational performance. Executive Council members take responsibility for a number of interdepartmental work groups, which are charged with identifying, resolving, and implementing administrative improvements associated with the plan's business operations. These cross-functional work groups include key personnel from various departments, such as Provider Services, Contracting, Claims, Appeals, Operations, Member Services, Medical Management, Quality Management, Finance, and Information Technology. Members of the Executive Council participate on each of these work groups so that we can make sure that operational changes and related messaging are consistently communicated and are transparent across all levels of the organization. Each of the groups described below report to our Vice President of Operations, who then reports to MCP's Executive Council. Some of the work groups addressing claims adjudication topics include:

- MCP's Claims Operations Work Group is led by our Director of Health Plan Operations and includes representatives from our Fraud, Waste and Abuse team, Claims Inquiry/Claims Research (CI/CR) team, Claims Education team, Member Services department, Provider Services department, and our Medical Management department. This work group's purpose is to proactively identify potential claims adjudication issues before they become problems for providers. They work group develop potential solutions to these issues and are empowered to implement the identified solutions. Topics such as contract implementation, claims payment, claims editing, audit findings, claims projects, system configurations, and provider data collection procedures are reviewed and, where necessary, solutions are developed, tested, and implemented.
- MCP's Provider Claims Appeals and Disputes Work Group is led by our Appeals Manager and includes representatives from Health Plan Operations, Provider Services, Member Services, Medical Management, Fraud, Waste and Abuse, CI/CR, and Prior Authorization. This work group meets weekly to review provider claims disputes, including trended data, which often involve denials of service and/or coverage determinations. This work group researches claims issues down to the root cause, which may be include incorrect provider claim submission, a provider add/load issue, or system set up issue where the claim was not set to pay according to the provider's contract. This work group also identifies and makes recommendations to resolve the identified factors that are causing the claims disputes.
- MCP's Joint Operating Committees (JOC) meetings. MCP's Provider Services team along with executive leaders, regularly initiate external meetings with hospitals, Federally Qualified Health Centers, skilled nursing facilities, and ancillary providers to communicate information, gather feedback, and resolve claims adjudication issues. The results of these meetings are shared with internal work groups, who are then charged with investigating, testing, and resolving claims adjudication issues.

As an example of this process, after receiving a notification from our largest DME provider concerning claims denials for diapers, our Claims Operations Work Group investigated the issue. Through a review of claims and the system configuration, the group identified the root cause: the provider's billing practices were causing their claims to hit the monthly unit limit. The provider was billing overlapping dates of service, causing excessive denials for these services. The Work Group made recommendations that were communicated by the provider services representative in a monthly billing workgroup with the provider. Corrected claims were submitted by the provider to clear their outstanding A/R, and we recommended changes to future billing practices to avoid these denials in the future. To avoid future occurrences on our end, we developed monitoring reports to identify similar issues on a global scale for these provider types.

As a result of these activities, our claims turnaround time for calendar year 2012 was 98 percent in 30 days, 99.5 percent in 60 days. Our 4th Quarter 2012 internal accuracy rate was 99.17 percent payment accuracy and 99.13 percent financial accuracy. All of this reduces the potential of a claims dispute and demonstrates the efficiency and accuracy of our approach.

### *Data Monitoring Strategies*

MCP utilizes a suite of tools including, but not limited to, scheduled and ad hoc reports to monitor claim activities and identify trends. Based on this analysis, health plan operations take appropriate action to address any trends that indicate a potential issue such as inappropriately adjudicated claims (overpayment or denials). It is our standard operating

procedure to immediately determine a root cause and develop and implement the appropriate action plan. These tools and reports include:

- Pended Claims and Aging Report – the Pended and Aging Claim Report is used by management, when and where necessary, to intervene to improve accurate and timely adjudication of claims. Populated hourly and reviewed daily, the tool presents claims counts and billed dollars by pend reason and claim age, with drill-down capabilities to gather data for reviewing detailed claims information.
- In-Process Claim Reports – MCP's Claims and Health Plan Operations Department reviews and monitors the in-process claims report on a daily basis to allow management to track and manage all claims in process. As a result, any needed interventions may be applied to improve the accuracy and timeliness of claims adjudication.
- Claims Payment Processing Reports – This is a set of retrospective claims adjudication reports that are produced and reviewed weekly to provide Claims, Health Plan Operations, and Finance personnel with data to support reconciliation of claim volume and adjudicated dollars including information to support the reinsurance process.
- Monthly Claims Dashboard –This management tool submitted to AHCCCS is used to identify trends related to critical claims metrics. The claims dashboard is reviewed monthly by Compliance, Encounters, Health Plan Operations, and Finance personnel to identify appropriate action plans.

***Continuous Process Improvement by Engaging and Educating Providers***

Our experience shows that engaging and educating providers about effective and efficient billing practices reduces the potential of a claims dispute. Engaging providers means actively listening to their concerns and learning from their experiences. MCP has and will continue to dedicate extensive resources to proactively identify and resolve potential business processes that may negatively impact the claims adjudication process and related provider disputes.

Claims Educator – MCP is also committed to training staff as well as providers about the claims process as well as how to identify claim processing irregularities that might negatively impact the claim process for providers. MCP employs a full time claims educator, who is a certified coder. This individual is responsible for educating staff and providers about MCP's grievance process, claims processing and provider services systems with a goal of helping stakeholders to effectively apply the claims administration process. They are also responsible for compiling, analyzing, and disseminating information learned from provider calls, identifying trends and developing strategies to reduce claims disputes, and holding regular meetings with providers and internal staff to facilitate effective communications.

**Obstetrix/Pediatrix Medical Group and Neonatal Specialists has three practices throughout Arizona, as well as numerous providers located in several hospitals throughout the valley. There are three tax identification numbers for these three practices.**

**This complex provider record setup has resulted in open issues from time to time. Mercy Care recognized the need for changes and was very responsive and collaborative in working with us to develop efficient solutions to resolving these issues. Mercy Care's implementation of their Joint Operating Committee was another effective approach to enhanced communication and operations.**

**It is clear to us, by the level of attention directed at our issues and concerns, that Mercy Care is committed to provider satisfaction. We commend them on their process and system improvements and value our working relationship.**

- Bonnie Durazo
Regional Manager – Patient Accounts

Provider Services Representatives – MCP's Provider Services Representatives (PSRs) are locally based and provide in-office information and education to improve our providers' understanding of industry standard and best practice approaches to billing. PSRs are dedicated to supporting providers through the prompt receipt and resolution of issues, inquiries, and requests for information including prior authorization, provider grievances and disputes, specialist availability, and community-based resources. We also pride ourselves on our ability to personalize our interactions with providers. PSRs are trained to access and review detailed claim history beyond the standard explanation of benefits so that they can help providers understand how a particular claim was processed. PSRs work with providers to support their understanding of the billing process and, as appropriate, assist them in identifying opportunities to improve future claims transactions.

Provider Communication Resources – MCP uses multiple vehicles for communicating with our providers. In addition to the important role of PSRs in training providers, we also use: 1) a toll-free number (1-800-624-3879) for our Claims Inquiry/Claims Research Line (CI/CR); 2) the MercyOneSource portal; 3) the MCP website; 4) our provider handbook; 5) provider newsletters; 6) provider forums or open houses; 7) targeted messaging on remittance advice; and 8) Instructor Led Training events. The purpose of our provider communication activities is to provide an efficient two-way communication between MCP and our providers. Through these communication tools we are able to assist with claim-specific issue resolution and to improve providers' understanding of the claims submission process. For instance, MercyOneSource is designed to foster open communication with our providers. Through MercyOneSource, providers are able to complete various functions, such as member eligibility verification, panel roster review, access a searchable provider list, and run claim status, remittance advice, or authorizations searches. The goal of these communication efforts is to educate providers about potential issues that may affect the claims adjudication process and so prevent delays in claims processing and provider payment.

Local Provider Resources – Local provider services staff, including our Provider Services Director, Provider Services Managers, and PSRs, are available to assist providers in resolving problems, respond to provider inquiries and complaints, and to educate providers. In addition, the Claims Administration Department has full-time, Phoenix-based CI/CR representatives to respond to provider questions, status inquiries, and claims payment issues via our claims-inquiry line.

A record of any provider inquiry, request, or complaint is maintained within our claims administration system's call tracking module. All reported issues are researched, resolved, or responded to within ten (10) business days, with response timeliness and resolution monitored by way of call management tracking reports. Whenever possible, reported issues are resolved immediately. Issues requiring in-depth research and resolution are submitted to the Health Plan Operations Department. Provider services personnel also respond to inquiries and requests for a claims review that are received through email, fax transmission, or mail. Lastly, network providers can access detailed information via MercyOneSource, our secure HIPAA compliant web portal.

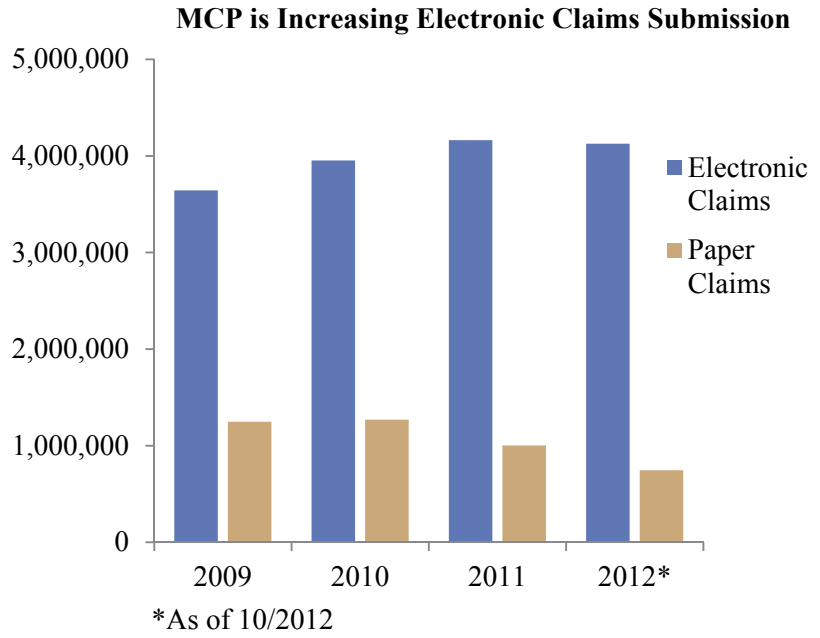
## Future Strategies

MCP has developed strong processes to identify, analyze, and correct the issues that cause provider disputes. This root cause analysis leads to proactive identification of process improvement and technology innovations that minimize the need for providers to utilize the claims dispute process. We are continuing to look for innovations using data sharing and technology to further improve our providers' experience.

### *Technology-based innovations*

MCP is building more streamlined technology applications that will reduce the claims administration burden on providers. Our data sharing applications, electronic health record technology and our claims management solutions will all increase the accuracy and efficiency of the claims adjudication process.

As we work with providers to increase their adoption of our Electronic Data Interchange (EDI) technology, we will see both the claim accuracy rate increase and see a reduction in the number of disputes and state fair hearing requests. MCP's technology platform and applications, such as iNexx (see below), will increase provider connectivity and alignment with provider electronic medical records, which simplifies the claim submission process and increases the accuracy of submitted claims.



MCP offers our providers a free technology tool called iNexx. It is an application that integrates with a provider's electronic medical record program to form a secure communication grid for sharing clinical data and related tasks online. iNexx establishes a unique, ad-hoc health information exchange specific to each individual provider and the data that is needed to be exchanged in order to provide a greater continuity of care.

***Business Process-based Strategies***

Our experience demonstrates that working directly with providers is the most effective way to identify and resolve potential claims adjudication issues. We will continue to invest in processes to validate data integrity and the accuracy of our claims system, including claims auditing. Our system for analyzing and identifying trends in claims adjudication, provider billing errors, clearing house transaction issues, and system configuration is key to our continually reducing provider claims disputes. The outcome of our analysis will be shared with providers and, in turn, provider input will help in perfecting our strategies and approaches.

MCP actively facilitates and supports providers in the successful completion of their revenue cycle. To this end, we are committed to helping providers reduce the claims adjudication and related administrative burden associated with delivering high quality care. We are also committed to increasing our data-sharing capabilities and our data and administrative transparency to the provider community as a way of helping providers navigate the claims adjudication process. Finally, we will continue to reach out to the provider community in order to identify ways to jointly improve the claims adjudication process, and to educate providers on how they can leverage our system to improve their business and clinical operations.

**Q10: 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:**

- Mercy Care Plan acknowledges that its participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No.10.
- Mercy Care Plan acknowledges that it will comply with the stated guidelines and calendar for this process.
- Mercy Care Plan acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal.

Mercy Care Plan

# CRS Narrative Submissions

Mercy Care Plan

# Access to Care/Network

**Q11: Describe the steps that the Offeror will take to ensure that individuals with a qualifying CRS condition under R9-22 1301 et seq. are able to access the care needed, including specialty care, to serve their qualifying medical condition(s) as well as their other medical and behavioral health needs. Also describe how the Offeror will leverage and balance the use of providers in the multi-specialty interdisciplinary clinics (MSICs) versus those in the broader community.**

Mercy Care Plan (MCP) is committed to ensuring that each individual with a qualifying CRS condition has access to the care they need. Our approach is to design, implement, and support a high quality provider network in a manner that is, first and foremost, responsive to the recommendations from stakeholders as articulated in the St. Luke's Health Initiative *Integrated Healthcare System for Children with Children's Rehabilitative Services (CRS) Eligible Conditions* report..The steps we will take are designed to maintain continuity of care and to work with all stakeholders, including MSICs and community-based providers, in order to achieve "win-win" improvements in the CRS system of care.

MCP has the experience necessary to successfully develop and support a network that is responsive to our members' complex needs and is based on the input of a wide variety of stakeholders, including those in the provider community. MCP has significant experience in providing care to children with special needs. Our network supports medical services to approximately 25 percent of the currently enrolled CRS membership and we have gained an understanding of their by managing their acute care benefits and in coordinating their care with the CRS system.

Our network currently supports over 9,000 Developmentally Disabled (DD) children and adults, many of whom have or have had CRS-qualifying conditions. MCP also has a large and successful ALTCS program and experience in managing dual eligibles. While fewer members in these last two groups have CRS-qualifying conditions, through our work we have gained experience in building and supporting networks capable of supporting members with complex medical and behavioral conditions. MCP also has experience in developing systems and protocols to obtain services through specialty providers outside of our network, including out-of-state specialists, for those times when such services are needed by a member. Finally, MCP is backed by the national expertise of our administrative subcontractor, Schaller Anderson, LLC (Schaller Anderson), an Aetna company, which manages health plans serving children with special needs.

MCP's Senior leaders have met with stakeholders from the CRS system, including all MSIC settings. From their input, we developed a strategy that is built on the need to support a smooth member transition process when MCP is awarded the CRS contract, the member's/member's family's choice of provider, and both MSICs and community-based providers in a way that optimizes their own ability to deliver effective specialty care. The goal is to create "win-win" situations with minimum disruption. To prepare our network to be ready to meet the requirements of this RFP, MCP developed the following steps.

## MCP's Steps to Implement the CRS Contract Beginning October 2013

**Step 1: Ensure Alignment with AHCCCS.** Upon contract award, MCP's first step in the implementation of our CRS strategy will be to meet with AHCCCS leadership. We anticipate that this discussion would include a review and approval of our preliminary network development plan and our strategy to partner with MSICs and other community providers as needed to accomplish AHCCCS' goal of increased access to care and the promotion of member choice.

**Step 2: Implement MCP's Ombudsman/Client Advocate Program.** Upon contract award, we will implement MCP's Ombudsman/Client Advocate program. MCP recognizes the importance of the Ombudsman/Client Advocate (O/CA) in achieving the transformation of the CRS system as laid out in the RFP. To go beyond the requirements in the RFP, we will create the Office of the Ombudsman (OOO) to support the functions of the O/CA and to help form, implement, and modify, as necessary, our strategic plan for serving CRS members and for involving stakeholders in every facet of the CRS program. A position will be filled at a senior management (director) level and will report directly to the Chief Executive Officer (CEO). Through the CEO, the Director (DO/CA) of the OOO will serve as the member's and stakeholders' voice to our Board of Directors. To capture the voice of members and their unique challenges, and to involve stakeholders from all CRS regions, we will embed one O/CA in each of the MSIC regions. This will enable the O/CA to understand and appreciate the uniqueness of the culture and the healthcare delivery system in that region. Through our experience we have learned that healthcare is best provided locally, especially for children and families with complex medical needs. This is why a regional approach is necessary in order to bring about a meaningful and sustainable transformation of the CRS system.

**Step 3: Establish Joint Operating Committees (JOC) with the MSICs.** Following the review and approval of our network development plan and strategy, MCP will build on our established relationships with each of the MSICs to implement monthly, or more frequent, Joint Operating Committee meetings. The purpose of JOCs will be to continuously integrate MSIC feedback about how we can work together to better manage and respond to the needs of CRS members. We will seek their input and adapt our system of care coordination to meet the needs of members in all four Coverage Types. Topics of discussion will include: 1) a review of accessibility standards and current status, 2) potential barriers to access and methods to mitigate them, 3) processes to maintain a full and high quality cadre of specialty providers willing and able to support the MSICs, 4) methods to supplement accessibility to care by inclusion of additional community-based providers, and 5) collaboration to assist the MSICs in their pursuit of high quality and sustainable programs.

**Step 4: Expand Relationships with Non-MSIC providers in all Regions.** The purpose of expanding these relationships will be to support access to specialists, reduce excessive waiting times for appointments, and support members and their families who choose to receive their care outside of MSIC environments. We will use our ability to establish positive relationships in the provider community to expand access and enhance continuity of care for CRS members in all regions. MCP has effective relationships and contracts with key providers including hospitals, physicians groups, clinics, and individual primary care and specialty providers throughout the GSAs (Maricopa and Pima) that service the two largest MSICs. MCP is building on this experience to establish positive relations with hospitals and providers in the two other MSIC regions (Flagstaff and Yuma). We already have some contracts and numerous Letters of Intent (LOIs) with hospitals and providers in those GSAs.

**Step 5: Enhance Primary Care and Non-CRS Specialty Services for CRS Members.** MCP recognizes that the CRS contractor must, depending on Coverage Type, provide the full range of acute care services, including EPSDT, to CRS members. We will secure agreements with local hospitals, local providers, and ancillary providers in all regions. These efforts will be designed to provide access to all covered services to the member within their Coverage Type. One way MCP will expand healthcare access for CRS members with other medical needs is by offering access to new health homes in addition to the health homes currently operating. For example, in the first quarter of 2013, MCP and the Alliance of Community Health Centers will launch two pilot programs, with both pilots strengthening the health home capabilities for physical, and incidentally, behavioral health services. As input from stakeholders is received, MCP will extend the health home agreement to other providers. Also with this agreement, we will implement a full range of new technology to support the Centers with integrated clinical, utilization, and financial reporting capabilities.

We recognized a need to further augment care for pediatric members and developed a relationship with NextCare Urgent Care facilities to create three pediatric-focused urgent care facilities called Tender Latenight Care (TLC) Pediatrics. The centers are staffed by Board-Certified pediatricians and supported by experienced pediatric midlevel providers. TLC allows members to make an appointment by phone or online and contacts the responsible party when the appointment time is 30 minutes away. The centers provide an additional convenient option for after-hours care for our members in selected geographic regions. To facilitate continuity of care, providers at TLC share information about MCP member visits with the member's assigned PCP.

**Step 6: Ensure Access to Behavioral Health Services.** MCP recognizes that the CRS contractor must, depending on Coverage Type and member choice, also provide Behavioral Health and substance abuse services to CRS members. MCP will establish a network of behavioral health providers. We will do this by building on the foundation of our ALTCS and Medicare Advantage networks with additional local facilities and agencies and their affiliated providers and community-based mental health agencies. Our network development protocols will be designed to include geographically accessible behavioral health providers, including licensed psychiatrists (child and adult), psychologists, substance abuse programs, and graduate level therapists with services needed to support members and their families.

**Step 7: Implement MCP's Data Sharing Strategy.** MCP has designed a data sharing strategy capable of ensuring that all providers in the CRS system have access to the data they need to coordinate care**.** Upon award**,** MCP will take the steps necessary to implement this strategy. We will work with all MSICs, and with all interested community providers to better understand their current capabilities and capacities to share data. We will assist them in identifying solutions to data sharing including implementing iNexx, our free HIE platform solution that makes it possible to share clinical information and data securely regardless of use of paper or electronic records or without regard to the type of electronic medical record system that is used.

**Step 8 Create and Implement a Transition Plan for Members Transitioning into MCP on October 1, 2013.** Because implementation of the requirements in this RFP will require some AHCCCS members with CRS-qualifying conditions who are not in MCP to change health plans, we will collaborate with AHCCCS and all other Acute care contractors to develop an extensive transition plan. The goal of the transition plan will be to facilitate transitions with as little disruption as possible. MCP has experience in accepting members from other contractors. From this experience, we have developed protocols for managing such events. Our protocols include establishing a Transition Coordinator to act as a single point of contact for all stakeholders during the transition process. One highlight from our protocols for transitions is that if a transitioning-in member's provider is not in the MCP network, we provide a 180-day period in which the member can continue to receive services from their current providers. During this period, MCP will pursue Letters of Agreement and/or contracts with these providers to maintain care continuity and ultimately expand the network when possible. In the event that a CRS eligible member's family, and/or caregiver, wants the member to remain with a provider that will not participate in our network, we will develop a single case agreement (SCA) using an agreement form approved by AHCCCS. We will follow AHCCCS' policy regarding the use of non-participating providers and continue to work with these providers to reach an agreement to participate in MCP's network.

**Step 9: Create Systems to More Effectively Coordinate Care Across the Continuum.** To meet the requirements of this RFP, it will be necessary to implement a care coordination program designed specifically to meet the needs of CRS members. Coordination of care across the four Coverage Types will require working not just within a network, but across various healthcare delivery systems. MCP will use its experience, protocols, and processes (which are designed to manage members with complex conditions) to adapt our case management system to the CRS system requirements in a way that effectively bridges the two into a single functional delivery system.

Key to our approach is to assure that the Case Manager will incorporate the member's Coverage Type in formulating the service plan and ensuring the plan is responsive to inputs from all stakeholders. We will be actively involved in and will oversee the member's care coordination regardless of Coverage Type. MCP will coordinate care with stakeholders in other systems including but not limited to (by Coverage Type):

1. CRS fully integrated: coordinate with the member's providers
2. CRS Partially-Integrated-Acute: coordinate with the TRBHA
3. Partially Integrated–BH: coordinate acute care with CMDP provider, DDD, and DDD's subcontracted acute providers
4. CRS only: coordinate with CMDP, DDD, DDD's subcontracted acute plans, TRBHAs, ALTCS EPD Plans, physical and behavioral health providers in IHS and tribally operated programs, and AHCCCS' AIHP leadership.

We will establish formal relationships and processes for each of these stakeholders.

**Step 10: Educate Members about Availability of Services and Access to Care.** We will educate members about their benefits and offer a variety of options for them to gain additional information and/or to access care (including transportation). MCP educates all members using our standard member communication protocols. These protocols include: 1) Website, 2) Member Handbook, 3) Member Newsletters, 4) Case Manager, 5) Care Plan, 6) Member Call Center, and 7) UM/PA (Notice of Action letter). In addition to these, we will educate members about the availability and accessibility of services at MSICs, PCPs, and community-based specialists. MCP also has other providers who can support CRS members with information and services. The MCP Nurse Line assists CRS members and family/caregivers in obtaining general information about their health (e.g., "What to do if my child has a fever?"). MCP places a requirement in PCP contracts to maintain after-hours telephonic access to assist and provide guidance regarding obtaining urgent or emergent care. Also, we offer financial incentives to practices that offer extended hours.

**Step 11: Provide Training to all Providers.** All Providers, including Providers with an SCA, will receive training regarding our quality management, fraud and abuse, prior authorization (PA), care for CRS members (including case management processes, communication, transitions into and out of CRS), and other critical functions. Provider training also includes information about cultural competency and standards for appointment availability and accessibility. MCP educates all providers using our standard provider communication protocols. These protocols include: 1) Provider Web Portal, 2) Provider Manual, 3) Provider Newsletters, 4) Provider Service Representatives, 5) Care Plan, 6) Provider Service Center, and 7) UM/PA approvals/denials.

**Step 12: Reduce Racial and Ethnic Barriers to Care.** We recognize that cultural competency in our personnel and in our provider network plays a pivotal role in our efforts to increase access to care. Our standard protocols to improve cultural competency in our programs and network include: 1) Recruiting and identifying providers who speak a language other than English in our printed and online provider directory, 2) As part of our efforts to increase accessibility and reduce barriers to care, MCP employs Bilingual Case Managers and member services call center representatives to assist Spanish speaking members, 3) We offer real time interpretation and translation services in 170 languages at no cost to members and providers, 4) MCP trains network providers on issues of cultural competency and reducing disparities in care by addressing potential health literacy issues. We will continue to apply this training throughout the state to be prepared for cultural considerations we anticipate encountering in the CRS population. 5) MCP collects information on members' language capabilities at the time of enrollment and we will continue to collect this information for CRS members, families and caregivers, so that we can anticipate and proactively resolve any language barriers, 6) We include all stakeholder groups and health delivery systems, even those beyond our network and engage them in our cultural competency efforts, and 7) All MCP staff participate in mandatory annual cultural competency training designed to increase our staff skills and competencies regarding the reduction of racial and ethnic barriers to care. MCP integrated AHCCCS' Cultural Competency Plan Requirements of the CRS contractor, and applies Culturally and Linguistically Appropriate Standards (CLAS) into MCP's cultural competency plan.

## Leveraging and Balancing MSIC Providers and Community Providers

In the above steps, we have described our approach to assuring access to services for CRS members. Our approach can be summarized as a member-centric approach that allows each member access to a network of providers of all types at an MSIC or non-MSIC location based on the member's/member's family's choice.

We will support the choice of the CRS member to see a specialist at the MISC with the option of being treated by a pediatric specialist in the community. The benefit of member choice is that the community provider may have convenient hours and may be located close to the member's home. We will collaborate closely with providers in all GSAs to continuously expand available services and programs and equally support MSICs in their pursuit of high quality and sustainable programs.

As we developed our approach, we took into consideration the input and ideas from all MSICs about the issues and problems that they faced in the current system as well as concerns they identified from proposed changes to the system. We also discussed these concerns with providers who work in community-based settings to get their input. Through this input, as well as through study of the recommendations from the St. Luke's Health Initiative *Integrated Healthcare System for Children with Children's Rehabilitative Services (CRS) Eligible Conditions* report, we have developed an understanding of the need to balance the benefits of the MSIC setting and leverage the availability of community providers to increase access to care for CRS members.

We are confident, based on our discussions with providers, that with our support for effective and coordinated MSIC management, specialist providers will continue to support their members who prefer to be seen in MSIC settings. Furthermore, we have had discussions with specialists who are interested providing services at MSICs and we would be able to facilitate with their recruitment. With adequate administrative and care coordination support, the member's care will be equivalent regardless of location.

Our approach to supporting MSICs will be to leverage our resources to not only implement sound business support of CRS-related specialty services, but to help MSICs expand their scope of services and thereby increase the diversity of their revenue and improve their overall financial viability.

For example, MCP will contract with all MSICs for all lines of business which will support the MSICs in treating more than just CRS members. MCP will work with MSICs to implement our PCMH™/Health Home models. Our health home models provide additional support for practices and align payment in a way that supports delivery of high quality services. Our analysis shows that the approaches we have just described will be particularly helpful in supporting MSICs in Phoenix and Tucson.

In the more rural regions, we will also support MSIC clinics and the hospitals that sponsor them by leveraging MSIC resources to support their capacity to offer broader regional specialty provider clinics capable of serving members from multiple payers. Our support for these MSIC clinics and the hospitals that support them will provide them the opportunity to increase services for the communities they serve and to help build sustainable revenue models.

MCP has designed our approach to not only meet the medical, specialty, and behavioral health needs of these special children, but also to support the member's/member's family's choice of provider. At the same time, we have designed our approach to support the sustainability of the MSICs and participation in the CRS System by community-based specialists.

Mercy Care Plan

# Program

**Q12: A 13-year old foster child diagnosed with Spina Bifida, Intermittent Explosive Disorder, history of poly-substance abuse, and PTSD resulting from sexual abuse, is enrolled in CRS. Describe the comprehensive treatment plan developed for all diagnoses to address the complex care needs of the child.**

Mercy Care Plan (MCP) has experience working with children with multiple medical, behavioral, and other bio-psycho-social issues. We understand the unique requirements of assisting children that have multi-agency and multi-system involvement. We understand CRS and the importance of care coordination among the member, parents, providers, foster parents, agencies and other funding sources to so that the best outcomes for members occur. We excel at working with agencies and providers to provide members the care they need.

In this particular scenario, this member is in CRS coverage type 3 (Partially-Integrated–Behavioral Health). Therefore, MCP is responsible for providing CRS services and Behavioral Health (BH) care. CMDP is responsible for providing acute care services, including EPSDT screening/services, because this member is a foster child. The priority for case management is that the member is seen by an appropriate BH provider(s) within 72 hours after notification from CPS that this member has been or is in the process of being removed from their home.

**Case Management**

Since this member has a qualifying CRS condition and is receiving acute care services from CMDP, this member will be placed in our Integrated Care Management (ICM) program at an intensive level of case management. ICM is for members who need individualized, relationship-based care management in order to positively impact their health status. Our case management program is based on the individual member's needs and provides an individualized, holisticmember-centered, bio-psycho-social model of care that includes care coordination, specific disease management interventions based upon disease-specific clinical guidelines, implemented in a systematic manner with an emphasis on maximizing the member's ability to achieve self-management and engage in health education.

This member will be case managed by an experienced, licensed, clinical professional. The CM will have the primary role of facilitating care coordination across all providers and agencies serving this member, including primary care, BH (including substance abuse), and other specialty care providers (CRS). CM's have expertise in and training on how the state agencies and systems work together and interact, thus being able to help members, families, and at times providers navigate the systems. CM's also have training in cultural competency to help them respond to the needs of members and their support system.

For this member, the CM will complete a comprehensive, holistic assessment that reviews the member's strengths, barriers, cultural preferences, goals, and addresses the full range of bio-psycho-social issues impacting the member's health and overall wellbeing. All MCPs CMs are trained in skills of motivational interviewing to help engage members in the identification of underlying issues driving any roadblocks to their recovery. This member's CM will apply our member-centric case management approach to create a comprehensive Integrated Care Plan (ICP) after completing the CM assessment, incorporating the member's existing medical and behavioral treatment plan(s), reviewing medical and behavioral records, as well as clinical practice guidelines. The development of the ICP will be completed in collaboration with the member, foster care providercare provider, CMDP, CPS and all medical/BH care providers. The member's ICP includes a review of strengths, preferences, needs, goals, cultural preferences and any identified barriers to treatment from the CM's assessment of the member. The CM will also perform an appraisal of the member's and foster care provider's health literacy level, so that education is provided in the most understandable format possible, tailored to the member's age group, and includes cultural considerations that could play a role in the member's overall wellbeing. The ICP incorporates medical and behavioral treatment plans with the case management plan and will meet all CRS service plan requirements. The ICP will be maintained with the member's providers (treatment plan) and CMDP.

To integrate and coordinate the member's care, the CM will:

1. Develop an ICP with input from the member, foster care provider, providers, CMDP and other stakeholders. The ICP will be shared with the member, foster care provider , medical and behavioral health providers, CPS, CMDP and any other entities involved in the member's care. The member's biological family will be included in the development and implementation of the ICP if authorized by CPS. MCP provides oversight of this process through monthly reviews of the CM records.

2. Educate the member, foster care provider and biological family (if appropriate) regarding the ICP, and monitor progress frequently throughout the course of the CM relationship. The CM updates the ICP as progress is made, modifies the ICP when there are changes that require modification of issues, interventions or goals based upon analysis of outcomes or changes in the member's condition, and sends the updated version to the member's care providers and all other stakeholders.

CM interventions:

1. Educate foster care provider on crisis prevention approaches, as well as available crisis services, if the member needs access to such services. Provide information to the foster care provider on how and when to contact the 24-hour behavioral health crisis line or after hours nurse line.
2. Discuss preferences in providers (male/female, location and ability to address specific cultural needs) with the member and foster care provider. Make referrals to appropriate services and providers, working in close collaboration with CMDP and the member's current providers. Complete a transition form with current information on the member's providers, specialized needs as outlined in the AHCCCS Electronic Transiton Information form, including the member's acute care providers while in the integrated program under MCP. Work with CMDP to find medical, dental and/or Patient Centered Health Homes (PCHHs) that include integrated behavioral health services for continuity of care. If the member transitions to a PCP under CMDP, facilitate the submission of medical records to the new PCP.
3. Educate foster care provider and biological family (as permitted) on CRS program and guidelines, how and where to locate CRS providers and services and the process for prior authorization if needed. Provide the CRS member handbook and educate about MCP CRS website.
4. Assess foster home/group home environment for any identified needs for assistive devices and coordinate with CMDP any identified needs for Occupational Therapy/Physical Therapy.
5. Facilitate as needed, the exchange and use of information between the member's providers. (All information will be shared in accordance with State and Federal regulations.)
6. Attend CRS and BH appointments with member and foster care provider as needed.
7. Coordinate with CPS to identify any current BH services being provided by CPS to avoid duplication of services. If a BH provider is currently seeing the member, the CM will work with the current BH provider to authorize services if out of network for continuity of care, refer to provider services to facilitate letter of agreement, provisional credentialing and potential contract with provider. In addition, the CM will assist with obtaining any medical records that CPS/CMDP requests. Communicate with CPS casework as the legal guardian and meet all state requirements.
8. Provide ongoing assessment of any gaps in the care being provided. If member is not in a PCHH, where BH and physical health are integrated, discuss with CMDP the possibility of referring to a health home as an alternative to resolving any gaps in care.Consider this option if member is transitioning from CMDP back to MCP.
9. Review member's needs during Interdisciplinary Team (IDT) meeting to provide additional input and direction to assist the care team's work. The participants of the IDT include a MCP Medical Director, psychiatrist, pharmacist, behavioral health coordinator, and CM. In addition, the member's foster care provider, other providers,CMDP care coordinator and other stakeholders will be invited.
10. In the event of an inpatient stay, work with internal and external partners so that appropriate follow-up care is provided to avoid unnecessary readmissions or emergency department visits. During the inpatient stay under CRS or BH, the CM will work with inpatient staff to anticipate and begin arranging for discharge needs. If the admission is acute, the CM will work with the CMDP concurrent review staff to assist in discharge planning and any needed CRS/ BH needs. The CM will follow up on all services ordered to see that they are in place for CRS and BH services and that all medications have been reconciled with pre-hospital prescriptions. The CM will coordinate these efforts with CMDP to facilitate communication , prevent dangerous drug interactions and monitor for gaps in medication refills.
11. Review if an Individual Education Plan (IEP) or 504 accommodation is in place. If so, the CM will coordinate with the school about following requirements set forth in AMPM regarding Medicaid School Based Claiming. If no IEP or 504 accomodation is in place, the CM will coordinate with the foster care provider and school to have school

evaluation completed for possible need for special education services. The CM coordinates with the school regarding providing services in the IEP.

12. Assess if the member needs transportation services. The CM will assist as needed in arranging these services.
13. MCP EPSDT information will be included in the transition to CMDP, CM will coordinate with CMDP if new BH needs are identified via the EPSDT screening form. In this case, the member will be enrolled long term in BH services and the CM will report back to CMDP regarding the member's appointments and follow-up. In addition, the PCP and CMDP will be informed of action taken on a Prior Authorization (PA) request and provide assistance to help the member get needed services through the appropriate means.
14. If applicable, provide resources to the foster care provider and biological family (if appropriate) to support groups and/or referral to family run organizations (e.g., MIKID or Family Involvement Center). The CM will followup on any support groups or family run organizations provided.
15. The CM will plan for all transitions such as a new living situation, changing service providers, and changing healthcare coverage type. Another critical transition is the transition into adulthood, not only because of issues related to biological, legal and other changes, but to ensure that the member has had the opportunity to make the one time decision to stay within the CRS program. The planning for the transition to adulthood will begin well before age of maturity in order to prepare adequately.

***Treatment Plan or ICP***

Although MCP is not responsible in this coverage type for the member's care that is covered under the acute benefit, we will take accountability for integrating CRS, acute and BH care for this member. We will work closely with CMDP to make sure that care is coordinated. The comprehensive service plan, which includes treatment plans for the member's physical and behavioral conditions, is detailed below. Significant to addressing the member's behavioral health needs is the acknowledgement that each of the diagnoses may interact and complicate each other. Additionally, for the purpose of this response, we refer to the plans for addressing the member's physical needs as treatment plans, which MCP considers to be part of the comprehensive service plan required in the CRS contract; we refer to the plans for addressing the member's BH needs as service plans.

***Issue #1 Spina Bifida***

Long-Term Goals: The member will achieve and maintain maximum level of function; the foster care provider, will receive support to navigate the healthcare system and engage community resources and other supports. The member will have all multidisciplinary care needs associated with the condition (Spina Bifida) addressed, as well as any other chronic co-existing conditions.

Short-Term Goals: Member and foster care provider will have an understanding of Spina Bifida and treatments necessary, how to access needed treatment/ services to prevent exacerbation of the member's condition. The member and foster care provider will verbalize understanding of Spina Bifida, the CRS program, the location of services and providers, and the MCP PA process. The member and foster care provider will have a good understanding of the member's CRS coverage type and how to best maximize, without duplicating, covered services.

Treatment Plan:

1. The CM will collaborate with CMDP to arrange specialist appointments and transportation and together, and follow up with the specialists on any needs identified through the specialist visits.
2. The specialist will complete a History and Physical, assess the severity of physical effects of Spina Bifida on the member, and address any resulting complications and additional conditions that may co-exist.
3. CM will follow up to assure the services ordered by the specialists have been provided in close collaboration with CMDP benefits. The CM will reach out to the member's CMDP coordinator and if necessary, the member's CPS caseworker, to orchestrate a smooth provision of all care, will communicate any changes in care on the ICP and will re-distribute to all stakeholders. The CM will arrange case staffing in the event that usual coordination efforts do not achieve the desired outcome.
4. Provide education to the member, foster care provider, and biological family (if appropriate) on the member's diagnosis and treatment (e.g. Spina Bifida); and refer to any applicable low or no cost community resources, including support groups. Follow up as indicated.

5. CM will coordinate with CMDP regarding any identified needs related to non-CRS covered services so that the member receives medically necessary services in a timely manner. MCP CRS will follow the AHCCCS Contractor Operations Manual (ACOM) Policy 409 on coordination authorizations with the Acute Care Plan to assure timely decision making. The CM will be empowered to authorize services or direct to a MCP Medical Director.

**For the purpose of this response we have listed the three identified behavioral health conditions separately. However, we recognize that better outcomes are achieved bymanaging co-occurring behavioral health conditions in an integrated and comprehensive service plan.**

***Issue #2: PTSD***

Long Term Goals: The member will report a reduction in the severity of Post Tramatic Stress Disorder (PTSD) symptoms; the member and foster care provider (or biological family as appropriate) will report improvements in overall functioning and the member will gain a sense of trust and safety in the member's environment. The member will remain in care for PTSD long term, until the member can reach optimal function, and ongoing as appropriate, based on exacerbations and long term effects of trauma.

Short Term Goals: The member will receive a psychiatric evaluation to assess for current PTSD symptoms and any additional behavioral health co-morbidities, in order to develop a comprehensive BH treatment plan that may involve specific evidence based therapies with or without evidence based pharmacotherapy.

Service Plan:

1. In collaboration with the MCP Behavioral Health Coordinator (BHC) the CM will make a referral, for a psychiatric evaluation. The referral will be to a Child and Adolescent Behavioral Health Medical Professional (BHMP), ideally one who has additional competencies in addictionology and trauma. The CM will forward the member's past medical records, including both medical and behavioral, to the BHMP. The CM will follow up to ascertain that the member is seen in a timely manner for the evaluation. The CM will confirm that the legal guardian has consented to the release of any substance abuse records requested by MCP/ CMDP and other providers of care for the member.
2. The BHMP will conduct an assessment of current psychiatric needs, including comprehensive assessment to confirm current diagnoses (including but not limited to a review of current and past substance use, trauma and symptoms related to PTSD and other co-occuring behavioral health conditions). The BHMP will include the foster care provider as a part of the comprehensive assessment and, if appropriate and feasible, the member's biological family. BHMP will use previous records to assess baseline and prior response to treatment to assist with developing the treatment plan. BHMP will review and make recommendations for current BH treatment needs, including pharmacotherapy, and/or evidence based therapy, such as Trauma-Focused Cognitive Behavioral Therapy.
3. If therapy is recommended, the CM will assist in facilitating a referral to an appropriate therapist (master's level or doctoral-trained child and adolescent therapist) and will coordinate this referral with CPS and the foster care provider. The therapist will conduct a comprehensive assessment (including predisposing, precipitating, and perpetuating factors, as well as protective factors) . The therapist will have available previous treatment records provided by the CM to assist in developing the treatment plan. It is expected that the therapist and BHMP will respect the member's and family's cultural and spiritual perspectives related to trauma, reactions to the trauma and specific interventions.
4. The therapist and BHMP will provide education to the member, foster care provider, and biological family (if appropriate) in order to promote understanding of the identified conditions and treatments.
5. The therapist and BHMP will coordinate behavioral health services with each other, as well as with other specialists as indicated. This includes information about the member's psychotropic medications and recommendations for managing problematic behaviors. The CM will assist with this coordination as needed and provide a medication list to CMDP.

***Issue #3: Intermittent Explosive Disorder (IED)Long-Term Goals: The member will reduce aggressive impulses, better manage those that remain and identify mechanisms to improve self-management of outbursts to improve daily function, social interactions, and quality of life.***

Short Term Goal: The member will have a psychiatric evaluation to clarify the diagnosis. The psychiatrist will then recommend treatment planning which may include pharmacotherapy as well as specific evidence based therapies.

Service Plan:

1. Following the comprehensive psychiatric evaluation previously referenced under (2) PTSD - BHMP will review previous treatment/service records (provided by the CM) and make recommendations for current treatment needs, including pharmacotherapy and evidence based counseling, such as Cognitive Behavioral Therapy.
2. If therapy is recommended, the CM will assist in facilitating a referral to an appropriate therapist (master's level or doctoral trained child and adolescent therapist) and will coordinate this referral with CPS and the foster care provider. The CM will coordinate, so that the BH therapist, is the same therapist treating the PTSD. The CM will also coordinate and follow up as needed, so that the already developed BH treatment plan incorporates a specific module to address the treatment needs for IED. Previous BH treatment records will be provided by the CM to assist in the development of the service plan and ICP.
3. The therapist will provide education to the member, foster care provider, and biological family (if appropriate) to promote understanding of the identified conditions and treatments. The CM will follow up to verify the member is seen for counseling services and monitor for compliance with the BH treatment plan.
4. The therapist and BHMP will coordinate BH services with each other, as well as the primary care provider and with other specialists as indicated. This includes information about the member's psychotropic medications and recommendations for managing problematic behaviors. The CM will assist with this coordination as needed.

***Issue #4: History of Poly-Substance Abuse***

Long Term Goals: Member to maintain sobriety from psychoactive substances.

Short Term Goals: The member will have ongoing assessments to determine current sobriety while in counseling and under psychiatric care. CM and PCP will also review member's treatment plan and ongoing care.

Service Plan:

1. BHMP will conduct a formal evaluation to determine the member's treatment needs. Included in this evaluation are the CRAFFT or the Alcohol Screening and Brief Intervention for Youth (9-18). The BHMP will screen for nicotine use, since there is a strong correlation for long term substance use problems in those who smoke from an early age. The evaluation includes a review of past BH treatment to assess responses to past treatment and to address the member's history of poly-substance abuse. Random toxicological screening will be a part of the BHMP's ongoing assessment. If it is determined that the member did not receive previous or effective treatment and that such treatment is necessary, then the member will also be referred for substance abuse counseling. The CM will coordinate with CPS and the foster care provider, as family therapy is a critical component to this treatment.The CM will follow up to see that all appropriate screenings were performed and on all referrals made to monitor timeliness and compliance.
2. The CM will make a referral to an appropriate therapist (master's level or doctoral-trained child and adolescent therapist) certified in substance abuse counseling. It is preferred that the therapist involved in the treatment of this member's other co-occurring disorders also be able to address the substance use; however if this is not feasible, the CM will facilitate coordination between BHMP and all therapists.
3. Substance abuse treatment will include, 1) maintaining the member's motivation and engagement towards sobriety, 2) exploring the motivation for past substance use, (3) developing relapse prevention strategies; 4) working with the foster care provider and biological family (if appropriate) to maintain supervision and monitoring, and 5) increasing prosocial behaviors that will help maintain sobriety, such as positive peer relationships.
4. The therapists and BHMP will coordinate BH services with each other, as well as with the PCP and other specialists as indicated. The CM will reinforce to all care providers the need to be aware of necessary monitoring for abuse of prescribed medications and avoid where possible those medications that may be abused. The CM will also facilitate communication among providers to share information about clinical findings and any behavioral changes that may indicate relapse, as well as the expectation that maintaining this awareness is a responsibility of this member's entire care team

**Q13: Describe the Offeror's approach to integrating and coordinating behavioral health services for CRS members.**

Mercy Care Plan (MCP) shares AHCCCS' commitment to the "Arizona Vision" for children, to be implemented in October 2013. This shared commitment comes from MCP's recognition of the impact of not only physical health (PH), but behavioral health (BH) conditions on the lives of CRS members and their families. Published reports suggest that BH conditions and/or needs are common among Children with Special Health Care Needs (CSHCN) in the United States. The 2009 National Survey of Children with Special Health Care Needs, sponsored by the U.S. Department of Health and Human Services, reported that twenty five percent (25 percent) of all CSHCN had BH conditions and/or needs. Arizona parents of CSHCN who were included in this survey reported the following behavioral health issues in their children: Attention Deficit Hyperactivity Disorder, or ADHD (28.4 percent), behavior or conduct disorders (15.8 percent), depression (12.4 percent), and anxiety (17.2 percent). Though the survey had no Arizona-specific data for Autism or Autism Spectrum Disorder, it is important to note that nationally, 7.9 percent of parents of CSHCN identified this condition. Survey data also suggests that families of CSHCN are impacted by a number of life stressors. Families of CSHCN frequently report that they have to cut back on work, have increased financial issues, have unmet medical needs, and do not utilize or have access to family-centered care or specialists. As concerning as these statistics are, it is very likely that this survey data underestimates the true impact of these conditions on CSHCN and their families because the surveys limited the conditions from which parents could choose. MCP also recognizes that the socioeconomic status of CRS members and their families further impacts their lives and health. Data from the American Medical Association (AMA) suggests that age, income, and socioeconomic status are all strong predictors of low health literacy and that low health literacy is independently associated with poor health outcomes. Thus, CRS members and their families are impacted not only by the CRS-qualifying conditions, but may have or be at high risk for behavioral and sociological conditions that can impact their health outcomes. From our analysis of these surveys and from other published data, and our experience in co-managing almost 25 percent of the CRS membership, MCP understands the need to integrate and coordinate BH with all other health services on behalf of CRS members and their families.

MCP's approach to integrating and coordinating behavioral health (BH) services is to leverage our integrated care management and strong case management program to serve as the single point of contact for members and their families regardless of Coverage Type. We will utilize effective early identification processes, evidence based-practices, support for health homes, ongoing stakeholder engagement, training and education, processes, and activities to provide members with the supports and services they need to improve health outcomes. We describe our approach to integrating and coordinating medically necessary and covered BH services below.

## Use of Tools for Early Identification of Behavioral Health Needs

Untreated behavioral health issues often become a barrier to members' overall wellness. Additionally, the member's physical and BH conditions often impact family dynamics. MCP's protocols are designed to identify the member's behavioral health needs early and accurately, along with the impact of the member's physical and behavioral health conditions, so that appropriate services can be implemented to resolve them. MCP has multiple mechanisms that support the early identification of these concerns. One of the mechanisms MCP uses to identify the BH needs of our members is the member Health Risk Questionnaire (HRQ), which will be completed within five business days of plan enrollment. MCP is in the process of developing a HRQ that is specific to the needs of members enrolled in CRS, which will be implemented upon contract award. The HRQ is being designed to identify members' bio-psycho-social needs and to assess the impact of the member's PH and BH conditions on the family. Other mechanisms used to identify members in need of BH coordination include: 1) our predictive modeling tool, which analyzes claims data to identify inpatient risk, Emergency Department (ED) use and other patterns of utilization that are often markers for BH issues, 2) referrals from providers, families, schools, and other agencies and services in the community, and 3) referrals from MCP areas, including but not limited to EPSDT screening tool results, concurrent review, prior authorization, our 24-hour behavioral health crisis line, Nurse Line, Member Services representatives, Quality Management Department, and Grievance and Appeals Department. All CRS members will receive an initial case management assessment within 30 days of enrollment, which is designed to further identify BH conditions and recognize strengths, preferences, goals and barriers of the member and the member's family. Subsequently, reassessments are performed based on member need, at least annually, or within five business days whenever a change in condition is identified, such as hospitalization, new diagnosis, or change in service level or Coverage Type.

## Using Case Management to Improve Integration and Coordination of Behavioral Health Services

MCP's holistic, member-centric case management program is designed to partner and collaborate with the member and the member's family to address their complex medical and behavioral health needs, including members enrolled in CRS. MCP's policies and protocols place the Case Manager (CM) in the central role of care coordinating and facilitating integration regardless of Coverage Type. The CM may also serve as the single point of contact for the member and the member's family. In our member-centered model, CMs are trained to address member BH needs and have five primary roles in addressing those needs: 1) assess the bio-psycho-social needs of the member and the member's family; 2) member-centered service planning to address the member and the member's family's strengths, needs, preferences and goals, including BH, across the continuum of care (including multiple agencies and systems when appropriate) to help the member achieve success in school, live with their family, and successfully manage their condition to improve quality of life; 3) help the member and the member's family navigate the healthcare system to access evidence-based BH care (including anticipation of crisis), medical and community-based services, identified within the service plan in a timely manner; 4) empower the member and the member's family by directly involving them in assessment, service planning, member and family training geared toward addressing the member's BH needs, and addressing their cultural and health literacy concerns; 5) monitor, evaluate and modify the service plan as needed to achieve the member's and family's desired outcomes; and 6) breaking down barriers to care through member advocacy within MCP, our provider network and the healthcare delivery system, including providing BH services in the members home and community if appropriate and feasible. To improve the integration and coordination of BH services, the CM has a variety of resources available to help meet the complex needs of our members and their families. The CM has direct access to the MCP Behavioral Health Coordinator (BHC), who is a behavioral health professional as described in Health Services R9-20, and is located in Arizona. The BHC is a critical resource to the CM when barriers to successful integration and coordination arise. The BHC serves as a resource in a collaboration with the CM in the following ways: 1) assists the CM in establishing contacts and resolving issues in integrating and coordinating care with BH providers and external entities, including but not limited to: CMDP, Child Protective Services, and DES/DDD, the Tribal/Regional Behavioral Health Authorities (TRBHA), 2) provides insight and problem solving support to the CM for problems related to coordination between BH care and physical health (PH) care providers, regardless of payer, 3) responds to EPSDT screening results that identify a member has behavioral health needs to assure a referral and services are implemented in a timely manner in accordance with AHCCCS performance standards; also informs the CM about the identified concern so that the service plan can be updated, 4) coordinates transitions for continuity and assists with transition of care concerns, 5) shares best practices for behavioral health services with the CM. The CM will utilize the BHC to review and track all BH referrals. The BHC will review: BH referrals for medical necessity when MCP is the payer, that an appropriate provider is identified to meet the member's needs with a focus on continuity of care between payers, and that AHCCCS timeliness standards are met (i.e. emergency appointments the same day or within 24 hours of the referral or request, urgent care appointments for CMDP enrolled members no later than 72 hours after notification by DES/CPS that a member has been or will be removed from their home, appointment for initial services within seven (7) days of referral, and appointment for ongoing services within 23 days of initial appointment). Additionally, MCP offers the MCP Interdisciplinary Team (IDT) case conference meeting as a resource for supporting the care team, including the CM, in meeting the member's needs, including behavioral health needs. IDT participants include a MCP Medical Director, Pharmacist, Psychiatrist, BHC, and assigned CM and other health plans based on Coverage Type. The member, along with family members, providers, or other natural supports, including staff from the member's school, is invited to attend, if approved by the family. The goal of the IDT is to review, analyze and create interventions specific to the member's presenting problem(s). These and other resources (e.g. medical directors, quality management, and ombudsman) support the CMs ability to be a single point of contact with the member and their family and to be the central point of coordination for their BH care.

## Using Stakeholders to Help Design, Implement, and Evaluate Integration and Care Coordination

Stakeholders will have a central role in MCP's approach to designing, implementing, and evaluating the CRS system. One way for them to participate is through a variety of stakeholder-focused meetings, described as follows.

As part of our Ombudsman/Client Advocate activities, MCP will hold **monthly community meetings** in the four different regions corresponding to the four MSICs. These meetings will include topics of interest to all CRS stakeholders and provide a forum for all stakeholders, including CRS members and their families, to provide input to the design, ongoing monitoring, and performance of the CRS system. MCP will use these stakeholder meetings to provide both an opportunity and a forum for stakeholders to have meaningful input into the implementation of MCP's approach to integrating and coordinating BH services. Feedback from stakeholders will be reported back to appropriate MCP committees for action, tracked for resolution and reported through the Ombudsman/Client Advocate.

In addition to general stakeholder meetings, MCP will use group-specific stakeholders meetings. One such meeting will be the MCP **CRS Member Advisory Council (CRS MAC)**. The CRS MAC will serve as an opportunity for members and their families to provide further input to MCP's approach to integrating and coordinating BH services. The **CRS BH System of Care Meeting** will provide be the formal opportunity for systems stakeholders such as the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) and their sub-contracted health plans; AHCCCS, Child Protective Services (CPS), CMDP, and Tribal/Regional Behavioral Health Authorities (TRBHAs). These meetings will focus on systemic coordination of care issues, ways to further enhance system integration through the share data, and developing additional health home opportunities. MCP will establish a **CRS Professional Advisory Committee (CRS PAC)**. The CRS PAC membership will include participating PH and BH providers. The purpose of these meetings will be to obtain clinical input and advice regarding integration and coordination of BH with PH.

MCP will establish monthly **Joint Operating Committee (JOC) meetings** with all MSICs. The purpose of JOC meetings will be to continuously integrate MSICs and Health Homes (integrated BH and PH sites) feedback about ways that we can work together to better manage and respond to the needs of CRS members as well as to guide our approach to BH integration and care coordination process.

As a result of these stakeholder meetings, MCP, through the Ombudsman/Client Advocate and through the actions of MCP committees, including QM, UM, and Policy and Procedure, will analyze, revise and implement improvements based on the voice of the stakeholders to achieve the goal of integration and coordination of BH services. The Ombudsman/Client Advocate has the authority to implement changes, monitor those changes and report the outcomes of those changes to both the CEO and stakeholder groups.

## Use of Training and Education to Increase Awareness of Behavioral Health

Critical to MCP's approach to integration and coordination of BH services for CRS members is to increase awareness of BH issues in CRS members and in their families. Our approach to increasing awareness is to provide effective and ongoing training to enable all staff and providers to be advocates for members with BH needs, as well as how to coordinate BH services for CRS members through the case management model.

**MCP Staff Training:** MCP staff receives initial and ongoing training regarding the behavioral health system in Arizona, MCP's role in that system, and the importance of identifying members with behavioral health needs, including families that may be in crisis. The MCP Behavioral Health Coordinator (BHC) and other behavioral health staff within the ICM Department provide training to MCP staff, including but not limited to the Ombudsmen/Client Advocate(s), Member Services, Quality Management, Grievance and Appeals, CMs, Prior Authorization staff, and Concurrent Review staff. Training is delivered using instructor-led classes, computer-based modules and self-paced learning approaches. Content is adapted to meet the educational requirements of the staff being trained. For example, CM training will include, but not be limited to, the bio-psycho-social model, roles and responsibilities in addressing the behavioral health needs of members based on Coverage Type, conducting comprehensive case management assessments, and motivational interviewing skills and techniques.

**Provider Training:** Providers including PCPs and specialists, including BH providers, both within MSIC settings and in community-based settings, will receive training through a variety of methods, including provider manual, provider bulletins, our website, and on-site visits and training. The training materials cover content including but not limited to: behavioral health screening tools, evidence-based practice guidelines (EBPGs), and the AHCCCS clinical tool kit for the treatment of anxiety, depression and ADHD. MCP has also developed a comprehensive provider training program under the umbrella of our Integrated Care Training Academy. Through this academy, providers receive comprehensive behavioral health training regarding the use of EBPGs for the screening, diagnosis, and treatment of behavioral health conditions, behavioral health services that vary by Coverage Type, the availability of psychiatric consultation through

MCP, as well as the integration and coordination of BH care. The Academy will include training for BH providers on how to manage and coordinate care for members with medically-complex needs, specific to the needs of the birth to five population, school age children, youth and adolescents, and young adults. Providers receive Continuing Medical Education (CME) credit for their participation.

**Member/Family and Stakeholder Education:** Members, families and interested stakeholders receive education on behavioral health conditions, covered behavioral health services that vary by Coverage Type, how to access those services, including the 24-hour BH Crisis Line and where to find assistance in accessing services. Members, families, and interested stakeholders receive this information through various means, tailored to meet their needs, including but not limited to, the Member Handbook, MCP website, newsletters, through education and assistance provided by the MCP CM, BHC, and through community meetings facilitated by MCP's Regional Ombudsmen/Client Advocates.

## Using Health Home Models to Improve Delivery of Integrated and Coordinated Care

MCP has developed a range of health home models including Patient Centered Medical Homes (PCMH) and Patient Centered Health Homes (PCHH) to meet the unique needs of each member. Specifically, the PCHHs are designed to increase the accessibility, integration and coordination of PH and BH services for members. PH and BH services are co-located at the PCHHs. PCHHs work to develop common health information systems and a shared treatment plan, which is then integrated into the CM's integrated care plan (ICP). The ICP incorporates the members' PH and BH treatment plans with the CRS service plan and the holistic CM care plan. Our Value Oriented Payment Models support PCHH practices by providing care management fees, enhanced fee for service payments and pay for performance (P4P) as well as non-financial incentives to encourage practices to improve meaningful outcomes. MCP will continue to develop PCHH models and identify and support practices, including MSICs, interested in implementing such models.

## Quality Management

MCP's Quality Management (QM) department will play a key role in improving the quality of care related to integration and coordination of care for BH. One of the most critical roles the QM department will play will be in the monitoring, investigation, reporting and process improvements related to timeliness of service delivery and Quality of Care (QOC) concerns. Known and potential concerns are identified through a number of mechanisms, including but not limited to surveillance of complaints and grievances, referrals by providers, or referrals from other MCP departments (e.g. Concurrent Review, Prior Authorization). Whenever a known or potential QOC concern is identified, MCP's QM department initiates an investigation to identify the cause of the concern and implement corrective action, if appropriate. All corrective actions are followed to verify that they have been fully implemented. QOC's are trended and reported through the QIC committee within MCP. The results of trends and analyses are reported through the Quality Management and Utilization Management (QM/UM) Committee and ultimately to MCP's Board of Directors. QOC concerns include those related to potential ineffective care coordination activities, delays in treatment that result in an adverse outcome, and/or adverse events related to poorly integrated care. For example, MCP received QOCs related to poor integration and coordination of services between network provider and BH providers for a particular RBHA. As part of the investigation, MCP's QM department identified that incomplete sharing of data between the PH and BH providers was frequently a root cause of a poor outcomes, which were leading to the QOCs. To improve member outcomes, MCP's entered into a two-way data sharing agreement with the RBHA for pharmacy and utilization data. MCP's case managers are now using this data to better coordinate care at the plan level and MCP is implementing processes to make this information available directly to MCP network providers. MCP also reports on the timely delivery of care for BH referrals. Analysis and trends are reported through the QM/MM committee and ultimately to MCP's Board of Directors.

## Use Data Sharing Mechanisms and Tools to Support Integration and Coordination

MCP will use data sharing mechanisms and tools to integrate and coordinate BH. To supplement our data sharing mechanisms and tools, we will also initiate data sharing agreements with appropriate agencies for the purpose of integrating and coordinating BH in a timely manner. We will also incorporate all data provided by AHCCCS at the time of implementing the contract. MCP has the necessary mechanisms and tools to facilitate the integration and coordination of behavioral health services for CRS members across the continuum of providers and payers. These mechanisms and tools are described below.

**CaseTrakker™ Dynamo** is a tool that supports service coordination and care management. The integrated care plan generated by the assessment includes member-centric actions, health literacy and culturally competent health education

needs and documentation of training, and care coordination needs including identification of the providers who will participate on the member's care team (BH, PH, CRS, and others). The integrated care plan can then be shared with the care team, the member and the member's family. The application's workflow rules prompt event-driven actions to support member and provider compliance with evidence-based clinical practice guidelines. An automated escalation alerts the care team of upcoming or overdue assessments and the audit report feature supports evidence-based clinical practice guidelines compliance. By sharing the data from CaseTrakker™ Dynamo with all members of the care team, the application supports a unified care planning process. This is the main tool of the CM for documenting care coordination needs and identifying member specific interventions to assure care is integrated across providers. The MSICs will be able to access the care plan and communicate with the CM.

To support coordination of care for CRS qualifying conditions and other conditions including BH, we utilize **ActiveHealth® CareEngine® System,** a claims based clinical support system that includes an automatic message generator called Care Considerations. The system analyzes a member's claims data (medical and pharmacy), clinical data, and laboratory results, and compares the results to accepted evidence-based clinical rules. It identifies member-specific ways to optimize care and sends evidence-based recommendations or "Care Considerations" for use by Care Coordinators and providers alike. The Care Considerations include information relevant to BH coordination, including but not limited to, drug/drug interactions and monitoring for adverse effects of medications. With implementation of data sharing agreements with other health plans and healthcare systems outside of MCP, ActiveHealth® CareEngine® System is sophisticated enough to use the data and send out information even when the provider is not an MCP contracted provider. This will offer MCP the ability to implement not only two-way data sharing, but to provide the benefit of the analytics and decision support provided by Care Considerations with TRBHA, Indian Health Service, CMDP and DDD subcontracted providers for those Coverage Types where some care will delivered outside of MCP.

**MercyOneSource** is a secure HIPAA-compliant web portal designed to foster open communication and facilitate access to member care data in multiple ways. It synchronizes data on a daily basis with our health plan information system. Through MercyOneSource, providers are able to perform various functions including member eligibility verification, panel roster review, and searchable lists for providers, claim status, remittance advice, and prior authorizations.

MCP uses **ProREPORT,** an online, web-based capability which gives providers access to review provider-specific reports critical to monitor care coordination events and outcomes. We will use ProREPORT to push Provider Profiles to providers both within and outside of MSICs. These profiles offer ready-made patient registries that support the provider to improve the healthcare delivery and measure outcomes. ProREPORT will also be used to share data compiled through data sharing agreements with TRBHA, CMDP, and DDD data to give the provider a holistic view of the member and their services.

**iNexx** is a secure downloadable platform offered free of charge to providers, and is based on solutions that support the Health Information Exchange movement. iNexx connects every member of the integrated care team, including medical and behavioral health providers, regardless of organizational boundaries and technological sophistication, so that care can be effectively coordinated around a common member. The iNexx core application suite provides the care team the ability to virtually connect providers, allowing them to share common information in a secured environment, facilitate communication between providers via a secure inbox, which includes viewing capability for paper-based practices, make referrals between providers connected to the iNexx platform, and store and modify member information. This technology allows providers who are not part of the MCP structure, such as behavioral health providers, the ability to coordinate and communicate in a manner consistent with the coordination afforded to the MSICs and patient centered medical homes.

Because some providers may not have reliable access to a computer or the internet, MCP will continue to support **phone-** and **fax-**based mechanisms for the purposes of sharing data with these providers. The CM plays an important role in identifying training needs and supporting providers in accessing these tools.

Furthermore, MCP understands and fully supports AHCCCS Policy 320-I TELEHEALTH AND TELEMEDICINE. We will demonstrate this support by encouraging the use of telemedicine technology for the care of CRS members. MCP has also met with, and supports providers who are innovating with new telemedicine technologies. As this technology develops, and as providers continue to develop protocols that support the use of telemedicine to increase access to care that increases the availability and quality of healthcare, we will support its appropriate implementation.

**Q14: Describe the mechanisms that the Offeror will use to ensure that all providers, including those within and outside of the MSIC setting, have access to the data needed to appropriately coordinate care for the member.**

## MCP's Data Sharing Mechanisms

As a provider-sponsored organization, Mercy Care Plan (MCP) is acutely aware of the challenges associated with having the right information for providers in the right place at the right time in order to most effectively coordinate care. In preparing for this RFP, MCP's senior leadership met with CRS stakeholders, including all MSIC settings. From this input we learned that each MSIC and community-based provider within the CRS system has varying capabilities to manage, send, and receive data. MCP's goal in designing our data sharing mechanisms is to support all providers, regardless of the technologies they use to send and receive data. At one end of the continuum, for MSICs and providers who have adopted electronic medical record systems, MCP is ready to consult with these settings and providers to promote implementation of newly available technologies that are designed to share data over a Health Information Exchange. At the other end of the continuum, MCP is able to assist MSIC's and providers who primarily use phones, faxes, and mail to share data and coordinate care. Our approach is designed to meet the provider where they are in terms of data sharing, but at the same time help providers move up the continuum to reach the optimal and most efficient data sharing mechanism possible.

Our analysis of the current CRS system informs us that technology is only one factor to consider when sharing data within and between providers in the CRS care system. MCP is aware that managing data sharing for the purposes of coordinating care requires an understanding of each stakeholder's internal data sharing mechanisms. This recognition is even more important based on the formalization of the "Coverage Types" as defined in this RFP. MCP will leverage its knowledge of the systems of care in Arizona and our understanding of the unique considerations of the various Coverage Types to achieve the desired outcome of ensuring all providers have access to the data necessary to appropriately coordinate care for the member.

## Current Data Sharing Mechanisms and Tools

MCP has the necessary mechanisms and tools to facilitate coordination of care for CRS members. These mechanisms and tools, listed below, require only a computer with access to the internet:

**CaseTrakker™ Dynamo** is a tool that supports service coordination. The application's workflow rules prompt event-driven actions that support member and provider compliance with evidence-based clinical practice guidelines. Automated alerts notify the care team of upcoming or overdue assessments. By sharing the data from CaseTrakker™ Dynamo with all members of the care team, the application supports a unified care planning process.

To support coordination of care for both CRS qualifying conditions and other chronic co-existing conditions, we utilize **ActiveHealth® CareEngine® System**, a claims based clinical support system that includes an automatic message generator called Care Considerations. The system analyzes a member's claims data (medical and pharmacy), clinical data, and laboratory results and compares the results to accepted evidence-based clinical rules. It identifies member-specific gaps in care and sends evidence-based recommendations or "Care Considerations" for use by Care Coordinators and providers alike. (*Note*: For providers without reliable internet access, these Care Considerations can be delivered via standard mail or fax).

**MercyOneSource** is a secure HIPAA-compliant web portal designed to foster open communication and facilitate access to a variety of data. Through MercyOneSource, providers are able to perform various functions including member eligibility verification, submit prior authorization requests, panel roster review, and perform searches of provider lists, claims, remittance advices, and prior authorizations.

MCP uses **ProREPORT,** an online, web-based capability which allows providers access to review provider-specific reports critical to monitor care coordination events and outcomes. One of the ways that ProREPORT is used by providers is to review reports regarding their performance on quality and utilization measures through a Provider Profile. The profiles contain member specific data for all of MCP members in the provider's practice. The data is organized in such a way that it provides a ready-made patient registry which supports the delivery of healthcare and the measurement of outcomes regardless of setting (MSIC or community-based).

**iNexx** is a secure downloadable platform offered free of charge to providers that supports movement of data across Health Information Exchanges. iNexx connects every member of the integrated care team in a secure environment,

regardless of organizational boundaries and technological sophistication, so that data can be shared across providers to improve care coordination. iNexx includes viewing capability for paper-based practices and supports making referrals between providers connected to the iNexx platform. The application also allows a provider to store and modify member information.

Based on our experience of working with providers in the various systems of care used by CRS members, we know that some providers may not have reliable access to a computer or internet connection. Therefore, we will continue to support **phone-**and **fax-**based mechanisms for the purposes of sharing data with these providers. A provider can elect to receive information in various formats, including phone, fax, and mail. MCP will support the provider's selection of data sharing mechanisms and tools.

Furthermore, MCP understands and fully supports AHCCCS Policy 320-I TELEHEALTH AND TELEMEDICINE. Our support for this policy will help encourage use of telemedicine technology for the care of CRS members. MCP has also met with and supported providers who are innovating with new telemedicine technologies. As this technology develops, and as providers continue to develop protocols that support the use of telemedicine to increase access to care that increases the availability and quality of healthcare, we will support its appropriate implementation.

## Future Data Sharing Enhancements

Our enhancements will be designed to improve care coordination for CRS members, member's family, appropriate community stakeholders, and providers. Upon contract award, we will implement enhancements to our web portal solutions. Examples of enhancements we will propose are outlined in the following table:

| Member Access | Provider Access |
|---|---|
| • View and print their own Care Plan and provide feedback to their Case Manager<br>• Secure messaging between member and their Case Manager<br>• View and update their profile including:<br>- Demographic information<br>- Phone numbers and email addresses<br>- Family/caregivers names/relationship<br>- Medication history reported through claims<br>- Utilization during the last year for: hospital stays, ER visits, PCP visits, and specialist visits<br>- Self-reported conditions and medications (including OTC, herbals and supplements)<br>• View and provide updates or feedback on "Care Consideration" alerts<br>• View and update information about advanced directives<br>• View upcoming appointments, both in list and calendar format<br>• View list of Care Team and their contact information (e.g., PCP, specialists, family) | • View and print member's Care Plan and provide feedback to the member's Case Manager<br>• Secure messaging between provider and Case Manager<br>• View a member's profile which contains:<br>- Member's demographic information<br>- High-risk indicator* (based on existing information, past utilization, and member rank)<br>- Conditions and Medications reported through claims<br>- Member reported conditions and medications* (including OTC, herbals, and supplements)<br>- Link to detailed member information for conditions, medications, and utilization data with the ability to drill-down to the claim level*<br>- Family/caregiver names/relationship<br>• View and provide updates and feedback on "Care Consideration" alerts<br>• View member assessment responses<br>• Submit a referral for Case Management<br>• Look up members not on their panel as appropriate<br>• Review a list of the member's Care Team and contact information<br>• View and change their own contact information |

*Members can limit provider access to clinical data

Our currently available mechanisms and tools, as well as the proposed future enhancements, allow the capture of complete and timely data and increase the accessibility of this data to all stakeholders involved in care coordination whether participating in an MSIC or a community provider setting. MCP designed its data sharing mechanisms and tools to provide resources that are simple to use and comprehensive in their capability of supporting data exchange. MCP's mechanisms and tools can be used regardless of the provider's sophistication in using technology.

## Strategic Framework for Sharing Data to Support Care Coordination in the CRS System

Our strategic framework for sharing data matches the CRS Coverage Types. MCP's framework offers a description of 1) mechanisms and tools that will be used and 2) the types of data to be shared. Using the structure of the Coverage Types, the following table summarizes our approach to the complex challenge of sharing of data in the CRS system.

***Note:*** *In all examples, the data will be shared multi-directionally (e.g., physical health provider to behavioral health provider, behavioral health provider to physical health provider, and each provider type back to the health plan). For all Coverage Types, the desired outcome is the same: to ensure each provider has access to the data they need to appropriately coordinate care for the member.*

| Coverage Type | Mechanisms and Tools | Data to be shared |
|---|---|---|
| **CRS Fully Integrated:**<br>(acute services + behavioral health services + CRS services)<br>Key factors driving our approach:<br>• Commonly, all provider types will be directly contracted with MCP.<br>• Occasionally, out of network, and even out of state providers will also serve members.<br>• Large specialty systems and hospitals may have existing technology infrastructure. | **High Tech Solutions:**<br>• Structuring more advanced levels of iNexx solutions, support for implementing a health information exchange, and eventually developing continuity of care documents<br>• Implementation of telemedicine/virtual clinic services and use of telemedicine equipment to support wide geographic access to diagnostic, consultation, and treatment services, and related medical data transfer<br>• CaseTrakker™ Dynamo<br>• MercyOneSource<br>• ProREPORT<br>• iNexx<br>• ActiveHealth®Care Considerations<br>**Low Tech Solutions:**<br>Fax, phone, and mail support | **Data- Within Network:**<br>• Integrated behavioral health, physical health and pharmacy data known to the plan including but not limited to: service plan, clinical data from IP and OP settings, IP and ED utilization data, known food and drug allergies, laboratory results, ancillary services, gaps in care (e.g., EPSDT), preventive service (e.g., immunizations), appropriate behavioral health data, IEP's, prior authorization (e.g., DME), referrals of all types, and dental and vision<br>**Data – Out of Network:**<br>• All data from specialty care delivered outside of MCP's network (e.g., out of state care) |
| **CRS Partially-Integrated – Acute:**<br>(Acute services + CRS services – but some or all BH services through TRBHA or Indian Health Service)<br>• Though many features are shared with fully integrated CRS Type, it will be necessary to integrate with TRBHA systems which are outside of MCP's network. | Where feasible, discuss and pursue with the TRBHA options for High Tech implementations<br><br>**Low Tech Solutions:**<br>Fax, phone, and mail support | **All data in Coverage Type- Fully Integrated (See above):**<br>**PLUS**<br>• Appropriate behavioral health data from TRBHA in all directions and all CRS and Acute services data to the TRBHA to support care coordination |

| Coverage Type | Mechanisms and Tools | Data to be shared |
|---|---|---|
| **CRS Partially-Integrated – Behavioral Health (BH):**<br><br>(Behavioral health services + CRS services)<br>• The relationships with providers of Acute Care services in this Coverage Type may differ between CMDP and DDD.<br>• CMDP's physical health providers may or may not be contracted with MCP.<br>• DDD members will have information in both DES's long term care system and in one of DDD's Acute Care subcontractors' systems. | **All High- and Low- tech solutions will be used:**<br><br>**PLUS**<br><br>• Collaboration with other health plans to identify potential technologies and methods for sharing data across plans<br>• Collaboration with CMDP and DDD to identify potential technologies and methods for sharing data between agencies and the CRS system | **All data in Coverage Type- Fully Integrated (see above):**<br><br>**PLUS relevant data to and from**<br><br>• Out-of-MCP network care to and from CMDP system physical health providers<br><br>• Physical health data for DDD members to and from DDD's subcontracted Acute Care health plans to the CRS Network including Behavioral Health providers<br><br>• Behavioral Health / CRS information to DDD's subcontracted Acute health plans and CMDP/ CMDP providers<br><br>• Expand data elements to include information on items such as CPS, foster care provider, legal guardian status, etc. |
| **CRS Only-** (CRS Services)<br>• CRS services must still be coordinated amongst CRS providers working within MSIC's and in independent community practices.<br><br>• Some or all services will occur in ALTCS, Indian Health Service, or tribally operated health care programs.<br><br>• It will be necessary to integrate with systems outside of MCP's network. | **All High and Low tech solutions will be used**<br><br>**PLUS**<br><br>• Collaboration with LTC health plans and Indian Health Service and tribally operated health care programs to identify potential technologies and methods for sharing data across systems | **All data in Coverage Type- Fully Integrated (see above)**<br><br>**PLUS relevant data to and from**<br><br>• Any relevant data from other systems to CRS Network including MSICs<br><br>• CMDP and DDD American Indian (AI) members from a TRBHA<br><br>• AIHP members who are choosing to receive physical or behavioral health services from an Indian Health Service including a TRBHA<br><br>• ALTCS/EPD members receiving BH and PH<br><br>• CRS data from MSIC and non-MSIC CRS providers to CMDP and to their American Indian members who choose to receive care from a TRBHA or other component of an Indian Health Service |

## Supporting a Successful Data Sharing Strategy

MCP has three main supports for our data sharing strategy. The first is to provide outstanding, on-the-ground, front line communication support to individual MSICs and community based providers. The second is to use our case management approach as the catalyst to facilitate data sharing at the member level. The third is to involve our stakeholders in all facets of the CRS program including the implementation and maintenance of our information systems.

**Provider Support:** MCP's information management applications are easy to adopt and implement, and they already support functions for our existing provider network. Thus, our applications that we will use for the CRS systems are already familiar to many providers across the State. Our Provider Services staff will function as the first line of support for providers including the MSICs and community based providers. Every practice is assigned their own Provider Services representative. Our provider services staff is easy to reach and have access to additional technical support at any time they need it. This support will help ease the implementation of our strategy at the system level and make clear and simple implementation for whatever method of data sharing mechanisms selected by the MSICs or community based providers.

**Case Management Support:** Our case management program provides an individualized, member-centered, bio-psycho-social model of care that includes care coordination and specific disease management interventions based upon evidence based clinical guidelines. We implement our case management protocols in a holistic, systematic manner with an emphasis on maximizing the member's ability to achieve self-management. Our CMs have the primary role of facilitating care coordination across all providers and agencies. Our CMs have expertise in and will receive additional training on how various health care systems in Arizona work together. As such, CMs will be able to better facilitate bringing all of the data together into the provider's office at the time it is needed to most effectively coordinate the care for the member using any of the mechanisms and tools available to them.

**Advocacy for the CRS Program Based on Stakeholder Input:** Upon contract award, we will implement MCP's Ombudsman/Client Advocate program. MCP recognizes the importance of the Ombudsman/Client Advocate (O/CA) in achieving a transformation of the CRS system as defined in the RFP. To go beyond the requirements in the RFP, MCP will create the Office of the Ombudsman (OOO) to support the functions of the O/CA and to help form, implement, and modify as necessary MCP's strategic plan for serving CRS members and involving stakeholders in every facet of the CRS program. A position will be filled at a senior management (director level) and will report directly to the Chief Executive Officer (CEO). Through the CEO, the Director (DO/CA) of the OOO will serve as the member's and stakeholders' voice to our Board of Directors. To capture the voice of members and their unique challenges, and to involve stakeholders from all CRS regions, we will embed one O/CA in each of the MSIC regions. This will enable the O/CA to understand and appreciate the uniqueness of the culture and the health care delivery system in that region. It is our experience that health care is local, especially for children and families with complex medical needs; therefore, a regional approach is necessary in order to effect a meaningful and sustainable transformation of the CRS system. Our Ombudsman/Client Advocates will work with MSICs and community-based providers to promote implementation of data sharing mechanisms and tools that will help them share data.

In summary, as a provider-sponsored organization, with an understanding of the various health care systems in Arizona, MCP is acutely aware of the challenges associated with having the right information in the right place at the right time in order to most effectively coordinate care. Our data sharing mechanisms and tools, our support for providers, members, members' families and all stakeholders in the CRS system, plus our flexibility and willingness to adapt our approach as necessary, will help us succeed as we implement this strategy.

Mercy Care Plan

# Organization

**Q15: Describe the role that stakeholder input will play in all facets of the CRS Program. Provide a written narrative outlining your organization's expectations, goals and responsibilities for the Ombudsman/Client Advocate as well as the client advocacy program.**

In preparation for stewardship of the CRS program, Mercy Care Plan (MCP) reviewed AHCCCS's waiver proposal, we studied the recommendations from stakeholders as articulated in the report titled *Integrated Healthcare System for Children with Children's Rehabilitative Services (CRS) Eligible Conditions* produced by St. Luke's Health Initiative, and we met with multiple CRS stakeholders from all regions of the State. As one of the largest Acute Care contractors in Arizona, MCP has co-managed one of every four CRS members, and we examined our own experience in co-managing members with CRS-qualifying conditions in preparation for the CRS Request for Proposal (RFP). From this preparation and self-examination, we have developed a comprehensive understanding of the CRS system as it exists today. We also fully support AHCCCS's goal of improving the quality of life for Children with Special Healthcare Needs through the transformation of the CRS system to be more accessible, more coordinated, more effective, and more accountable to all stakeholders in the system.

In this response, we identify key facets of the CRS system that must be addressed and describe our investment – which significantly exceeds the requirements in the RFP - in the Ombudsman/Client Advocate (O/CA) function. We have designed an approach that will engage stakeholders at the forefront of every process involved in transforming the CRS system to achieve the desired outcomes.

## Key Facets of the CRS Program

As described above, we used multiple viewpoints and resources to identify the "facets" of the CRS system to better understand which strategies may be successfully used to help achieve the desired outcomes. These key facets are:

- Operation of a single, fully integrated healthcare system that would serve CRS-eligible children
- The formalization of "Coverage Types"
- The regional nature of Arizona and the uniqueness of each MSIC setting
- Care coordination for children with special healthcare needs
- The need to increase the ability of the integrated CRS managed care organization (MCO) to collect and analyze data to better assess the health needs of their members with a CRS condition from a holistic approach
- Fragmentation of the current healthcare delivery system and the effect it has on the children and families of CRS-eligible children
- The importance of demonstrating improved health outcomes
- The need to promote the sharing of information between CRS, acute and behavioral health providers and to allow for greater collaboration in designing a service plan to address members' whole health needs

Importantly, our analysis gave us the understanding that each of these facets is interrelated. As a whole, they combine to embody the system of care for CRS members and their families. We recognize that each facet presents CRS members and their families with both opportunities and barriers to achieving their goals. Additionally, as a not-for-profit, locally owned, provider led health plan, MCP will rely on stakeholders, as the ultimate beneficiaries of the system, to fully engage in, develop, endorse and provide feedback on the strategies that will be used to address each facet of the CRS system, ultimately effecting change on the system as a whole.

## Defining CRS Stakeholders

For the purpose of this response, we identify examples of stakeholders. Our examples of stakeholders included herein are not intended to be exhaustive, but merely to reflect our understanding of the breadth of stakeholders that exist. In our preparation for this RFP, we identified CRS stakeholders including but not limited to: members, members' families, community advocates, AHCCCS, providers, agencies serving children, (e.g. Child Protective Services), the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD), the Arizona State Legislature, hospital systems, professional associations such as the Arizona Chapter of the American Academy of Pediatrics (AzAAP), governmental agencies (e.g. Centers for Medicare and Medicaid Services, Arizona Department of Health Services, Office of Children with Special Healthcare Needs [ADHS/OCSHN], Arizona Department of Juvenile

Corrections, Indian Health Service, tribally operated programs, including Tribal Regional Behavioral Health Authorities (TRBHAs), Comprehensive Medical and Dental Plan (CMDP), the Arizona Department of Economic Security's Arizona Early Intervention Program (DES/AzEIP), schools and school systems, and national/local community resources and organizations such as the Spina Bifida Association, Epilepsy Foundation, Special Olympics of Arizona, Children's Action Alliance, and the Center for Disability Law.

## Stakeholders' Central Role

MCP defines the central role of stakeholders is to collaborate with MCP to drive the CRS system forward to achieve AHCCCS's goal of improving the quality of life for Children with Special Healthcare Needs through the transformation of the CRS system to be more accessible, more coordinated, more effective, and more accountable to all stakeholders in the system. In doing so, MCP expects that stakeholders will play a significant, ongoing role in all facets of the CRS Program. Stakeholders will participate in providing input into all proposed changes to systems, the procedures and processes that will be designed to implement those changes, and in the evaluation and interpretation of data that will be used to assess the effectiveness of the changes in meeting the goals of the CRS program.

To involve the stakeholders and to address all facets of the system, we propose to invest in strengthening the Ombudsman/Client Advocate function so that stakeholders are at the forefront of the process for transforming the CRS system to achieve the desired outcomes. A description of our proposed approach is below.

## Office of the Ombudsman; MCP's approach to engaging stakeholders

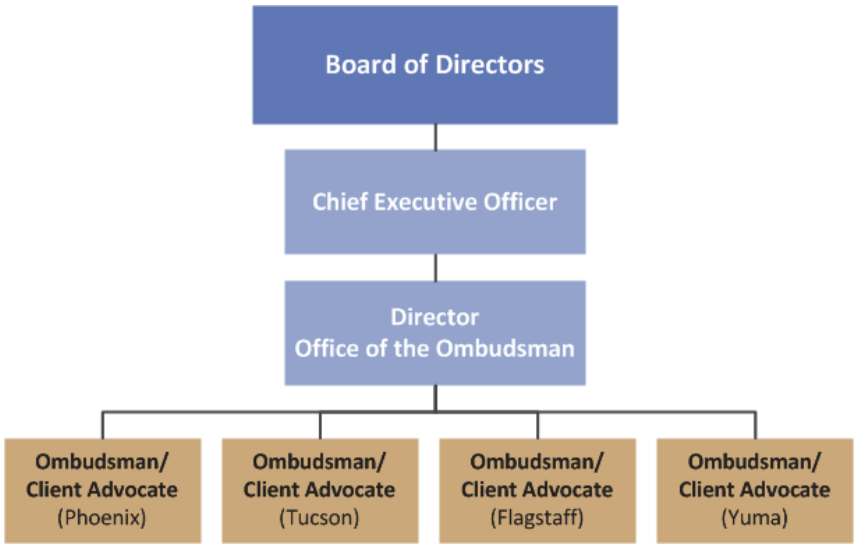
MCP recognizes the importance of the Ombudsman/Client Advocate (O/CA) role in engaging stakeholders. MCP will create the Office of the Ombudsman (OOO) to support the required functions of the O/CA and to help form, implement, and modify as necessary MCP's strategic plan for serving CRS members and involving stakeholders in every facet of the CRS program. The head of MCP's OOO will be the Director Ombudsman/Client Advocate (DO/CA). This position will be filled as a senior management role (director level) and will report directly to the Chief Executive Officer (CEO). Through the CEO, the Director (DO/CA) of the OOO will serve as the members', members' families, and stakeholders' direct voice to MCP's Board of Directors. The OOO and the employees who will serve as O/CAs represent MCP's commitment to properly resource and to be held accountable for stakeholder communication. MCP's Board and senior management are fully committed to the approach that realizes every person in the health plan is a representative of MCP. Therefore, they are responsible, accountable and fully empowered to respond to any member or stakeholder's needs.

To capture the unique challenges facing CRS members and their families, and to involve stakeholders from all CRS regions, MCP will embed one O/CA in each of the MSIC regions. This will enable the O/CA to understand and appreciate the uniqueness of the culture and the health care delivery system in that region. Through our experience we have learned that one must understand the local healthcare community including its unique culture, strengths and needs in order to fully understand stakeholders' viewpoints. Through the process of communication and building of common understanding stakeholders become not only informants, they become agents for change. Our approach is designed to create maximum opportunity for stakeholder engagement by locating an O/CA in each region corresponding with a MSIC. The O/CA will also function as an advocate for their communities.

The DO/CA position is also critical to the structure of MCP'S OOO. The DO/CA will promote cohesiveness among the regionS, where common messages, challenges and opportunities exist. The DO/CA, based in Phoenix, will also have the responsibility for frequent and meaningful contact with appropriate state agencies, stakeholders and other entities that are based in Phoenix. This is why a regional approach is necessary in order to bring about a meaningful and sustainable transformation of the CRS system.

On the following page we demonstrate our proposed reporting structure for the Office of the Ombudsman.

**Office of the Ombudsman Organization Chart**




## Organizational Expectations, Goals and Responsibilities

### *Expectations*

It is MCP's expectation that the professionals that fill these roles within the OOO will wield influence throughout the organization. As previously mentioned, the director (DO/CA) position will be filled at a senior management level. The DO/CA must have or be able to effectively develop a close working relationship with community health organizations, advocates and related services providers. MCP will require the DO/CA to have specialized experience in providing direct services to disabled individuals. The DO/CA must be knowledgeable of, and have appropriate or comparable experience with: CRS statutes, rules and regulations, policies and procedures; AHCCCS statutes, rules and regulations; applicable CMS regulations; and The Americans with Disabilities Act. Most of all our expectation is that the DO/CA will possess a strong commitment to Children with Special Healthcare Needs.

The regional O/CA's will work directly with our CRS members, their families and with local community healthcare professionals and advocates. We will expect and require our O/CA's to have situational awareness of the local healthcare delivery and community support systems, work within local communities, meet with local stakeholders, obtain member and family input and feedback to identify local issues and collaborate for solutions, and to conduct outreach and serve as agents for change at the local community level. The regional O/CA's will be required to have three to five years of experience working with special needs populations, including disabled individuals, and be familiar with managed care principles. Candidates may be a Registered Nurse, Licensed Practical Nurse, or Licensed Clinical Social Worker or have a Bachelor's or Master's degree in a health-related field.

### *Goals*

Ultimately, the goal of MCP's O/CA function is achieve transformation of the healthcare system for children with special healthcare needs by involving stakeholders in every facet of the program.

### *Responsibilities*

All O/CA's will have the responsibility to work closely and cross-functionally with all MCP departments and programs, including but not limited to the EPSDT Coordinator, Behavioral Health Coordinator, DDD Member Liaison, Member Services, Grievance and Appeals, Provider Services, Fraud, Waste and Abuse Coordinator, Quality Management, Claims, and Medical Management (e.g., Case Management, Prior Authorization and Concurrent Review). In their work with these departments and programs the O/CAs will have the responsibility to bring their knowledge of local community issues and input to MCP, propose solutions, work to resolve identified problems and to report back to the local community stakeholders the actions taken and the status of ongoing initiatives.

In performing these duties, the O/CA will: act in the best interests of members; participate in training activities that improve MCP's understanding of the physical and behavioral needs of CRS members and their families; participate in training activities that improve MCP's understanding of the cultural, linguistic, racial and ethnic diversity of the CRS membership; and act in a manner that protect each member's rights.

The O/CA will also work collaboratively with other departments to ensure that MCP operations are effectively advancing the goals of the CRS program. For example, all community providers will continue to receive ongoing Provider Services support. Our approach is designed to have our O/CA and local Provider Services Representative work collaboratively as they outreach to providers. Together, they will deliver high contact, high visibility contact with community-based providers and MSICs in a manner that identifies and resolves problems early, and when possible, anticipate problems and proactively implement solutions to improve health plan operations, increase the efficiency of the provider's practice, and ultimately improve the quality and cost efficiency of the delivery of care.

The O/CA does not replace the case manager as the primary contact with the member and family. The O/CA will have the primary responsibility of facilitating communication from members, stakeholders and community providers into MCP operations.

Additional responsibilities of the O/CAs within the Ombudsman/Client Advocacy Program include:

- Continuously keeping members and members' families best interests at the forefront of the program
- Facilitating the CRS Member Advisory Council meetings and related activities
- Participating in all CRS-related councils and committees (e.g., Quality Management, Policy and Procedure, Pharmacy and Therapeutics, Medical Management, Contracting, Cultural Competency)
- Promoting cultural competency in every aspect of the member's experience
- Continuously identifying stakeholders (e.g., Center for Disability Law, etc.), putting them on our contact list, maintaining stakeholder communication, developing relationships with new stakeholders and enhancing current stakeholder relationships
- Finding ways to engage these stakeholders (e.g., set up meetings; provide information through Member Services Department; communicate through website and other means)
- Serving as a centralized mechanism for bringing stakeholder feedback to the attention of the organization at the highest levels (e.g., executive/strategic; multidisciplinary; policy committees
- Disseminating results of stakeholder participation/input back to stakeholders
- Attending outreach events within the community
- Collaborating with MCP's Provider Services teams and Business Development and Strategy to support the success of the regional MSICs
- Serving as the primary point of contact for providing training and technical assistance as requested by the MSICs

***Additional Responsibilities***

MCP's DO/CA will be also responsible for increasing the ability of MCP's CRS program to collect and analyze data to better assess the health needs of members with a CRS condition using a holistic approach. Our DO/CA, with the support of appropriate subject matter experts and consultants, will be responsible for collecting and analyzing regional and statewide data and using the results of analysis to recommend and/or implement process improvements to evaluate the effectiveness of the interventions and to better identify disparities affecting healthcare delivery. MCP's DO/CA will have the responsibility of analyzing and reporting the overall effectiveness of the program. The DO/CA will engage stakeholders during this process. The O/CAs, with the appropriate support of the DO/CA, subject matter experts and consultants, will be responsible for comparable regionally based activities to facilitate the gathering and dissemination of data to contribute to regional performance improvement efforts.

The DO/CA will play a central role in advocating for strategies that advance the implementation of health information technologies such as, electronic health records, health information exchanges, telemedicine/telehealth technologies and technologies that increase members' access to care and promote care coordination.

***Accountability***

MCP will measure the success of our Ombudsman/Client Advocate/Advocacy Program using an evaluation plan that will be developed in collaboration with stakeholders. MCP anticipates that accountability measures may include, but will not be limited to the following examples:

- Member satisfaction surveys
- Provider satisfaction surveys
- Numbers of complaints/grievances
- Feedback from other MCP departments (e.g. Member Services, Quality Management)
- Reduction in unnecessary costs (e.g., unnecessary ED visits and readmissions)
- Other stakeholder feedback
- Timeliness of care delivery
- Quality and clinical outcomes

The results of the evaluations will be for continuous process improvement activities and to increase transparency and accountability in this important program serving vulnerable children with special needs.

In summary, MCP recognizes the importance of stakeholders in contributing to the success of the CRS system. MCP operates under the philosophy that change comes from the bottom up and that all stakeholders must have an equal voice in the system. As evidence of our commitment to the program's success, MCP has gone above and beyond the requirements to establish the Office of the Ombudsman in order to achieve AHCCCS's and MCP's shared vision of transforming the system to be more accessible, coordinated, effective and accountable to Arizona's Children with Special Healthcare Needs and their families.