Response to AHCCCS

RFP # YH14-0001

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THE UNIVERSITY OF ARIZONA
HEALTH PLANS

University Family Care

January 28, 2013

THE UNIVERSITY OF ARIZONA
HEALTH PLANS

MISSION

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

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D. Executive Summary

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

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

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

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

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

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

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

Medicare Structure

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

Integration of Medicare and Medicaid Services

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

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

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

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

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

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

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

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

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

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

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

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

Grievance System: The health plan's grievance and appeals (GA) system is currently integrated in a single department. While current requirements under the program are not integrated, health plan employees are cross-trained and the structure is designed for a seamless transition to the requirements of the Demonstration. Through the use of the PDSA process, the GA department has improved member and provider resolution timelines. In addition, by cross-training employees and expanding technology the GA department has enhanced reporting, tracking and trending and streamlined processes. Enhanced processes and interdepartmental teams are established to monitor claims disputes, resolutions, and claims negotiations as mechanisms aimed at identifying avoidable grievances and appeals. Once identified, operational changes are implemented to ensure the avoidable grievance or appeal will not occur again in the future.
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Branding: UCA is a brand that is successfully launched in five counties, largely due to its affiliation to UFC. Branding strategies, including graphic representation, website design and content, brochures, and communication methods promote the relationship between UCA and UFC. The sales and communication strategies are designed to target dual-eligible members with UFC as their health plan, to educate them on the benefits of care coordination through enrollment in the same AHCCCS and Medicare plan. UFC will employ these same strategies in new counties, and will employ a comprehensive communication and education plan if passive enrollment is realized.

Conclusion

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

D. Disclosure

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

University Family Care does not have any Moral or Religious Objections

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VALUES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 1. UFC Access to Care Rates by CYE

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

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

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

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

UFC Ensures a Sufficient Structure to Efficiently Implement Program Operations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UFC Identification of Network Deficiencies

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

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

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

UFC Effectively Manages the Network

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

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

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

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

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

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

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

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

UFC Makes Improvements to the Network

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

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

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

UFC Sustains a Robust Network

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

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

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

Driving Improvement through Data and Evidence-Based Decision Support Tools

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

Table 1. Target Areas and Minimum Performance Standard Benchmarks

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

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

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

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

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

Table 2: UFC-Chronic Disease Total Cost of Care

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

Table 3: UFC- Diabetic Metrics

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

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

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

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

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

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

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

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

Table 4

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

Member Experience - Access to Care: UFC is well poised to meet the needs of current members, as well as anticipated membership growth. UFC uses GeoNetworks, appointment availability, member satisfaction, and other core metrics to ensure optimum network capacity. When access to care is limited, UFC reaches out to providers to address gaps. Member Service Representatives (MSR) inform members searching for PCPs in PCMHs near their home and, through Siebel notification, educate members due for a preventive service during phone interactions. UFC care coordination efforts have directly improved the members' access to healthcare services as reflected by AHCCCS Access to Care Performance Measures which exceeded the MPS in 2012 for 12 month through 19 year old members.

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

Outcome and Value-Oriented Payment Models

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

UFC's Incentivized Payment Model

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

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

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

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

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

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

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

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

Care Coordination for Mr. Andrews

Referral and Intake Process

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

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

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

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

Case Management Services

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

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

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

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

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

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

Improving Outcomes for Members with Chronic Conditions

Addressing the Impact of Chronic Conditions

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

Table 1. Prevalence of Chronic Conditions

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

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

Prevention and Health Promotion Programs

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

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

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

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

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

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

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

Complex Case Management

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

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

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

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

Behavioral Health Case Management

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

Provider Engagement

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

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

Table 2. UFC Performance Measure Improvements

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

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

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

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

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

The UFC Approach to Care Coordination

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

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

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

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

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

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

Care Coordination for George

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

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

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

Hospital Coordination

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

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

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

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

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

Discharge Planning and Coordination During Care Transitions

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

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

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

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

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

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

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

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

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

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

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

University Care Advantage's Arizona Experience and Accomplishments

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

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

Table 1, 2013 Four- and Five-Start Measure Results

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

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

Maximizing Care Coordination and Member Experience

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

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

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

Health Risk Assessment and Member Outreach

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

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

Interdisciplinary Care Teams (ICT)

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

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

Provider Expertise in Caring for Special Needs Populations

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

Case Management Programs

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

Table 2. Diabetic Testing Improvements

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

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

Integrating Behavioral Health Into Primary Care

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

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

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

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

Innovative Program: Healthy Together Care Partnership (HTCP)

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

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

Interdepartmental collaboration to Improve Member Experience and Improve Outcomes

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

Member Engagement

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

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

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

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

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

Increasing Alignment of Dual-Eligible Beneficiaries

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

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

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

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

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

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

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

A) Using Published Guidelines To Prevent Unnecessary Services

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

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

B) Prevention

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

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

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

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

C) Sharing of EHR Data

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

D) Provider Financial Incentives

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

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

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

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

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

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

Provider and Member Engagement	Providers, Members	10/1/13-7/1/15	Exceed Diabetes Performance Measures MPS; Reduce Diabetes Cost of Care by 5%, Launch Member Portal

Initiative 2 – Improve Operational and Administrative Efficiency

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

A) Reduction In Administrative Expenses

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

B) Leverage and Invest in Technology To Optimize Operations

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

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

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

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

Initiative 3 – Reduce Waste Resulting from Fraud

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

Initiative 3 Summary	Stakeholders (other than UFC, AHCCCS)	Timeline	Anticipated Outcomes
Reduce Waste from Fraud and Abuse	Providers, Members, OIG, Law Enforcement, local community, vendors	10/1/13 – Ongoing	▪ Annual Work Plan ▪ 25% Increase in Provider, Member and Employee Fraud and Abuse Awareness ▪ Three New Fraud and Abuse Tactics Identified and Implemented

Conclusion

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

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

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

Activities Taken/Resources Deployed to Limit Fraud and Abuse

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

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

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

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

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

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

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

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

Activities Taken/Resources Deployed to Identify Fraud and Abuse

UFC Department Activities: Fraud and abuse activities are not just the responsibility of the Compliance Department, but the responsibility of all the workforce. Below is a sample of various departmental activities deployed to identify fraud.
Claims: To ensure provider payments are appropriate, the Claims Department (Claims) monitors for fraud and abuse via iCES, which applies pre-payment system edits, live payment edits and coordination of benefits. UFC's Pharmacy Benefit Manager (PBM) employs point-of-sale edit software and coordination of benefits. Claims monitors for trends and provider patterns and reports suspicious activity to the FWA Analyst via Siebel. Claims conducts quality audits of its individual Claims Processors. Should the audit identify consistent or suspicious errors, Claims re-trains and may discipline the processor. When suspicious billing is identified, Claims can place a provider on manual review status in the GE MCA system and require review of all claims prior to payment.
Compliance: The Compliance Department deploys eight auditors, including a licensed R.N. and two Certified Professional Coders (CPCs), a Medicare Advisor (MA), along with the FWA Analyst. All focus on areas of risk – including fraud and abuse identification and annual audits of UFC subcontractors to ensure that fraud and abuse prevention programs are in place. Claims Auditors conduct monthly quality audits to review processed claims for financial and processing accuracy. They look for unusual claims payment patterns. Compliance also monitors sanction screening and exclusion databases to ensure employees and vendors are eligible to participate in federal and state programs.
Network Development: In the course of servicing providers, UFC Provider Relations Representatives (PRR) makes unannounced provider office visits. Sometimes the PRR is joined by other UFC representatives, including the CMO, Medical Director, Quality Management Director or Director of Medical Management. If a provider is confirmed by AHCCCS OIG, the Attorney General's Office or MEDIC to be engaged in fraudulent activity, immediate action is taken to terminate the provider. Network Development also monitors the sanction screening and exclusion database to ensure providers and subcontractors are eligible to participate in federal and state programs.
Medical Management: The Medical Management Systems Unit retrospectively reviews claims, including DME, professional and facility claims. Medical records are examined to determine medical necessity and appropriate care. The review evaluates services or treatment including medications that have been provided and are based on AHCCCS criteria, CMS guidelines and business decisions on correct coding and associated reimbursements. Should fraud and abuse be suspected, a referral is made to the FWA Analyst via Siebel. For example, while reviewing mobile anesthesiology claims, the Retrospective Review team noted the provider submitted lengthy documentation, but analysis determined the provider billed using a self-created formula for time spent on "oxygen while under conscious sedation." The case was reported to AHCCCS OIG. UFC identified $6,214 in suspicious billings and the savings realized by AHCCCS may be greater.
Quality Management: The Quality Management Department (Quality) includes added steps to identify fraud and abuse. The Quality Manager supplies abuse of member reports to the FWA Committee and investigates member abuse allegations. When cases of suspected child or elder abuse are encountered by UFC staff, these are referred to Quality to ensure appropriate reporting occurs, including notification to AHCCCS. This includes but is not limited to investigations of unexplained deaths, inappropriate treatment by a caretaker and inappropriate use of chemical restraints with anti-psychotics in nursing homes for members transitioning to ALTCS. In 2012 a quality-of-care case was opened when a member complained of not being able to obtain medical records from his former PCP. When Quality examined the records, they discovered inadequate documentation. The Peer Review Committee reviewed the case and confirmed the results. A referral was made to the FWA Analyst and the same medical records were requested for review. Upon receipt it was evident the newly supplied records had been inappropriately modified to better support payment for services, in some cases they were modified a year after the service delivery. UFC met with an AHCCCS OIG investigator to collaborate and the case was immediately referred to an Attorney General's Office investigator. UFC identified $21,740 in suspicious billings and the savings to AHCCCS may be greater.
Pharmacy: The Pharmacy Department works to provide safe and appropriate medications, but it sometimes identifies members who misuse medications, the most common of which are prescribed opioids. UFC's Pharmacy team developed processes to address the misuse of opioids. These include: 1) Pharmacy and Therapeutics Committee oversight, including PA edits for most long-acting opioids and carisoprodol, a medication commonly associated with inappropriate opioid use,

was removed from the formulary because there are safer alternatives to replace it; 2) Conducting a complete medication history review as part of the PA process for long-acting opioid prescription requests and any "refills too soon" or lost prescriptions are thoroughly researched; 3) Reviewing retrospective drug utilization reports from the PBM to identify members exhibiting drug-seeking behaviors, including multiple prescribers, multiple pharmacies and frequent prescriptions for small quantities of controlled substances; 4) Encouraging communication between PCPs, pain specialists and UFC to better manage member care; 5) Researching and responding to drug-seeking member referrals from the FWA Analyst, Case Managers, pharmacy providers and medical providers. When substantiated, the FWA Analyst reports the member to AHCCCS OIG and/or MEDIC, and AHCCCS members can be locked to a specific pharmacy and/or prescriber to better monitor care. Since 2011, UFC has identified 13 drug-seeking members. These members were offered case management and a care plan developed in collaboration with the PCP. Identification of drug-seeking members within the population has improved with UFC's recent access to the State Board of Pharmacies Controlled Substances Prescription Monitoring Program (CSPM). This enables UFC to view all controlled-substance utilization by members, even if the medication is paid in cash and by-passes encounter data. Since August 2012, UFC has submitted more than a dozen queries to the CSPM and identified two members exhibiting drug-seeking behavior in their use of multiple prescribers and pharmacies. A comprehensive opiate utilization program is being implemented for members who over-utilize opiates. Additionally, UFC actively participates in the AHCCCS Behavioral Health Performance Improvement Project, which coordinates exchange of medication information between UFC and the Regional Behavioral Health Authority.
Member Services: UFC monitors members, including members who move out-of-area, no longer qualify for benefits or may be "doctor or prescription shopping" for illegal drugs. All Member Service Representatives (MSR) are required to report suspicious activity. UFC's Member Services Department (MS) conducts outbound service verification calls and calls members to verify receipt of paid service. The call is documented in Siebel and reported to AHCCCS. Should a member indicate a service was not provided; a referral would be made to the FWA Analyst. Since 2010, MS has made 36 referrals, MM has made 62 referrals and QM has made five referrals. When a member is engaged in a suspicious activity, MS identifies that member in Siebel. When others use Siebel, including Case Managers, UM or QM, this is evident and a member's care is managed with that in mind. In 2012, MS received a call from a DME provider. The provider was using the eServices portal to check eligibility and found a discrepancy for a member's date of birth. MS checked AHCCCS On-Line and discovered two members with the same name – a father and son. The father was a member of Mercy Care and no longer eligible for service, but the son was still an active UFC member. After review, it was determined the father was likely using the son's AHCCCS ID card to receive care. The FWA Analyst found claims tied to the father and discovered some were submitted and processed in error. The member was reported to AHCCCS OIG and $2,029 in UFC claims were reversed. AHCCCS may realize even greater recoveries.

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

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

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

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

Activities Taken/Resources Deployed to Address Fraud and Abuse

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

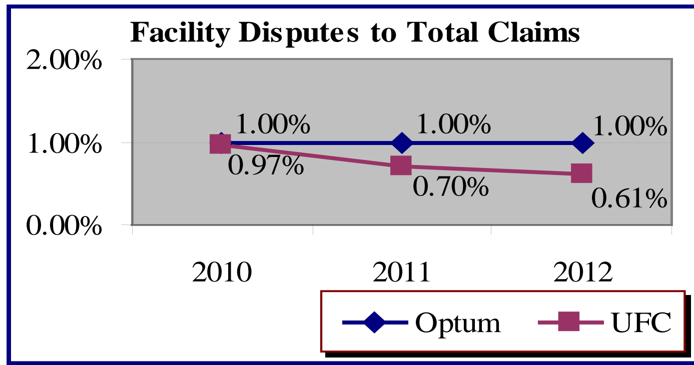
Continuing Education and Awareness: UFC requires the Compliance Officer obtain compliance certification. UFC's Compliance Officer has CHC certification from the respected Health Care Compliance Association. Maintaining this certification requires continuing education, including training on innovative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

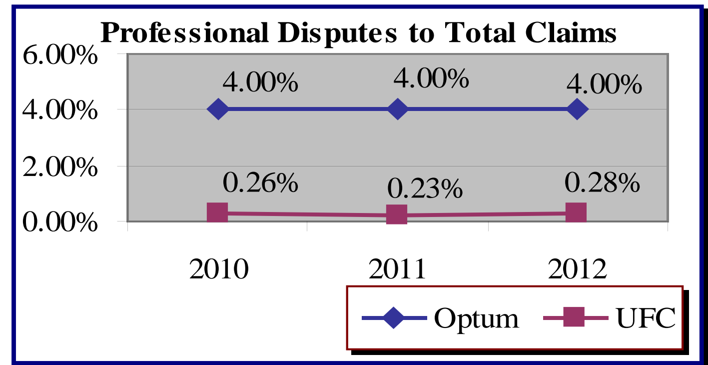
Annual Work Plan: UFC's FWA Committee is launching an annual work plan that will include a minimum of four fraud, waste and abuse education activities per year for providers, members and employees along with three fraud and abuse analyses per year based on current literature and findings. The FWA plan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

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

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

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





UFC Minimizes the Need to Utilize the Claims Dispute Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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