


**EXHIBIT A: OFFEROR'S CHECKLIST**

The Offeror must complete the Offeror's Checklist. The Offeror's Checklist must be submitted with the Proposal and shall be the initial pages of the Proposal. The Offeror's Checklist includes all submission requirements for the Proposal. It is the Offeror's responsibility to ensure it has submitted all requirements in the RFP notwithstanding the items included in the Offeror's Checklist.

In the column titled "Offeror's Page No.," the Offeror must enter the appropriate page number(s) from its Proposal where AHCCCS may find the Offeror's response to the specified requirement. Refer also to the **Submission Requirements** outlined in RFP Section H: Instructions to Offerors.

<b>OFFEROR'S CHECKLIST</b>		
<b>Submission Requirement</b>	<b>RFP Section</b>	<b>Offeror's Page No.</b>
Offeror's Bid Choice Form	RFP Exhibit B Refer to Bidders' Library	2
Offeror's Completed and Signed RFP Solicitation Page	RFP Section A	3
Offeror's Signed Signature Page(s) for each Solicitation Amendment	Refer to Bidders' Library	5
<b>Capitation Bid Submission</b>		
Capitation Bid Template/Tool(s)	Instructions to Offerors	11
Capitation Actuarial Certification(s)	Instructions to Offerors	14
<b>Executive Summary and Disclosure</b>		
Executive Summary	Instructions to Offerors	16
Moral or Religious Objections	Instructions to Offerors	19
<b>Narrative Submission Requirements</b>		
Program #1	Instructions to Offerors	20
Program #2	Instructions to Offerors	25
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Access to Care/Network #7	Instructions to Offerors	50
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Administrative #10	Instructions to Offerors	65
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<b>Oral Presentations</b>		
Names and Titles of Participating Individuals	Instructions to Offerors	222
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Completed and Signed Attestation	RFP Exhibit F Refer to Bidders' Library	236

EXHIBIT B: OFFEROR'S BID CHOICE FORM

ALTCS E/PD YH18-0001 BID CHOICE		
<p><b><u>UnitedHealthcare Community Plan</u></b>                      Offeror's Name</p>	<p>is bidding on the ALTCS E/PD Program                      in the GSA(s) <u>checked</u> below:</p>	
<p>GSA North: Mohave, Coconino, Apache, Navajo and Yavapai Counties                      GSA South: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties                      GSA Central: Maricopa, Gila, and Pinal Counties</p>		
PERMISSABLE BIDS BY GSA		
N/A	Central Only	No
N/A	Central and South Only	No
<input type="checkbox"/>	North Only	Yes
<input type="checkbox"/>	South Only	Yes
<input type="checkbox"/>	North and South Only	Yes
<input type="checkbox"/>	Central and North Only <sup>1</sup>	Yes
<input checked="" type="checkbox"/>	Central and North and South <sup>2</sup>	Yes
<p><sup>1</sup>In order to be considered for award in the Central GSA, the Offeror <u>must</u> submit a competitive bid in the North GSA as well. A submission for the Central GSA that does not include a proposal for the North GSA will not be considered. However, AHCCCS may choose not to award a contract for both GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.</p> <p><sup>2</sup>AHCCCS does not intend to award contracts for all GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.</p>		
<p style="text-align: center;">                      _____                      Authorized Signature</p>	<p style="text-align: center;"><u>January 3, 2017</u>                      _____                      Date</p>	
<p><b><u>Joseph G. Gaudio</u></b>                      Print Name</p>	<p><b><u>CEO, UnitedHealthcare Community Plan</u></b>                      Title</p>	





**OFFER**

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final Proposal revisions (if any). Signature also certifies Small Business Status.

Arizona Transaction (Sales) Privilege Tax License No.:

N/A

Federal Employer Identification No.:

86-0813232

E-Mail Address: jgaudio@uhc.com

UnitedHealthcare Community Plan  
Company Name

1 East Washington, Suite 900  
Address

Phoenix                      AZ                      85004  
City                              State                      Zip

For clarification of this offer, contact:

Name: Joseph G. Gaudio

Title: CEO, UnitedHealthcare Community Plan

Phone: (602) 255-1717

  
Signature of Person Authorized to Sign Offer

Joseph G. Gaudio  
Printed Name

CEO, UnitedHealthcare Community Plan  
Title

**CERTIFICATION**

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

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.
4. The Offeror certifies that the above referenced organization \_\_\_\_\_ is /  is not a small business with less than 100 employees or has gross revenues of \$4 million or less.

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

Your offer, including all exhibits, amendments and final Proposal revisions (if any), contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached Contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS. The Contractor is cautioned not to commence any billable work or to provide any material or service under this Contract until Contractor receives written notice to proceed.

This Contract shall henceforth be referred to as Contract No. YH18-0001.

Award Date: \_\_\_\_\_

**MEGGAN HARLEY, AHCCCS Chief Procurement Officer**



SOLICITATION AMENDMENT #1		
<b>YH18-0001</b> ALTCS E/PD RFP	Solicitation Due Date:  <b>January 23, 2017</b> <b>3:00 pm Arizona Time</b>	Chief Procurement Officer: Meggan Harley  Email: <u>EPDYH18_QuestionstoRFP@azahcccs.gov</u>

A signed copy of this amendment must be submitted with your solicitation response.



This Solicitation is amended as follows:

**RFP Section I: Exhibits, Exhibit E: Medicare Requirements:**  
**Participation as a Medicare Advantage Special Needs Plan**

All ALTCS E/PD Contractors will be required to provide Medicare benefits to dual eligible members as a D-SNP in all awarded counties. Contractors will be required to implement Medicare business on **January 1, 2018** and thus all Offerors are required to submit a non-binding Notice of Intent to Apply (NOIA) as a D-SNP to CMS no later than ~~November 10, 2016~~ **November 14, 2016**. Additional information and exact submission dates for 2017 can be found here:

<https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/>.

To comply with the statute A.R.S. §36-2906.01, the NOIA must be submitted under the Medicare entity name. D-SNPs must have a contract with AHCCCS to enroll ALTCS E/PD full benefit dual eligible members and must have a D-SNP subset that matches this Contract. All Offerors must also submit D-SNP applications to CMS by ~~February 2017~~ **February 15, 2017**. Additional information on D-SNPs can be found at: <http://www.cms.gov/SpecialNeedsPlans>.


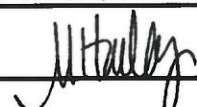
<b>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</b>	<b>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</b>
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: 
TYPED NAME: Joseph G. Gaudio	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO, UnitedHealthcare Community Plan	TITLE: Chief Procurement Officer
DATE: 11/3/2017	DATE: 11/7/2016

<b>SOLICITATION AMENDMENT #2</b>		
<b>YH18-0001</b> ALTCS E/PD RFP	Solicitation Due Date:  <b>January 23, 2017</b> <b>3:00 pm Arizona Time</b>	Chief Procurement Officer: Meggan Harley  Email: <u><a href="mailto:EPDYH18_QuestionstoRFP@azahcccs.gov">EPDYH18_QuestionstoRFP@azahcccs.gov</a></u>

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

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

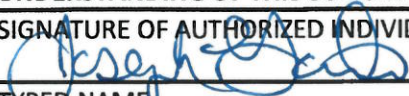
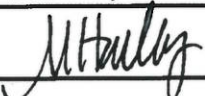
<b>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</b>	<b>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</b>
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: 
TYPED NAME Joseph G. Gaudio	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO, UnitedHealthcare Community Plan	TITLE: Chief Procurement Officer
DATE: 1/3/2017	DATE: 11/21/2016

<b>SOLICITATION AMENDMENT #3</b>		
<b>YH18-0001</b> ALTCS E/PD RFP	Solicitation Due Date:  <b>January 23, 2017</b> <b>3:00 pm Arizona Time</b>	Chief Procurement Officer: Meggan Harley  Email: <u><a href="mailto:EPDYH18_QuestionstoRFP@azahcccs.gov">EPDYH18_QuestionstoRFP@azahcccs.gov</a></u>

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

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

<b>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</b>	<b>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</b>
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: 
TYPED NAME: Joseph G. Gaudio	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO, UnitedHealthcare Community Plan	TITLE: Chief Procurement Officer
DATE: 11/3/2017	DATE: 12/19/2016




<b>SOLICITATION AMENDMENT #3</b>		
<b>YH18-0001</b> ALTCS E/PD RFP	Solicitation Due Date:  <b>January 23, 2017</b> <b>3:00 pm Arizona Time</b>	Chief Procurement Officer: Meggan Harley  Email: <a href="mailto:EPDYH18_QuestionstoRFP@azahcccs.gov">EPDYH18_QuestionstoRFP@azahcccs.gov</a>

**A signed copy of this amendment must be submitted with your solicitation response.**

This Solicitation is amended as follows:

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

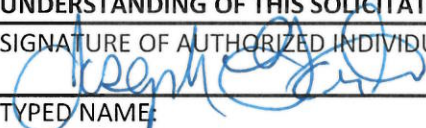
<b>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</b>	<b>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</b>
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: Joseph G. Gaudio	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO, UnitedHealthcare Community Plan	TITLE: Chief Procurement Officer
DATE: 1/11/2017	DATE: 01/06/2017

<b>SOLICITATION AMENDMENT #4</b>		
<b>YH18-0001</b> ALTCS E/PD RFP	Solicitation Due Date:  <b>January 23, 2017</b> <b>3:00 pm Arizona Time</b>	Chief Procurement Officer: Meggan Harley  Email: <a href="mailto:EPDYH18_QuestionstoRFP@azahcccs.gov">EPDYH18_QuestionstoRFP@azahcccs.gov</a>

**A signed copy of this amendment must be submitted with your solicitation response.**

This Solicitation is amended as follows:

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

<b>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</b>	<b>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</b>
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: Joseph G. Gaudio	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO, UnitedHealthcare Community Plan	TITLE: Chief Procurement Officer
DATE: 1/11/2017	DATE: 01/06/2017

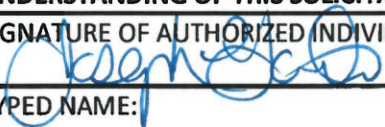
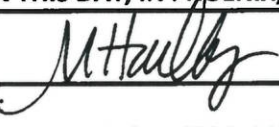
**SOLICITATION AMENDMENT #5**

<p><b>YH18-0001</b> ALTCS E/PD RFP</p>	<p>Solicitation Due Date:  <b>January 23, 2017</b> <b>3:00 pm Arizona Time</b></p>	<p>Chief Procurement Officer: Meggan Harley</p> <p>Email: <a href="mailto:EPDYH18_QuestionstoRFP@azahcccs.gov">EPDYH18_QuestionstoRFP@azahcccs.gov</a></p>
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**A signed copy of this amendment must be submitted with your solicitation response.**

This Solicitation is amended as follows:

1. The attached IT Demo Calendar revisions are incorporated as part of this solicitation amendment.

<p><b>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</b></p>	<p><b>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</b></p>
<p>SIGNATURE OF AUTHORIZED INDIVIDUAL: </p>	<p>SIGNATURE: </p>
<p>TYPED NAME: Joseph G. Gaudio</p>	<p>TYPED NAME: Meggan Harley, CPPO, MSW</p>
<p>TITLE: CEO, UnitedHealthcare Community Plan</p>	<p>TITLE: Chief Procurement Officer</p>
<p>DATE: 1/13/2017</p>	<p>DATE: 01-11-2017</p>




<b>SOLICITATION AMENDMENT #6</b>		
<b>YH18-0001</b> ALTCS E/PD RFP	Solicitation Due Date:  <b>January 23, 2017</b> <b>3:00 pm Arizona Time</b>	Chief Procurement Officer: Meggan Harley  Email: <a href="mailto:EPDYH18_QuestionstoRFP@azahcccs.gov">EPDYH18_QuestionstoRFP@azahcccs.gov</a>

**A signed copy of this amendment must be submitted with your solicitation response.**

This Solicitation is amended as follows:

**Section D: Program Requirements, Paragraph 80 – Value- Based Purchasing**

**Value-Based Purchasing Initiative:** The purpose of the VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 318 CYE 16 and CYE 17 and as specified in Attachment F3, Contractor Chart of Deliverables. Quality distributions to Contractors will be funded by assessing 1 percent of Prospective Gross Capitation (Quality Contribution) exclusive of Acute Care Only payments. One hundred percent (100%) of the Quality Contribution will be distributed to one or more Contractors according to the Contractors’ performance on selected Quality Management Performance Measures relative to minimum performance standards established by CQM and the Contractors’ ranking on QMPMs. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a Contract Year basis. It is the intent of AHCCCS to require that the Contractor move to the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 effective October 1, 2017. Additionally, AHCCCS intends to update ACOM Policy 318 CYE 16 and CYE 17 requirements regarding the percentage of payments that must be governed by VBP strategies. That language shall require that both the ALTCS E/PD Contract, and the MA-DSNP Contract for ALTCS E/PD Duals, each reach 35% and 50% of total payments governed by VBP strategies for CYE 18 and CYE 19 respectively. Inclusion of payments for Room and Board for members residing in Nursing Facilities (which are included in per diem payments and not separately identifiable) are permissible when computing the percentage of total payments that are governed by VBP strategies.

<b>OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.</b>	<b>THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.</b>
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: Joseph G. Gaudio	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO, UnitedHealthcare Community Plan	TITLE: Chief Procurement Officer
DATE: 1/18/2017	DATE: 01-17-2017

**ALTCS/EPD RFP Bid Template -**  
**Scored Rate Components by Risk Group and GSA**

<b>Dual</b>	<b>North</b>	<b>South</b>	<b>Central</b>
Medical Component	\$2,563.59	\$2,782.09	\$2,847.45
Case Management Component	\$158.00	\$150.00	\$150.00
Administrative Component	\$180.00	\$180.00	\$180.00
Sub-Total of Scored Components	\$2,901.59	\$3,112.09	\$3,177.45

<b>Non-Dual</b>	<b>North</b>	<b>South</b>	<b>Central</b>
Medical Component	\$5,124.09	\$5,628.30	\$6,227.87
Case Management Component	\$158.00	\$150.00	\$150.00
Administrative Component	\$180.00	\$180.00	\$180.00
Sub-Total of Scored Components	\$5,462.09	\$5,958.30	\$6,557.87

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**ALTCS/EPD RFP Bid Template -**  
**Scored Rate Components by Risk Group and GSA**

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January 12, 2017

### Actuarial Certification

I, Bonnie M. Punch, Actuary at UnitedHealthcare, Member of the American Academy of Actuaries (MAAA), and an Associate of the Society of Actuaries (ASA), am certifying that the capitation rates presented in the Capitation Bid Template/Tool are reasonable and appropriate for the populations and services covered under the Contract/RFP No. YH18-0001 for the initial contract period. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board, specifically the guidance put forth in the Actuarial Standards of Practice #41 and #49.

Medicaid capitation rates are “actuarially sound” if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

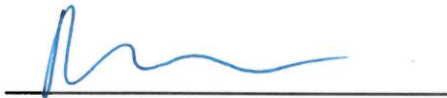
In developing the capitation rates proposed by UnitedHealthcare that are covered by this certification, we relied on data and information provided by Arizona Health Care Cost Containment System (AHCCCS) in the Contract/RFP No. YH18-0001 under Section F - Bid Submission Information, as well as other internal UnitedHealthcare data and information sources. The medical component of the capitation rates proposed by UnitedHealthcare and covered with this certification fall within the published actuarially-determined rate ranges as presented by AHCCCS Actuaries in the “Medical Components Ranges” document of Section F – Bid Submission Information. The non-medical components of these capitation rates proposed by UnitedHealthcare include provisions for administrative expenses, including medical management, and underwriting gain that are reasonable and appropriate for the populations and services covered under the Contract/RFP No. YH18-0001 for the initial contract period. The capitation rates proposed by UnitedHealthcare that are covered with this certification do not include the following provisions that will be determined by AHCCCS Actuaries and provided to UnitedHealthcare prior to October 1, 2017:

- Share of cost amounts
- Nursing facility/home and community-based services mix percentages
- Reinsurance offsets
- Premium tax percentages
- Prior period coverage capitation rates
- Capitation rates for members with acute care-only benefits
- Actuarial assumptions that were not previously included in the published capitation rate ranges or the awarded capitation rates

The capitation rates proposed by UnitedHealthcare rates that are covered with this certification are considered actuarially sound for purposes of a capitation rate acceptance, and meet the criteria for the actuarial soundness requirements of 42 CFR 438.6(c) in that they,

1. have been developed in accordance with generally accepted actuarial principles and practices;
2. are appropriate for the populations to be covered, and the services to be furnished under the contract; and
3. have been certified, as meeting the requirements of this paragraph [42 CFR 438.6(c)], by actuaries who meet the Qualification Standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

The actuarially sound rates that are associated with this certification are effective October 1, 2017 through September 30, 2018 for the Arizona Long Term Care System Elderly & Physical Disability Program, and are based on a projection of future events. Actual experience will vary from the experience assumed in the rates.



Bonnie M. Punch, ASA, MAAA  
Director, Actuarial Services

## Executive Summary and Disclosure

### Executive Summary

#### OVERVIEW OF ORGANIZATION AND RELEVANT EXPERIENCE

Arizona Physicians IPA, Inc. (d.b.a. UnitedHealthcare Community Plan hereinafter referred to as UnitedHealthcare) thanks Arizona Health Care Cost Containment System (AHCCCS) for releasing this RFP as a demonstration of their tremendous commitment to the citizens of Arizona and the future of the health care and human service system through the development of the Arizona Long Term Care System (ALTCS) program. It is our privilege to be a part of the innovation and evolution of health care and human services delivery in Arizona.

As an industry leader in long-term care (LTC) programs, we have been a partner in the ALTCS program since 1989. An important component of our innovation is our statewide coverage. As the sole managed care company to deliver services to all three geographic service areas (GSAs), we are and have historically committed to be part of the same community as our ALTCS members. We are responsible for supporting communities, informal supports and expanding access to services, so as many members as possible can live safely and happily in integrated community settings. Throughout our tenure in the state, we forged meaningful relationships with our providers and communities to provide a program for our members that maintain consistency of services with the least amount of disruption. Our current experience providing statewide coverage to more than 10,000 members across all three defined GSAs affords members continuity of care, greater network access and mobility if they travel or relocate. We look forward to continuously evolving with the times and being proactive to the developing landscape.

#### ADDING VALUE THROUGH OUR APPROACH TO DELIVERING CONTRACT REQUIREMENTS

At UnitedHealthcare, our mission – *helping people live healthier lives* – drives and guides us. The values that serve as the foundation of our mission statement mirror the guiding principles of AHCCCS and stem from our commitment to **Integrity, Compassion, Relationships, Innovation** and ultimately our **Performance**. These values direct us to meet the needs of our members through a person-centered approach; support system change by focusing on the services and supports members need to maximize independence; and scaling our systems to meet all of our diverse members' needs regardless of their health care setting or conditions.

#### Member-Centered Case Management

We empower all of our members to participate actively in the development of a care plan as a full partner to make decisions about their care and services to help them achieve their outcomes. We recognize these outcomes will look different for a member starting his/her young life than for a member at the end of life, but both focus on their goals and desires, whether it is comfort, experiences or achievements.

**Adding Value:** At the core of our approach to supporting members through case management is a commitment to implementing a me\* member empowerment culture. **me\* was recognized and published by the Medicaid Health Plans of America as a national Medicaid Plan Best Practice in 2014-2015.** Its focus is to find opportunities to engage members to be active participants in their individualized plan of care and communities, and increase their quality of life.

#### Member-Directed Options

Empowering our members and engaging them in managing their care helps improve their quality of life, achieve their health care goals and meet their needs. We have designated leads for the self-directed attendant care and the Agency with Choice benefit. Additionally, our provider advocates serve as educational and support resources for all providers of the ALTCS service delivery options.

**Adding Value:** We recognize an important facet to supporting members' choice, control and flexibility is supporting their caregivers. Based on research on family caregiver needs, *uhcforcaregivers.com* helps caregivers solve common



problems in a holistic way. Designed to provide comprehensive support to family caregivers, this site offers educational resources, functionality to share information with other care providers, family and friends, and a task/calendar manager.

### Person-Centered Planning

Aligned with the goals of the ALTCS program, we built our model of care on a person-centered, whole-person, recovery-oriented culture that drives the development of our care coordination programs, processes, procedures and approach to working with our members. Our person-centered model is an integrated approach incorporating flexibility based upon the changing needs and goals of the individual. We assign a case manager appropriate to the member's primary area of need (medical, behavioral, functional and social), conduct a comprehensive assessment and develop a member-specific care plan collaboratively with the member, his/her family, caregivers, providers and community supports.

**Adding Value:** As we augmented and expanded our IT system capabilities to be more user-friendly and accessible to our members and providers, we focused on initiatives relating to emerging trends, social determinants of health and the State's priorities, which drove our decisions in investing in IT systems to support a person-centered environment.

### Consistency of Services

As the sole LTC plan in all three GSAs in Arizona, we know the importance of maintaining consistency of services for our members. Providing a statewide program ensures no disruption or compromise to medically necessary services in any way that would jeopardize our members' health. Our shared documentation platform keeps the interdisciplinary care team (ICT) team aware and involved in our members' care. Our culturally responsive staff and locally based case manager model leverage peers to support members and providers where they are today. ICTs of ALTCS dual and LTC members are potentially broad and diverse, including integrated physical, BH and community-based network of providers, family or other representatives.

**Adding Value:** CommunityCare, our comprehensive electronic care management system, tailors all aspects of our care management programs to meet the unique geographic, demographic and cultural characteristics of the members and providers we serve. It integrates members' acute and preventive care, chronic disease management, medical, behavioral, social and long-term services and supports (LTSS) into a comprehensive record. CommunityCare enables care coordination through web-based access for the care team, primary care providers, specialists, members, caregivers and others — as permitted by the member.

### Accessibility of Network

Since the inception of the ALTCS program in 1989, we have continuously tailored our network to innovatively meet all of our members' immediate and long-term needs. We place a priority on assisting our members, when appropriate, to reside or return to their home versus residing in an institutional or alternative residential setting. Critical network development focus areas include, developing services and settings that support the care plan through all service settings (e.g., nursing facilities, assisted living facilities, home); supporting informal support systems through respite services, adult day health programs and other community resources; developing home and community-based services (HCBS) and settings for members with cognitive impairments, behavioral health (BH) needs and other special medical needs; developing services to address the diversity of our members; and establishing provider training/education programs.

**Adding Value:** We are the only comprehensive statewide network. Recognizing the need for alternative network needs in Arizona, we have enhanced and expanded our telehealth service delivery model in rural Arizona; providing primary, specialty, BH and therapy services. Mountain Health and Wellness (Horizon) and Assertive Community Treatment (ACT) in Yuma are two of our telehealth providers for BH services. We work with providers to meet the unique needs of our members, including those with specialized BH and medical conditions. In recent years, we have collaborated with providers in Northern Arizona to develop specialized BH programs and placement options in skilled nursing facilities, Rim Country, the Winslow Campus of Care and an assisted living alternative with the Austin House. This allows our rural-based membership to live closer to their families and provides better opportunities for the member's family to participate in the member's recovery, including discharge planning to a local, less-restrictive setting.

## Most Integrated Setting

ALTCS members eligible for services come to our program living with chronic illnesses and functional limitations that affect activities of daily living. **Compassion** and the ability to genuinely listen and empathize with our members' reality to then respond with services and advocacy for *each* individual member is a skill practiced by our case management team as a whole and not specific to one particular sub-specialty program. Our members have access to a comprehensive array of services and placements that address their needs through multiple treatment modalities. We provide LTC services in the most home-like setting that can meet members' medical, social and BH needs.

**Adding Value:** The UnitedHealthcare myConnections™ initiative provides members with benefits and services that address social and economic factors that contribute to poor health, increased health care utilization and higher health care spending. myConnections is a system for integrating, organizing and distributing support services for low-income populations while addressing social determinants with the greatest opportunity to improve health outcomes. To date, we have 35 contracted community-based organizations that intake direct electronic referrals from our case managers and our brick and mortar community center in Maryvale. Our myCommunity Connect Center creates innovative social service and community programs enabling individuals and families to improve their well-being and independence. The philosophy of myCommunity Connect Center is to integrate, organize and distribute support services for consumers, providing them greater access to safe housing, transportation, education and job training – essential to good health.

## Collaboration with Stakeholders

The **Relationships** with our community partners and providers helps our clinical team gain a better understanding and ability to implement strategies to reduce or minimize continued patterns. Through special value-based purchasing partnerships with select physician groups and community-based providers, we use a team approach to address utilization patterns, identify change of condition and quickly implement preventive strategies aimed to improve health and wellness outcomes. Our staff at all levels of the organization are dedicated members of the communities in which they live and contribute through positions on town councils, nonprofit boards and organizations such as the Arizona Coalition for Military Families, Work Incentive Information Network (WIIN) and Alzheimer's Association, to name a few.

**Adding Value:** We constantly solicit feedback on areas to improve our program and collaborate with key stakeholders in Arizona. As a result, we proactively implemented an electronic visit verification (EVV) program designed to reduce hospital and ER admits and costs. This program implements Addus Health Care's EVV timekeeping system in which home care agency direct-care workers use smartphones to clock in and out of their home visits with our members. The technology helps improve care outcomes by confirming timely service delivery for our members, including real-time service gap reporting and monitoring. Through the change-in-condition program, members' case managers receive real-time member assessments so we can engage members on actionable areas to improve health and social outcomes, i.e., housing, food, utility issues. Addus caregivers report anything different about our member since the last visit, which does not require emergency intervention, to our high-risk case manager who engages the member's case manager for outreach to the member.

## MEETING MEDICARE REQUIREMENTS

We meet and abide by the requirements specified in RFP Section I, Exhibit E, Medicare Requirements. UnitedHealthcare began administering a dual special needs plan (D-SNP) in Arizona in 2005. Since then, we grew from serving 7,396 members in five counties to 38,574 UnitedHealthcare Dual Complete members and 3,422 UnitedHealthcare Dual Complete ONE (Fully Integrated Dual Eligible [FIDE]) members in 14 of 15 counties (as of Oct. 1, 2016). This represents 50.1 percent of the Arizona D-SNP market share, demonstrating we are the D-SNP of choice in Arizona. In 2016, we accounted for 85 percent of all D-SNP growth in Arizona. We intend to expand our D-SNP to Gila County as of Jan. 1, 2018, to become a statewide D-SNP covering all 15 counties in Arizona. We filed a notice of intent in November 2016 and will submit our formal filing in February 2017.

### ***Moral or Religious Objections***

We do not restrict coverage for any services because of moral or religious objections, nor do we place any constraints on the coverage, reimbursement or delivery of services based upon moral or religious principles. We provide access to all Medicaid services covered under our contract with AHCCCS. All of our provider agreements contain a clause that allows the provider to refuse to provide any service they find objectionable because of moral or religious grounds. In that situation, we assist the member to access another provider who is willing to provide the service.

## Section I: Exhibits

### Program

#### 1. An 85 year old American Indian member currently enrolled with the Offeror, with Medicare Part A and Part B, and ...

This scenario presents a challenging set of factors related to the deteriorating health status of an elderly tribal member living in a rural area and experiencing fragmented, unmanaged care. In our experience, we have encountered these types of circumstances where American Indian individuals, especially women living in rural areas, are isolated without a consistent support system so when health issues arise, they move between the Indian Health System and ALTCS systems and access care from multiple providers. In this case, from what we know about our member (whom we will refer to here as Ms. M) and her health conditions, Ms. M **faces increasing health and safety risks** due to her impaired vision and cognition related to cerebral vascular accident (CVA), transient ischemic attacks (TIAs), behavioral conditions and her lack of adherence to a consistent and appropriate medication regimen. Effective intervention in this scenario involves a series of actions with the **goal of establishing a consistent and reliable case management plan** for Ms. M and involves a case manager that can stay in an ongoing and effective relationship with her. A pragmatic and individualized plan of care (IPC) is necessary to address several multifaceted behavioral, physical and social dimensions. These dimensions include managing agoraphobia and panic, determining capacity and supports for continued independent living and orchestrating supports for medication adherence. Overall, due to Ms. M's history of CVA and stroke, a plan must be in place for close, ongoing monitoring and consistent primary care to proactively identify further decline in her functional abilities.

Our first priority is to engage Ms. M with respect and understanding for her American Indian culture, seek to understand the degree of Ms. M's desired tribal affiliation, her motivations and health care behaviors and establish a relationship with her. Decisions about establishing a primary care affiliation through one of the health systems of care available to her and the subsequent development of an IPC must take into account Ms. M's cultural preferences and experiences, the individuals she wants closely involved with her wellness plan, and also considers the realities of her rural location and the available resources. Our case manager will focus on facilitating assessment and immediate interventions and being resourceful to mobilize resources necessary to address the most serious and imminent threats to Ms. M's safety. We recognize in Ms. M's case, especially considering the importance of medication management, there may be great benefit to her if she was enrolled in our D-SNP plan. However, as part of comprehensive longer range planning in conjunction with her identified interdisciplinary care team (ICT), our case manager will support Ms. M in making her choices **among the feasible options** for best managing her health and ensuring her well-being across the systems available to her.

UnitedHealthcare is one of two Medicare Advantage Plans serving La Paz County. Ms. M would benefit from enrollment in our D-SNP plan to more easily monitor medication adherence in near-real time, improving Julie's ability to monitor Ms. M's overall health status and respond quickly to changes in Ms. M's condition or utilization patterns.

### APPROACH TO MEMBER ENGAGEMENT AND PERSON-CENTERED CASE MANAGEMENT

We will engage Ms. M in assessment, care planning and ongoing monitoring processes that align with the **ALTCS Guiding Principles** of Member-Centered Case Management and Person-Centered Planning. Even in the face of Ms. M's growing cognitive issues, it is important to empower Ms. M to actively participate as a full partner in all phases of the case management process so she can make decisions/choices about her care and services in meaningful ways and feel comfortable with the services and supports that are a part of her IPC. Our assigned case manager's contact with Ms. M **will support and promote the values of both our corporate culture and the AHCCCS program**, including dignity, independence, individuality, privacy, self-determination and choice that foster a member-centered holistic approach to care planning activities.

The **assignment of a case manager** who can best engage and build a relationship with Ms. M is a vital first step. With the multiple transitions Ms. M has had between Tribal ALTCS and ALTCS EP/D, we will strive to maintain case manager



consistency for her. Should a new case manager be needed, we aim to assign a case manager with accountabilities for establishing an effective, coordinated and sustainable care plan for Ms. M. by taking into account cultural and language factors and leveraging experience with similar members and working knowledge of the systems, providers and types of resources likely to be important to this member's IPC. We are fortunate to have a diverse case management staff who meet AHCCCS licensure and experience requirements. We will assume, our case manager "Julie," an RN licensed in Arizona, with over a decade of experience serving ALTCS members in the region where Ms. M resides, is assigned to Ms. M. She brings a deep understanding of the local dynamics of American Indian culture and tribal health resources and she has established **Relationships** with local tribal health providers, IHS and 638 facilities. As such, Julie understands the importance of American Indian care coordination and support. Her demonstrated resourcefulness will be important to develop a collaborative approach to care planning that precludes future "churning" between systems and reduces gaps in care. However, in the short term — given Ms. M's current social isolation and behavioral health (BH) conditions, rural location and safety risks — Julie will be instrumental in immediately finding ways to address issues with Ms. M's current living situation. In support of the **ALTCS Guiding Principle** of "Most Integrated Setting," Julie will work with Ms. M to maintain her safely in the most integrated, least restrictive setting or facilitate another appropriate and available option.

## ASSESSMENT AND CARE PLANNING PROCESSES

**Member engagement, assessment and planning:** Julie reviews available data within our information system (e.g., the State's 834 enrollment file and historical medical, behavioral and pharmacy claims, and utilization data). Using this data, she generates a prospective risk level for Ms. M and documents conditions and potential care gaps to explore during the assessment process. Because Ms. M is currently and was previously a member of our ALTCS E/PD plan, we can potentially confirm what she has previously revealed about her tribal affiliation. Based upon her location, we suspect she may be Navajo and is a member of the Colorado River Indian Tribes (CRIT). Julie reviews both the Medicaid and Medicare gap in care/adherence information and claims history available. Because Julie knows Ms. M has sought care from IHS/638 facilities, she will reach out to social service contacts within the tribal system to obtain additional information, such as behavioral health treatment history.

**Member contact, rapport and information gathering:** Julie follows the applicable standards as outlined in **AMPM Chapter 1600 and Exhibit 1620-1** while conducting case management activities. It is important Julie hold a face-to-face meeting to assess and begin to address Ms. M's **immediate safety risks** while also gathering information to complete a comprehensive assessment. Based upon any insights gained from past history or Julie's knowledge in the community, Julie engages Ms. M first to determine who could be present as part of Julie's visit with her to talk about her health care. If Ms. M prefers to communicate in Navajo, Julie will arrange our interpretive services or a community health representative. Interacting with Ms. M in person requires sensitivity to both her BH conditions and **diminished vision**. When she visits with Ms. M in her home, Julie makes sure Ms. M has Julie's contact information in a large print format. Julie gains Ms. M's agreement to give Julie's contact information to at least one other person nearby who can serve as primary contact for Julie in case she cannot reach Ms. M. Julie relies on her interactive skills and training to establish rapport and help Ms. M continue to be safe in her home and access the health care she needs. At the same time, Julie re-explores how culture and personal beliefs may be influencing Ms. M's health care decisions, including understanding her values, customs, language preferences and traditions.

Julie prioritizes her use of key screening and assessment instruments to collect as much information as possible regarding her BH (e.g., PHQ-9 for depression and anxiety), mental status (assessing cognition via word recall) and functional status as well as current social and environmental factors affecting her well-being. Assessment tools **include AHCCCS's Home and Community-Based Services (HCBS) Needs Tool (HNT) and Uniform Assessment Tool (UAT)**. Julie's aim is to gain a comprehensive understanding of Ms. M's health status and develop a holistic picture of Ms. M's needs across clinical, behavioral, social and functional domains.

As part of this process given Ms. M's current cognition challenges and vision impairment, Julie verbally reviews the member rights and responsibilities and the ALTCS HCBS and residential benefits and options available to her as outlined in the *Member Handbook* and leaves written materials with Ms. M.

**Interdisciplinary Care Team (ICT) and Individualized Plan of Care (IPC):** Julie identifies resources and organizations that are important for informing and supporting Ms. M's IPC. The IPC will address services required to optimize Ms. M's health status, independence and well-being, based upon her major health goals and priorities, and Julie seeks guidance and agreement from Ms. M regarding the participants who will comprise the ICT. Considering Ms. M's location and reliance on supports from multiple systems and resources, the participants on her ICT should likely include a provider (in our network or in an IHS facility) located in Ms. M's area (Parker) to serve as PCP; collaborating specialists (e.g., neurology/psychiatry, other BH, internal medicine/cardiology and vision); and community-based providers who can provide resources essential to Ms. M's support (e.g., food, transportation). Julie schedules an ICT meeting to share and make recommendations for establishing an individualized, strength-based IPC that includes a set of identified benefits and services.

The IPC will also include a **contingency plan** for replacement of critical services when needed as described under Ms. M's care plan goals. Julie also develops a disaster plan with Ms. M. The disaster plan is in place to address contingency actions in the event there is a natural disaster or loss of power, water, housing or other vital resources. Julie reviews this plan at each assessment and updates it on an annual basis and upon changes warranting an update.

**Advance Directives:** Julie determines if Ms. M has an advance directive in place, including Power of Attorney (mental health, durable and medical) and living wills. If they exist, Julie will ask if Ms. M has given a copy to her PCP and other treating providers. In the likelihood Ms. M may not remember this detail, Julie offers to send a copy to all treating providers with Ms. M's permission. If Ms. M does not have advance directives in place, Julie provides culturally appropriate education around the importance of Ms. M making her treatment including end of life wishes known to her providers and family and encourages Ms. M to execute one. Julie provides this education during every assessment visit until such time Ms. M executes an advance directive.

### Anticipated Care Plan Priorities

**Address safety concerns:** Ms. M is at increased risk for falls due to her age, decreased vision, TIAs and history of CVA, medication adherence/side effects, and confusion. Priorities include creating a fall prevention plan by initially helping Ms. M remove any tripping hazards and increase lighting. In addition to addressing the environmental hazards, Julie contacts services for the visually impaired and requests an assessment of and plan for Ms. M's home. Julie also coordinates a home-safety assessment through a physical or occupational therapist. Julie will suggest an emergency alert device to see if this is the best option for Ms. M to contact emergency help. Parker can have limited cellphone services so an emergency alert device might be optimal.

**Establish consistent sources for primary care and ongoing care management:** Seeking to ensure consistency in her case management during the assessment phase, Julie has discussed with Ms. M the transitions she has experienced between Tribal ALTCS and our ALTCS health plan over the past three years. With insight into why Ms. M has received services from multiple facilities and providers and why she changes health plans, as part of her IPC development, Julie verifies if Ms. M is happy with and has recently seen her PCP, and if she needs help picking a consistent PCP. Julie verifies BH and other providers engaged in Ms. M's care. Although she is free to choose between providers and health plans, Julie explains to Ms. M the benefits of selecting and staying with one health plan and one PCP for consistent care. In light of her past BH diagnoses, Julie will facilitate engagement of a PCP with an integrated model of care to ensure close monitoring and collaboration with BH providers as necessary for long-range management of BH-related pharmacology and symptom monitoring. Julie also discusses Alternative Healing as additional treatment options for Ms. M, which will be a value-added benefit offered in our long-term care plan mid-2017.

**Establish a comprehensive, updated case management plan:** Several physical and BH issues require updated evaluations and inputs to a comprehensive care management plan, including a medication management regime that optimizes Ms. M's cognition, minimize disruptions from anxiety and depression, and ability to function safely in an independent living setting. Ms. M has had a CVA and TIAs. Julie determines the last time Ms. M saw a neurologist and coordinates with her PCP to determine if she needs further neurological evaluation and assessment of her current risk of another CVA. If Ms. M is unable to leave the home due to her agoraphobia, Julie will talk to her PCP about in-home options for evaluation. She makes certain a home health arrangement is in place with a plan for monitoring vital signs, medications and other sets of indicators relevant to Ms. M's several chronic conditions, and arranges protocols to consistently share this information with her PCP.

**Ensure medication adherence:** With a current medication plan based upon updated physical and BH clinical assessments, one of Ms. M's IPC goals is to establish a system that works for her so she is able to take her medicine safely and as prescribed. Julie has explored Ms. M's challenges with medication adherence which may likely be multifactorial (e.g., confusion, side effects she does not like, visual limitations, depression, apathy or lack of motivation, or challenges with time management) and takes a step-wise approach to eliminating factors leading to medication mistakes. Julie engages Ms. M's PCP to do a medication review. For example, reducing Ms. M's medication to daily or twice daily doses may improve her ability to consistently adhere to a regimen. If Ms. M currently has both a BH prescriber and a PCP prescriber, Julie sends a Behavioral Health Coordination of Care Form to both providers detailing what each other is prescribing. Any other known prescriptions and over-the-counter medications are included in the information. Julie requests a pharmacy evaluation from our pharmacy consultant to assess her medications and review our medication-adherence reports. She works with Ms. M to see if she agrees to having a home health nurse come to her home to help organize medications in a mediset container and observe Ms. M taking them. This provides an opportunity for additional assessment of the medication challenge and an avenue for Ms. M to receive education and practice with her medications. Julie also can work with the pharmacy to provide medications in daily bubble packs or coordinate a medication auto dispense service to reduce medication errors by Ms. M.

**Establish a treatment plan for chronic BH issues:** Ms. M previously has been diagnosed with depression and agoraphobia with panic attacks. In fact, public research tells us American Indian women who live alone have one of the highest incidents of agoraphobia with panic attacks. Julie explored Ms. M's current symptoms and assessed the degree to which these diagnoses are affecting her day-to-day life during screening and comprehensive assessment. As these conditions can present challenges to Ms. M's ability to access care and to follow her IPC, a major IPC goal is for Ms. M's symptom relief, thus enabling her to leave her home for appointments or enjoy social interactions and maintain a level of recovery from her agoraphobia. In collaboration with Ms. M's PCP, we can facilitate help from both her Tribe and a BH provider who has treated such situations so she has a treatment plan that will provide stabilization for her complex combination of diagnoses. If Ms. M is unable to leave her home due to the agoraphobia, Julie arranges an alternative appointment. Julie will ask Ms. M if she has a BH provider preference, will call the provider to discuss evaluation and possible treatment options, and determine if the provider can come to her home or support a telemedicine assessment. We have been successful with expanding our telemedicine initiatives to our ALTCS membership through partnerships with Mountain Health and Wellness (Horizon) and Assertive Community Treatment (ACT) in Yuma. Julie will work with the BH provider and Ms. M to identify stressors and triggers that may elevate symptoms. Julie also will explore opportunities for Ms. M to streamline her care between providers. If Ms. M is not currently using the La Paz Regional Health Clinic — where a BH provider is located with a PCP — this may be a good resource and practice to establish an integrated care network for Ms. M. Alternatively, perhaps Ms. M would like to go to her appointment with a community health representative or direct care worker escort to help reduce anxiety in getting to the appointments. If translation services are necessary during appointments, Julie will coordinate these services with Ms. M.

**Seek eye care to address visual impairment:** Ms. M has cataracts that are limiting her ability to see, affecting her daily functioning, increasing her fall risk and may affect medication adherence. Julie and Ms. M talk about her cataracts and the extent of her vision impairment. If Ms. M wants treatment for her vision, Julie will arrange for an eye exam. If Ms. M

is unable to leave her home, Nationwide, our vision provider, can provide an initial eye exam and refraction at Ms. M's home and provide her with recommendations on the next step for treatment. During the in-home vision evaluation, she will have the opportunity to ask the optometrist questions about her eye care needs and options. If, or when, Ms. M is able to leave her home, Julie can set up an appointment with an ophthalmologist to discuss treatment for her cataracts.

**Optimize functional status for independent living:** Ms. M needs assistance with activities of daily living and using the findings from the HNT, Julie determines the level of in-home supports needed, such as meal preparation, attendant care and home health nursing. Julie verifies if the current authorized services, agency and direct care worker are reliable and meeting Ms. M's current needs. Changes may be made after the reassessment of Ms. M's status. Julie also identifies other relevant information, such as Ms. M's available natural supports including family or friends, her durable medical equipment or home modification needs, or special dietary requirements. When Julie and Ms. M initially selected Accentcare to be the attendant care provider, it was because they have a familiarity working with people from Ms. M's Tribe in the Parker area. If Ms. M's income is preventing her from having enough food, Julie will work with the La Paz County Food Bank to coordinate home delivery of food boxes. Julie reminds Ms. M how hot it gets in the summer in Parker and while Ms. M may not feel thirsty, she still needs to drink water and explains some ways to tell whether she is properly hydrated. During the discussion, Julie asks Ms. M what she considers important to her quality of life. Ms. M tells Julie she wants to remain living in her home. Julie works with her to develop a member service plan that can support this goal by providing supports and ongoing assessment of her safety needs. While Julie works with Ms. M to meet the goal of living in her home, Julie also describes the alternatives Ms. M has available, including assisted living and skilled nursing facility placement options now or in the future.

**Addressing current and future risks of social isolation:** If Ms. M is not connected to her family and tribal community, Julie will contact her Tribe to determine if there is a program or liaison who can provide information on how to re-engage. Julie discusses options for socialization in the community that might be of interest to her. In addition, a referral to NAZCARE for social supports and helping her connect with her Tribe could be provided. NAZCARE currently includes the Colorado River Indian Tribes as a part of their service network. Julie explores the types of activities or hobbies Ms. M enjoys that make her happy and could be a personal goal to reclaim her cultural or tribal values and reduce her isolation. A referral to the Art Awakenings program may be a therapeutic alternative option to consider. Art Awakenings might be able to come to her home through peer support or a behavioral day support to provide her with socialization and additional behavioral supports. Julie will track Ms. M's social goals through the member empowerment (me\*) program.

## Ongoing Monitoring

The IPC will include trackable opportunities, goals and interventions determined to address each IPC priority and Ms. M's health goals to produce the best possible health outcomes. Julie monitors and documents Ms. M's progress in our comprehensive electronic care management system. She tracks the completion of interventions and continuously monitors indications that Ms. M's health status, needs or living situation have changed. This includes signs or symptoms of an acute illness or deterioration in Ms. M's health, a hospitalization, an ER visit, a care setting transition, loss of caregiver support or indications Ms. M is not adhering to her IPC. When Julie identifies changes in Ms. M's health status or sees indications she may be experiencing a "triggering event," she will engage Ms. M and use the ICT to implement timely, targeted interventions to meet her needs, collaboratively reassess her needs and update her IPC, as needed. Julie uses her clinical acumen and judgment to continuously monitor Ms. M for indications her health status may be changing using a variety of methods, including:

- Conducting face-to-face assessments every 90 days and through monthly contact in between visits
- Monitoring Ms. M for indications she may not be adhering to her IPC or may be experiencing a change in condition by reviewing the results of predictive modeling analysis of claims and preventive care gap reports
- Tracking timely, relevant, actionable information about Ms. M, such as inpatient or ER admission
- Reviewing input from the ICT team



## 2. A 71 year old Hispanic member, residing in Kingman, diagnosed with schizophrenia, Opiate Use Disorder, diabetes ...

This scenario points to the important steps that must be taken to manage care for an individual with multiple and significant chronic physical and behavioral health (BH) conditions, a history of instability requiring court-ordered residential treatment, and cognitive impairment due to dementia. Over the course of our experience, the positive outcomes we have achieved in initiating and managing care for ALTCS recipients with similar profiles, resulted from applying a targeted, collaborative and resourceful approach **to facilitating transitional care and effective discharge planning**, linking it to longer range care planning as well as ongoing monitoring and care management supports. Our focus on transitional care planning is crucial in cases of such complexity and safety risks, i.e., we know from research a discharge from a psychiatric facility can increase suicide risk, and statistically this member is at heightened risk as he is an elderly male, living in a western state with serious mental illness (SMI) and an opiate use disorder. In this scenario, the member has been stabilized under court-ordered treatment (COT), and one important task will be to coordinate either the continuation or end of the court order. Our decades of experience as an ALTCS contractor managing COT, including transfers and evaluating COTs for effectiveness and appropriateness post stabilization, will be valuable as we develop this member's care plan.

Importantly, our approach to initiate and manage care for this member, whom we will refer to as Mr. V, leverages our considerable knowledge and experience in working across treatment systems in Arizona (i.e., with residential and outpatient mental health providers including psychiatry, substance abuse providers, primary care and community support organizations) to structure systematic and ongoing assessment, planning and monitoring. Especially in light of Mr. V's history of opiate use disorder and the significant implications if he were to relapse post discharge from the Kingman psychiatric facility, we must consider the **landscape of opioid use** and the strength of recovery supports wherever Mr. V might reside post discharge. Additionally, he requires multifaceted physical and BH supports be available to him to sustain medication adherence, avoid relapse and/or complications from uncontrolled diabetes, and foster positive social supports as a part of his ongoing recovery.

From the limited facts of the scenario, we know Mr. V's family is involved and prefers Mr. V's proximity to them in Flagstaff. His family's involvement points to a significant aspect of our work with ALTCS members. Critical to positive outcomes is our commitment to a **person-centered approach to case management that includes the ALTCS Guiding Principles** of Member-Centered Case Management and Person-Centered Planning. These principles inform the manner in which we engage and build a relationship with Mr. V; we support his empowerment as a decision-maker in his care planning. We must evaluate the benefits or drawbacks to Mr. V living in close proximity to his family, informed by BH assessment and most of all, by Mr. V's input and preferences. We must consider the cultural and language dynamics important for building trust and effective communication in all aspects of our involvement.

## INITIATING TRANSITION PLANNING

**Assigning a case manager and initial contacts:** Based upon the case referral information provided by AHCCCS regarding BH diagnoses including an SMI determination, as indicated on the 834 file, and COT, our BH coordinator initiates contact with the psychiatric facility where Mr. V resides to initiate a transition of care process. If the 834 does not note Mr. V as SMI, a referral for an SMI determination will be made to the Crisis Recovery Network. The primary treatment coordinator at the facility is engaged to understand relevant information pertaining to the existing COT and determine if the court order will be transferred to us or discontinued; if it continues, the transfer process will be initiated. At the same time, one of our multifaceted case managers, "Debra," is assigned to work with Mr. V and **coordinate both his physical and BH needs**. Debra has the appropriate education, skills and experience in managing care for individuals like Mr. V, with significant BH and physical health care issues, including the relevant and appropriate **cultural and language sensitivities** to relate well to the member and his family. Debra works with high-risk members in Northern Arizona and understands the requirements and processes involved in cases involving COT, such as informing Mr. V about his rights to a judicial review of the court order every 60 days. She contacts our transition coordinator at the northern Arizona Regional Behavioral Health Authority (RBHA), Health Choice Integrated Care (HCIC), to obtain a copy of his COT and past

services received through HCIC. Our established contacts at the HCIC clinic will work with us to identify immediate needs and ensure no lapse in services or gaps in care for Mr. V during his transition from the HCIC to ALTCS. Debra will coordinate the transfer of responsibility of his COT to UnitedHealthcare via a letter of intent to treat.

Since Mr. V is ready for discharge, Debra schedules an immediate internal case review with our ALTCS case management team to internally discuss what may be appropriate treatment and placement options for Mr. V. This step proactively confirms the placement options and services that may be considered when Debra meets with Mr. V and his family. Working within the time frames outlined in **AMPM Chapter 1600 and Exhibit 1620-1**, Debra contacts the hospital's business office to inform them of his ALTCS enrollment. She also notifies the manager of his psychiatric unit she is now working with Mr. V on discharge. Debra identifies the core members who should be included as part of Mr. V's discharge care planning team including, in addition to Mr. V, key hospital staff and his current HCIC clinician.

**Engaging the member and his family:** Debra arranges to meet with Mr. V in person at the psychiatric facility to introduce herself and explain her role in helping him resettle outside of the psychiatric facility. Using her skills and training in working with individuals with SMI and dementia, Debra engages Mr. V to help her understand his needs and if there are particular individuals Mr. V would like to be part of his care planning team, including his family. Beginning with this initial interaction and throughout our engagement with Mr. V, Debra will continue to explain her role in helping Mr. V and focus on eliciting his expressed needs, goals, preferences and choices. Her interactions with Mr. V reflect the **values of our corporate culture and the AHCCCS program** in respecting Mr. V's choice, dignity, independence, individuality, privacy and self-determination. Even in the face of his dementia, Debra will encourage and empower Mr. V to participate as actively as he is able in all aspects of discharge planning and to make decisions/choices about his care and services, knowing persons with dementia can become frustrated when asked to process information that is confusing or overwhelming. Using targeted communication skills, Debra explores Mr. V's interest in living near his family. Based upon information she learns from Mr. V about his preferences, Debra will take steps to appropriately engage Mr. V's family in the discharge planning and individualized plan of care (IPC) processes. If they are not able to travel to Kingman, Debra will engage them by phone or even via video conferencing, if available and appropriate, to introduce herself and explain her role. As appropriate, Debra arranges for translation services to be available to Mr. V and his family during their interactions as part of ongoing discharge and IPC planning.

**Information gathering:** Based upon her experience in working with individuals **transitioning from psychiatric facilities** and in accordance with our **proactive discharge planning protocols**, Debra evaluates the background information available at the facility and from other sources, to understand Mr. V's current BH status, physical health, particularly diabetes, medication management, and cognitive and functional status. In addition to clinical records, Debra reviews the Pre-Admission Screening (PAS), that was completed to determine Mr. V's eligibility for ALTCS to understand Mr. V's current strengths in activities of daily living (ADLs) and his responsible party contact information. As required by AHCCCS for new members enrolled in ALTCS, Debra meets with Mr. V, within 12 business days, to complete our health assessment tool and the **AHCCCS Uniform Assessment Tool (UAT)** to gain a comprehensive understanding of Mr. V's health status, strengths, goals, preferences and discharge planning needs. These assessments help her determine the need for additional condition-specific screenings including those for diabetes and the PHQ-9 for depression; assess BH needs; and help identify and recommend appropriate services. She documents the resulting information in our electronic care management platform and the Client Assessment Tracking System (CATS) as appropriate. Debra spends time with Mr. V to review information such as his habits and patterns of dealing with his medications, perceptions about leaving the residential facility, feelings about his impending discharge; and where he thinks he would like to live. She identifies and documents any information gaps that will be important to address to fully prepare for discharge planning.

As part of their initial meeting, Debra reviews the *Member Handbook* and describes the ALTCS benefits available including all applicable direct care service options. She reviews the components of the **Member Acknowledgement Form** that documents education on Member's Rights and Responsibilities, advanced directive status, confirms member representative if Mr. V chooses one, PCP, and Medicare or other insurance or provider information. During the **review**

**of covered services**, Debra describes how services are delivered in a home setting, assisted living facility (ALF) and in a skilled nursing facility (SNF) – the three options within ALTCS. She explains in detail the direct care service options including Agency with Choice, spousal attendant care, if applicable, and self-directed attendant care. If Mr. V does not have a Power of Attorney or formal guardian, Debra explores these avenues further to protect his interests. Debra is careful how she presents information to Mr. V, working with appropriate family members and facility staff on the best approach for communication of information dependent upon his response to excessive stimuli.

## DISCHARGE PLANNING PROCESS

An effective discharge plan must seek to ensure continuity of care and member safety, and prevent avoidable worsening of conditions and/or readmissions. This requires a planning process to anticipate potential post-discharge issues while also taking a strengths-based approach to develop a discharge plan that will be used in conjunction with Mr. V's IPC to address his comprehensive, ongoing needs. The discharge planning process for Mr. V will be **proactive, collaborative and multifaceted** involving a series of steps. Mr. V's identified discharge planning care team convenes and considers relevant information about his needs, treatment goals and recommended treatment plans, including Mr. V's expressed personal goals and preferences. The team provides initial guidance about priorities and resources for Mr. V's transition from the residential facility to ensure Mr. V's safety and ongoing recovery. Debra uses these recommendations, working with Mr. V, to evaluate and make choices from appropriate options. Following this, a discharge plan is agreed to and finalized, and steps are taken to accomplish Mr. V's transition from the residential facility to another setting. Implementing the discharge plan is part of a larger ongoing effort that begins with the discharge planning process but continues as necessary to develop a comprehensive IPC for Mr. V that will guide the care management for him as an ALTCS member living in his new setting.

## Anticipated Discharge Plan Priorities

Based upon Mr. V's complex mix of health needs, his dementia and high safety risks related to his opioid dependence, we anticipate Mr. V's discharge plan must identify the most safe but least restrictive setting that will provide close monitoring and supports required for Mr. V's continued recovery and overall stability. This includes fostering medication adherence to a regimen related to diabetes, schizophrenia and opioid dependence, and being able to proactively identify any mood and behavior changes indicating increased suicide risk. Additionally, Mr. V should be in a setting offering supports for living with dementia and increasing cognitive decline.

## Evaluating Options and Finalizing a Discharge Plan

A key to this process is to understand Mr. V's goals and desires on where he wants to live, including the recommendations of the discharge planning team and the parameters important for his safety, well-being and input, as appropriate, from Mr. V's family. Based upon his documented capacities to manage ADLs, an ALF may be an option for Mr. V as the safest, least restrictive setting. If Mr. V desires to involve his family in planning and wants to live in close proximity, Debra will explore potential ALF options available in Flagstaff, keeping in mind Mr. V's expressed goals and desired outcomes. She will explain the member's responsibility for room and board and how it is determined. Based upon our knowledge, there are no suitable ALFs in Flagstaff to meet Mr. V's current needs. Debra identifies an option of a SNF in Flagstaff (i.e., The Peaks). However, potential ALF options exist in nearby communities, such as the Austin House in Cottonwood, an hour's drive from Flagstaff. This ALF appears to be a good option for Mr. V, having an integrated medical and BH program and services specifically for persons with dementia and BH disorders.

If the family is involved in the process, Debra provides contacts and packets of information for both facilities and offers to facilitate the family visiting each location. If they choose Austin House, Mr. V would benefit from their integrated physical and BH care in one setting. After Mr. V and his family review the options, they make a decision. The decision made does not represent a final long-range choice. If Mr. V's condition further stabilizes and risks diminish, he potentially could move to a non-BH setting. Based upon his dementia increasing over time, he may move to a SNF. In Arizona, a person with a COT cannot live in a facility that has not notified ADHS they are willing to work with persons on

court-ordered treatment. Most SNFs and ALFs do not opt to work with persons with COT. If, at some point, he no longer needs a court order, there could be additional living options available to him.

## COMPLETING THE TRANSITION AND ADDITIONAL CARE PLANNING

Once the discharge plan is finalized and agreed to by Mr. V and his discharge team, Debra implements the plan to transition Mr. V to his chosen setting, ensuring **continuity of his care as he transitions between care settings** by closely monitoring handoffs, reviewing information and establishing relationships between Mr. V and his new care team. Once Mr. V successfully transitions from the hospital to his new setting, Debra **collaborates with him and his care team at the facility along with his family** to develop an IPC that addresses his identified needs and his additional goals for recovery, and will produce the best possible outcomes for Mr. V.

## POST-DISCHARGE CARE PLAN AND MONITORING

After Mr. V transitions to his new care setting, Debra facilitates completing the IPC that addresses Mr. V's ongoing needs in his new care setting. Ideally, a goal of the IPC is to support Mr. V in safe transition to a lower level of care in line with his stated goals and preferences; however, the course of Mr. V's dementia is a complicating factor that will influence his required level of care. Debra identifies, with Mr. V's input, an interdisciplinary care team (ICT) comprising his PCP, psychiatrist, other treating providers, representatives from his care setting, and others from the community such as peer advocates or other community supports involved in supporting Mr. V. The team periodically, and as necessary, convenes to review updated information, hear from Mr. V and his family, as appropriate, regarding his goals and preferences for care, and update the IPC accordingly.

## Anticipated Individualized Plan of Care Priorities

**Safety plan to monitor, assess and respond to suicidal ideation:** A safety plan requires Mr. V be monitored closely. Clinical protocols specify observation, documentation and reporting protocols for staff to follow at the setting where Mr. V resides. Depending on the facility, a resident or external BH clinician (e.g., psychiatric nurse practitioner [NP]) will see Mr. V on an ongoing basis, elicit any suicidal ideation and take action to mitigate it. If additional resources are needed, we can provide peer support services through NAZCARE or a local BH clinic. If family or providers wish to have training on what it takes to help someone be safe, we offer the **Safe Return program** or the **Question, Persuade, Refer (QPR) program** within UnitedHealthcare.

**Maintaining stability and control of SMI:** Mr. V maintains psychiatric stability with the support of ongoing, on-site monitoring and consultation with psychiatric NP. The BH clinician conducts regular rounds to assess symptoms, adjusts medications and ensures Mr. V, family and staff understands the medication regimen. Debra will inform the HCIC transition coordinator that psychiatric services are in place and confirm there are no gaps in care so HCIC can close their case. In addition, Mr. V is assessed for counseling services, and he will participate, as he is able. Quarterly, our licensed BH professional will complete a review of the appropriateness of services and treatments and stability of his condition.

**Addressing Opioid Use Disorder:** Mr. V has assistance with recovery from opioid use, and any need for prescription opioids is coordinated between the medical and BH prescribers and documented by Debra in Mr. V's IPC. If prior opiate use was related to pain management and specific medical conditions, his plan will address his opiate use disorder with referral to treatment provider(s) as appropriate (e.g., specialty care, substance use disorder [SUD] provider or pain management clinic). While the onset of dementia and Mr. V's schizophrenia can make it harder to determine the current effects opioids might have on him, it is important to start to define the problem. Many opiate users, whether street drugs or prescription drugs, age into the long-term care system. We have a network that includes both pain clinics and substance abuse providers to provide thorough evaluations and coordinated care. The PCP/psychiatric NP will assess Mr. V's need for medication-assisted treatment (MAT) for opioid dependence. If it is determined this would be an effective way to treat his dependence, he will be referred to an outpatient clinic that provides MAT. The PCP/psychiatric NP will consult with the outpatient clinic for treatment and provide the clinic with a list of Mr. V's current medications and



diagnoses. If his current level of cognition permits, he might also benefit from counseling or group supports. Once a level of dementia is present, peer support is often more useful to help him manage his anxiety related to addiction.

**Improving Medication Adherence:** Debra engages with Mr. V's PCP/psychiatric NP to assess and determine a course to improve medication adherence. Actions include regularly scheduled medication administration times, adjusting them around meals/snacks, and working with Mr. V on an ongoing basis to verify he understands the need for each medication and the expected time he should take each medication. As the PCP/psychiatric NP is there frequently, he/she is able to inform Mr. V about the benefits and potential side effects of his medications, and Mr. V can ask the PCP/psychiatric NP any question he may have concerning his medications.

**Addressing Mr. V's Diabetes:** The PCP/psychiatric NP work with staff at the facility and Mr. V to develop a regimen for his diabetic care, including diet, physical activities and medications. The PCP/psychiatric NP manage the risk associated with having this diagnosis such as hypertension and hypercholesterolemia, retinopathy, nephropathy and neuropathy. A protocol will be followed for vision screenings and lab tests to monitor metabolic syndrome assuming this is a consequence of long-term psychotropic medications.

**Addressing Mr. V's Dementia:** The PCP/psychiatric NP determine if any medications would be effective to slow the progression of dementia. The clinical team at the facility will develop a set of behavioral supports, which will include activities to help with cognition, daily exercise, identified triggers that can necessitate redirection, use of outside supports and family, and ongoing monitoring of medications.

**Addressing Mr. V's Desire to Live Independently:** Debra engages Mr. V and his care team at each required 90-day reassessment visit to evaluate his satisfaction with current services, his desire to live in the community and his ability to transition to a lower level of care beyond the ALF. Debra will use our High Risk Placement Decision Support Tool (HRPDST) as a guide to evaluate feasibility of a step down in services and to provide education to his family and support system regarding ALTCS services available while living in HCBS settings. These services include direct care options (e.g., Self-Directed Attendant Care [SDAC], spousal attendant care [AC], and Agency with Choice or traditional AC services) and respite services to support Mr. V and his caregivers. If continued signs of stabilization occur, Debra may suggest overnight visits or therapeutic passes to gain a better understanding of Mr. V's ability to transition to a lower level of care. This includes discussions with Mr. V's family to determine receptiveness to Mr. V living with a family member and helping him/her understand the care and oversight Mr. V will need. **All of these possible steps are contingent upon the level of Mr. V's dementia and its progress.**

## Ongoing Monitoring

Debra continuously monitors Mr. V's progress to verify he is experiencing desired health outcomes. She looks for indications Mr. V's health status or needs may have changed, signs or symptoms of an acute illness or deterioration in Mr. V's health, hospitalization, an ER visit, a care setting transition, loss of caregiver support or indications Mr. V is not adhering to his IPC. Reassessments are conducted every 90 days (sooner if a triggering event occurs) using our HRPDST to verify the appropriateness of a current placement or to determine if Mr. V is stable enough to safely transition to a lower level of care. As part of this protocol, a UnitedHealthcare licensed BH professional assigned to Mr. V's case consults with Debra to review Mr. V's BH needs, confirm Mr. V is receiving the services needed for recovery and health maintenance, and collaborates with Debra about interventions to achieve the best outcomes for Mr. V. Debra monitors and documents Mr. V's progress against the IPC in our comprehensive electronic care management system, reviewing a set of metrics that align with the goals and interventions included in the IPC, as well as ongoing data and predictive analytics that flag emerging issues (e.g., lab values, ER visits, medication non-adherence). When Debra identifies changes in Mr. V's health status or sees indications he may be experiencing a "triggering event," she will initiate a case review with our medical director and BH coordinator and engage Mr. V and his ICT to implement timely, targeted interventions to meet his needs, collaboratively reassess his needs and update his IPC, as needed.

### 3. Provide a description of the Offeror's past experience as a Medicare D-SNP Plan. The Offeror must include examples...

#### EXPERIENCE AS MEDICARE D-SNP PLAN

UnitedHealthcare began administering a dual-eligible special needs plan (D-SNP) in Arizona in 2005. Since then, we have grown from serving 7,396 members in five counties to serving 39,703 UnitedHealthcare Dual Complete members and 3,529 UnitedHealthcare Dual Complete ONE (Fully Integrated Dual Eligible [FIDE]) members in 14 of 15 counties (as of Dec. 1, 2016). This represents 50.1 percent of the Arizona D-SNP market share, demonstrating we are the D-SNP of choice in Arizona. In 2016, we accounted for 85 percent of all D-SNP growth in Arizona. We intend to expand our D-SNP to Gila County as of Jan. 1, 2018, to become a statewide D-SNP covering all 15 counties.

Nationally, UnitedHealthcare manages more than 400,000 dual-eligible members through D-SNPs in 19 states and the District of Columbia. In addition to D-SNPs, we operate two additional FIDE-SNP plans in Massachusetts and New Jersey and two Medicare Medicaid Plan (MMP) plans in Ohio and Texas as part of the CMS Dual demonstration. In Hawaii, Arizona, New Mexico, New York, Florida, Delaware, Tennessee and Texas, we serve D-SNP individuals who are aligned with our long-term services and supports (LTSS) plans.

#### EXAMPLES OF OUR EFFECTIVE INITIATIVES IN ARIZONA

Nationally, approximately 84 percent of UnitedHealthcare Medicare Advantage members will be in four-star plans for 2017 Star Ratings, up from 80 percent the previous year. Approximately 64 percent of our national UnitedHealthcare D-SNP members will be in a 4+ Star plan, up from 39 percent last year.

As an existing D-SNP provider in Arizona, the initiatives we describe below are ones we currently deliver statewide, exclusive of CMS mandates and supplemental benefits, and illustrate our commitment to resolving the challenges and issues that face our members. As D-SNPs have evolved over the years, we have met each challenge by offering solutions that reflect and demonstrate our company's values by increasing access to health care services, elevating the quality of care, and improving efficiencies and cost-effectiveness.

The programs and initiatives below build on a robust infrastructure of services and benefits we have offered our dual-eligible members for more than 11 years in Arizona. Our member-centered focus holistically addresses our members' health risks and needs, personal and community-

based realities, and members' individually defined health improvement goals. Our approach emphasizes member choice, access, safety, independence and responsibility. Specifically, for our LTC members, they benefit through full alignment in our FIDE-SNP allowing us to provide them a highly coordinated clinical approach that produces positive health outcomes and improved quality of life, protecting and preserving dignity and independence.

One way we support our members is through support of their providers. We employ a high-touch model for our providers through provider advocates and clinical practice consultants (CPCs) who help providers close gaps in care and address quality of care. Engaging our providers on this level achieves better member experience and health, and improves quality and provider satisfaction. Below are five added investments to improve health outcomes for our members:

- **Improving Member Experience:** In Arizona, we seek to understand the experiences of our members, in part, through outreach and a specialized concierge team for our D-SNP members. Our local concierge team directly assists members to make appointments, understand benefits, reminds members of appointments and lab tests, coordinates transportation if needed and encourages compliance with the individualized plan of care (IPC).
- **HouseCalls:** Members in our HouseCalls program receive an in-home clinical visit with a certified nurse practitioner or physician. During the visit, the provider reviews our member's health history and medication; completes a wellness evaluation; reviews the home environment; provides education on chronic conditions; conducts lab tests; and discusses topics and questions for our member's next PCP appointment.

- **Member navigators:** Our member navigator initiative assesses barriers to care to help our D-SNP members close gaps in care, increase quality and address whole person needs, including social determinants of health.
- **Preventive colorectal cancer screening:** We provide an in-home, easy-to-use testing kit to any of our Medicare members with an open gap for this measure.
- **UnitedHealthcare PATH Excellence in Patient Services Awards (PATH):** The PATH program annually rewards physicians who meet certain performance-based criteria, including achieving or exceeding compliance targets for 17 specific HEDIS measures and proactively completing annual care visits.

## IMPROVING MEMBER EXPERIENCE

Each year, we reach out to 100 percent of our Arizona Medicare D-SNP membership to determine if they have unmet needs or concerns. We ask members about their perceptions of their health care, doctors, ease of obtaining medications, concerns about getting a flu shot, issues with durable medical equipment (DME), as well as more personal questions, such as ability to perform simple activities or issues with bladder control. This information, collected by Eliza Corporation, allows our internal, dedicated concierge team to speak with the member to address identified issues via warm transfer, callbacks or three-way calling. We assist members by encouraging flu shots, changing PCPs if they are unhappy, education on navigating pharmacy and other benefits, and using probing questions to identify other issues.

In addition, as a part of our commitment to improving our Arizona LTC/FIDE members' experience, we **are adding six gaps-in-care coordinators** to our concierge team in 2017 to support our FIDE members. Our concierge team focuses on D-SNP quality of care goals and conducts member outreach, assists with appointments, coordinates documentation, conducts post hospital assessments to reduce hospital readmissions, and increases compliance with medication adherence.

Initiative Name	Improving Member Experience
<b>Implementation Date</b>	2015 in Arizona
<b>Metric/Measurement Process</b>	Member outreach for D-SNP members
<b>Size of Medicare D-SNP Membership</b>	All of our D-SNP members are eligible for this program.
<b>Number of members Participating in Initiative</b>	<b>Arizona:</b> In 2015, we outreached to all of our membership.
<b>Outcomes</b>	<b>Arizona:</b> In 2016, we reached out to 37,000 members and placed 3,154 follow-up calls to help members resolve issues such as medication confusion, health decline, etc. through care coordination and benefit education. This program appears to have had an impact on our overall membership as measured by an independently conducted Medicare CAHPS survey. Following initiation of this program, the following measures improved from 2015 to 2016: rating of health plan went from 83 percent to 87 percent; treated with courtesy and respect went from 87 percent to 93 percent; got urgent care went from 81 percent to 85 percent; got routine care went from 80 percent to 83 percent; rating of drug plan went from 86 percent to 89 percent; getting needed prescriptions went from 91 percent to 93 percent; ease of getting prescribed medications went from 89 percent to 93 percent; and got influenza vaccination went from 61 percent to 68 percent.

**HouseCalls:** In Arizona, at the end of 2013, we began the HouseCalls program to provide targeted outreach to engage members in appropriate, early treatment. The primary goal of HouseCalls is to close open gaps in care and does this by addressing up to 24 different measures during the visit. Although this program is open to all members, we focus on those living with a chronic condition or who are homebound. We use this program as a complement to a member's

relationship with his/her provider. By meeting our members where they are, we help them improve their health with a focus on wellness support through recovery, resiliency and self-sufficiency.

Initiative Name	HouseCalls
Implementation Date	Q4 2013 in Arizona
Metric/Measurement Process	Our primary measure is completed visits for our members. We track scheduled visits, member declines, and member attempts and canceled visits. HouseCalls provides member-level reports weekly to our local leadership team.
Size of Medicare D-SNP Membership	All of our D-SNP members are eligible for this program.
Number of Members Participating in Initiative	Completed Visits: <b>Arizona:</b> 2014: 5,558; 2015: 11,543; 2016: 15,037 (YTD Dec. 12, 2016) <b>National:</b> 2014: 54,893; 2015: 90,539; 2016: 109,484 YTD (Nov. 16, 2016)
Outcomes	<b>Arizona and National:</b> Out of 41,663 members eligible for the HouseCalls program, we met with more than 15,000 members. This program has proven to improve members' care and engage them in their health care, as shown by national studies such as a RAND Corporation study published in <i>Health Affairs</i> (December 2015, Vol. 34, No. 12, 2138-2146), which evaluated the effectiveness of the HouseCalls program for UnitedHealthcare Medicare Advantage (MA) plan beneficiaries. <i>Results show HouseCalls program participants had up to 14 percent fewer hospital admissions, lower risk of admission to nursing homes, and a 2-6 percent increase in physician office visits between 2008 and 2013.</i> In addition, in a comparison of eight measures such as adult BMI, breast cancer screenings, blood sugar and eye exams for diabetics, <i>closure rates for members with a HouseCall visit ranged from 78-100 percent, while those without a HouseCall ranged from 58-92 percent. Measures for members with a HouseCall improved between 8-27 percent.</i>

**Member Navigator:** Our member navigators engage each member's interdisciplinary care team (ICT) if needed; assist our member in making and keeping health care appointments; assure our member understands treatment protocols; and provide information on his/her benefits. Because social determinants are a significant driver of an individual's health, member navigators also provide connections to local resources including food banks, nonprofits providing grants for utility bills, and faith-based organizations. Member navigators outreach to our members by phone and, if unable to reach them, go into the community to reach each member in person. They meet our members where they are at that point in their life, help them overcome those barriers, solve their problems and help them to visit their doctor.

Initiative Name	Member Navigator
Implementation Date	2014 in five states, including statewide in Arizona; 2015 added seven states, for a total of 12 states; 2016 added three states, for a total of 15 states
Metric/Measurement Process	We measure success to closing gaps in care for the Medicare Star measures listed below through self-reporting by members or when member navigators schedule appointments with physicians to perform these screenings/tests. Member navigators confirm both by validating appointments with office staff or through claims data for specific Star measures: breast cancer screening; colorectal cancer screening; diabetes – eye exam and kidney disease; medication adherence – cholesterol, diabetes and hypertension; SNP-functional assessment, pain screening and medication review; osteoporosis management; adult BMI assessment; high-risk medications; annual flu vaccine;



Initiative Name	Member Navigator
<b>Size of Medicare D-SNP Membership</b> <b>Number of Members Participating in Initiative</b>	and rheumatoid arthritis. All members are eligible <b>Arizona:</b> As of September 2016, member navigators have reached and engaged over 5,500 D-SNP members, reflecting a reach rate of 58 percent. <b>National:</b> As of September 2016, member navigators have reached and engaged over 23,000 members, reflecting a reach rate of 60 percent.
<b>Outcomes</b>	<b>Arizona:</b> In 2015, our member navigators closed 35 percent of gaps in care, while those who navigators were unable to reach only closed 9 percent of gaps in care; nearly four times less. Based upon the success of this program, we added 12 member navigators throughout Arizona and will add two more in 2017. Current member navigator locations include five in Maricopa County, three in Pima County, one in Mohave County, one in Yuma County, one in Cochise County, and one in Yavapai County.

**Colorectal Cancer Screening:** Preventive cancer screenings can identify health issues before they have an opportunity to intensify and lead to costly complications that can have a negative impact on member’s quality of life. Our colorectal cancer screening initiative provides an in-home testing kit to any of our Medicare members who have an open gap for this measure. The member performs the test and returns the specimen via mail to a lab. We then send the results to the member’s PCP.

Initiative Name	Colorectal Cancer Screening
<b>Implementation Date</b>	March 2015 in Arizona
<b>Metric/Measurement Process</b>	We mail kits to members who either completed the kit last year, have a colorectal cancer screening gap this year, or upon request. We expect to see, on average, a 45 percent return rate in 2016 based upon year-over-year learned behavior and conversations with members when they requested the kit nationally. We receive weekly reports to track progress.
<b>Size of Medicare D-SNP Membership</b> <b>Number of Members Participating in Initiative</b>	All members with open colon screening gaps are eligible. <b>Arizona:</b> Mailed to D-SNP members with open gap, 2015: 630; 2016: 5,078 Kits returned: 2015: 108; 2016: 895 <b>National:</b> Mailed to D-SNP members with open gap, 2015: 7,635; 2016: 33,203 (YTD Nov. 18, 2016) Kits returned for D-SNP members, 2015: 1,854; 2016: 6,093 (YTD Nov. 18, 2016)
<b>Outcomes</b>	<b>Arizona:</b> This year, we mailed 5,078 kits to members in the two groups mentioned above. Members returned 17 percent of these kits. <b>National:</b> We mailed 393,221 kits to all Medicare members with an open gap. In 2015, we saw a return rate of 35 percent, and anticipate a higher return rate for 2016 based upon year-over-year learned behavior and/or information learned from member conversation when they requested the kit.

**PATH Financial Compensation for Physicians:** The PATH program is part of our commitment to shift the nation’s health care system to one that rewards quality and value instead of the volume of procedures performed. We use financial incentive programs like PATH to reward providers who take the extra time and commitment to help our MA, including D-SNP, members, become more engaged with their preventive health care. The goal of this program is to improve

member experience and health and provider satisfaction by focusing on specific HEDIS measures and diagnosis and documentation through early detection and management of chronic illness.

Initiative Name	PATH Financial Compensation for Physicians
<b>Implementation Date</b>	2013 in Arizona
<b>Metric/Measurement Process</b>	Measures included in the program can vary slightly year over year as CMS retires measures and adds new measures. Current measures include: breast cancer screening; colorectal cancer screening; osteoporosis management in women; diabetes care – eye exam, kidney disease, blood sugar control; medication adherence – diabetes, hypertension, cholesterol; high-risk medications; adult BMI assessment; and rheumatoid arthritis management.
<b>Size of Medicare D-SNP Membership</b>	We offer this program to all practices seeing Medicare members.
<b>Number of members Participating in Initiative</b>	<p><b>Arizona:</b> 2014: 104 practices and 18,801 members; 2015: 171 practices and 23,899 members; 2016: 246 practices and 30,175 members</p> <p><b>National:</b> 2014: 2,860 practices and 674,624 members; 2015: 2,802 practices and 989,394 members; 2016: 3,787 practices and 1,344,818 members</p>
<b>Outcomes</b>	<p><b>Arizona:</b> We recognized nearly 80 care providers in Arizona with the 2015 UnitedHealthcare PATH Excellence in Patient Service Awards for their commitment to improving health outcomes for MA members. These care providers earned nearly \$7 million in quality of care bonus payments for achieving <b>Performance</b> metrics in the PATH Program and successfully addressing care opportunities when treating nearly 66,000 of our members.</p> <p><b>National:</b> We recognized more than 1,900 care providers with the 2015 UnitedHealthcare PATH Excellence in Patient Service Awards for MA members. These care providers earned more than \$148 million in quality of care bonus payments for achieving performance metrics in the PATH Program.</p>

**Planned Pharmacy Initiatives:** In Arizona, we currently conduct initiatives addressing members’ prescription needs, including retail pharmacy point of service, provider facing and member engagement initiatives, beyond CMS-mandated programs. To help our members with medication adherence, we are launching a new pharmacy initiative in 2017 to provide member education and individual member support. We **hired a clinical pharmacist** to tackle medication adherence on two fronts: telephonic outreach to our members and face-to-face visits with providers and pharmacies. The pharmacist will engage members to educate them on their medication usage, dosage and encourage members to follow up with their PCPs. This pharmacist also will conduct face-to-face visits with providers to deliver and present data and scorecards on high-risk members and medications to identify members in need of extra attention.

## REPLICATING INITIATIVES IN AWARDED GSAs

As a current Medicare D-SNP plan in Arizona, we provide the initiatives above in all GSAs to our members, yielding results aligned with the mission and value of AHCCCS — choice, dignity, independence, individuality, privacy and self-determination. These statewide programs and initiatives enhance care coordination and timely information sharing to improve alignment for dual-eligible members. We are constantly developing and evolving our programs to improve efficiency and effectiveness to drive exceptional performance for health plan operations, raising clinical quality measures and improving member satisfaction. Our commitment to the quality of care and the experience for our members continues to guide our long-term investments and drive our daily priorities.

#### 4. Approximately 20% of the ALTCS E/PD population dies annually representing a significant percentage of the membership....

Our corporate culture closely aligns with **AHCCCS's mission and values** in respecting choice, dignity, independence, individuality, privacy and self-determination. To realize our shared values in practice, we imbed them as part of standardized approaches and processes deployed by our case management teams to compassionately support our members' life transitions. Accordingly, our policies support our members' decision-making and care needs in accordance with **42 CFR 438.3 (j) and 422.128 as well as AMPM Policy 640 and 930**. Our supports for members' life transitions align with the overall dimensions of comprehensive, person-centered care:

- Incorporate life transitions as an issue to be addressed comprehensively, across the continuum of member engagement, assessment, planning and monitoring
- Leverage technologies to capture and use relevant data to flag an impending or actual transition, and document and share information when a member may be approaching and/or in the midst of a life transition
- Provide materials and supports for prevalent types of conditions and transitions in alignment with our members' stated goals and desired outcomes
- Maintain a member's continuity of care through comprehensive transition planning
- Help families with coordination of benefits and with navigation of the health care system
- Proactively prepare the member and his/her family to manage all forms of life transitions at any age

### OUR EXPERIENCE SERVING MEMBERS DURING LIFE TRANSITIONS

We have over 28 years of experience helping Arizonans in the ALTCS Program manage life transitions such as aging, declining health and terminal illness. Including our 10,400 ALTCS members in Arizona, we currently serve more than 263,000 members nationally in 13 LTSS programs. Our experience **managing the care of these members** has provided us with a breadth and depth of understanding about our members as they plan for and approach **declining health, aging or terminal illness**. While **Compassion** is important in working with our members at all times, it is even more important when helping members facing end-of-life decisions so they may experience the **comfort and quality of life** that can be realized through advanced care planning.

### Prioritize Key Relationships

The key to our approach to supporting our members through life transitions is developing a trusted relationship between the case manager and the member. It is our goal that the case manager becomes the member's trusted adviser, helps him/her navigate the health care system to meet their needs, goals and desired outcomes at each life stage. At each touch point, the case manager works with the member and his/her interdisciplinary care team (ICT) to develop and continue to build a respectful, collaborative partnership that allows the case manager to **proactively** collaborate with the member and adjust the member's care plan to meet changing needs.

Our expert staff helps members navigate through various life stages using their experience and engagement with the community. For example, Patricia Dorgan, our LTC director of case management for Southern Arizona, serves on the recently established Pima County End of Life Care Coalition.

### Proactively Monitor Health Status

The case manager and ICT continuously monitor each member for indications that the member's health status, needs or living situation have changed. They do this through quarterly face-to-face reassessments of the member (every 180 days for members in a nursing facility), valuable discussions with the member and the ICT, and by using data analysis and predictive modeling from our clinical care management system. Indications may include physical observations, such as signs or symptoms of declining cognition, diminishing vision or an acute illness; changes that may be verbalized, such as a desire to change their living situation or the loss of a family member or caregiver; or utilization of services that may indicate a deterioration in the member's health, such as a hospitalization or an ER visit. When the case manager

identifies changes in the member's health status, sees indications that a member may be experiencing a life transition or is at risk for experiencing a life transition, the case manager engages the member and family to discuss the need to update the member's individualized plan of care (IPC) to include supports as the member's transitional decline proceeds.

## Resources to Support Life Transitions

**Member education:** Whenever the case manager engages with the member, the case manager provides education about resources to help manage life transitions, such as self-referrals for counseling, direct care service models, the use of respite to prevent caregiver burnout, placement options, caregiver and peer support groups or programs, online self-help and educational programs, and community resources to supplement services not covered by the ALTCS Program.

**Advance directives:** Our case managers are taught to discuss all advance directives options (including psychiatric advance directives) at each reassessment, encouraging those without a directive to create one and inquiring if there have been any changes to a member's advance directive since their last meeting. Case managers educate members about their rights to establish advance directives, direct their own health care decisions, determine their medical treatment preferences should they become incapacitated, and accept or refuse medical or surgical treatment. We provide written information to the member regarding advance directives, including our **Member Handbook**, which we give to the member upon enrollment and is available online.

As part of our approach for end-of-life discussions and advance directive plans, case managers ask questions in the third-person and frame statements in a positive, caring manner. For members who do not have an advance directive in place, after rapport has been established and confirmation of family members or decision-makers involved in the member's care, the case manager can introduce hypothetical situations to the member about how he/she would like certain aspects of his/her care delivered and continue to build/expand/explore ideas with each visit until such time the member executes an advance directive. Review of the **5 Wishes** document with the member allows for an easy-to-understand explanation of an advance directive. If the member does not have a psychiatric advance directive, the case manager educates the member about the resources available on *myuhc.com*, and how to consult with a psychiatrist to express mental health treatment preferences. We maintain documentation of advance directives in the member's medical file and share it with the member's PCP as required by state and federal laws.

## Care Planning to Address Supports for Life Transitions

At required intervals and when indicated by ongoing monitoring of the member's health status, the case manager collaborates with the member and the ICT to address impending or actual transitions that are in progress. Reassessment processes rely on standardized, routinely used assessment instruments (e.g., our comprehensive health assessment, AHCCCS's HNT, UAT, and other specialized assessment instruments particular to the condition, e.g., dementia and cognitive decline). The assessment process leads to an active engagement of the member and his/her family and caregivers in updating the member's IPC with current and realistic goals and desired outcomes for the phase of transition that is in progress. As part of care plan development, we accommodate the member's communication preferences, such as arranging for translation services at the planning meeting. The case manager uses motivational interviewing techniques to promote self-determination and encourage and empower the member and his/her representatives to actively participate in the decision-making about their care and services that are most supportive and meaningful to the member's quality of life goals.

**Engaging the ICT:** The case manager engages the ICT through scheduled meetings that allow the team to review findings from assessments; to identify the member's needs, goals, desired outcomes and preferences for care; and to confirm they have a comprehensive understanding of the member's needs, goals, desired outcomes and preferences. As the primary advocate for the member, the case manager engages the ICT to discuss the interventions, services and supports it recommends for inclusion in the IPC for all transitions but in particular, for those at end-of-life.

**Engaging the PCP:** The case manager may refer the member to his/her PCP to evaluate clinical reasons for the member's decline and explore therapeutic or restorative alternatives. For instance, are gait/fall issues related to



problems with the feet or with medications? Is dehydration or poor nutrition related to medications or social isolation at meal times? Are difficulties walking related to something as “simple” as the member needing routine foot care? The case manager helps the member schedule the appointment or arranges transportation, if assistance is needed. If the member is unable to travel to the PCP’s office, the case manager coordinates a home visit with the PCP, where available.

**Case review and peer-to-peer consultation:** The case manager may escalate the member’s case for review with our LTC medical director, Dr. Mark Russell, and our case management ICT to discuss the member’s change in health status and options and recommendations required for the member’s transition. When indicated, Dr. Russell conducts peer-to-peer consultation with the member’s PCP to collaboratively discuss the member’s treatment plan options and facilitate access to additional services and supports or care in alternate care settings. For example, many providers are not familiar with the broad range of covered services in the ALTCS program, and Dr. Russell uses the peer-to-peer opportunity to inform and educate the PCP/specialists on how we can collaborate and coordinate hospice, palliative care, or any other clinical, and support services to assist the member.

### Ongoing Training to Support Members’ Life Transitions

We train our case managers and members of the ICT to recognize changes associated with life transitions and work with the member to complete a reassessment of the member’s strengths, needs, preferences, health status, goals, desired outcomes and issues specific to the total care plan. We provide training for all staff and have processes in place to confirm we are continuously monitoring and identifying those members experiencing life transitions and are prepared to assist the member and his/her family through those transitions. Training includes how to assess members for new safety risks, cognitive decline, social isolation, self-care decline, altered mood, substance use/abuse and signs of depression. We also train case managers how to approach member discussions around end-of-life care, including any specific or special kind of care they want. For example, case managers participate in annual training delivered by the Alzheimer’s Association, which details the support and services available from the association for our members and their caregivers. Training such as that provided by the Arizona Geriatric Society, “Your Life Your Choices” — training on advance directives, including cultural considerations related to advanced care planning — is also available to our case managers.

### Approaches to Specific Life Transitions

Based upon our experiences and additionally, learnings such as from the book “Being Mortal,” by Atul Gawande, we have developed approaches to specific life transitions that are prevalent among our members.

**Alzheimer’s/Dementia:** We recognize that members with these conditions will experience incremental phases of decline that present their own challenges and require coping strategies on the part of members, their families and caregivers. Case managers experienced in working with these members have skills and knowledge of resources and approaches to working with individuals experiencing Alzheimer’s/dementia, and in each case, engage the member and his/her family and caregivers with the rest of a member’s ICT, to review and agree upon available options that provide the best support given the member’s current condition. The members of the ICT provide valuable and timely guidance for care management strategies as a member’s condition shifts over time. ICT participants, approved by the member, may shift over time but may include a neurologist or behavioral health provider or organizations, such as the Alzheimer’s Association. The case manager brings relevant data about cognitive changes and patterns of behavior to the ICT for its consideration; then in collaboration with the member and the ICT, the case manager develops a strength-based IPC, focused on retained cognition and daily skills, rather than deficits. In alignment with the member’s goals and desired outcomes, the IPC will include activities and services to avoid unnecessary changes in member placements, help the member live in the safest, least restrictive setting and include advanced care planning. The case manager will explore placement options as needs arise, such as adult day care or wandering dementia units in assisted living facilities. The case manager will support the member’s family as they experience loss with the member’s disease progression by connecting them with respite services and community supports, such as caregiver support groups and regional Alzheimer’s Association Chapters, which provide education, tools and resources to help manage the member’s care.

**Loss of a family member/caregiver:** The loss of a family member or caregiver prompts a case manager's review of the member's IPC. In addition to the usual grief process and its associated impact, the loss of the person who may have been providing transportation, doing the shopping, preparing meals and managing the finances will have a dramatic impact on the member's life. Changes in the daily routine occur; there are questions concerning the ability to remain safely in the home; there is an increased risk of depression and suicide. The case manager collaborates with the member to update his/her IPC, including identifying covered services and community resources to support the member, such as grief support resources. The case manager educates the member about the resources on grief and loss available through our secure member portal, *myuhc.com*, including information about the loss of loved ones and addressing life changes. The case manager can provide information on county burial services if the member does not have financial resources.

**Terminal Illness:** When a member is diagnosed with a terminal illness or is facing end-of-life issues, the case manager meets with the member to reassess his/her needs, goals and desired outcomes and evaluates the member's caregivers for burnout. The case manager may engage our **End of Life Transition Care team**, which reviews the member's needs, services/care options, placement options and outside agencies for possible inclusion in a comprehensive plan that provides for the best member outcome. In alignment with the member's end-of-life goals and outcomes, the case manager discusses the End of Life Transition Care team's recommendations with the member and the ICT. The case manager explores support options to help the caregiver, such as making the caregiver aware of resources available on *uhcforcaregivers.com*. The case manager discusses the use of the **respite benefit** before considering long-term placement in a nursing facility or assisted living facility. The case manager evaluates the possible need for **hospice** services. When hospice care is indicated, the case manager collaborates with the hospice agency staff to develop an IPC that coordinates the ALTCS services with those provided by the hospice provider. The coordinated plan will include interventions to relieve the member's physical, mental, emotional and spiritual suffering by providing medication. Many members will be **dual-eligible** with hospice services provided under their Medicare benefit. The case manager ensures the member's needs are met through both his/her Medicare and Medicaid benefits.

## INNOVATIONS TO SUPPORT MEMBERS WITH DECISION-MAKING AND CARE NEEDS

We have implemented member-friendly programs, resources and tools to help support members and their families during stressful life transitions to provide for the best member outcome in each situation. Relevant **Innovations** for members experiencing life transitions include:

**Palliative Care Program:** Working with one of our providers, Soreo Hospice and Palliative Care, we piloted a palliative care program that resulted in a significant improvement in quality of life, zero subsequent urgent care or ER visits and no hospitalizations for a member that was at end of life but not certified as terminal. Soreo worked with the case management staff to coordinate specific services needed for the member, in addition to what was available through the ALTCS benefit. They provided palliative nursing support care on an as-needed basis while LTC provided the usual covered benefits of durable medical equipment (DME), medical supplies, pharmaceuticals, attendant care and other necessary services. We are finalizing details of this program to make it **available in 2017 for all of our members** moving through this difficult life transition.

### Providing a Member with Palliative Care

Our 85-year-old member, Mrs. C, was chronically ill and in declining health. She had been hospitalized repeatedly for chest pain related to heart failure and was being considered for hospice enrollment. However, her providers could not certify that she had less than six months to live. Working with Soreo Hospice and Palliative Care, we enrolled Mrs. C in our pilot palliative care program. As a result, she experienced a significant improvement in her quality of life, zero subsequent urgent care or ER visits and no hospitalizations. Mrs. C received palliative care nursing support beyond what would have been available from traditional home health nursing services, in addition to the other LTC covered benefits. Mrs. C ultimately passed peacefully in her home 226 days following her engagement in our palliative care program.

**Hospice PRN Program:** For members who may not require hospice care 24 hours a day, seven days per week, the case manager coordinates the delivery of these services through this program. Implemented in 2014, our program efficiently

provides **hospice services** in our Central and Northern GSAs on an “as-needed” (PRN) basis so we can be most responsive to member needs. We have engaged several hospice providers, including Hospice Compasses, Living Waters and KRMC Hospice that work with us in this manner to **expand the program to additional areas and members**.

**End of Life Transition Care Team:** When a member is diagnosed with a terminal illness or **is experiencing end-of-life changes**, the case manager escalates the member’s case for review by this team. The team discusses the member’s needs, services/care options, placement options and outside agencies that can deliver care for possible inclusion in a comprehensive care plan to provide the best member outcome. The team comprises Dr. Russell, the case manager, the case manager’s manager and high-risk case-management team specialists.

**Hospital to Home (H2H) Program:** Hospitalizations often are one of the first indications of declining health. An H2H RN conducts an in-home, post-hospital assessment to understand the member’s perception of the cause of the hospitalization, if the member feels his/her condition is stable or if he/she needs more assistance. The RN completes medication reconciliation, reviews the discharge summary with the member, answers questions, helps schedule follow-up appointments, arranges transportation and provides AHCCCS-approved disease-specific education. The RN reports changes in condition to the case manager and collaborates with the member regarding possible changes to the IPC.

**Our Advanced Illness (AI) Case Management Program:** Our AI case management program is **available to all of our D-SNP** members in Arizona, and provides comprehensive care for individuals facing an end-of-life illness. The program focuses on improving the member’s quality of life by honoring and supporting his/her unique traditions, attitudes and beliefs regarding life and health and addressing issues of physical, emotional and spiritual comfort. It provides a **structured approach to educating members and providers about caring for members with an advanced illness**, which can lead to expectations that are more realistic, greater member and family satisfaction, improved symptom control, better allocation of resources and improved longevity.

**High-Risk Nurse Home Health Nursing Liaison:** Our high-risk nurse (HRN) home health nursing liaison coordinates home health nursing through reviewing requests and orders for nursing (including respite cases), obtaining notes from PCPs/specialists, arranging services, and providing oversight and monitoring of the effectiveness of those services. Using her established relationships with our contracted home health agencies, our HRN matches members with agencies best able to meet the member’s unique needs. For example, she knows which agencies to approach for a member located in a rural or difficult-to-serve location, with complex treatment needs, language needs, challenging behaviors, replacement situations and those able to staff immediately to accommodate hospital discharges.

**Electronic Visit Verification (EVV) and Change in Condition Monitoring:** Our EVV program uses Addus Home Care’s EVV timekeeping system in which home care agency direct care workers use smartphones to report start and end times for home visits with our members, with the phones geo-fenced to the member’s address to verify location. The technology helps improve care outcomes by confirming timely and complete service delivery, including real-time service gap reporting and monitoring. However, through the change in condition monitoring program, **Addus caregivers can report any member changes (e.g., appetite, activity level, level of engagement, observed changes in cognition and behaviors) since the last visit to our high-risk case manager** who engages the member’s case manager for outreach to the member to mitigate any worsening in condition and to treat the member accordingly as soon as a change occurs.

**UHCforcaregivers.com:** This intuitive, interactive website will be **available for ALTCS members in 2017**. It provides support to family caregivers and helps them manage member care through the website’s Resource Center, which provides information about how to best care for their elderly parent or loved one. MyCommunity, also available through *myuhc.com*, allows for information sharing with other care providers, family and friends, and features task/calendar management tools. This is a great communication tool for family members living out of the area.

#### 5. The Offeror has a newly enrolled 32-year-old male with a Traumatic Brain Injury who temporarily resides in a ...

This scenario is familiar to our case management team for its complexity and overlay of neurologic and psychological issues that compound efforts to address this member's physical health care needs. Our pragmatic and person-centered approach to the development of an individualized plan of care (IPC) is important to build an engaged, ongoing relationship with this new member, we will refer to as Mr. B, whose care needs will require a consistent case management plan and support for a sequence of activities over time, vital to achieving his major health goals.

In working with Mr. B as a new member to an ALTCS plan, our case manager will be sensitive to Mr. B's cognition post traumatic brain injury (TBI) and his emotional state when conducting initial activities related to his new enrollment, such as completing assessments and explaining benefits, rights and responsibilities. Given his morbid obesity and the fact he is already experiencing significant skin breakdown, Mr. B's IPC must take advantage of Mr. B being in a skilled nursing facility (SNF) to target interventions to prevent further complications and restore his skin integrity as quickly as possible. At the same time, this is a setting in which to evaluate and plan for addressing the multifaceted physical, behavioral and social dimensions that will affect Mr. B returning to the productive, independent lifestyle that is his expressed goal. Mr. B's TBI will influence efforts to address his stated health goals, and his IPC will include strategies in working with him that are sensitive to TBI. Overall, the case manager will play a vital role to engage a multidisciplinary team of resources that will contribute to Mr. B's ongoing IPC and his evolving needs. Through the appropriate sequence of activities, we will chart a course to facilitate the transition of Mr. B from his current placement setting to the most integrated setting appropriate to his needs. Depending upon Mr. B's current location, his care plan may involve a transfer to a SNF specialized in bariatric and brain-injury care for initial case management and planning for re-entry into a more independent setting. For example, if he is not already in this facility, the Foothills SNF's specific expertise in managing patients with both bariatric and TBI needs, established wound care program, and integrated approach to behavioral health needs would all benefit Mr. B's IPC.

### APPROACH TO MEMBER ENGAGEMENT AND PERSON-CENTERED CASE MANAGEMENT

As a **newly enrolled health plan member**, we will initiate contact with Mr. B after a complete review of existing information about his case, which has come to us from the State and assignment of a case manager to Mr. B, based upon his specific needs, case manager skills, work experience and geographic location. In this case, one factor in the assignment of the case manager, whom we will refer to as "Denise," is her long-term experience working with complex and challenging member dynamics and familiarity with our contracted facilities with specialization in bariatric and brain-injury care. Our case manager will coordinate the collection and review of all available documents such as utilization data and existing treatment plans and medications.

We conduct all case management activities according to standards outlined in **AMP Chapter 1600**. As such, Denise contacts Mr. B with a **welcome call**, which occurs within seven days of enrollment for all new members. She introduces herself as his case manager and tells him she is available to answer any questions before her on-site initial assessment. Denise also determines whether he would like **anyone else invited to the initial assessment, such as a family member, provider or other advocate**. She discusses her role as a case manager to assemble/engage these people to act as his interdisciplinary care team (ICT) to determine the best way to meet his identified needs (medical, functional, social and mental health needs) in the least restrictive and most integrated setting possible. Denise focuses on building a respectful, collaborative partnership with Mr. B using motivational interviewing techniques to promote self-determination and participation in planning activities. As key aspects of our corporate culture and operational processes, Denise engages Mr. B in person-centered assessment, care planning and ongoing monitoring processes, which align with the **ALTCS Guiding Principles** of Member-Centered Case Management and Person-Centered Planning. Our standardized processes encourage and **empower Mr. B to actively participate** as a full partner in all phases of the case management process, to make decisions/choices about his care and services in meaningful ways. His input allows him to direct the development of an IPC that includes the services and supports to help Mr. B achieve his needs, goals and desired outcomes. Because Mr. B directs the planning process, his IPC reflects his vision of his future.



## Assessment and Care Planning Processes

Denise prepares for her face-to-face meeting with Mr. B by reviewing his medical history, current diagnoses, existing treatments and medications and active providers reflected in his record at the SNF using the Minimum Data Set (MDS) 3.0 available and the Preadmission Screen (PAS) conducted by AHCCCS. Through review of the AHCCCS 834 file, Denise identifies if Mr. B has an indicator for serious mental illness (SMI). Denise reviews the wound-care treatment plan, confirms other specialty providers' involvement and progress with therapies, reviews the Preadmission Screening and Resident Review (PASRR), reviews prior care plan meeting notes and the MDS including documentation of his interest in returning to the community. Denise verifies if an assessment has been completed to evaluate potential cognitive deficits related to the TBI and how significant the injury affects his ability to make life decisions.

**Engaging the member in assessment and planning:** Denise completes her face-to-face assessment of Mr. B within 12 business days from enrollment. Using our comprehensive health assessment and AHCCCS's UAT, she applies motivational interviewing techniques to collaborate with Mr. B to determine his readiness for care planning and begin to understand his long-range goals. During her interview, Denise may use the Braden Score Supplemental to assess skin integrity and the PHQ-9 to assess current levels of depression. Finally, Denise identifies other active participants that Mr. B would like to be part of the development of the treatment plan like family members or advocates. Since Mr. B is a newly enrolled member, Denise reviews the *Member Handbook* with him and particularly describes the ALTCS benefits including direct care service options, the Member Acknowledgement Form, Member's Rights and Responsibilities, advance directives and confirms member representative and PCP information along with Medicare or other insurance information. Once he signs his member service plan, Denise documents information gathered in the assessment in our comprehensive electronic care management system and in the Client Assessment and Tracking System (CATS).

**Convening an interdisciplinary care team for IPC development:** Mr. B's IPC involves the identification of an ICT. Importantly, Mr. B's ICT will need to include several key sources of expertise and input related to his multifaceted needs and priorities, including Mr. B himself and any individuals that he identifies he would like to be part of his planning and support. Based upon her review of available background information regarding Mr. B's current treating providers and his past health care records, Denise will reach out, as appropriate, and hold interviews with key professionals involved in Mr. B's care to fully understand the implications of his conditions and treatment, services and supports required. Based upon her understanding of the social factors influencing Mr. B's psychological and physical status, Denise pursues information from individuals and potentially community-based organizations that have in the past, or may in the future, offer support to Mr. B. She reviews information that she has collected with Mr. B. Denise coordinates a meeting of the ICT using the foundational information she has collected to date as part of her review and assessment process, including interviews with professionals already involved in Mr. B's care, as well as identified specific risks and challenges.

Several areas are prioritized and addressed systematically. **Skin integrity:** One of the priorities for Denise, Mr. B and the ICT is the improvement of skin integrity and reducing the ongoing risk of skin breakdown related to Mr. B's Stage 3 pressure ulcer. She works with the wound care team at the facility to complete an additional assessment. Part of Denise's assessment includes determining where the pressure ulcer was acquired. If acquired while at the current facility, she completes a Quality of Care Concern report to submit to our quality management team for an appropriate investigation, and reports this information to the facility's director of nursing. Regardless of how the wound was acquired, Denise reviews the facility records to confirm the treatment plan includes the appropriate providers and caregivers. This could potentially include a community-based wound specialist for continuity of treatment once Mr. B discharges from the SNF. **Traumatic brain injury:** It is important to understand the ramifications of Mr. B's TBI and the implications for how to structure his IPC needs around his ability to constructively participate and benefit from planned interventions. Denise works with information and recommendations provided by neurologic evaluations and she engages neuropsychiatry as part of the ICT as appropriate. **Behavioral health:** Denise takes steps to assess what is required for the appropriate management of Mr. B's depressive symptoms during the course of his treatment. Mr. B may need separate evaluation to determine the severity of his depression and treatment options in light of his TBI. **Weight loss and increased mobility:** Denise works with the ICT to individualize Mr. B's Bariatric Treatment Plan. The ICT

addresses Mr. B's short- and long-term goals related to the appropriate pace of his weight loss, provisions for exercise and activity, and other potential interventions in an effort to chart a course toward realizing Mr. B's expressed desire to "become active again." Denise documents the identification of safe and gradual weight loss targets with continuous coaching support to meet Mr. B's goals as part of the IPC. **Community living and need for social interaction:** A possible goal is that, upon the completion of physical and occupational therapy, Mr. B is physically able to complete some of his own personal care tasks and/or walk unassisted. Such improvements would allow for choice and preferences to living a quality life in the least restrictive and cost-effective setting. The ICT will work to identify resources and opportunities for Mr. B to increase his sense of responsibility and social interaction without placing added stressors that could affect his personalized treatment plan. **The best setting for IPC priorities requiring skilled nursing care:** Mr. B's current SNF placement is examined to make sure he is in a setting most qualified to address his specific IPC needs. For example, one of our contracted facilities offers specialized resources in bariatric and traumatic brain injury (e.g., Foothills). Denise ensures the facility is aware of Mr. B's eligibility information, including prior period coverage and prior quarter coverage, if applicable.

## Anticipated IPC Priorities

With Mr. B's input, several components of his IPC are anticipated to address Mr. B's needs and goals. These include:

***A plan to maintain optimal skin integrity while continuing efforts to heal the Stage 3 pressure ulcer on his buttocks, and address risk of long-standing skin integrity issues due to his multiple comorbidities:*** Denise may recommend a referral to an outside wound clinic for evaluation and treatment, especially if the pressure ulcer was facility acquired. The ICT confirms the cause for Mr. B's pressure ulcer to minimize the risk of another developing. If the wound was due to the type of wheelchair used, improper technique with transfers or repositioning, or sitting upright for a long period, we explore a different treatment approach with a community-based provider who can maintain continuity of care once Mr. B is discharged from the SNF. The team supports him further by listening to his needs and agreeing on a dietary plan to safely address his weight loss goal, while at the same time adding foods or supplements to help with wound healing. For instance, if Mr. B requires a plan that includes increased proteins, the PCP will assess renal function to confirm high levels of protein and fluid intake is appropriate. If Mr. B needs a seating evaluation, coordinating a seating consult to assess current equipment or evaluate for pressure-relieving devices, may be appropriate. Both conservative and more aggressive measures for optimal healing will be explored, with contingencies for factors that may contribute to slow healing, such as smoking or lack of engagement with efforts to increase activity.

***Incorporating results of neuropsychiatric evaluation in specific approaches across Mr. B's IPC and facets of his rehabilitation program:*** The evaluation helps determine potential deficits related to the TBI and indicates how significantly the injury affects his ability to make life decisions, rationalize, problem-solve and demonstrate impulse control. These are all factors to consider as to how much stimulation and activity to include in his bariatric and overall treatment plan.

***Providing appropriate treatment and ongoing monitoring to improve identified levels of depression:*** A separate evaluation may be needed to address the severity of his depression related to his divorce and other personal losses. Interventions may include prescribed medications as indicated and individual or other therapies, depending upon recommendations of the behavioral health (BH) care team member(s). Initial supports may include a behavioral modification plan if indicated and engagement of social and/or peer supports linked to his plan for weight loss. Once Mr. B is able and ready to explore social outlets, Denise can educate him on the self-management tools and resources to address depressive symptoms through numerous online resources available on our secure member portal, *myuhc.com*, including a link to our *liveandworkwell.com* site. Denise will also educate him about courses available to him, such as the Social Skills Workshops at the Direct Center for Independence and peer support groups, and assist him with engagement with those resources. She will monitor his goal achievement progress through our member empowerment (me\*) program and celebrate successes with him. At the core of our approach to supporting members through case management is a commitment to implementing a me\* member empowerment culture. me\* focuses on the member's

expressed needs, goals and desired outcomes. We empower the member to actively participate as a full partner to make decisions about his/her care in meaningful ways and to direct the development of his/her care plan. me\* was recognized and published by the Medicaid Health Plans of America as a national Medicaid Plan Best Practice in 2014-2015.

**Addressing the need for significant weight loss:** The IPC must include a specialized Bariatric Treatment Plan, addressing dietary and caloric intake, emotional and mental health aspects, and exercise or activity level to help with accomplishing weight loss goals. In addition, Denise evaluates and considers the need for a more intensive weight loss approach involving medical management, taking into account other health factors (e.g., Mr. B's TBI, depression and skin integrity). The Bariatric Treatment Plan takes into consideration high-protein foods and supplements needed to promote wound healing. A change in lifestyle requires continual reinforcement, assessing readiness to change, addressing barriers, encouragement and at times, adjustments to the treatment plan from the ICT (PCP, dietician/nutritionist, behavioral health provider, physical and occupational therapists).

Denise continually assesses Mr. B's desire and commitment to his weight loss goals and plans for the longer-range approach and resources that will be necessary to sustain an effective weight loss regimen for Mr. B. These include opportunities for rehabilitation services consisting of education, coaching and an exercise program outlined and monitored through physical therapy that will incrementally build over time. Denise seeks recommendations from an occupational therapist to aid and promote self-care leading to his increased social confidence and progress toward transition to lower levels of care.

**Evaluating options for return to community living:** Denise educates Mr. B and explores with him lower level of care service options available in the community (e.g., home, apartment or assisted living facility). Through ALTCS benefits, there are several programs and services available, as described below. When appropriate, based upon guidance from the ICT and Mr. B, if the desire is to move to a home or apartment, Denise may enlist the help of a UnitedHealthcare **reintegration specialist (RS) or HUD housing coordinator** to assist in locating housing options. The RSs are dedicated case managers who can either assist the facility-based case manager or assume full transition responsibilities entirely (depending upon complexity and challenges to discharge) to help with reintegration into a community setting. The RS may use separate assessment tools to evaluate other factors for reintegration, such as financial resources, housing, transportation or supports available. Available resources and tools include:

- **Community Transitional Fund:** Available to assist members residing in an institutional setting to reintegrate into the community by providing financial assistance. Community Transitional Service funds are also available from AHCCCS via AMPM 1240-C.
- **Community Transition Catalog:** Created by us, this catalog serves as a visual aid to give Mr. B a better idea as to the type of household items that he can purchase if he were to move into the community from the SNF.
- **Treasure Chest:** Collection of new and gently used items of nominal value that our case managers put together to use as rewards for achieving milestones set by the member, for items not allowed via other funding.

Additionally, a **Skilled Nursing Service** (from a home health nurse) may be available upon discharge to treat or monitor existing pressure ulcers or provide education to maintain stability of his chronic conditions. **Attendant Care Services** can be coordinated in which a direct care worker can provide assistance for routine household activities such as shopping, cooking, homemaker/cleaning and personal care assistance with activities of daily living (ADLs). This service can be provided through a traditional agency model, Agency with Choice or Self-Directed Attendant Care (SDAC) model, based upon Mr. B's preference. If he were to move into an assisted living facility (ALF), services are bundled within these settings and include, but are not limited to, personal care, homemaker, meals and social recreation. There are several formal services available, but Denise will also coordinate informal supports and community resources to best supplement his ALTCS benefits. For example, Denise may consult with our **HUD housing coordinator** to help identify affordable placement options to best match Mr. B to a setting, location and price range desired. Our HUD housing coordinator secures Section 8 vouchers or affordable housing options in the community to best match members to their

desired setting. The HUD housing coordinator also works with case management staff in the rural and urban counties to assist them and keep them informed about current housing opportunities in their region.

**Plan for vocational re-entry and social re-engagement:** The neuropsychiatric assessment and progress across aspects of Mr. B's IPC will guide the approach to this goal. It is important he understands the range of services to best help him shape long-term goals and envision a different future. Denise will share and educate Mr. B about different resources and information such as Arizona Disability Benefits 101, vocational rehabilitation services and supported employment programs, continuing education, Freedom/Ticket to Work program and peer support groups. Mr. B may benefit from participating in smaller or more controlled environments. Such small social situations may help Mr. B engage with others, such as joining the nursing facility's resident council or joining Denise at the UnitedHealthcare Advisory Council. If he expresses a desire to attend, Denise will invite Mr. B to our **Abilities Workshop** where he can obtain more information about services and resources available in the community. The *Abilities Workshops* are coordinated exclusively for LTC members to learn more about services and resources available in their communities and provide an opportunity to interact and socialize with other members. *Abilities Workshops* may include providers from the community sharing information about programs and resources, educational opportunities, information about employment, volunteerism and activities/hobbies of leisure as a way to further integrate members into their communities. The local Member Advisory Council plans and facilitates *Abilities Workshops*, which we conduct in eight counties on an annual basis.

Other important resources for Mr. B are the educational materials available to him on [myuhc.com](http://myuhc.com), which has a link to resources on [liveandworkwell.com](http://liveandworkwell.com). For Mr. B, this would be ideal information that centers on TBI and adult depression, health assessments, online CBT for depressive symptoms and our mental health toolkit. Additional online resources include education and tools to promote early awareness, detection and prevention of BH disorders. Our online health and wellness library features more than 12,500 articles and 300 videos relating to BH, lifestyle and well-being issues from reliable resources.

## Ongoing Monitoring

Denise visits Mr. B as often as necessary to monitor and support the ICT. Denise continues to build on his short- and long-term goals with each contact, which may be telephonic or in-person, but always acting as a compassionate, supportive coach. Denise will continually monitor the progress of Mr. B's goals, adjusting the IPC as needed to facilitate progress. When she identifies changes in Mr. B's health status or sees indications that he may be experiencing a "triggering event," Denise will engage Mr. B and his ICT to implement timely, targeted interventions to meet his needs. Denise will use her standardized process, clinical acumen and judgment to continuously monitor Mr. B for indications that his health status may be changing using a variety of methods, including at a minimum:

- Having regular touch points (with formal assessments every 180 days for members in a nursing facility) verifying Mr. B is achieving his goals and outcomes and looking for indications that his health status has changed
- Reviewing of the results of predictive modeling analysis of claims for indications Mr. B may not be adhering to his IPC or may be experiencing a change in condition
- Tracking timely, relevant, actionable information about Mr. B, such as inpatient or ER admission or the results of an HbA1c test that indicates poorly controlled blood sugar levels
- Tracking the completion of interventions identified in Mr. B's IPC
- Ongoing communication with his providers and ICT



## 6. A young male Veteran with a service connected spinal cord injury and Post Traumatic Stress Disorder (PTSD) is ...

The scenario of this member is one familiar to us in our work with veterans who return from service with significant and permanent life-changing disabilities. In these cases, we recognize the member faces the difficult challenge of re-envisioning his life pathway and constructing a sustainable system of supports for independence and quality of life, while often also dealing with the lingering effects of trauma such as PTSD. We play a critical role to support and empower this member (whom we will refer to as Mr. S) to navigate benefits and services available through multiple systems to establish and implement a multifaceted individualized plan of care (IPC) that is in keeping with **AMPM Policies 1620 A, B and E** as well as the **ALTCS Guiding Principles** of Member-Centered Case Management, Member-Directed Options and Person-Centered Planning, to name a few. We must address Mr. S's needs relative to housing, mobility, ongoing physical health and behavioral health (BH) supports and, importantly, re-establishing productive work and recreation lifestyle dimensions as appropriate. The experience and skills of a case manager who will be assigned to this case are critical for a truly person-centered approach to working with Mr. S. to realize his personal goals. In the context of this effective relationship, our case manager will understand and advocate for Mr. S's individual needs and preferences while also supporting a collaborative process with an interdisciplinary care team (ICT) to develop and implement the IPC that ensures and leverages his continuing benefits, informal supports and community-based resources to address Mr. S's goals. We must address short- and long-term priorities in Mr. S's IPC. Through an appropriate sequence of activities, we will facilitate the transition to an appropriate community-based living arrangement and address a pathway to vocational engagement, while linking Mr. S to other resources through which he can pursue his recreational interests. Importantly, as part of the IPC, the case manager will be instrumental to monitor and make certain Mr. S is coping with his PTSD, and not experiencing roadblocks in his IPC implementation. In our experience, we most frequently play a lead case-management role working with our veteran members and their ICT; however, the member guides us regarding roles and contributions from others and we maintain continued engagement to monitor ICT implementation and respond to needs that arise.

### APPROACH TO MEMBER ENGAGEMENT AND PERSON-CENTERED CASE MANAGEMENT

A critical priority is to establish a **consistent, person-centered approach** in all aspects of our work with Mr. S. Therefore, it is important to assign a case manager who can relate to Mr. S's experience and establish an effective working relationship with him. With the limited facts in the scenario, it is possible that Mr. S is a new member who needs a case manager assigned to him, or he already has an assigned case manager with background knowledge about Mr. S's condition. Regardless of when Mr. S joins UnitedHealthcare, we **assign a case manager based upon Mr. S's specific needs** (including primary language preferences), case manager professional affiliation, skills, work experience and geographic location of Mr. S.

In this scenario, we assign "Javier" as Mr. S's case manager. **Javier is one of our 10 military/veteran resource navigators** in Phoenix, Tucson and Prescott, where the three VA hospitals and state veteran homes are located. These navigators are case managers who serve as a resource for veteran members and help veterans access VA services. Javier is a retired Army Lt. Colonel and is a military/veteran resource navigator, certified through the **Arizona Coalition for Military Families**. He has extensive knowledge about veteran services and programs in Arizona from his own personal experience receiving care from two systems as well as from his experience as a case manager with our health plan; he identifies with veteran perspectives and needs and understands how to access benefits available to veterans. Additionally, Javier is assigned to our members living at the assisted living facility (ALF) where Mr. S resides, many of whom are military veterans. Javier is an experienced resource for assisting Mr. S in accessing and coordinating care through multiple providers. Throughout his engagement with Mr. S, Javier is responsible for fostering and advocating for a person-centered approach in all interactions between Mr. S and his team of caregivers and supports. Javier also empowers Mr. S to actively participate as a full partner in all phases of the case management process through expression of preferences about his care and services in meaningful ways.

## ASSESSMENT AND CARE PLANNING PROCESS

One of Javier's key roles is to facilitate the development of Mr. S's IPC that includes the multifaceted services and supports involving multiple systems (e.g., BH, medical and community-based services) that help Mr. S achieve his needs, goals and desired outcomes. He uses **defined case management protocols and processes**, along with individualized efforts to develop member options and solutions. Development of Mr. S's IPC also requires the active engagement of an **ICT** specifically constituted to include individuals identified by Mr. S, including providers and other resources that may provide key supports and services to him as part of the IPC. Besides himself and the case manager, Mr. S's ICT may include a case manager or other staff from the VA system he accesses, staff at the ALF he resides in, physical health and BH providers engaged in his care, family and friends, our local staff such as the LTC medical director and BH coordinator, and additional parties of Mr. S's choosing.

**Assessing readiness:** Javier sees Mr. S frequently because he is at the ALF on a weekly basis. While Javier meets with Mr. S every 90 days at a minimum, he is available to Mr. S at any time between visits, and generally sees him at least monthly when he is at the ALF. A key step in this case is **to assess Mr. S's readiness for care planning** to address his long-range goals. As foundational components of our care management model and workforce training and skillsets, case managers employ motivational interviewing and talk with members during every interaction to find out if they have identified or are ready to identify a personal goal that can enrich their health and quality of life. At the same time, they are also continually educating our members about the various services and options available as an ALTCS member.

**Formulating goals and IPC development:** Mr. S tells Javier he has several goals he has set for himself and expresses his concerns they may have an impact on his benefits. Mr. S and his case manager begin to work together to formulate a set of goals, preferences and options to be discussed with the ICT. Javier coordinates a meeting among Mr. S and other members of his ICT, to participate in the care planning discussion to consider actions required to meet short- and long-term goals so Mr. S experiences a safe transition to independence. As part of this process, Javier will assist Mr. S to prioritize and systematically address each of his goals. As the IPC is developed, there are several factors for Mr. S and the ICT to consider related to independent living, BH and employment. **Independent living:** While Mr. S wants to own a home, he may consider renting an apartment or home initially to evaluate his satisfaction with living on his own with outside supports. Javier will assist Mr. S to identify housing options (with the assistance of our local housing coordinator) and resources to assist with housing expenses through both VA and community programs. The level of independence that Mr. S has for assistance with activities of daily living (ADLs), based upon the severity of Mr. S's spinal cord injury and resulting physical limitations, is critical to how we approach his IPC. He recommends implementing routines while Mr. S is at the ALF that mirror the routines he would have living on his own in the community. This will allow time for Mr. S to get comfortable with tasks and routines in an effort to build his confidence and self-management skills that he may not have today. Javier will engage the ALF staff to participate with the education and training program that prepares him for independent living. Monitoring and treatment of his skin integrity will be included in the IPC. Mr. S may be independent with, or require assistance with his bowel and bladder routine. Based upon the input from Mr. S and his ICT and assessments completed by Javier (including **AHCCCS UAT, HNT and CES**), Javier and Mr. S determine what level/frequency/quantity of support he will need in an independent setting. **Behavioral health:** Mr. S already may be engaged in counseling or other support services that he would continue if he moved. However, if not currently in place, based upon his risk factors, arranging for BH supports is a critical component of the IPC that we must consider especially during the time of his transition to independence. **Employment:** Javier will educate Mr. S about the **AHCCCS Ticket to Work program** that encourages ALTCS members to participate in the workplace without losing their benefits or income. Through his partnerships with the local Centers for Independent Living (CIL) and VA, Javier will provide information about available volunteer, work/career and vocational training opportunities.

## Anticipated Individualized Plan of Care Priorities

Initial steps to implement the IPC begin while Mr. S is living at the ALF, engaging ALF staff with tools and resources to prepare Mr. S for the transition to independence once he moves out on his own. Incorporating Mr. S's input, several IPC

priorities are anticipated to address his successful transition to an independent living setting; his vocational goals; his overall physical health related to his paraplegia; his BH especially considering his PTSD and the extra stresses of the transition to independence; and his overall social adjustment and well-being.

**Managing Mr. S's Transition to a Safe Independent Home Environment:** Mr. S's goal is to transition out of the ALF and live in his own home. Our planning process focuses on what Mr. S defines as the "best outcomes" for him. Javier provides Mr. S with information available through the Arizona VA. Javier shares that veterans are eligible for home loans through the VA, which require no money down, lower monthly payments and mortgage assistance. The VA also provides grants to service members and veterans with certain permanent and total service-connected disabilities to help purchase or construct an adapted home, or modifies an existing home to accommodate a disability. Javier shares information on two grant programs: the Specially Adapted Housing (SAH) grant and the Special Housing Adaptation (SHA) grant. Javier works with Mr. S to investigate these options. Javier also discusses with Mr. S that he may want to live in an apartment setting while he is looking to purchase a home so he can gain experience living independently in the community with support services. Javier also discusses that the Room and Board agreement can be adjusted during the time Mr. S transitions into the community, which allows Mr. S more of his assets to use to set up his household expenses. Javier also contacts the case management manager in Pima County who can put Mr. S on the Section 8 waitlist for an apartment.

Medically necessary and cost-effective home modifications are available through the VA and UnitedHealthcare. This will allow Mr. S to have an accessible home. Javier identifies the durable medical equipment (DME) and adaptive equipment Mr. S may need once Mr. S is ready to move into his own home, including bathroom grab bars, a ramp at the home's entrance, a sliding shower bench, a device to help him reach and any other equipment that will help Mr. S live independently in his own home. While still residing in the ALF, Javier discusses Mr. S's DME needs and requests an order from the PCP for this equipment. Prior to moving to his own home, Javier conducts a **comprehensive assessment** with Mr. S, including the completion of the UAT and HNT tools to evaluate what quantity and frequency of attendant care hours and other services Mr. S might need to help him with his personal needs (e.g., bathing, dressing, grooming, shopping and meal preparation). Together, Mr. S and Javier develop an agreed-upon care plan that has the services and supports Mr. S will need to meet his needs in a community setting. When Mr. S is prepared to move, he will participate in the interview process to select one or more direct care workers to assist him. Javier describes the various service options to provide personal care, attendant care and homemaker services, such as traditional, Agency with Choice and Self-Directed Attendant Care (SDAC). Javier advises Mr. S that family members or friends can become formal, paid caregivers. His family members or friends could apply to work with a Direct Care Worker Agency that is contracted with UnitedHealthcare or become his direct care worker through the SDAC option. Javier recommends that Mr. S select a direct care worker from Addus. Addus uses an electronic visit verification (EVV) system to track the delivery of services and monitor change of condition status for members. Javier recommends this agency because they are able to identify no-show employees immediately and provide timely backup coverage for those situations. Mr. S may be compromised if his attendant does not show up for his/her shift.

**Developing and Implementing a Meaningful Return-to-Work Strategy:** Mr. S would like to pursue career opportunities, is motivated to return to work but is concerned about losing health care and other benefits. Javier provides Mr. S with education (including a demonstration) about Arizona Disability Benefits 101 (AZ DB 101) and the AHCCCS Ticket to Work program and explains **how he could return to work without losing his SSDI or his ALTCS benefits**. Javier explains that Arizona has Centers for Independent Living (CILs) that provide resources for persons with disabilities, including information on local educational programs. Javier gives Mr. S contact information for the Direct Center for Independence in Tucson. Javier discusses educational opportunities with Mr. S and inquires about his career and work goals. Some community colleges and universities in Arizona have programs specific for persons with disabilities. The Arizona Department of Economic Security (DES) has a Veterans Program developed with support programs that increase opportunities for veterans to obtain employment and job training. This program works with the Disabled Veterans Outreach Program (DVOP) and Local Veterans Employment Representatives (LVERs) and has locations statewide. Javier

educates Mr. S on his benefits and any limitations of them should he become gainfully employed. Javier enlists an employment specialist to connect Mr. S to resources such as the DVOP. The DVOP specialists provide intensive services to meet the employment needs of special disabled veterans, disabled veterans, veterans and eligible persons. Javier approaches Mr. S about getting involved with volunteer situations where he can practice responsibilities as he moves toward his goal of employment. He also educates Mr. S about ADVS Veterans Services Division, which provides a network of veteran benefits counselors (VBCs) who give information, counseling and assistance to veterans, their dependents and survivors in matters pertaining to federal and state benefits earned by honorable service in the armed forces. Javier invites Mr. S to our upcoming **Abilities Workshop** for members. These annual workshops are hosted by the Advisory Councils in each area of the state and provide education about programs for housing, employment and education, and local resources available to him in the community.

**Establishing Options and a Plan to Engage in Outdoor Recreational Activities:** Mr. S expresses interest in exploring outdoor recreational activities that he pursued prior to his deployment and injury. Javier suggests formal or informal peer support, available to our members with a spinal cord injury or any other catastrophic injury, and who are interested in outdoor activities. Javier provides Mr. S with information on The Next Step, Peer Mentoring and More in the Phoenix area, a nonprofit provider. The Next Step, Peer Mentoring and More was created to **improve and empower life after injury** through education and recreation, and offers support services to individuals and families along with opportunities to explore the outdoors. The president and founder of this organization is a survivor of a spinal cord injury, is a UnitedHealthcare member and is an active participant on AHCCCS's State Medicaid Advisory Committee. The organization has peer connections statewide. Javier also provides information on recreational services provided by Direct Center for Independence in Tucson. Javier asks about Mr. S's interest and, because of the conversation, offers information about a wheelchair basketball league and provides him contact information for the wheelchair basketball team in his community. Javier also will invite Mr. S to attend "The Day at the Lake," a day organized specifically for people with spinal cord injuries that want to participate in water activities.

**Minimize Suicide and Substance Abuse Risks Associated with PTSD:** With his diagnosis of PTSD and his military service, Mr. S. has an increased risk of suicide and potential substance abuse issues. As part of ongoing assessments that are incorporated into Mr. S' IPC, Javier screens Mr. S for the presence and severity of depressive and PTSD symptoms at regular intervals during in-person visits. He uses **evidence-based mental health screening tools** such as the PHQ-9 to assess depression and determine the severity of Mr. S's current symptoms, suicide risk and the Post-Traumatic Stress Disorder Checklist-Military Version (PCL-M), intended for military members and veterans. If one has not been completed as part of his care while at the ALF, Javier recommends to Mr. S and his PCP a psychiatric evaluation as Mr. S may have depression, anxiety or another BH condition related to his PTSD from a service related injury. On an ongoing basis, if screening demonstrates issues that need to be addressed (e.g., an affirmative response on the ninth question or a score of 11 or higher on the PHQ-9), Javier will help confirm Mr. S receives counseling or other BH services as indicated and verify that both the BH and physical health providers are informed about the medications and services Mr. S is receiving. Javier provides Mr. S with the 24 hour a day, seven days a week crisis line number. Javier instructs Mr. S on how to access [myuhc.com](http://myuhc.com), our secure member portal. Javier shows the various [myuhc.com](http://myuhc.com) resources to Mr. S, including our **Wellness Recovery Action Plan (WRAP)** app. WRAP is an iOS and Android-based app that can be used to develop an individualized Crisis Plan to guide others as to how they want them to respond when the member cannot make decisions, take care of themselves, or keep themselves safe.

**Ongoing Supports for Living with PTSD:** In addition to screenings and services as described above, Javier refers Mr. S to the Wounded Warriors Project, which provides assistance and services to veterans with service-connected injuries. Javier also advises him that there is a spinal cord injury group for men that he may like to join; they meet weekly in Tucson at Direct Center for Independence. The group is led by peers and covers topics such as employment issues/challenges, exercise, relationships and sexuality issues, as well as many other topics that relate to spinal cord injuries. One of our LTC case managers who identified the need for some of her members initiate the support group. Javier shows Mr. S how to access — through our secure member website [myuhc.com](http://myuhc.com) — a link to resources on



**liveandworkwell.com** including information on Disabled American Veterans, Military OneSource, National Resource Directory, Real Warriors Campaign, the Defense and Veterans Brain Injury Center and guides such as *Returning From the War Zone: A Guide for Military Personnel*.

Javier will provide Mr. S the opportunity to apply for a service animal to assist him in meeting some needs if/when he lives independently, if he would like to explore that option. Specifically, the American Service Animal Society Soldier's Best Friend provides United States military veterans living with combat-related PTSD or traumatic brain injury (TBI) with service or therapeutic companion dogs, most of which are rescued from local shelters. A service dog may be an ideal support and companion for Mr. S.

**Managing Health Risks Associated with Paraplegia:** Because of his spinal cord injury resulting in paraplegia, Mr. S sits in his wheelchair for extended periods during the day, increasing his risk for skin breakdown. At each assessment, Javier completes the Braden Score and Skin Risk Assessment, which rates Mr. S's risk for skin breakdown. Javier shares the assessment results with Mr. S's PCP and inquires if the PCP would like to see Mr. S or order a home health nursing evaluation that Javier can coordinate. Staff at the ALF educates Mr. S on the need to check his skin daily for any changes and will report any changes immediately. If Mr. S has a skin breakdown, Javier will assist with coordination of the necessary evaluation, treatment and follow-up care, which may include home health nursing, a wound specialist or wound clinic dependent on the severity. Once discharged to the community, Javier encourages Mr. S to see his PCP regularly or arrange for routine home health nursing services to monitor his status. Javier confirms that Mr. S has an exercise plan in place to maintain his core and upper body strength. If he does not have an exercise plan in place, Javier will educate Mr. S on the importance of maintaining his physical strength and assist him with locating an exercise/physical fitness resource in his community. If Javier identifies — through his assessment and evaluation of Mr. S's DME needs — that Mr. S would benefit from physical therapy or occupational therapy for teaching increased independence with his ADLs, Javier coordinates a referral for evaluation from his PCP. Mr. S may also benefit from a seating evaluation to verify he has the proper wheelchair and seating arrangement/support. If he is not independent with his bowel and bladder care, home health services are coordinated to ensure his bowel and bladder care needs are being met in the ALF and ultimately in the community.

### Ongoing Monitoring

Javier maintains frequent contact with Mr. S to keep him motivated towards achieving his personal goals. He monitors Mr. S's progress and will assist him with any barriers he may encounter. He assists in the coordination of any referrals needed to build his skills or address his needs. Javier reassesses Mr. S in accordance **with AMPM Policy 1620-E and Exhibit 1620-1** and documents Mr. S's status in our care management system. He also addresses changes to Mr. S's IPC as changes are needed or requested by Mr. S. Javier continues to provide Mr. S with information and resources that support his goal of living in the community and owning a home; returning to the workforce; and increasing his recreational activity level.

## Access to Care/Network

7. It is estimated one in four Arizonans will be over the age of 60 by 2020. It is reported that this increase in the aging ...

UnitedHealthcare has been a longstanding partner in the Arizona LTC program since 1989 and we operate LTC programs in 13 states. Our extensive experience in coordinating access to LTC service providers for our members includes addressing the growing challenges LTC providers face maintaining an adequate paraprofessional workforce and understanding the impact of associated labor market trends. Our various LTC networks serving seniors and individuals with disabilities require paraprofessionals with targeted roles such as nurse aides in nursing facilities; home health aides serving individuals in their homes; and personal care workers made available through direct care service agencies that provide attendant, homemaker, companion and respite care services in community-based settings. In Arizona, we are building on our LTC program experience to develop innovative solutions that meet the critical and growing demand for paraprofessionals, working in partnership with the State, community leaders and LTC stakeholders. Our priorities for paraprofessional workforce expansion include, increasing our labor pool via innovative strategies, collaborating closely with key stakeholders, increasing workforce competencies via training and support and increasing our proactive workforce monitoring and data analytics via enhancing our monitoring systems.

### PERSPECTIVE ON ARIZONA'S CURRENT PARAPROFESSIONAL LABOR MARKET

We know a significant percentage of personal care/home care service providers are the member's non-paid spouse or relative. However, as people age and need more assistance, caregiver reliance often shifts to external paid sources of personal care. Adding to Arizona's aging demographic and ever-increasing need for caregiver paraprofessionals, LTC providers in Arizona find themselves in fierce competition with other industries—such as schools, restaurants and retail stores—also hiring persons with skill sets and wages similar to those of paraprofessionals.

As noted above, by 2020, one in four Arizonans will be over the age of 60. UnitedHealthcare proactively monitors the paraprofessional workforce through available, credible sources such as the Paraprofessional Healthcare Institute (PHI). **According to PHI's 2015 statistics, Arizona's paraprofessional workforce totals 65,130 direct care providers (e.g., independent providers, nursing assistants, home health aides and personal care aides).** While this workforce number is adequate today, from our direct perspective, it will need to increase proportionately to meet aging Arizonan demand.

We also identify general trends and challenges to expanding the Arizona paraprofessional workforce during interactions with our contracted direct care agencies. In speaking with our top agencies and assisted living facilities (ALFs) in both urban and rural locations, we had the following insight: 1) the cost of certification is costly; 2) direct care worker (DCW) wages are low compared to other industries; 3) there is a lack of caregiver career paths; 4) caregivers believe the work is hard compared to compensation; 5) transportation in the rural areas can be difficult; and 6) agencies that hire DCWs compete with other industries (e.g., retail), and a DCW may change professions for a small change in wages.

In January 2017, Proposition 206, the Healthy Working Families Initiative, took effect resulting in a seven percent increase to the HCBS provider fee schedule for certain service codes. The new law affects agencies serving LTC and intellectual and/or developmentally disabilities (IDD) populations by positioning them to offer more competitive salaries to DCWs—allowing them to work within their budget and hire adequate paraprofessional staff. We are aware that the State is addressing additional, recently raised concerns related to Proposition 206 for agencies.

### ANTICIPATED LABOR NEEDS TO ADEQUATELY SERVE LTC MEMBERSHIP

As noted above, we proactively analyzed the population growth expansion focusing on aging populations that will need LTC services. The US Bureau of Labor Statistics' Quarterly Census of Employment and Wages (QCEW) program (QCEW Employees & Non-QCEW Employees, Emsi 2016.4 Class of Worker) reports the number of Arizonians over 60 will increase by 12 percent by 2020. We also use data and sources such as the information in the accompanying callout box to assess the capacity of our existing paraprofessional network and to anticipate future workforce development needs.

As a sign of growing demand for paraprofessional services, the Medicaid and CHIP Payment and Access Commission (MACPAC) states the national home care workforce has almost doubled over the past 10 years— from 700,000 jobs in 2005 to over 1.4 million in 2015. Personal care aides accounted for 64 percent of this growth. Because the primary driver of growth in LTC is home and community-based services (HCBS) supports for members, the homecare workforce will be impacted the greatest now that more than 51 percent of all LTC is provided in community settings. MACPAC’s HCBS national spending reports support this perspective, increasing from \$28B in 2003 to over \$60B in 2014. We also review national paraprofessional data and trends supplied by organizations such as the PHI, Kaiser Family Foundation, American Association of Homes and Services for the Aging, Institute for the Future of Aging Services and CMS’ website on a continual basis and apply that information to our various LTC markets, such as Arizona.

### Maintaining Insight into Arizona’s Expected Paraprofessional Growth

The Arizona paraprofessional workforce will need to correspondingly increase to meet aging resident demand. Paraprofessional Healthcare Institute (PHI) growth projections for Arizona 2012-2022 include:

- Personal care aides: 40%
- Home health aides: 37%
- Nursing assistants: 27%
- All Direct Care Workers: 36%
- All Occupations: 22%

To measure and monitor paraprofessional labor needs to serve our ALTCS members, we will use the following solutions.

## Measuring and Monitoring Workforce Needs

### *Workforce Sustainability*

We will enhance our existing efforts and implement strategies that measure, monitor and forecast our workforce’s long-term sustainability. Without such an infrastructure in place, we risk destabilization of the HCBS care system that enables our members to remain at home as independently as possible, or have a home-based placement available when transitioning back to the community from an institutional setting. By developing such a system, we will be able to: 1) proactively identify potential challenges and threats to the viability of the workforce; 2) conduct analysis of the potential effect of the challenges and threats to access to care for members; 3) develop and implement interventions to prevent or mitigate threats to workforce viability, and 4) develop indicators to measure and monitor workforce sustainability. To assess needs and foster workforce sustainability, we will use the following methodologies:

- **Recruitment:** We will establish baseline recruitment numbers and monitor recruitment activity as indicators to confirm we are identifying the right talent in our members’ communities, including family/friends as fitting.
- **Training and development:** We will confirm paraprofessionals receive adequate training to understand our members’ needs and quality service delivery expectations; or, development opportunities, which will be offered to DCWs. To help identify these training and development programs and collectively work on plans to improve the workforce, we will meet with community leaders who support these provider types — such as individuals from the Arizona Direct Care Worker Association, AHCCCS’ Direct Care Worker Training and Testing Program, Direct Service Worker Resource Center, Arizona Health Care Association, Arizona Assisted Living Home Association and Arizona Assisted Living Federation of America.
- **Compensation:** We will promote compensation commensurate with the marketplace and key skill sets.

### *Network Adequacy and Capacity*

During our long involvement in Arizona’s ALTCS program, we have relied on a paraprofessional workforce largely recruited and hired by health systems and service agencies that are part of our broader network. Our established Arizona network employs paraprofessionals including attendant care agencies, licensed home health agencies, skilled nursing facilities (SNFs), behavioral health (BH) agencies (e.g., three peer support providers), ALFs and habilitation facilities to deliver care for LTC members statewide. We actively engage with our provider agencies and system partners (at a minimum, annually) regarding their staffing challenges and regularly survey them via mail to identify projections for

DCW needs. This is in addition to the routine network analysis and monitoring we conduct to assess adequacy of our integrated, continuum of services. We receive feedback from our LTC case management staff on potential gaps in service and difficult to serve areas, and reach out to contracted agencies with this information to recruit new providers, as necessary, to meet the needs. For example, we recently contacted an agency to conduct a targeted recruitment of caregivers for the outlying area of Green Valley in Pima County, which was a successful effort. Another agency agreed to conduct a special recruitment for us in Vail, AZ, resulting in a new contract with an attendant care agency serving Vail and part of Santa Cruz County. We also monitor gaps in service and proactively identify areas for mitigation via our Ball vs. Betlach Report, submitted to AHCCCS on a semi-annual basis.

As part of our LTC Network Development and Management Plan, we analyze network adequacy and capacity by taking into consideration the regional size and geographic distribution of Arizona's current and aging LTC population and leveraging expected trends and observed shifts in demographics, as reported in labor department statistics and our member data. Data includes cultural, language and other demographic characteristics of the population. We analyze the potential impact of the challenges and threats to our members' access to care by looking at the current service mix, member complaints and demographic data. With oversight by our Arizona network development staff, **our monitoring also will include a system to track and trend difficult placements, which will help us to better identify network needs. The system will include the demographics, gender, primary language and condition of the member.**

### Workforce Training and Development

From our analysis of the Arizona labor market, we anticipate the need for a more highly trained workforce to better assist members, particularly those with complicated issues and needs (e.g., behavioral issues). Training will broaden the pool of qualified caregivers, allowing our network agencies to better staff cases and result in a more viable workforce. We facilitate, recommend and provide links to relevant paraprofessional training opportunities for network agencies — collaboratively exploring new training programs and resources in mediums that work for the needs and schedule of DCWs. For example, over the past three years, we have offered **free continuing education sessions** to Arizona ALF caregivers on topics such as behavioral issues, dementia care, diabetes and traumatic brain injury to improve knowledge and quality of care. These sessions, led by Arizona LTC experts, have received very positive feedback. We will continue to sponsor such educational opportunities, using feedback from both our network and partners to identify relevant topics.

The State has taken a series of important steps to further develop the paraprofessional workforce, including establishing training requirements and programs for DCWs (e.g., the "Principles of Caregiving" model curriculum). We understand this curriculum is a requirement and, for agencies new to our network, we will reinforce requirements, confirm curriculum compliance and direct the agencies to the State's online resources.

### INNOVATIVE PARAPROFESSIONAL RECRUITMENT, HIRING AND RETENTION STRATEGIES

We recognize the urgency of developing strategic and innovative approaches to meet growth targets for our Arizona paraprofessional workforce. Our approach to developing innovative workforce strategies and solutions involves proactive planning, collaborative partnerships and maintaining rapid cycle evaluation of ongoing efforts to revise, enhance and expand what works best. For example, our National Advisory Board focused on the national paraprofessional workforce shortage for the past year— developing training and recruitment techniques to allow us to more quickly source DCWs, better match DCW training with member needs and provide viable DCW career pathways so we can improve recruitment and retention. This board is developing a whitepaper on this subject and plan to pilot implementation of identified strategies in the near future. In addition, we will support new avenues of recruitment for future planning, capitalizing on social research about local neighborhoods, informal networks and social media; most relied upon community resources such as local unemployment offices and training centers; and cultural affiliations that represent trusted sources of information. Similarly, we will re-imagine approaches to training that capitalize on available training resources while fostering creative approaches, such as engaging peers, using simulation and linking training to DCW career pathways. We will consider the types of financing and incentives we can structure in collaboration with the



state and agency partners. Lastly, we will engage with those populations currently serving as paraprofessional workers in LTC to guide our strategies for recruitment, training and retention.

## Recruitment and Hiring Strategies

**Implementation of HCBS Incentive Programs:** We piloted Arizona HCBS value-based payment models and will leverage that successful experience to update and refine the model for use in 2017, with attendant care agencies, where agencies can earn additional bonus payments by meeting quality targets. We will design and define this model's **Performance** measures to align with quality metrics relevant to LTC services and expected outcomes for improved ALTCS and D-SNP member experience. Our plan is to build the model for larger personal care attendant agency participation using attribution models, with a quality measure focus on prevention, early detection and effective management of leading chronic diseases in Arizona (including diabetes and heart disease). The model will require a percentage of the bonus payment be shared directly with the caregiver. **Our participating attendant care agencies can use this opportunity for caregivers to earn incentives as both a recruitment strategy and an employee retention strategy.**

**Collaboration with Network Agencies and Relevant Partners:** Leveraging and expanding upon current Arizona practices, we will encourage both our rural and urban home health agencies, 43 agencies, to add attendant care to their scope of practice and hire/train DCWs—aligning with the State-mandated rate to reinvest in their staff and community. Our larger home health agencies may already have existing scholarship program monies available to build their nursing pool, which they can grow via recruiting and training exceptional DCWs. This strategy benefits all parties, feeding into the home health agencies' nursing shortage, our need for DCWs and establishing a career path for interested employees/applicants. For smaller home health agencies, we will offer DCW scholarships for career advancement (qualifications based upon employment record and time spent with the agency; after which, the DCW could serve as a certified nurse assistant in the home health pool or move to a nursing facility or ALF). Adding attendant care to home health agencies is a strategy we are already using in southern Arizona with providers like Dependable Home Health, Reliable Nurses, NSI and others, which we will expand and employ throughout the state.

One of our case management managers, Bill Fulton, serves as a **Tier 1 Ambassador to the State's WIIN (Work Incentive Information Network)**. WIIN focuses on expanding the paraprofessional workforce for individuals with disabilities and developing a sustainable network of professionals and community partners to aid an already strained system. Through our WIIN involvement, we meet regularly to discuss, strategize and plan for new organizational and systems-level policies and practices, instituting work incentive outreach and education into business practices.

Our network development staff will continue to **target key Arizona provider associations as resource pools for paraprofessional provider solicitation and contracting**, including state associations for home care, disabilities, Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs). For example, in October 2016, we held three different Community and Provider Council meetings in Sierra Vista, Casa Grande and Payson (locations in expansion counties for UnitedHealthcare), where the attendees included a mix of HCBS-related entities (e.g., AAAs, VA, ALF, attendant care agencies and transportation providers).

We also **use our regular Provider Advisory Council meetings and town hall sessions** to obtain valuable feedback on paraprofessional workforce issues and the best ways to address, identify recruitment targets, answer questions related to network applications and ask for attendee assistance in promoting our LTC network. For example, we held our most recent HCBS Provider Advisory Council meeting in Pima County on October 17, 2016, and included discussion of the projected impact of Proposition 206 and the challenges of recruiting certified caregivers, including what has worked for different facilities and planning for continuing education sessions to benefit caregivers and other facility staff.

**Expansion of Workforce Recruitment Sources:** Through our myConnections™ initiative, we encourage workforce development through community employment service organizations such as St. Joseph the Worker and Chicanos por La Causa. myConnections™ provides members with benefits and services addressing social and economic factors that contribute to poor health, increased health care utilization and higher health care spending. Specifically, our myWork

Connect component helps individuals obtain and maintain employment and supports seamless integration of employment supports, training, counseling, identification and post-employment support.

To fully meet the care needs of a growing Arizona elderly population, we understand that paraprofessional recruitment efforts will need to consider non-traditional source populations. We are exploring opportunities to expand the available worker pool by including **individuals with IDD who are capable and un/underemployed, older adults looking for a second career, veterans and other groups** beyond those just entering the workforce. We will also work with the Arizona Department of Economic Security (DES) to identify training opportunities for unskilled workers to become paraprofessionals, as well as **partner with Centers for Independent Living like Ability360** (formerly ABIL) to support employment programs for individuals with IDD.

**Assistance Developing a Career Ladder:** We will assist family members and other individuals interested in paraprofessional or nursing career paths (e.g., homemakers to home health aides to LPNs, etc.) by encouraging them to be a part of the paraprofessional group. To identify interested parties, we will look to the community in schools, faith-based organizations, community clinics and similar resources. UnitedHealthcare will work with community agencies in underserved areas to identify and offer training scholarships, such as certified nursing assistant (CNA) or caregiver certification, for workers interested in a continuing career in the paraprofessional health care field.

## Retention Strategies

We **meet with our network agencies that employ paraprofessionals** regularly to collaborate on identifying workforce challenges and conducting community outreach, planning and assessment of potential referrals to help mitigate those challenges. This close partnership allows us to address or avert issues early on (e.g., mitigating the challenge of losing paraprofessional staff to a large, new retail or industrial employer in the area).

**Transportation Assistance:** One known challenge affecting workforce retention is transportation to care for rural members. To help address, we will work with our local or national transportation vendor(s) to offer **transportation to workers who cannot travel to distant rural areas** for member care, as well as offer special provider reimbursement rates for drive time/mileage. We have successfully used this strategy in Florida via a custom single case agreement with Helping Hands of North Florida Inc./Senior Support Services to reimburse provider travel to rural HCBS members.

**Caregiver Support and Recognition:** Caregivers often leave the paraprofessional field because they do not receive needed support or recognition. Our innovative strategies to help retain caregivers include the following:

- To help new Arizona paid care attendants, as well as family members serving in the role of caregiver, we developed our **uhcforcaregivers.com** site. This **free resource** provides articles, product recommendations and other educational resources specific to all caregiver types.
- To help retain non-professional family caregivers, we develop targeted ad hoc materials to improve awareness and recognition of member changes (e.g., blurred/double vision, abnormally hot/cold, trouble sleeping or night sweats), and potential effects on the member's health.
- Through our Arizona ALF partners, we understand caregivers often struggle to find the money and time to complete the certifications and testing needed to remain in compliance. To assist, we will sponsor an annual Caregiver Fair and offer CPR/first aid classes for certification, Mental Health First Aid classes, stress management tools, 'care of the caregiver' sessions and other continuing education classes. We will offer financial assistance for caregiver compliance as appropriate, particularly to family caregivers without monetary resources.
- To demonstrate that we value our network paraprofessionals, we implemented our annual Caregiver Recognition Program. Members or their colleagues can nominate caregivers for outstanding contributions in their field and health care. Each year, we focus on caregivers in a different Arizona GSA. We publically honor and present an award to selected caregivers at our sponsored banquet.

#### 8. A 16 year old male who is paraplegic secondary to a gunshot wound to the spine is currently enrolled with the ...

The care management needs of this adolescent member (whom we will refer to as “Jason”) are multifaceted and complex, given the physical, behavioral, developmental and social dynamics at play. In the short term, arrangements must be made for his discharge and transition from A Behavioral Health Residential Facility to another appropriate setting; however, the planning for Jason’s placement must take into account a complex set of factors that will influence his health and well-being into the future. Jason will soon enter adulthood with both complex medical and behavioral health (BH) challenges that he will need the skills and resiliency to manage. Our challenge will be to identify a setting that will ensure a safe environment, foster ongoing recovery related to his BH issues and inappropriate sexual behaviors, provide physical accommodations and supports for Jason’s functional adjustment to his paralysis, and consider his stage of development and particular needs as an adolescent. As in other similar types of cases that we have encountered during our experience serving AHCCCS members, our approach to care planning for Jason’s placement and services will follow the **Children’s Service Delivery Guidelines** that include the AHCCCS Clinical Guidance Documents, Working with **Child Family Teams** and the Arizona **Vision-12 Principles for Children Service Delivery** as outlined in AMPM Policy 430, AMPM 1620-A and AMPM 1620-E. As we work with Jason and his family, and seek guidance from his Child Family Team (CFT), we cannot assume that an out-of-state placement is in Jason’s or the family’s best interest. Despite issues in the relationship between Jason and his family, and the fact that Jason cannot legally determine his placement, it is vitally important that Jason be empowered as an active participant in decision making about his future placement location. At the same time, his family also must be supported, understanding the range of their issues and concerns, to engage with Jason and AHCCCS around his placement in a way that will result in a positive and cost effective outcome embraced by both Jason and his family.

### APPROACH TO MEMBER ENGAGEMENT AND PERSON-CENTERED CASE MANAGEMENT

A critical priority is to establish a consistent, **person-centered** approach in all aspects of our work with Jason and his family. Therefore, initial steps in this scenario are to assign a case manager who will establish a direct relationship with Jason and his family and engage the Behavioral Health Residential Facility in an effective transition of care process. Based upon the limited facts in the scenario (e.g., Jason is currently a UnitedHealthcare member), it is possible that Jason already had an assigned case manager who worked with him prior to his inpatient admission and therefore may have background knowledge particularly about Jason’s physical condition. Otherwise, prior to or upon notification to our case management unit about an impending discharge from the behavioral health residential facility, a case manager from our high-risk BH team (whom we will refer to as “Mary”) with experience and skills matched to the case in question is immediately assigned with accountability for maintaining a consistent, long-term relationship with Jason and his family. In this case, the assigned case manager, Mary, is a **licensed BH professional** experienced working with children with a history of trauma and who face physical, BH, social and functional challenges. **Mary holds accountability** throughout her engagement with Jason, to foster and advocate for a person-centered approach in all interactions between Jason and his team of caregivers and supports, and to empower Jason to actively participate as a full partner in all phases of the case management process through expression of preferences about his care and services in meaningful ways.

One of Mary’s key roles is to facilitate the development of Jason’s individualized plan of care (IPC) that includes the multifaceted services and supports involving multiple systems (e.g., BH, medical services and school systems) that help Jason achieve his needs, goals and desired outcomes. She uses defined case management protocols and processes, along with individualized efforts, to develop member options and solutions. UnitedHealthcare maintains an internal **care management team** that includes a manager (Della Wood), BH coordinator (Theresa Robben), network administrator (Larry O’Connor), psychiatrist (Dr. Jeffrey Schwimmer), case management administrator/manager (Francine Pechnik) and LTC medical director (Dr. Mark Russell). This team contributes to monitoring and development of solutions to address our member’s needs through a case review process that also can be triggered as necessary to provide case managers like Mary with case-specific support, assistance or recommendations. Development of Jason’s IPC also requires the active engagement of an **interdisciplinary care team (ICT)** specifically constituted to include individuals identified by

Jason and family and that include providers and other resources that provide key supports and services as part of Jason's IPC. As will be discussed in subsequent sections of this response, our care management team members also may be identified to participate in part of any member's ICT.

## ASSESSMENT AND CARE PLANNING PROCESSES

One urgent challenge is to determine Jason's post-discharge placement. Making this arrangement requires convening of a CFT that will review relevant information about Jason's case and provide guidance regarding placement.

Comprehensive assessment and planning for Jason's placement and services requires a series of activities to collect information and plan for the CFT review and consideration of Jason's status, projected needs and placement options. Mary facilitates identification of CFT members desired by Jason and his parents, and schedules a CFT meeting to discuss the placement request elected with the approval of Jason and his parents. Besides himself, members include, at a minimum, Jason's parents, any additional advocates, family or support persons requested by the member or the family, Jason's treating staff at the clinic where he receives his BH services, the LTC case manager, the LTC manager and or BH coordinator, staff from the Behavioral Health Residential Facility and staff from Jason's school. Additionally, if Child Safety, Probation or Substance Abuse programs are used, participating staff are invited to join the team.

Mary compiles information from Jason's previous assessments and regarding his inpatient course of treatment and recovery. As part of our transitional care protocol, relevant background information and records are made available and reviewed in a case conference between Mary and the Behavioral Health Residential Facility case manager. Mary obtains information regarding current BH status including Jason's degree of recovery and supports required, any depression or anxiety related to his current living environment, risk for or desire to use substances, trauma from the shooting or other life events, and his progress for treatment of inappropriate sexual behaviors. The staff at the Behavioral Health Residential Facility will have insight into his current daily care needs, strengths, future goals and motivation in treatment. Mary asks for their recommendations on his placement options and treatment needs and invites them to the upcoming CFT meeting. Additional information needed to plan for Jason's placement and services include current physical functional capacity as well as demonstrated adaptive strategies and physical rehabilitation and support needs. Mary calls his PCP and other providers to inform them about Jason's impending transition and obtain input about outstanding physical health goals, referrals and treatment recommendations. With input from Jason's inpatient stay; historical medical, behavioral and pharmacy claims and utilization data; and status of EPSDT screenings and immunization, Mary uses the AHCCCS UAT to assess his level of care and our Pediatric Core Assessment, which includes a comprehensive assessment of his functional, medical and BH needs. Together, these assessments give an overall picture of Jason's self-reported functional capacity and level of assistance required for activities of daily living (ADLs), medical needs, social needs and BH needs and help to understand the relative risks that must be addressed and the strengths that can be built upon in Jason's IPC.

Mary talks with his parents to obtain their input on his status and to identify what they need from her for the meeting. She also will contact his teachers to check on his school progress. Throughout the entire process, Mary manages any required consent or approvals. If any member of the team cannot attend the CFT, Mary will present information she has received from them. Throughout care planning, **Mary always empowers Jason** to realize his goals and desired outcomes, guided by an individualized, strengths-based wraparound care planning process. She uses motivational interviewing techniques to promote self-determination and encourage Jason and the planning team to actively participate in the decision-making process.

## ADDRESSING PLACEMENT IN CONJUNCTION WITH OTHER IPC PRIORITIES

Jason's IPC will focus on care, quality services, personal responsibility, resiliency, recovery and wellness. It will be stored in our comprehensive electronic care management system, available to authorized providers through a secure mechanism. The online availability of this IPC allows the sharing of critical, relevant and timely member information across a continuum of services, providers and care delivery setting. **Member preferences and choices guide** all aspects of developing the IPC. In Jason's case, throughout the care planning process, Mary works with Jason to identify



preferences for how, when, where and how often to conduct care planning meetings, confirms the people that Jason would like to include in the planning process, and ensures accommodations for Jason's communication preferences. It is also important that **Mary engage Jason's family** to gather their input, and to advocate for Jason while also fostering affirmation and positive communication between Jason and his family.

### Anticipated Care Plan Priorities

An immediate priority for Jason is securing an **appropriate, in-state, long-term care placement that meets the needs of Jason and his family**. Determining a placement for Jason must take into account several other care plan priorities related to his paraplegia, age, BH status and his family dynamics. A placement must include provisions for the **following priorities that include:**

- **Address Health Risks Resulting from Paraplegia:** The provision of evaluations, appropriate teaching and equipment to Jason to prevent skin breakdown, improve and maintain his physical strength and mobility, and maintain healthy bowel and bladder habits.
- **Provide Assistance for Drug and Alcohol Exposure:** Engagement of Jason in a treatment program for teens with substance abuse issues or a family history of substance abuse issues.
- **Prevent Future Episodes of Inappropriate Sexual Behavior:** Engagement of Jason in treatment for minors who have sexually abused other minors. Jason's family members will engage in counseling.
- **Continue Jason's Education:** A short-term education plan to finish high school and a long-term plan for continuing Jason's education, obtaining employment or volunteering.
- **Provide Support Services to Jason's Family:** The provision of referrals and resources to Jason's family, by Mary that include counseling, support groups and social service supports in their community.

**Determining Post-Discharge Placement Options:** Mary will inform our lead BH coordinator Theresa Robben that Jason's family has requested an out-of-state placement. Theresa will schedule a case review with Dr. Mark Russell, LTC medical director; Francine Pechnik, case management administrator; and Della Wood, BH case management manager (Mary's supervisor) and Mary to discuss the request for out-of-state placement and to review Jason's current BH and medical needs and available in-state options. Mary will bring the recommendation of the case review to the CFT. She will inform the CFT that, before any out-of-state placement can be considered, in-state options must first be thoroughly evaluated to see if one or more options can meet the member's specific needs. All out-of-state placements require the prior approval of AHCCCS.

It is important that Mary engage Jason's parents with understanding. She identifies what factors led to the request (e.g., location, services and recommendation) and what they feel the out-of-state facility has to offer for Jason's recovery. Being transparent, she tells them that options will be discussed at the CFT meeting. She will use the information the family provides about the out-of-state group home to offer similar in-state options. This conversation is necessary to help remove any potential conflict around where Jason moves. Although the family has indicated a group home, Mary needs to get the current facility's recommendations, including whether a group home or type of structured living setting would best meet his needs to maintain progress. Placement outside of the home may be an interim solution while Jason continues with his recovery. There may be plans for Jason to return home with family, depending upon his progress and recommendations of the CFT.

Mary will advocate for the best care and services for Jason as the stigma and risk of further alienation exists. It is important that Mary also consider Jason's wishes and feelings when selecting a placement. During the CFT meeting, the team reviews and **discusses several placement options**. The LTC Behavioral Health Residential Homes provide personal care services to support assistance with ADLs as part of their licensure scope of work, and have nursing personnel available to assist with medical needs for Jason. Mary explains how the LTC Behavioral Health Residential Homes are different from the short-term placement he has now and how coordination with job services/employment and educational services will occur to provide long-term supports based upon his goals. Sonoran Sky is one provider that has

an active habilitation day program that he can attend when he is not in school. They also have the ability to help him meet his educational goals online. Inspirations is another provider that specializes in working with male teens. When he is closer to approaching the legal age of adulthood, Mary will engage the CFT in looking at independent living options and using long-term supports to maintain his independence.

A therapeutic foster home could be another option for Jason with the assistance of A New Leaf, who has experience helping youth with BH needs, including developing foster homes for teens that have experienced abuse or have been the abuser. A New Leaf has extensive experience with helping children continue their education curriculum while managing the adolescent's recovery journey. Additionally, if the CFT knows of a provider who has not traditionally worked with long-term care but is an AHCCCS registered provider and has the experience and programs to meet Jason's needs, a single case agreement or a contract with the provider may be facilitated with the assistance of our BH coordinator and the network administrator. As long as the placement can meet Jason's needs and is a covered benefit under ALTCS, we recruit the provider to join our network. Mary reviews all of these options with Jason's parents and the CFT. Jason has the opportunity to visit the placements, giving him input into where he lives.

Once the team has met and reviewed the in-state options, Jason and his family can tour the placements so they can see that we can provide in-state programs that will meet Jason's needs. Along with the CFT, Jason and his family will select a placement. Continued in-home counseling supports will be available to foster positive behaviors and growth. Mary will confirm that his medical, BH, educational and social goals are a part of the IPC at the new placement. These goals either include the potential for moving back home with his parents if appropriate, or eventually out on his own once he turns 18. Throughout the process, Mary works with Jason and the CFT on long-range goals for developing independence and helping develop the skills needed to enter adulthood and live successfully with his medical and BH challenges. This includes connecting him with community services through **Abilities 360**, BH peer mentoring services, job services and natural community supports of his choosing.

If an appropriate placement is found in Arizona and the parents still request the out-of-state placement, a **Notice of Action (NOA)** will be provided to the parents. Mary will review the NOA with Jason's parents. When we deny a service authorization request, we send a state-approved NOA letter to our member/representative within the required timelines. The NOA letter provides Jason's family with a clear explanation, and the basis for the adverse determination is written in easily understood language and in our member's primary language. It explains the action taken or intended to be taken; the reason for the action; our member's right to file an appeal with us and the procedures for exercising appeal rights; the circumstances when expedited resolution is available and how to request it; the procedure to request a state fair hearing following exhaustion of the appeal process; and our member's right to have benefits continue pending the resolution of the appeal, the procedures for continued benefits and our member's potential financial obligation. Jason can request a copy of the benefit provision or protocol used to make the decision.

***Address Health Risks Resulting from Paraplegia, Including Skin Breakdown, Potential Bowel and Bladder Issues:***

Jason's IPC addresses his current physical functional needs and his level of recovery from the gunshot wound. Depending upon where Jason is in his recovery from the gunshot injury, if not already completed, in coordination with referrals from Jason's PCP, Mary arranges a seating evaluation to determine if Jason has the correct wheelchair and positioning in his wheelchair and if needed, have the necessary adjustments to his chair to reduce the potential for skin breakdown. If not already completed, Mary arranges for physical and occupational therapy to teach him proper positioning, pressure relieving techniques, physical fitness activities to prevent further loss of mobility and ways to be more self-sufficient with his ADLs with a goal of living independently. Jason will receive training from licensed professionals on how to monitor his skin to prevent skin breakdown and manage his bowel and bladder regime. If his injuries are such that he cannot independently monitor his skin and manage his bowel and bladder regime, Mary will arrange home health nursing to meet these needs.

***Provide Assistance for Drug and Alcohol Exposure:*** Mary determines if Jason is seeking drugs or alcohol and whether he would benefit from substance use treatment or attending support groups for teens. If the CFT recommends either of these or if Jason expresses a desire for treatment or support, Mary will make a referral for and coordinate substance

abuse treatment. The first option is a referral to his current BH treatment agency. If the agency does not have a team program, he can be referred to another program such as Jewish Family and Children's Services, New Foundations or New Pathways, which also has a variety of services for teens exposed to poverty, gangs, substance abuse and violence. If the family member(s) express interest in treatment for themselves, in the context of family systems theory, Mary provides them with resources for treatment services.

**Prevent Future Episodes of Inappropriate Sexual Behavior:** The inappropriate sexual behavior is currently being addressed through the treatment Jason is receiving at the Behavioral Health Residential Facility. Recommendations by the CFT for continuing or expanding therapy will be provided as recommended on an ongoing basis. This therapy can continue regardless of where Jason is to live. To support his family and his sibling, family therapy is offered on an outpatient basis.

**Continue Jason's Education:** With a move to a new placement, Jason's educational setting may change. The CFT addresses concerns with changing to a new school setting. If he has to change high schools and leave his friends, this adjustment may require the support of counseling services. Mary also will support Jason's long-term goals after he graduates high school. Mary will work with Jason to identify personal goals to include educational goals and, in partnership with the school, to modify his Individualized Education Plan (IEP). He also may have work or volunteer goals that will be included in his CFT planning. Mary will coordinate the referrals or resources recommended by the CFT. Mary will provide education around how members can work and still maintain their Medicaid benefits through certain programs such as the AHCCCS Freedom to Work Program. Jason is eligible for this Program now that he is 16. Mary also provides Jason with information about our UnitedHealthcare On My Way (OMW) application. OMW is an interactive program that helps prepare youth for many real-world situations that lie ahead. OMW teaches the practical skills of managing bank accounts, securing housing, creating a resume, finding job training and applying for college. These resources will give Jason and his family vital information as Jason develops his long-term personal goals.

**Provide Support Services to Jason's Family:** Mary verifies if family members are receiving counseling services or other supports. If they are not, she will assist them in locating those resources. If the family is having other issues, not directly related to Jason that impact the overall health and stability of the family such as limited income, lack of food or inadequate housing or other social determinants, Mary will offer to help them find resources to help as applicable.

## STRENGTHENING PLACEMENT OPTIONS WITHIN THE ALTCS SYSTEM OF CARE

In the past 10 years, we have been successful, through the efforts of our clinical and network staff, in **securing in-state placements for 100 percent of our members** (children, adolescents and adults) requiring specialized placements. We have reached agreements, including work statements, with a variety of settings, such as skilled nursing, BH, bariatric care, ventilator and tracheostomy care facilities. We have collaborated over the years to develop specialized behavior units in skilled nursing facilities including Rim Country and Winslow Campus of Care. We also collaborated with the Austin House to develop an assisted living alternative for members that live in Northern Arizona with specialized BH needs. These arrangements have allowed our rural-based membership to live closer to their families, providing a better opportunity for the member's family to participate in the member's recovery. We also develop specialized single case agreements with providers when there has been a need for individualized care. We believe that all members should be able to live in their community so they can continue to work on family relationships and continue to grow within their own community of family, friends and culture.

## 9. The Offeror holds an ALTCS E/PD Contract for both the Central and North GSAs and receives \$280 million per year in...

UnitedHealthcare recognizes the importance of collaborating with providers and incentivizing them to achieve the *Quadruple Aim* of improving population health and patient experience, delivering the best possible quality outcomes, reducing medical costs and trends, and improving the work life of health care clinical and support staff. This is why we have offered value-based payment (VBP) incentive programs to Arizona LTC providers since 2014 and to D-SNP providers since 2012. UnitedHealthcare is a thought leader when it comes to VBP methodologies and is fully committed to implementing Alternative Payment Models (APMs), while directly supporting provider efforts to accept shared responsibility for clinical and financial outcomes.

Unlike other VBP models, which have a limited focus on specific outcome measures, our impactful VBP arrangements are largely **total cost of care** models. We have determined this approach to be the best strategy for Arizona because it empowers the VBP provider partner to influence all aspects of behavioral and/or physical health cost of care. Our flexible contracting approach **allows us to address the LTC and D-SNP annual expenses in all the noted service categories** (e.g., inpatient hospitalization, physician, pharmacy, skilled nursing facility [SNF] and home health, emergency department [ED], outpatient facility or other medical), **cover members in any of the stated residential settings and include any standardized quality metric (e.g., HEDIS)**. For Arizona, we have:

- Implemented our Quality Shared Savings (QSS) Program model statewide, aligning with APM 3, where the **relevant outcome measures** for LTC members include **reduced inpatient readmissions and ED visits**, as well as comprehensive diabetes care (centering around HbA1c testing, LDL-C screening and a retinal eye exam) and total cost of care regardless of the category of spend or residential setting (e.g., nursing facility or HCBS/Alternative HCBS setting). In addition to total cost of care, QSS program relevant outcome measures for D-SNP members include inpatient readmissions and ED visits. We currently have innovative QSS VBP contract arrangements in place with Northern Arizona Medical Group (North GSA), Providers Direct (South GSA), District Medical Group (Central GSA) and IPC/Hospitalists of Arizona (Central and South GSAs). One success story is with Northern Arizona Medical Group in Kingman who reduced hospital readmissions from 22.8 percent to 20.5 percent, and ER utilization from 235/1,000 to 187/1,000 over six months (Oct 2015 to March 2016).
- With 50.1 percent of all Arizona duals enrolled in our D-SNP health plan, including 33.4 percent of our eligible LTC members, VBP arrangements for these populations are a key component for our success. We have also implemented D-SNP Medicare Advantage Primary Care Provider incentive (MAPCPi) contracts (APM 2) for our Arizona D-SNP members, including FIDE SNP (our LTC Medicare members), where the relevant outcome measures include all of the CMS Star HEDIS measures and incentives are earned for completing annual wellness visits early, meeting HEDIS quality targets and achieving a minimum overall practice Star rating. These agreements work synergistically with the total cost of care [i.e., Benefit Cost Ratio (BCR)] models, which give participating providers an added opportunity to earn incentives by actively engaging our D-SNP members with the highest risk conditions and ensuring proper revenue reimbursement via risk adjustment, all while proactively impacting their total cost of care.
- We have also implemented our Accountable Care Shared Savings (ACSS) total cost of care model with Arizona accountable care communities (ACCs), accountable care organizations (ACOs) and other multi-TIN organizations. The ACSS model includes the **key quality measures** noted above, but alternatively allows us the flexibility to distribute administrative payments that support practice transformations, which help achieve superior **member health outcomes**. With ACSS, we offer a monthly clinical integration payment when a practice meets at least

### Planning Ahead...

As of Q4 2016, our Arizona VBP agreements accounted for 22 percent of total payments for LTC members and 32.4 percent of total payments for FIDE SNP members, with at least nine additional providers/ACOs already targeted in the North and Central GSAs to exceed the 50 percent requirements by 2019.



three of **four process measure targets**: 1) access to care; 2) follow-up from inpatient visit in seven days; 3) follow-up from ER visit in seven days; and 4) seeing high-risk members at least once every 90 days.

- We also proactively seek out, support and implement VBP contracts with newly registered Integrated Clinics (ICs), which provide fully integrated physical and behavioral health (BH) care.

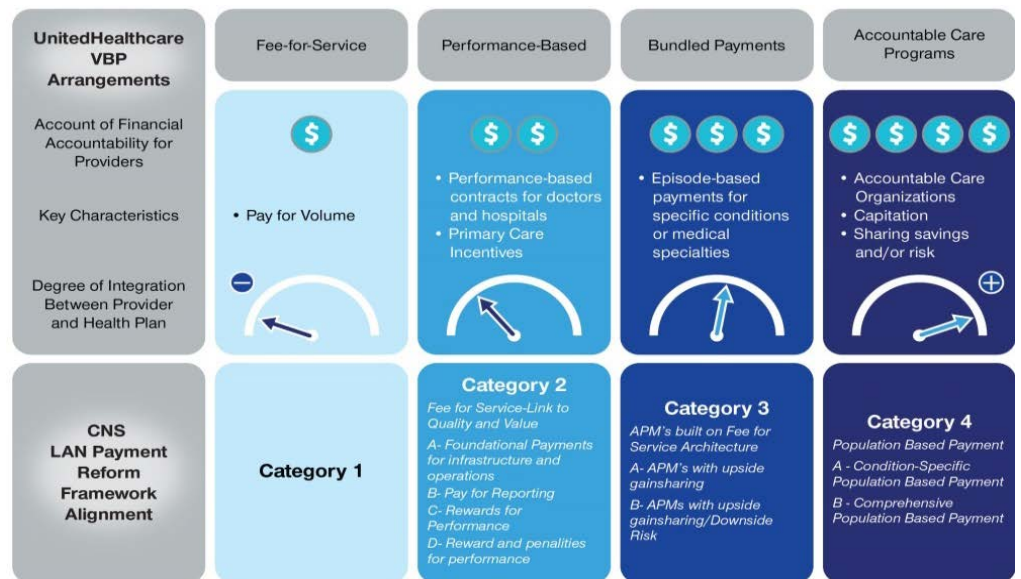
Nationally, we have developed programs across all lines of business (LOBs) to advance and integrate evidence-based models of care with VBP contracts, customized for markets and populations such as LTC and D-SNP. These contracts include **performance-based and bundled payments** and involve ACCs, patient-centered medical homes, ACOs and full capitation arrangements. These experiences will continue to guide our learning and how we move forward in Arizona.

In the remainder of this response, we highlight our APM model alignment, the challenges and differences we have identified when developing VBP models for the targeted populations, and our plan for meeting the increased percentage of payment goals by 2019. We also discuss how we support providers who participate in our advanced VBP arrangements, and how we will guide our members to these providers and report on VBP **Performance** status.

## VALUE-BASED PAYMENT ARRANGEMENT ALIGNMENT

### Alignment with Learning & Action Network Alternative Payment Model Framework

We understand AHCCCS' intent for contractors to move to the Learning & Action Network's (LAN's) APM Framework by October 1, 2017. As shown in the figure here, our continuum of available VBP models is aligned to the APM Framework and will help meet AHCCCS' goals. Our D-SNP MA-PCPi quality-based program falls under APM model 2C, while our ACSS and QSS models align with model 3A and our Episode-Based Shared Savings model is under 3B. In any of our APM/VBP models, the PCP is responsible for all facets of care by including medical expense from all physical and BH services and encouraging either practice integration or collaboration with BH providers.



**Figure 1.** Demonstrating alignment between our VBP arrangements and the LAN Payment Reform Framework. All Arizona LTC VBP models fall under APM Category 3, while D-SNP models fall under APM Categories 2 and 3.

Our over three-year Arizona VBP experience allows us to understand the unique challenges of developing effective provider incentives, including:

- Finding ways to normalize for fluctuations in the small LTC populations assigned to each VBP partner, where there is potential volatility, while still incentivizing quality improvement with reductions in total cost of care. **While this issue exists across the state, it is especially evident in our work in the rural areas across Arizona.** As we explore possible partners, the majority of our members are located in placements that rarely hold more than a handful of individuals, or with PCPs who by themselves have relatively small panels. Even when consolidating

entities within the same ownership, or via practice aggregation models, the number of members remains small. **These small populations can cause sharp changes in baseline cost and targeted quality metrics, making improvement in rural areas more difficult to measure than in urban environments.**

- Recognizing **rural markets present a greater challenge** of aggregating small member populations over a larger geographic area, which can require enhanced clinical models, shared support systems and communications.
- Designing equitable models for the population, which must account for the reality of less PCP ‘impactable’ (e.g., total cost less nursing facility room and board and HCBS expenses) LTC spend improvement opportunities.
- Accounting for coordination of benefits; the majority of LTC members have other forms of insurance (Medicare, commercial), so there is a not always a direct relationship among utilization, cost and quality outcomes.
- Understanding that these factors can cause unpredictable changes in baseline and targeted metrics, we have devised a credible BCR, which is medical/revenue, and retrospective evaluations when needed to assess and adjust fairly for unanticipated circumstances to be equitable with our committed partners.

While these challenges may appear significant, we will use our already developed models and planned strategies to help mitigate them and meet the State’s current VBP contracting percentage goals.

Our extensive experience has also helped us to understand and address the **similarities and differences regarding VBP contracting approaches in the Medicaid and Medicare LOBs**. While our general VBP contracting methodologies are purposely aligned for both LOBs (e.g., we use and target total cost of care/BCR and quality measures for both), there are differences when establishing goals, identifying preventable and/or impactable cost opportunities, as well as challenges where membership assigned to and receiving care from a unique provider group are small in number. For example, while Medicaid (LTC) VBP contracting focuses more on **AHCCCS-based quality metrics**, in Medicare (D-SNP) we focus on **CMS Star quality measures**—with some overlap between the two. Another difference for Medicare dual members is that we add our MA-PCPi, where additional incentives may be earned for Star quality improvement and timely annual wellness visits. In Medicaid (LTC), we focus on a single model that not only jointly address total cost of care and quality, but also adds flexibility to customize the incentive linked to each quality improvement opportunity, helping us address the unique financial challenges of total cost of care contracts with small populations. In addition, there are typically quality incentives that bring value to both the Medicare and Medicaid systems (e.g., reducing unnecessary ER utilization, inpatient stays and readmissions) for our FIDE SNP members. In other words, our greatest flexibility comes through shared models and models that operate in tandem, allowing for incentives rewarded by affecting quality and savings with our D-SNP members, LTC members and our dually enrolled members.

### PLAN TO MEET THE INCREASED VBP CONTRACTING PERCENTAGES

Given our national experience and local knowledge, our anticipated payment models will be a combination of total cost of care and pay for value arrangements.\* We analyzed our current spend and have identified a pool of existing providers in the North and Central GSAs to engage for VBP arrangements as a means to meet the targets noted in the table.

	2017	2018	2019
<b>AHCCCS VBP Percentage Targets</b>	<b>25%</b>	<b>35%</b>	<b>50%</b>
Anticipated Percentage for LTC (North & Central Regions Only)	28.1% <i>Objective: Work with 4 existing entities; add 3 more</i>	39.8% <i>Objective: Work with 7 existing entities; add 6 more</i>	53.6% <i>Objective: Work with 13 existing entities; add 2 more</i>
Anticipated Percentage for D-SNP (North & Central Regions Only)	32.4% <i>Objective: Work with 14 existing entities</i>	52.4% <i>Objective: Work with 14+ existing entities; add 6 more</i>	60.2% <i>Objective: Work with 21+ existing entities; add 2 more</i>

*\* As additional VBP models and partners for current models are explored and identified for implementation in Arizona (discussed below), we believe we will achieve even higher percentages than what is shown in the table above. Furthermore, in addition to the North and Central GSAs, we currently have active targets and VBPs in the South GSA.*

**As demonstrated, UnitedHealthcare will exceed AHCCCS' percent VBP payment requirements via APM 2 and 3 contracting arrangements in every contract year.** Our strategy and path forward is in place. We will first work with our existing QSS providers (APM 3), selecting those best qualified to meet the increased percentages based upon experience and amending agreements to add LTC. We will then take this specific approach for next steps:

- Continue to identify and pursue any additional multi-tax identification number (TIN) consolidated and aggregator organizations (e.g., ACOs, hospital systems, etc.) for VBP contracting via our QSS Program
- Pursue groups with the largest number of assigned members
- Build added membership density with new and existing VBP partners
- Achieve consistency and operational value by pursuing VBP agreements with groups with existing acute or D-SNP agreements, allowing groups with higher acute populations to apply the same utilization and quality tools processes to smaller LTC populations
- Work with all providers who are looking to meet same quality and cost-saving objectives as us

**In addition to using our current Arizona VBP agreements, we are expanding agreements and clinical engagement statewide in all three GSAs** (e.g., North Country Community Health Center, MIHS and Optum Medical Network) using models that are easy to implement and make it simpler for providers to deliver high-quality care. These VBP models, along with our existing programs, will expand our historical success by increasing the number of providers and members under quality and total cost of care arrangements.

Beyond these initial contracting plans, we also will target and evaluate other provider groups to offer our suite of VBP contracting opportunities over the next two years. For providers being considered for shared savings/risk models, we will conduct a quantitative and qualitative evaluation of their readiness using a survey that evaluates their organizational structure, operational sophistication and total cost of care/population health experience with other payers. We continuously review our network to identify providers who meet the eligibility requirements for our VBP structures and collaborate with them to determine what model is most appropriate. Further, given our Arizona market position, strong provider **Relationships** and innovative incentive model experience, **providers have approached us about entering into innovative VBP arrangements** (e.g., Pathfinder Health, the largest ACO in Northern Arizona, contacted us and we are currently in active discussions with them).

**Alternative programs we are exploring** for increased ALTCS and D-SNP payment arrangements include the following:

**Quality Model for HCBS Providers (APM 2):** We have explored Arizona HCBS VBP models in the past via pilot programs and will leverage that successful experience to update and refine the contracting template for use in 2017 with HCBS providers. As we know that affecting quality measures for members attributed to these provider types are different from medical providers, we will work to define this model's performance measures and expected outcomes for improved ALTCS E/PD and D-SNP member experience. We are currently developing a model for larger personal care attendant agency participation using attribution models, with a specific quality measure focus on the prevention, early detection and effective management of leading chronic diseases in Arizona (including but not limited to, diabetes, heart disease and stroke). We also will ensure the HCBS providers share a percentage of the bonus directly with caregivers.

**Nursing Facility (NF) Strategies (APM 3):** We will leverage and expand our Arizona OptumCare CarePlus program, which provides specialized services to members with complex needs. We currently manage 803 Institutional SNP/LTC members in NFs and 243 D-SNP members in assisted living facilities (ALF). This arrangement specifically provides ongoing in-person services where our providers comprehensively assess each new member assigned and conduct face-to-face visits to reduce unnecessary medical costs, accurately code the member's conditions and improve quality measures by sharing

noted gap in care information with OptumCare for resolution. Expanding upon this successful existing model, conceptually we are now moving toward a base fee-for-service (FFS) or base rate NF VBP model, tiered at a higher rate based upon achieving specific quality-based outcome metrics (e.g., length of stay, readmission rates).

**Integrated Clinic (IC) Strategies (APM 2):** We have existing clinical **Relationships** and VBP arrangement in place with ICs for our D-SNP members (including FIDE SNP members) and are currently in the process of adding additional D-SNP and LTC members to our partner IC groups. We are also meeting with these practices monthly to collaborate on how our clinical model can best integrate and measure BH metrics.

## COLLABORATIVE PROVIDER SUPPORT FOR SUCCESS

We successfully provide data, transformation resources, technology and tools for providers to enable practice transformation, achieve defined outcome measures and support models that truly align incentives. Since practices may have different capabilities and preparedness, and we work with each to ensure VBP contract readiness and success.

Practices with VBP arrangements in APM models 2, 3 and 4 will typically be supported by our ACC clinical model and local support team, which is designed to vigorously promote clinical transformation **via a dedicated UnitedHealthcare practice consultant, quality consultant and medical director who assists them with managing outcomes and tracking performance on an ongoing basis**. Our data analytics and health care economics team uses both provider self-reported data and our robust analytical and data warehouse tools to monitor and review provider quality performance. Monthly and quarterly aggregate and provider/member level performance reporting based upon quality and targeted criteria are shared with provider. Our support team produces and reviews performance trend scorecards with practices at Joint Operating Committee (JOC) meetings with a focus on sharing and evaluating integration strategies, data and processes, as well as making performance improvement recommendations. We have found the ACC model and its accompanying support team to be especially impactful for rural Arizona providers, who are often less resourced than urban providers. Quarterly JOC meetings support VBP practices not in an ACC model, where prospective and retrospective data is shared. We also conduct a full reassessment VBP provider performance every two years, reviewing several years' worth of experience data to establish a credible cost and quality baselines for contract renewal.

## GUIDING MEMBERS TO PARTICIPATING VBP PROVIDERS AND CENTERS OF EXCELLENCE

We know that guiding members to high-value providers, such as those participating in VBP/APM contracting and Centers of Excellence (COE), is a key focus for AHCCCS and a logical way to improve member care. We will continue to use proven strategies to guide our members to providers who participate in the VBP initiatives above and who offer value, as determined by measureable outcomes. Guidance strategies include collaborating with our ACC, IC and COE partners (e.g., using selective member reassignment based upon geography or medical diagnosis); using our case managers to educate members on our unique VBP relationships and assist with PCP assignment; and employing our Provider Recommendation Engine (PRE), as we currently do for our Arizona D-SNP members, to recommend high-value PCPs (e.g., a VBP Tier 1 or Tier 2 provider, the highest quality and most cost effective) for unassigned members. While we guide members as much as possible via these noted strategies and tools, we are respectful of and agree that our members must always retain their freedom of choice and can select a different PCP.

In addition to guiding members to COEs, we will also continue our existing compliance of all AHCCCS VBP reporting requirements for COEs.

## SUMMARY

In summary, our total cost of care models have helped transform the way care is delivered and reimbursed to improve the health of our Arizona members, all with a focus on confirming that we are aligning provider incentives with AHCCCS' quality goals. We are uniquely poised to implement meaningful VBP agreements and meet the APM framework to all providers statewide, regardless of the member's geographical location, residential placement or LTC/D-SNP plan.



## Administrative

### 10. The Offeror recently received an authorization request for an increase in attendant care hours for a member.

A major component of our responsibility to AHCCCS and our members is facilitating the availability of necessary health care resources and support services. We do this using **well-defined protocols and processes** for authorization requests and approvals, as well as appeals and provisions for the resolution of disputes that fully empower our members and give them every consideration. As this scenario illustrates, there are occasions when dissatisfied members go outside of these processes with their requests. In these circumstances, we take urgent steps to engage members and all involved parties in member friendly communications and processes to rapidly resolve concerns. At the heart of our effort is ensuring that decision-making is based upon consistent, evidence-based protocols, the timely and comprehensive assessment of needs, and the engagement of members and caregivers who are well informed to understand available options and empowered to choose among them. In response to this scenario, we would take steps to problem solve beginning with a face-to-face visit to assess our member's needs and continuing through the process to determine the appropriateness of the attendant care hours and the denial and appeals process. We want to avoid this stressful situation in the future by making sure that our member and his/her spouse understand how to contact the assigned case manager, the processes to request a change in services in the future and the resources available to answer any questions and resolve any concerns at any point in time. Throughout the process, our case management administrator, Francine Pechnik, will keep AHCCCS informed about the action steps taken to resolve our member and his/her spouse's/representatives' concerns. Ms. Pechnik will communicate the findings and the justifications for any decisions to the pertinent parties contacted, including the AHCCCS administration.

On an ongoing basis, our **overall goal is to continually manage the relationship with our member** to monitor his/her health status and to prevent the situation portrayed in this scenario from occurring.

### REASSESSING OUR MEMBER'S AND HIS/HER SPOUSE'S NEEDS

When the case manager receives notification of our member's request for additional hours of attendant care, he/she will **immediately** call our member and the spouse to set up a face-to-face meeting to complete a reassessment of our member's needs. During the call, the case manager will determine if there are any immediate needs and offer interim respite services until the face-to-face visit can take place. The case manager will use communication techniques during all touch points that stress the importance of listening with empathy and trying to understand where our member and his/her spouse are coming from. The assigned case manager and perhaps a manager will visit with the member and family to provide support to the member and family, gain additional insight into the case, provide clarification for the member and convey to the member and his/her spouse that their concerns are being addressed. Because of the escalated nature of this case, a manager will work closely with the case manager to address the member's and spouse's concerns and follow up with them once the concern has been resolved to confirm continued understanding and provide ongoing support, as appropriate.

Based upon our experience, several issues could be at play in this scenario. It is possible that the member and spouse misunderstand or feel uncomfortable using established avenues for grievance and appeals. It is important to review these processes with them and to assess their understanding and comfort level expressing needs and requests. The case manager's priority will be to understand if and to what degree changes in the member's status have occurred using our comprehensive health assessment tool and AHCCCS's UAT and the HNT. These tools paint a holistic view of our member's overall health status, which will determine the appropriateness of the request to increase attendant care hours and help identify services that can be delivered in lieu of increased hours, as appropriate. It is important that the case manager review the member's ALTCS Member Contingency/Backup Plan to confirm the information in the backup plan is accurate and updated. The review must confirm that our member and his/her spouse have contact information for Critical Service Provider(s), AHCCCS, and their case manager during business hours and after business hours. With



caregiver burnout a serious concern, the case manager will assess the spouse for burnout and explore support options such as a family member, local support groups, and other informal support or community services.

## **FOLLOWING UP ON NEEDS OR CONCERNS IDENTIFIED IN THE ASSESSMENT PROCESS**

If there appears to be a change in condition, the case manager confirms when the PCP last evaluated our member and whether the PCP is aware of the member's reported recent decline. The case manager's goal is to confirm the member is seen quickly by whichever PCP the member chooses, in the setting the member chooses, and understands the importance of a medical home for the member. Should the case manager determine that our member is likely experiencing a significant change in condition; the case manager will escalate our member's case for review with our LTC medical director, Dr. Mark Russell, and the case management interdisciplinary team. Dr. Russell conducts telephonic/web-conference rounds attended by case management staff and other staff, such as clinical program managers, pharmacists and the behavioral health director. The team will discuss our member's change in condition, including the request for an increase in attendant care hours, and services and supports in addition to, or in place of, the increase in attendant care hours for possible inclusion in the care plan. When indicated, Dr. Russell will conduct peer-to-peer consultation with the member's PCP to collaboratively discuss the member's treatment plan options and to facilitate access to additional services and supports or care in alternate care settings.

## **Updating Our Member's Individualized Plan of Care and Authorizing Services**

Once the case manager completes the assessment visit, he/she will collaborate with our member and his/her spouse to determine whether an update to the individualized plan of care (IPC) is required including the services and supports our member needs, in alignment with our member's goals and desired outcomes. The case manager uses the UAT level of care (LOC) criteria, the scoring of the functional areas in the HNT and relevant clinical, behavioral and HCBS decision support tools and criteria to determine the appropriate level of formal care hours. The case manager and his/her manager conduct a secondary review to verify the accuracy of the determination, that all of the member's circumstances have been considered and the attendant care hours support our member in the safest, least restrictive environment of his/her choice and helps achieve his/her goals and desired outcome. As per our protocol, whenever there is a change in a member's care plan, the case manager completes a cost-effectiveness study (CES) in advance of any service changes to confirm the change in services is cost-effective for our member to remain in the current placement setting and that our member's needs continue to be met in that placement. If the new IPC is not cost effective and/or is unable to meet the safety and well-being of Mr. P, the case manager will develop and implement a managed risk agreement.

## **Revisiting a Decision to Approve or Deny Increased Attendant Hours**

Upon completion of the assessment process, the secondary review and the CES, the case manager will discuss with our member and spouse the member's care needs and acuity criteria determined by the assessments, and explain how the determination of the appropriateness of the attendant care hours is made. We approve or deny the request and work with our member and spouse to make sure their needs are met, as described in the following sections. If the case manager determines there is a significant change in our member's functional status that supports the requested increase in attendant care hours, he/she will review with our member and spouse the attendant care service options available so our member may receive the assessed hours. If the spouse elects to provide any additional attendant care hours, the case manager will review the Spousal Attendant Care Guidelines set forth by AHCCCS. For example, the case manager will explain that a spouse may provide up to 40 hours per week of attendant care services. Additionally, if the spouse elects to provide more than the current 20 hours of attendant care hours, the increased spousal income could affect our member's eligibility for ALTCS E/PD Program services or other publicly funded benefits. He/she will also explain that any attendant care services over 40 hours per week will have to be provided by a different caregiver and educate our member and his/her spouse about direct care service options for receiving attendant care services. This includes Agency with Choice or Traditional Attendant Care Services, and our member's right to select the direct care service agency of his/her choice. The case manager will provide the names of contracted critical service providers in the

area where our member lives and help to arrange services, if needed. The case manager will refer our member and spouse to the resource contacts on the Spouse Attendant Care Acknowledgement of Understanding form for follow-up on any publicly funded benefits they may be receiving. The case manager will have our member sign a new Spouse Attendant Care Acknowledgement of Understanding form if the spouse elects to provide the additional hours.

If the case manager determines the requested increase in hours is not appropriate, the case manager will advise our member and his/her spouse of the hours that can be authorized and explore other options to meet our member's needs. The case manager will explore and coordinate formal paid services to meet our member's and spouse's needs on a continuing, short-term or as needed basis. If the case manager determines the need is ongoing, rather than increasing attendant care hours it may be more appropriate to offer the option of adult day health care (ADHC) services. Our member could attend ADHC several days per week, providing the spouse with personal time and reducing the risk of further caregiver burnout and providing our member with outside socialization. If the case manager, member and spouse agree the need is short-term or on an as-needed basis, the case manager will offer the member and spouse respite care, which can be provided for several hours per day or for a 24-hour period in- or out-of-home, depending upon our member's preference. The case manager notes our member's and spouse's agreement or disagreement with the assessed hours in the updated care plan. Our member signs the updated member service plan, and the case manager provides a copy to him/her. The case manager explains the next steps of the denial of services process, our members' right to appeal and offers to help file the appeal if they so desire. The case manager initiates the denial process, as described in the following section.

## **OUR ROUTINE PROCESSES ASSOCIATED WITH DENIALS OF REQUESTS AND APPEALS**

### **Educating Our Member and Their Spouse**

In accordance with 42 CFR Part 438 Part F and Section F Attachment F-1, the case manager educates our member and his/her spouse about requirements (e.g., the Spousal Attendant Care Guidelines) and processes, such as the denial process, including the Notice of Action (NOA) letter; their right to appeal our decision; how to file an appeal; the pre-appeal process; and the resources available to help them file the appeal. The case manager will confirm our member and his/her spouse have the information they need to contact their case manager as their primary source of support and, additionally, how to get help 24 hours a day, seven days a week. We communicate our appeal process, expedited review procedures and the state fair hearing process to members in a variety of ways, including our *Member Handbook*, *myuhc.com* and through a variety of AHCCCS-approved letters sent to our members throughout the denial, appeal and state fair hearing processes. All of the methods used repeat the contractually required procedures and time frames and meet cultural competency and limited English proficiency requirements.

When we deny a service authorization request, in addition to verbally communicating the denial, we send a state-approved NOA letter to our member within the required timelines, which provides the member and his/her spouse with a clear explanation and basis for the adverse determination. Each NOA is written in easily understood language (generally a sixth grade reading level) and in our member's primary language. The NOA includes the action taken or intended to be taken; the reason for the action; our member's right to file an appeal with UnitedHealthcare and the procedures for exercising appeal rights; the circumstances when expedited resolution is available and how to request it; the procedure to request a state fair hearing following exhaustion of the appeal process; and our member's right to have benefits continue pending the resolution of the appeal; the procedures for continued benefits and our member's potential financial obligation. Our member can request a copy of the benefit provision or protocol that was used to make the decision.

### **Investigating and Resolving a Member Appeal**

We understand that filing a formal appeal is stressful for our member during a time when he/she is already dealing with an overwhelming health concern. We are committed to a fair and open appeal process to minimize anxiety for our members. Our policies and procedures make certain that our members and their representatives are treated

respectfully and have access to the information necessary to pursue their appeal of our action. Our structured appeals process gives members recourse to have their appeal resolved in a professional, consistent and timely manner. We are committed to responding to member concerns so we can resolve issues at the earliest opportunity. If our member appeals the adverse service determination, we schedule a pre-appeal conference to resolve the issue as expeditiously as possible and avoid having to proceed to the formal appeals process. The pre-appeal conference includes our member and his/her chosen representative, the involved case manager and his/her manager. To provide an objective view of the situation, we include a case manager and his/her manager who were not party to the original decision in the conference. We give all parties the opportunity to present information and ask questions to obtain a thorough understanding of our member's needs and attempt to resolve the issues during the conference.

If the case cannot be resolved through the pre-appeal process, we resolve member appeals in accordance with all applicable federal and state laws and regulations. We log the appeal in our grievance and appeal tracking system to track the appeal and facilitate prompt resolution. The dispute and appeal manager provides each member or the member's representative a reasonable opportunity to present evidence and allegations of fact or law and an opportunity to receive medical records and other documents considered by UnitedHealthcare during the appeal process. The dispute and appeal manager informs our member or the member's representative of the limited time available in cases involving expedited resolution. For nonclinical issues, the appeals analyst researches and adjudicates the appeal. For clinical appeals, the appeals analyst assembles relevant information from our prior authorization, claims systems and clinical systems and forwards the matter to a medical director who has appropriate clinical expertise to review the matter. Only medical directors or other health care professionals with the appropriate clinical expertise, and those not involved in previous levels of review or decision making, review appeals.

### **Communicating the Resolution of the Appeal Investigation**

We make reasonable efforts to provide verbal notice to a member regarding an expedited appeal resolution. We also communicate the resolution of the appeal using a Notice of Appeal Resolution, which contains the results of the appeal resolution process, including the legal citations or authorities supporting the determination and the date it was completed. We will send the Notice of Appeal Resolution via certified mail within five business days of resolution. For appeals not resolved wholly in favor of our member, the Notice of Appeal Resolution includes information, including our member's right to receive continued benefits pending a hearing and how to request continued benefits; the right to request a state fair hearing, including the requirements our member must follow to file a written request for a state fair hearing; how to request a state fair hearing; and an explanation of continuation of benefits, including that our member may be held liable for the cost of benefits if the hearing decision upholds our decision. We also prepare for and participate in state fair hearings. For medical cases, a medical director will attend the hearing; for LTC services, the case manager, the case manager's manager, our case management administrator, Francine Pechnik, and our appeals analyst, Tanya Johnson, attend the hearing.

### **ONGOING PROACTIVE EFFORTS TO SUPPORT DECISION MAKING ABOUT CARE NEEDS**

It is our standard practice to continuously monitor the health status of all our members so that we understand their changing circumstances and can provide interventions, services and supports, as needed, to support the member's evolving needs, goals and desired outcomes. Such methods include:

- Quarterly member touch points (every six months for members in a nursing facility)
- Reviewing the results of predictive modeling analysis of claims for indications the member may not be adhering to their IPC (e.g., a member with asthma not filling prescriptions for a rescue inhaler)
- Tracking timely, relevant, actionable information about our member, such as inpatient or ER admission, gaps in care reports or the results of an HbA1c test that indicates poorly controlled blood sugar levels.

- Monitoring progress by tracking the completion of IPC interventions that help the member engage in activities and receive services and supports to achieve their goals.
- Input from providers and the member's ICT

The key to our approach is developing a trusting relationship between the case manager and our member. It is our goal that the case manager remains our member's trusted adviser and helps them navigate the health care system and engage in activities that meet their goals and desired outcomes. At each touch point, the case manager works with our member and the interdisciplinary care team (ICT) in a respectful partnership to proactively collaborate with our member to monitor his/her care and health status and adjust the care plan to meet changing needs. Our ongoing engagement with our member should prevent the situation portrayed in this scenario from occurring.

## ADDITIONAL MEMBER RESOURCES

In addition to making sure that our member and his/her spouse understand how to contact their case manager to get the services they need, we have implemented resources and tools to help avoid this stressful situation for the family in the future. These resources can answer questions, resolve concerns and provide assistance when our member and his/her spouse need help 24 hours per day, seven days per week.

- **Pre-appeal process:** Our pre-appeal process reduces the number of formal appeals and resolves issues more quickly for our members. We schedule a pre-appeal conference to give all parties the opportunity to present information, ask questions so we can obtain a good understanding of our member's needs, and attempt to resolve the issue during the conference.
- **Confirmation letter:** When there is an agreed upon change to the member's care plan, we send a confirmation letter to the member to verify he/she is aware of and in agreement with the change. The letter provides a safeguard before we finalize care plan changes, particularly in cases where the member has changed his/her decisions. **We are the only managed care organization that sends a confirmation letter to our members.**
- **Advocate4Me:** By providing members with access to a member services advocate (MSA) 24 hours per day, seven days per week, Advocate4Me supports the efforts of our case managers. The MSA "owns the member inquiry" until resolution and helps resolve issues, helps file appeals, answers questions about benefits, helps locate and select providers, schedules appointments, arranges transportation and coordinates connections with resources, such as case managers, NurseLine<sup>SM</sup>, behavioral health and crisis clinicians, and providers.
- **Uhcforcaregivers.com:** is an intuitive, interactive website that we will make available to the ALTCS Program members in 2017. It provides comprehensive support to family caregivers and helps them holistically manage member care through a unique combination of resources. The Resource Center provides information to caregivers so they can decide how to best care for their elderly parent or loved one.
- **myConnections™:** The UnitedHealthcare myConnections™ initiative provides members with benefits and services that address social and economic factors that contribute to poor health, increased health care utilization and higher health care spending. myConnections is a system for integrating, organizing and distributing support services for low-income populations while addressing social determinants with the greatest opportunity to improve health outcomes. To date, we have 35 contracted community-based organizations which intake direct electronic referrals from our case managers and our brick and mortar community center in Maryvale. Our myCommunity Connect Center creates innovative social service and community programs enabling individuals and families to improve their well-being and independence. The philosophy of myCommunity Connect Center is to integrate, organize and distribute support services for consumers, providing them greater access to safe housing, transportation, education and job training – essential to good health.

## 11. A provider who is a specialty surgeon, filed a claim dispute contesting the Offeror's recent recoupment of the ...

This scenario is a challenging situation for the provider, due to the late nature of the recoupment of the claim. Despite our proactive efforts to ensure proper provider payment, with all information communicated at the time of the claim submission, there may be times when our efforts fall short and a provider disputes our payment action. To confirm we can substantiate our recoupment, our claim dispute coordinators research available information including, case notes, medical records, claims, claim notes, recoupments, disputes and other provider interactions. We use factual and legal arguments when addressing this dispute, assuming no wrongdoing on the part of the provider.

**Maintaining strong, positive provider Relationships is our foremost goal.** We offer providers several ways to resolve concerns through our relationships—averting the need to file claims disputes or go to a State Fair Hearing (SFH). Our medical directors are accessible for peer-to-peer discussions around claims payment concerns, contacted often by providers and used to avert the need for over half of our SFHs. Provider advocates use our Provider Resolution Insight and Service Model (PRISM) to capture provider issues, quickly resolve issues and monitor for patterns and trends affecting other providers. In 2016, we averted 97 percent of SFH requests using these approaches.

In this scenario, there are many assumptions we could make regarding provider contracting status, emergent status of the service provided, proper filing of the dispute and authorization requirements. Our response has not made any specific assumptions, so we can highlight all processes used to research this dispute. We outline the possible outcomes for the surgeon in this particular scenario in the section “Acting on the Decision.” Our perspective is from that of a Medicaid claims dispute and recoupment.

We have an established process and maintain strict policies to resolve provider claim disputes and facilitate a fair and timely resolution. We review all policies and procedures at least annually to verify adherence to program standards. Compliant with **AHCCCS requirements in Sections D42, E19 and Attachment F2**, our dispute process allows providers to challenge payments, denials or recoupments when filed in writing with us no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. As pertinent to this dispute, we will comply with all AHCCCS processing and reporting requirements if the member is defined with serious mental illness (SMI).

Available online 24 hours a day, seven days a week, our *Provider Manual* (see Attachment 11-1 AZ Provider Manual for Participating Providers) includes a specific section on our provider-dispute system policies and procedures, including high-level instructions regarding how to contact us to file a claims dispute. We also communicate our policies and procedures with all providers via the remittance advice (see Attachment 11-2 Remittance Advice for Providers).

### STEPS AND ACTIVITIES CONDUCTED IN RESPONSE TO CLAIM DISPUTE

We use our Escalation Tracking System (ETS) for tracking and trending all provider dispute data. It contains sufficient information to identify the complainant, date of receipt, nature of the claims dispute, resolution of the claim dispute and the date of resolution. Upon receipt of a provider claim dispute, in our Phoenix, Arizona location, we stamp all documentation related to the dispute with the received date and then enter the dispute into ETS. UnitedHealthcare files all claim disputes in a secure designated area and retains the information for five years following our decision, AHCCCS decision, judicial appeal or close of the claims dispute, whichever is later, unless otherwise provided by law.

As shown in Attachment 11-3 Sample Claim Dispute Acknowledgement Letter to Provider, we acknowledge the claim dispute in writing to the provider within five business days of receipt. The assigned claim dispute coordinator performs a thorough investigation of all correspondence received in addition to applicable statutory, regulatory, contractual, administrative handling of the claim and policy provisions to create a response for the provider. Our clinical services team reviews disputes for any decision needed regarding the clinical components of the claim. Our next steps are:



## Determine the Validity of the Dispute

In this scenario, the provider has submitted a dispute. Our first task is to determine if the dispute is valid by (1) determining if disputed claim is in the system, and (2) determining if the dispute is timely filed within 60 days of an adverse action per ARS 36-2903.01(B)(4). If one or both of these criteria fail, a denial letter is sent to the provider (covered under the section “Act on the Decision” below).

## Gather Pertinent Information Regarding the History of the Claim

In this scenario, we need to learn more about the provider and the original claim handling. Our next task is to collect all information required to research the claim. The steps in the process include:

1. Validate member’s AHCCCS eligibility
2. Validate provider’s AHCCCS registration and provider type, and determine provider’s participation status with us (impacts authorization requirements) and service category to validate billed services
3. If coordination of benefits is involved, validate primary carrier; validate if QMB (A.A.C. R9-22-302) or non-QMB (A.A.C. R9-29-303) applies for proper cost sharing responsibility purposes
4. Research the claim history to corroborate the provider’s dispute information
5. Determine if services are covered, authorization required or if services related to emergent service
6. If authorization is required, determine if an authorization is on file for the provider or the facility and if entire hospital stay was approved
7. Review appropriate reimbursement policies for billed services

## Research Recoupment Validity

In this scenario, the provider had a claim recouped 26 months after payment. We take the following steps to review recoupment validity:

1. Determine status of recoupment
  - a. If no recoupment is found in the system, the dispute is denied due to no adverse action taken under A.R.S. 36-2903.01(B)(4) and we redirect the provider to our recovery services team
  - b. If recoupment has occurred, and it was more than a year from original payment:
    - Confirm with recovery services team if the recoupment was approved by AHCCCS
      - If no State approval on file, we reverse the recoupment and overturn the claim dispute
      - If a State recoupment approval on file, we continue our review of the dispute
  - c. Determine if the recoupment was for medical necessity

**Reducing Administrative Burden**  
As a good steward of public dollars, we have an obligation to recoup erroneous claims payments according to contractually compliant protocols. Wherever possible, we streamline, minimize and expedite recoupments to reduce administrative burden for the provider.

Controls are in place to confirm claims to be recouped are adjusted within a 12-month period from original payment date. If they cannot be adjusted in this timeframe, we follow contract guidelines and ACOM 412 to seek AHCCCS approval for the recoupment. We additionally seek AHCCCS approval if the claim was over \$50,000 (single or cumulatively) for a single tax identification number (TIN).

## Determine Medical Necessity and Authorization of Services

Now that we have gathered all administrative information about the disputed claim, we engage the clinical services team in the review as the provider stated all services were critically necessary and extensive medical records were

submitted with the claim. We send the claim dispute to the clinical team along with all the research findings. Clinical review steps include:

1. Review dispute and associated medical records, via our shared image system that enables staff to review records submitted with the claim and dispute
2. Check medical necessity:
  - a. Determine emergent need and necessity of services on the claim
  - b. If service is non-covered or exceeds AHCCCS recommended edit limits, but is determined to be medically necessary, we notify our LTC medical director and chief medical officer (CMO) to determine if AHCCCS review is recommended for possible update of covered services. If our medical director(s) and/or AHCCCS determine the service should be covered, the dispute is overturned. If not, the dispute is denied
3. Notate clinical decision and return to claims dispute coordinator

### Act on the Decision

We now have all administrative and clinical information to make a decision regarding the dispute. For this provider's scenario, the following five possibilities exist with outcomes noted in parentheses:

- Authorization on file and services found to be medically necessary (dispute overturned)
- Authorization on file and some services found to be medically necessary (dispute could be partially overturned)
- Services not found to be medically necessary, whether authorization on file or not (dispute denied)
- Authorization not on file, but services found to be emergent (dispute overturned)
- Not all services are covered due to incorrect billing, whether authorization on file or not (dispute denied, provider educated on correct billing and possible resubmission of claim)

After we make our decision, we then take the following steps:

1. Create a Notice of Decision letter (see Attachment 11-4 Sample Notice of Decision Letter to Provider) to send to the provider, which includes the following details:
  - a. Nature of claim dispute and specific factual and legal basis for dispute, including but not limited to: explanation of facts that pertain to claim dispute, member name, pertinent dates of service, dates and specific reasons for our denial/payment of claim and provider contract status.
  - b. Explanation of: 1) relevant and specific facts as applied to the relevant laws that support our decision, and 2) applicable statutes, rules, contractual provisions, policies and procedures, if applicable. References to general legal authorities alone are not acceptable.
  - c. Provider's right to request a SFH by filing a written request to us no later than 30 days after the date the provider receives our decision.
2. If the claim dispute is overturned, in full or in part, we reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of the decision
3. We mail the Notice of Decision letter to the provider via certified mail within 30 calendar days of receipt, unless there is an agreed upon extension between the provider and UnitedHealthcare — communicated, documented and arranged via a Claim Dispute Extension Request letter (see Attachment 11-5 Sample Claim Dispute Extension Request Letter to Provider).

#### Minimizing State Fair Hearings

In alignment with the State's goals, we strive to minimize SFHs whenever possible. For example, in 2016, 0.2 percent of claims disputes went to SFH and all were settled in favor of UnitedHealthcare. We log and categorize all SFH requests for trending.

## STATE FAIR HEARING PROCESS

The provider may file for a SFH request, in writing, if they disagree with the claim dispute decision within 30 calendar days of receipt of the Notice of Decision letter. Upon receipt of the provider's request, we confirm that all supporting documentation and the appropriate cover letter is received by AHCCCS, Office of the Administrative Legal Services (OALS) no later than five business days from the date we received the hearing request. We then take the following steps:

1. Create a SFH cover letter including: provider's name, address and phone number (if applicable); member's name and AHCCCS ID; date dispute received; summary of actions taken by us to resolve the claim dispute; and basis of the determination.
2. Create a case file including written request for hearing filed by provider; copies of entire file, including pertinent records and our decision; and other information relevant to the decision.
3. Verify receipt of SFH request within 30 days of the provider receipt of the Notice of Decision. If not, the SFH request is denied and appropriate information provided to OALS with a copy sent to provider (see Attachment 11-6 Sample State Fair Hearing Request - Denied for Timely Filing).
4. Mail a letter to AHCCCS, copying provider, which lets them know we submitted SFH request to AHCCCS — communicating and confirming that his/her request has been submitted to the AHCCCS Office of Administrative Legal Services (see Attachment 11-7 Sample State Fair Hearing Request).
5. Review the SFH request to confirm the issue is the same as the claim dispute decision. The SFH staff will call the provider to notify his/her request is not related to the claim dispute and advise the provider of his/her claim disputes rights and ask provider to withdraw request.
6. Take same steps as in the dispute process to validate: member and provider eligibility using AHCCCS' website and PMMIS; authorization; provider contracting status; recoupment status; status of coverage of billed services; claims actions; and medical necessity

If payment is deemed appropriate and approved after all reviews, the claim is forwarded for payment and the SFH coordinator will contact the provider, advise him/her of the decision and request that the provider submit a request to withdraw the fair hearing.

If it is determined we recouped the services appropriately, the SFH coordinator will contact the provider to explain the rationale and verify if the provider wants to move forward with the hearing. The appropriate AHCCCS medical policy or applicable AHCCCS fee-for-service document is provided to support the denial of services, including contractual and reimbursement policies (e.g., covered services, limitations and exclusions).

The SFH coordinator will offer a peer-to-peer review between UnitedHealthcare's CMO and the provider if further discussion is needed to alleviate the need for the hearing. If the matter is not resolved before the hearing date, the SFH coordinator, along with any relevant witnesses, will attend the hearing. For example, our CMO may be called as a witness to speak to and support the denial of services based upon *MCG guidelines* applied to the medical record information.

Hearing attendees will be prepared to discuss the legal and factual arguments, as well as cite applicable regulations, based upon the extensive research performed during dispute review. They will be prepared with all research done in conjunction with the dispute, along with posted policies pertaining to the dispute, such as UnitedHealthcare's prior authorization list and reimbursement policies. In addition applicable regulations will be cited, such as non-covered services/not medically necessary (A.A.C. R9-22-101; A.A.C. R9-22-202(B)(1); A.A.C. R922-202(b)(9), lack of prior authorization (non-emergent non-contracted A.A.C. R9-22-705; A.R.S. 36-2901) and recoupment A.A.C. R9-22-703(F)(1)(2), when the claim dispute is denied.

When we receive the AHCCCS director's decision, the following could apply:

- If the AHCCCS director's decision states 'sustained,' the claim will be paid within 15 business days, along with any applicable interest.
- If the AHCCCS director's decision states 'denied,' no further action is required by UnitedHealthcare.
- If our or the SFH decision reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, we will authorize or provide the services promptly and as expeditiously as the member's health condition requires irrespective of whether we contest the decision.

## TRACKING, TRENDING AND PREVENTING CLAIM DISPUTES

Using our Escalation Tracking System (ETS), our grievance and appeals staff maintain, record and store all grievance and appeal activity, including policy-mandated timeframes for provider contract and appeal or grievance resolution. ETS allows staff to identify open, outstanding or priority grievances and appeals requiring resolution and to query and review a specific provider's grievance and appeals history. Our data analytics capability allows us to self-monitor and trend the reasons why providers file grievances and appeals. When warranted, we initiate provider education if we see provider trends in disputes.

We also look internally to validate we are accurately paying claims and avoiding the errors leading to disputes. We have created several tools to minimize claims disputes: **Predict, Provider Early Warning System (PEWS) and Smart Audit Master (SAM)**. **Predict** checks for accuracy of provider data loading during the contract and demographic load process. This tool helps to minimize human errors and reduce incorrect claim payment. **PEWS** supplements our claims audit efforts by alerting us to the risk of claims denied in error, fluctuations in claims receipts, rejected claims and cash flow paid to providers to improve provider satisfaction with claims payment. Finally, we use **SAM** to conduct both pre-disbursement and post-disbursement systematic claim edit reviews. These edits allow a processor to review a claim in question and take action to validate accurate claim payment.

## SUMMARY

We understand that it is not ideal for providers to have to dispute claims and further understand it is our accountability to find our own errors before the provider needs to dispute. Nonetheless, claims disputes may happen and when they do, we are prepared to thoroughly and quickly address provider concerns. Our grievance system processes remain efficient and accurate through continual process review and implementation of improvements, as needed. We value our provider relationships and incorporate feedback from them via multiple methods, including disputes, call center trends, meetings with provider advocates, and our issue resolution process and provider surveys. Our primary goal is to minimize unnecessary provider burden.



## 2016 Long Term Care Program

Physician, Health Care Professional, Facility and Ancillary

# Provider Manual



## Welcome to UnitedHealthcare Community Plan

This provider manual is designed as a comprehensive reference source for the information you and your staff need to conduct your interactions and transactions with our Long Term Care program in the quickest and most efficient manner possible. Much of this material, as well as operational policy changes and additional electronic tools, are available on our website at [UHCCommunityPlan.com](http://UHCCommunityPlan.com).

Our goal is to ensure our members have convenient access to high-quality care provided according to the most current and efficacious treatment protocols available. We are committed to working with and supporting you and your staff to achieve the best possible health outcomes for our members.

If you have any questions about the information or material in this administrative guide or about any of our policies or procedures, please do not hesitate to contact Provider Services at 800-377-2055.

We greatly appreciate your participation in our program and the care you provide to our members.

## Important Information Regarding the Use of This Guide

In the event of a conflict or inconsistency between your applicable Provider Agreement and this guide, the terms of the Provider Agreement shall control.

In the event of a conflict or inconsistency between your Provider Agreement, this guide and applicable federal and state statutes and regulations will control. UnitedHealthcare reserves the right to supplement this guide to ensure that its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This guide will be amended as operational policies change.

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# Ch. 1 UnitedHealthcare Corporate Overview

UnitedHealthcare, a business unit of UnitedHealth Group, the nation's largest health and well-being company, is the country's premier provider of high quality, personalized public sector health care programs. Our mission is to help the people we serve live healthier lives. UnitedHealthcare understands that health care cannot be delivered in a vacuum. That is why our services seek to address the social and economic factors that affect a person's health. Since 1989, UnitedHealthcare, through its predecessor affiliates, has served the public sector market. Today, we facilitate care for 2.8 million beneficiaries of government health care programs in more than 26 states, plus the District of Columbia.

A number of factors distinguish UnitedHealthcare from other companies serving Healthy Options and other government health care programs:

- UnitedHealthcare has a private sector focus on cost accounting, data analysis and fiscal discipline, coupled with sensitivity to the imperatives of public sector accountability.
- UnitedHealthcare invests in the systems and personnel required to successfully manage our business.
- UnitedHealthcare emphasizes service to all our customers — regulators, members and providers.
- UnitedHealthcare understands the unique needs of the populations we serve and our Health Plans are designed specifically to meet those needs.

Moreover, UnitedHealthcare understands that compassion and respect are essential components of a successful health care company. UnitedHealthcare employs a diverse workforce, rooted in the communities we serve, with varied backgrounds and extensive practical experience that gives us a better understanding of our members and their needs.

## Our Approach to Health Care

Innovative health care programs are the hallmark of UnitedHealthcare. Our personalized programs encourage the utilization of services. These programs, some of them developed with the aid of researchers and clinicians from academic medical centers, are designed to help our chronically ill members avoid hospitalizations and hospital emergency room visits — in short, to live healthy, productive lives.

The unique UnitedHealthcare Personal Care Model™ features direct member contact by UnitedHealthcare clinicians trained to foster an ongoing relationship between the Health Plan and members suffering from serious and chronic conditions. The goal is to use high-quality health care and practical solutions to improve members' health and keep them in their communities with the resources necessary to maintain the highest possible functional status.

Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, UnitedHealthcare's Healthy First Steps program uses an early identification to:

- Help overcome common social and psychological barriers to prenatal care;
- Increase member understanding of the importance of early prenatal care;
- Increase the mother's self-efficacy by identifying and building a mother support system;
- Ensure appropriate postpartum and newborn care;
- Develop the physician/member partnership and relationship before and after delivery.

In addition to the usual Health Plan reminders to get preventive care services, UnitedHealthcare employs its proprietary Universal Tracking Database to identify members who have fallen behind in scheduling appointments and providers who are failing to focus on preventive care and optimal treatment.

## Welcome to UnitedHealthcare Community Plan

UnitedHealthcare Community Plan offers many plans in Arizona. UnitedHealthcare Community Plan's Long Term Care plan services the vulnerable, elderly and chronically ill by offering enhanced medical coverage for both institutional and community residents, the Medicare and Medicaid population, through the collaboration of case managers, physicians, and other health care providers. UnitedHealthcare Community Plan plans are built on the foundation of comprehensive care management, providing an in-depth assessment and an innovative benefit package to maintain individuals in the least restrictive setting appropriate to maintain quality of life.

- **UnitedHealthcare Community Plan** – A Medicaid/Arizona Health Care Cost Containment System (AHCCCS) product in Maricopa, Apache, Coconino, Mohave, Pima, Yuma, La Paz, Santa Cruz, Yavapai, and Navajo Counties. Enrollees must be enrolled with ALTCS and assigned to UnitedHealthcare Community Plan. Contract Services are funded in part under contract with the State of Arizona.

### UnitedHealthcare Community Plan products operate in all residential settings:

- **In the nursing home** – UnitedHealthcare Community Plan increases preventive care through a collaborative approach involving a UnitedHealthcare Community Plan Case Manager and teams of health care providers who work with nursing home staff to help maintain the health and well-being of enrollees.
- **In the community** – A Case Manager works with the family, the primary care physician, other health care providers, and community organizations to help ensure optimal use of available health care and other community resources.

## UnitedHealthcare Community Plan Mission Statement

Helping people live healthier lives.

### Vision

UnitedHealthcare Community Plan is a driving force in maximizing the health and well-being of America's aging, vulnerable and chronically ill individuals. Our success is built on the foundation of:

- **National Leadership** – UnitedHealthcare Community Plan is the recognized leader in creating and shaping a full continuum of comprehensive services for the population we serve.
- **Innovation** – UnitedHealthcare Community Plan is revolutionizing the creation and delivery of programs and services that consistently provide individualized solutions to meet the unique and diverse needs of our clients.
- **Reputation** – UnitedHealthcare Community Plan is known as the employer, provider and partner of choice for those committed to serving aging, vulnerable and chronically ill individuals. Our culture represents integrity, collaboration and mutual respect for the people we serve and our employees.
- **Demonstrated Results** – UnitedHealthcare Community Plan provides value to our clients and partners by consistently delivering quality and customer-focused service. Our attention to results ensures the financial soundness of our company.
- **Partnerships** – UnitedHealthcare Community Plan has strong alliances with public and private sectors that support our mission and share our commitment to continuously improve the well-being of the people we serve.

## VALUES

---

### **Integrity**

Honor commitments  
Never compromise ethics

### **Compassion**

Walk in the shoes of the people we  
serve and those with whom we work

### **Relationships**

Build trust through collaboration

### **Innovation**

Invent the future, learn from the past

### **Performance**

Demonstrate excellence  
in everything we do

**Customer Call Center** .....800-293-3740  
 Available Monday through Friday from 8 a.m. to 5 p.m.  
 Eligibility, Member and Claims Services.....800-293-3740  
 Provider Relations..... 800-377-2055  
 Main Phone .....602-255-8188 or 800-377-2055  
 General Fax.....855-465-3075  
 Prior Notification Phone.....602-255-8188 or 800-377-2055  
 Prior Notification Fax.....800-278-2907

**Case Management Offices**

**Apache County/Navajo County** (Show Low)

Pebble Creek Plaza, Suite I.....800-233-9867  
 2707 South White Mountain Road, Suite I.....Fax: 928-537-5082  
 Show Low, Arizona 85901.....Local: 928-537-1797

**Coconino County** (Flagstaff)

1016 W. University Ave, Suite 210.....888-437-5249  
 Flagstaff, Arizona 86001.....Fax: 928-226-1475

**Maricopa County** (Phoenix)

1 East Washington, Suite 800.....800-377-2055  
 AZ009-800E.....Fax: 855-465-3075  
 Phoenix, Arizona 85004.....Local: 602-255-8913

**Mohave County** (Kingman)

2404 Stockton Hill Road, Suite D.....800-598-3047  
 Kingman, Arizona 86401.....Fax: 928-753-2453 Local: 928-753-2403

**Mohave County** (Lake Havasu City)

1963 McCulloch, Suite 105.....800-659-6886  
 Lake Havasu City, Arizona 86403.....Fax: 928-680-0343 Local: 928-680-6886

**Pima County** (Tucson)

6245 E. Broadway #650.....Fax: 520-748-5019  
 AZ124-1000  
 Tucson, AZ 85711

**Yavapai County** (Prescott)

2825 N. Glassford Hill Rd, Suite B  
 Prescott Valley, AZ 86314

**Yuma/La Paz County** (Yuma)

3970 W. 24th St., Suite 204.....Fax: 928-388-6810  
 Yuma, AZ 85364



**Utilization Management and Prior Notification**

**Medical Management Department**

1 East Washington, Suite 800 .....800-377-2055  
AZ009-800E.....Fax: 800-278-2907  
Phoenix, AZ 85004

**Quality Management**

Quality Management Coordinator.....800-377-2055  
1 East Washington, Suite 900.....Fax: 602-745-7950  
AZ009-800E  
Phoenix, AZ 85004

**Member Services and Provider Claim Disputes**

1 East Washington, Suite 800 .....800-377-2055  
AZ009-800E.....Fax: 877-395-5993  
Phoenix, AZ 85004

**Claims Research Department**

UnitedHealthcare Community Plan.....800-293-3740

**Access to UnitedHealthcare Community Plan Website:**

[UHCommunityPlan.com](http://UHCommunityPlan.com)

# Ch. 2 Member Services and Eligibility

The Customer Service Center provides assistance to enrollees and providers. The functions of Customer Service include:

- Answering benefit and claims questions
- Changing of primary care providers
- Verification of member eligibility
- Claims status and limited research
- Assistance with identifying participating providers
- Logging member complaints and appeals and forwarding to the site

## The Customer Service Center can be reached at:

800-293-3740

Available Monday to Friday

8 a.m. to 5 p.m.

## ALTCS Eligibility

All individuals on UnitedHealthcare Community Plan must meet eligibility requirements set forth by the state of Arizona to become eligible for benefits under the ALTCS program. UnitedHealthcare Community Plan is not involved in eligibility determination or enrollment/disenrollment.

In counties where multiple program contractors are available to provide ALTCS services, a member will have the opportunity to choose which program contractor they will be enrolled with to receive ALTCS services. The member and/or the member's authorized representative will be provided with informational material from each program contractor to assist them in making a choice. If a member does not choose, they will be assigned to a program contractor by AHCCCS based on an auto-assignment.

## Identification Cards

Each ALTCS member is issued an AHCCCS identification (ID) card when the member enrolls with UnitedHealthcare Community Plan. If a member presents for services without an AHCCCS ID card or loses their ID card, he or she may call the Customer Service Center at 800-293-3740 to request a new card.

The ID card contains the member's name, ID number, date of birth, and group number.

Presentation by a person with an UnitedHealthcare Community Plan ID card may not be an absolute guarantee of eligibility at the point of service.

## Verifying Member Enrollment and Eligibility

All providers should verify enrollment prior to rendering services. For up-to-date enrollment information, UnitedHealthcare Community Plan providers may use [UHCommunityPlan.com](http://UHCommunityPlan.com) or call the Customer Service Center.

### The number to call is:

800-293-3740

Available Monday to Friday

8 a.m. to 5 p.m.

### For faster service, please have the following information ready when you call:

- Provider/Facility AHCCCS ID number
- Name of the caller and contact phone number
- Member's name, AHCCCS ID number and date of birth

You can call AHCCCS at 602-417-7200 within Maricopa County or at 800-331-5090 outside Maricopa County, within Arizona. Or you can register to use the AHCCCS online website. More information is available at [azahcccs.gov/commercial/AHCCCSOnline.aspx](http://azahcccs.gov/commercial/AHCCCSOnline.aspx).

## UnitedHealthcare Community Plan Welcome Packet

Upon enrollment with UnitedHealthcare Community Plan, members will receive a Welcome Packet in the mail that includes:

- A welcome letter
- A Member Handbook, which includes:
  1. The member rights and responsibilities as defined in this chapter.
  2. Notice of Privacy Practices

## Members' Rights

Members have the right to:

- Access to care
- Respect and dignity
- Culturally competent care
- Privacy
- Information
- Communication
- File a complaint or grievance
- Consent/Refusal of treatment (medical care)

If members have any questions regarding cultural competency or concerns about specific providers, they are directed to contact their case manager or Member Services at 800-293-3740.

## UnitedHealthcare Community Plan has no Policies Which Prevent the Provider from Advocating on Behalf of the Member:

UnitedHealthcare Community Plan will not prohibit a physician or health care provider, acting within the scope of his or her lawful practice, from advising, acting or advocating on behalf of the member about the member's condition, risks and treatment options. We are committed to promoting dignity, quality of life, and appropriate standards for assuring quality care for all of our members. We believe that our members

and their families deserve the best care and that they can enjoy an improved quality of life if given the opportunity to understand and access their rights.

## ALTCS Enrollee Responsibilities

AHCCCS identifies the following as ALTCS enrollee responsibilities. UnitedHealthcare Community Plan enrollees and/or the enrollee's authorized representative are informed of their responsibilities regarding ALTCS services. These responsibilities include but are not limited to the following:

### 1. Utilizing Services

- a) Ask questions if you do not understand your rights or plan of treatment.
- b) Keep your scheduled appointments.
- c) Cancel appointments in advance when you can't keep them.
- d) Always contact your primary care provider (PCP) first for non-emergency medical needs.
- e) Be sure you have approval from your PCP before going to a specialist.
- f) Understand when you should and should not go to the emergency room.
- g) Know who to call if you need a ride to the PCP or other medically necessary service.

### 2. Giving Information

- a) Tell your PCP and your Case Manager about your current health and changes in your health.
- b) Tell Member Services and your Case Manager about changes in your Medicare, Medicare HMO or private insurance coverage, such as the addition or termination of other insurance coverage.
- c) Talk to your providers and your Case Manager about your health care needs and ask questions about the different ways your health care problems can be treated.

### 3. Follow Instructions

- a) Work as a team with your PCP and Case Manager in deciding what health care is best for you.
- b) Understand how the things you do can affect your health.
- c) Do the best you can to stay healthy.
- d) Treat providers and staff with respect.

## Grievances and Complaints

As a provider, you may come across a member that wants to file a complaint or grievance with UnitedHealthcare Community Plan. You may assist or instruct the member on how to do so. We are providing you with a summary of the steps the member should take. For more information, this process is explained in the member handbook.

The member should first contact their Case Manager directly to assist in answering questions or resolving the issue. If the Case Manager was able to help, the complaint or grievance will be considered resolved and the member will not receive any further notification from UnitedHealthcare Community Plan. If the Case Manager cannot help the member to their satisfaction, the member may file a grievance or complaint with UnitedHealthcare Community Plan. This can be done either verbally (call 800-293-3740) and the caller tells the Customer Service representative they wish to file a grievance; or they may file in writing.

To file a grievance in writing they may submit a letter to the following address:

### **UnitedHealthcare Community Plan Member Grievance and Appeal Manager**

1 East Washington, Suite 800  
AZ009-800E  
Phoenix, AZ 85004

Members who call to file a complaint regarding a provider are encouraged to contact the provider first. If the member is not satisfied with the answer given by the provider, Member Services may intervene. If your office receives a call from a Member Services representative the intent is to clarify the situation and provide appropriate direction to the member.

Once UnitedHealthcare Community Plan receives the complaint, the Member Grievance Coordinator will investigate the issue and respond to the member.

## Member Appeals

If the member was denied a requested service, the response will include how to appeal the decision. If the member is not satisfied with UnitedHealthcare Community Plan's decision, the member may file an appeal. An appeal may be filed over the phone or in writing. All letters of appeal need to be sent to the address listed above.

After UnitedHealthcare Community Plan has completed its review of the member's appeal, we will send a written decision letter that explains how we reached our decision. As a provider, you may file an appeal on behalf of the member if the member gives you that authority in writing and a copy of the authorization is sent to UnitedHealthcare Community Plan with the appeal. No punitive action will be taken against a provider who files an appeal on behalf of a member.

If the member is not satisfied with the decision of the appeal, the member may request a State Fair Hearing in writing within 30 days from the date of the appeal decision. UnitedHealthcare Community Plan will arrange the hearing. An Administrative Law Judge will conduct the hearing. The member may represent him or herself or use legal counsel, a relative, a friend or other representative if the member has given written consent. The Administrative Law Judge will issue a Recommended Decision to ALTCS who will review the decision. The member will receive a written decision from ALTCS.

## Mail Order Pharmacy

UnitedHealthcare Community Plan offers mail order pharmacy services to its enrollees. To assist enrollees in arranging mail order pharmacy services, please advise the enrollee to contact Optum RX at 877-889-6510.

## Primary Care Provider (PCP) Assignment

UnitedHealthcare Community Plan offers enrollees the opportunity to select an UnitedHealthcare Community Plan contracted PCP when more than one contracted PCP is available in the enrollee's geographic service area. If the enrollee fails to elect a PCP, the case manager will assist the member in identifying an appropriate PCP at the time of the initial assessment visit. The enrollee is responsible for knowing the name of his or her assigned PCP. The Provider Services Department maintains a current list of all contracted PCPs by service area.

Pregnant enrollees will be allowed to choose an OB physician or health care provider as their PCP during the duration of the pregnancy and up to six weeks post-partum. They will then be automatically reassigned to their original PCP.

### UnitedHealthcare Community Plan enrollees may be assigned to a PCP as follows:

- **Enrollee Request** – All enrollees are asked to choose who they want as a PCP. If the enrollee identifies a PCP, UnitedHealthcare Community Plan will assign that enrollee to the requested PCP.
- **Auto Assignment** – If an enrollee does not choose a PCP within 10 days, the case manager will assist the member in identifying an appropriate PCP at the time of the initial assessment visit.
- **Re-enrollments** – Enrollees that lost their ALTCS eligibility and have become eligible again will be reassigned to the previous PCP unless the enrollee requests a different PCP at the time of re-enrollment.

## How to Reassign an Enrollee to Another PCP

PCPs may request an enrollee reassignment to another PCP. Allowable reasons include:

- If the enrollee behaves in an abusive manner to PCP or office staff;
- If the enrollee is non-compliant with UnitedHealthcare Community Plan policies and procedures;
- If the enrollee continually cancels or fails to keep scheduled appointments.

All requests must be submitted by the PCP in writing to the Member Services department and include the specific reason(s) for reassignment. The physician or health care provider is strongly encouraged to communicate his or her concerns to the enrollee before requesting reassignment.

Upon receipt of the request, the enrollee is referred to Case Management for assessment and intervention. A minimum of two weeks is required to complete the Case Management investigation. If the physician or health care provider/enrollee relationship remains problematic after Case Management intervention, the PCP may pursue reassignment.

If the UnitedHealthcare Community Plan Case Manager approves reassignment, the enrollee will be dis-enrolled from the originating PCPs practice effective the last day of the month that the request was received. Exceptions are granted on a case-by-case basis.

Member Services will notify the enrollee in writing of the PCP disenrollment. The enrollee will be allowed to select another PCP if deemed appropriate by the Case Manager. Enrollees who have had several previous PCP reassignments may be automatically assigned.



# Ch. 3 Physician and Health Care Provider Responsibilities

This chapter is intended to provide an overview of provider responsibilities. More information on provider responsibilities is located throughout this Provider Manual.

## Responsibilities and Expectations

The responsibilities and expectations of UnitedHealthcare Community Plan contracted physicians and health care providers are as follows:

1. Follow the terms and conditions of the signed agreement with UnitedHealthcare Community Plan.
2. Submit full and complete credentialing and re-credentialing applications and supporting documentation to UnitedHealthcare Community Plan as requested and in a timely manner.
3. Maintain all required professional licenses and certifications.
4. Deliver services to UnitedHealthcare Community Plan enrollees in a non-discriminatory manner with regard to race, color, creed, religion, sex, sexual preference, a national origin, health status, income level, or on the basis that the enrollee is enrolled in the ALTCS/Medicaid program.
5. Comply with the Americans with Disabilities Act (ADA) and provide reasonable accommodations to enrollees when applicable.
6. Report any known or suspected cases of fraud and abuse.
7. Notify UnitedHealthcare Community Plan of any factor affecting the agreement with UnitedHealthcare Community Plan, such as change in licensure or credentialing status, change of address, or change in insurance coverage as per the provider agreement.
8. Submit encounter documents (for capitated services) and claims to UnitedHealthcare Community Plan in a timely and complete manner.
9. Verify enrollee eligibility and obtain any necessary authorization prior to initiation of services.
10. Maintain patient medical records and other record-keeping systems in a complete and legible manner, in accordance with applicable laws, regulations and rules, and retain such records for the duration established in the provider agreement. Medical records must be provided in a timely manner, in accordance with HIPAA, federal and state regulations, upon request. Enrollees have the right to obtain copies of their medical records. Medical records must be made available free of charge to UnitedHealthcare Community Plan, AHCCCS or Medicare for purposes of quality review or other administrative requirements.
11. Cooperate with UnitedHealthcare Community Plan and any authorized regulatory agency regarding quality management and utilization management programs.
12. If provider is an Emergency Services facility, services must be available on a 24-hour, seven-days-a-week basis. If the provider is a PCP, the PCP or an appropriate on-call physician must be available for services, consultation or prior approval activities on a 24-hour, seven-days-a-week basis.
13. Comply with all applicable federal, state and local laws, rules and regulations, including anti-kickback and self-referral laws and implementing regulations.
14. Maintain all insurance coverage required by the provider agreement.
15. Comply with federal and state laws regarding Advance Directives.
16. Comply with the drug formulary established by UnitedHealthcare Community Plan and follow UnitedHealthcare Community Plan's exception authorization guidelines for dispensing of drugs not included in the formulary.

17. Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, including Patient Health Information (PHI) privacy requirements.
18. Advocate on behalf of an enrollee when asked by the enrollee or when the provider recognizes an enrollee in need of advocacy assistance.
19. Advise or advocate on behalf of the member regarding the following:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or non-treatment.
  - The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatments.
20. Meet all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility.

In addition, physicians and health care providers contracted to provide services to UnitedHealthcare Community Plan enrollees are responsible for the following:

1. Comply with the terms and conditions of the AHCCCS Minimum Subcontract Provisions, which is included in the UnitedHealthcare Community Plan provider agreement.
2. UnitedHealthcare Community Plan follows the regulations and policies as set forth in the AHCCCS Medical Policy Manual (AMPM). Providers are to comply with the standards as defined in the AMPM and all other applicable AHCCCS regulations.
3. Maintain a current AHCCCS Provider Identification Number and NPI number (if applicable).
4. Verify enrollee eligibility through AHCCCS and obtain any necessary authorization prior to initiation of services.
5. Recognize that Medicaid/AHCCCS/ALTCS and UnitedHealthcare Community Plan are, by law, the payer of last resort, and therefore assist UnitedHealthcare Community Plan in the identification and primary billing of other third-party payers including, but not limited to, the federal Medicare program.
6. Nursing home and assisted living facility providers are to comply with Enrollee Share of Cost, Enrollee Room and Board and patient trust fund accounting procedures and requirements as established by UnitedHealthcare Community Plan.

## PCP as Medical Manager

Primary care physicians (PCPs) play a central role in our enrollees care. PCPs are responsible for the delivery of health care to their assigned enrollees. PCPs are accountable for ensuring proper documentation in medical records. Some of the responsibilities specific to PCPs are:

- PCPs must be contracted with UnitedHealthcare Community Plan if they have any enrollees that are UnitedHealthcare Community Plan primary.
- For EPSDT services to enrollees under age 21, as described in Chapter 10 of this Provider Manual.
- PCP's are responsible for care, including but not limited to, immunizations, history and physical assessments and examinations, disease-risk assessments, well-woman and well-child examinations.
- Patient education, including but not limited to, examination findings, symptoms or side effects of treatments or medications, medically necessary treatment options, health maintenance, disease-prevention counseling and education on the difference between urgent conditions and emergent conditions and what to do in those situations.
- PCPs must have coverage 24-hours-per-day, seven-days-per-week. PCPs must arrange for after hours and vacation/sick coverage. The covering provider must be registered with AHCCCS if the PCP or covering provider provides services to a UnitedHealthcare Community Plan member.
- Document and report members with excessive cancelled or missed appointments.
- Appropriate response time to telephone calls during office hours and after hours. After-hours response should either automatically forward calls to another number or identify the number in which the enrollee can call to reach the on-call provider. Phones should not ring more than five times and the hold time after answer should be less than five minutes.
- Maintain continuity of care by reducing duplication of diagnostic procedures including all medical records for services provided to the enrollee and forwarding these to the specialist.
- If the enrollee has a behavioral health diagnosis, the PCP must aid in care coordination with the enrollee's Behavioral Health Case Manager.
- PCPs assigned to ventilator dependent patients must ensure each vent enrollee is evaluated annually by a pulmonologist to assess the prospects of weaning the enrollee from dependency on the ventilator.
- PCPs agree to make every effort to utilize contracted network providers.

## Referrals and Prior Authorization

Contracted health care professionals are required to coordinate member care within the UnitedHealthcare Community Plan provider network. If possible, all UnitedHealthcare Community Plan member referrals should be directed to UnitedHealthcare Community Plan contracted providers. Referrals outside of the network are permitted, but only with prior authorization from UnitedHealthcare Community Plan.

The referral procedure and prior authorization procedure are particularly important to the UnitedHealthcare Community Plan managed care program. Understanding and adhering to these

procedures is essential for successful participation as a UnitedHealthcare Community Plan provider.

Prior authorization is one of the tools used by UnitedHealthcare Community Plan to monitor the medical necessity and cost-effectiveness of the health care members receive. Contracted and non-contracted health professionals, hospitals, and other providers are required to comply with UnitedHealthcare Community Plan's prior authorization policies and procedures. Noncompliance may result in delay or denial of reimbursement.

UnitedHealthcare Community Plan requires practitioners and providers to obtain prior authorization before making referrals to certain specialists or providing certain procedures or services. Prior authorization allows for the evaluation of services for continuity of care, coverage under applicable program guidelines and policies, cost, and efficiency before services are rendered.

Because the PCP coordinates most services provided to a member, it is typically the PCP who initiates requests for prior authorization; however, specialists and ancillary providers may also request prior authorization for services within their specialty areas.

## Specialists Responsibilities

A specialist is responsible for responding timely to a PCP referral for specialist intervention and to report back their results to the PCP in a timely manner. UnitedHealthcare Community Plan will measure compliance with, including but not limited to, medical-records keeping practices, appointment availability, staff competencies, professional standards, confidential exchange of enrollee information and

timeliness of response and communication with the PCP. Specialists are also responsible for enrollee education and training, 24-hour availability coverage and proper eligibility verification, authorization and claims submission for services.

## Confidentiality and Release of Medical Records

There are federal privacy standards, state laws and AHCCCS rules and regulations that pertain to the safeguarding and release of confidential enrollee information. Each provider and their employed staff are required to adhere to all rules and regulations pertaining to the confidentiality and safeguarding of PHI. Each provider is responsible for ensuring the appropriate release of confidential information in accordance with the federal, state and AHCCCS rules and regulations.

## Appointment Standards

Contracted physicians and health care providers servicing UnitedHealthcare Community Plan enrollees are expected to adhere to appointment standards and waiting times established by AHCCCS. UnitedHealthcare Community Plan monitors quarterly provider compliance with Appointment Standards to ensure AHCCCS standards are met. UnitedHealthcare Community Plan will develop a Corrective Action Plan for providers that do not meet the appointment standards. The appointment standards\* are as follows:

\*For the purpose of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the enrollee's health.

### **Primary Care Provider (PCP)**

1. Emergency appointments same day or within 24 hours of the enrollee's telephone call or other notification, or as medically appropriate.
2. Urgent care appointments within 2 days.
3. Routine care appointments within 21 days.

### **Specialty Referrals**

1. Emergency appointments within 24 hours of referral.
2. Urgent care appointments within 3 days of referral.
3. Routine care appointments within 45 days of referral.

### **Behavioral Health Services**

1. Emergency appointments within 24 hours of referral.
2. Routine care appointments within 30 days of referral.

### **Dental**

1. Emergency appointments within 24 hours of referral.
2. Urgent care appointments within 3 days of referral.
3. Routine care appointments within 45 days of referral.

**Maternity** – Initial prenatal care appointments for pregnant enrollees as follows:

1. First Trimester appointments within 14 days of request.
2. Second Trimester appointments within 7 days of request.
3. Third Trimester appointments within 3 days of request.
4. High-risk pregnancies within 3 days of identification of high risk by UnitedHealthcare Community Plan or maternity care provider, or immediately if an emergency exists.

## **Waiting Times**

As with the Appointment Standards, UnitedHealthcare Community Plan actively monitors provider compliance with Waiting Times to ensure AHCCCS standards are met. UnitedHealthcare Community Plan will develop a corrective action plan for providers that do not meet the waiting time standards. The waiting time standards are as follows:

### **Physician Services**

Waiting times should not exceed 45 minutes except when the provider is unavailable due to an emergency.



## Service Gap Reporting

AHCCCS requires that Home Care providers, Attendant Care, Personal Care, Homemaker services or Respite Care document and report any non-provision of services (NPS) to the appropriate program contractor. The reporting will be done in the AHCCCS required format. Completion of the NPS log will be submitted by the provider to UnitedHealthcare Community Plan by the 5<sup>th</sup> calendar day of the month.

The information submitted identifies enrollees where a gap in service occurred, how quickly replacement services were obtained and how the replacement services were obtained. Providers who do not have a copy of the Service Gap Contingency Plan policy should contact the Case Management department.

### I. Instructions for Completing the NPS Log:

The NPS log form should be completed by the provider/agency and/or program contractor:

- When the authorized services are not provided as scheduled;
- When scheduled services are no longer available because a replacement cannot be found;
- When a request for DDD nonscheduled respite is made and not met.

Program contractors will determine what fields should be completed by the provider/agency and any additional instructions for the completion of the form. Program contractors will need to complete any fields that the provider/agency does not complete. Reporting timelines will be provided by the program contractors.

If you have any questions please call your respective ALTCS program contractor.

### II. NPS Column # Instruction/Explanation

0. **Program Contractor ID Number** - Program contractor fills in column with identification number 110049.
1. **Provider Registration Number** - Provider's AHCCCS Identification numbers. Column to be filled in by provider or program contractor. **When the provider is Self-Directed Attendant Care (SDAC) please use 000000 to represent all SDAC services. Do not use the SDAC worker's AHCCCS provider identification number (this was added 2/1/08).** Please ensure that this column is completed.
2. **Date Called In** – The date the agency was notified of the NPS. Use the following format 02/01/05.
3. **Time Called In** – The time the agency was notified. **Use military time** e.g., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
4. **NPS Date** – The date the NPS occurs. This date may be the same as the date in column 1 or the consumer may have waited to call. Use the following format: 11/01/04.
5. **Time Service Scheduled to Begin** – Insert the time the service was regularly scheduled to begin. **Use military time** e.g., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.

6. **County Code** – The county of residence code from the following chart:

County	Code
Apache	01
Cochise	03
Coconino	05
Gila	07
Graham	09
Greenlee	11
La Paz	29
Maricopa	13
Mohave	15
Navajo	17
Pima	19
Pinal	21
Santa Cruz	23
Yavapai	25
Yuma	27

7. **Member's Name** – List consumer's name, last name, first name and middle initial – Jones, Mary J.
8. **Member's Zip Code** – Member's zip code – this column can be filled in either by the program contractor or the provider.
9. **Member's AHCCCS ID** – List consumer's AHCCCS Identification Number – A12345678.

10. **Select from the following authorized service type** – Select what service the consumer was to receive and list the corresponding alphabetical bullet in Column 10. A consumer may be receiving more than one service (i.e., personal care and homemaker). Please list member's name twice and use a separate line to record the second service.

Service Type	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D

11. **Member Service Preference Level at the time of notice** – Agencies shall obtain from the member/representative the Member Service Preference Level at the time the provider/agency either receives a call from a consumer advising of a NPS or the provider/agency contacts the member/representative. The Member Service Preference Level is a designation of how quickly the member chooses to have a service gap filled if the scheduled caregiver of that critical service is not available. The member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now.

Insert the Member Service Preference Level as indicated by the member/representative at the time the provider/agency makes contact with the member. Column to be filled in by agency/provider.

Member Service Preference Level	
Needs services within two hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

12. **Member Service Preference Level** at time of last Case Manager’s visit – Insert the Member Service Preference Level indicated by the member/representative during the initial or reassessment interviews. Column to be filled in by program contractors.

Member Service Preference Level	
Needs services within two hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

13. **Reason for the NPS** – List the reason the non-provision of services occurred. Use the corresponding numerical bullet only. Use number 9, only when a non-scheduled respite service has been requested and the agency does not have a caregiver available. Provide a brief explanation in Column 22, “Comments,” if “Other” is used.

Reason for Non-Provision of Service	
Caregiver cancelled	1
Caregiver did not show	2
Caregiver left early	3
Caregiver refuses to go or return to an unsafe or threatening environment at the member’s residence	4
Caregiver quit	5
Member not available to receive services when caregiver arrives at the scheduled time	6
Replacement caregiver not available	7
Non-scheduled respite service request	8
Member refuses services	9
Member called to cancel/reschedule services	10
Other	11

14. **Explain how NPS was resolved** – List how the NPS was met on the day of the NPS. Use the corresponding alphabetical bullet only. Unpaid Community Organization could be the consumer’s church or civic organization. Unpaid Caregiver could be an unpaid family member, neighbor, friend, etc. who has been designated by the member/representative to assist in an emergency. If an unpaid caregiver is willing to stay with the member until the agency can get another caregiver to the home use “H.”

Explain How NPS Was Resolved	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D
Unpaid Caregiver	E
Unpaid Community Organization	F
Other	G
Unpaid/Paid Caregivers	H

**Note:**

- 1) If an “E”, “F” or “H” is recorded in Column 14, then Column 21 must be completed.
- 2) If “G” is used then an explanation must be included. Begin explanation(s) of “Other” in column 22, “Comments”. A “G” should not be used to indicate that no services were provided. If no services are provided leave the column blank.

15. **Original Hours Authorized** – The amount of hours authorized by the Case Manager for the date of the NPS being reported.

16. **Hours provided to resolve NPS on the day of the NPS** – Number of hours provided by all entries in Column 14 above to meet member’s needs. For example, Case Manager authorized eight hours for attendant care services; agency was able to get a replacement caregiver to provide six hours and unpaid caregiver provided two hours until replacement arrived so a total of eight hours should be recorded. Note: If Column 16 is less than the number of hours authorized in Column 15, then Column 20 must be completed.

17. **Length of time before services replaced** – Time to resolve NPS in service hours – e.g., the time between the agency/contractor notification and the delivery of service. Please record time to resolve NPS in hours – a half day as 12 hours; one day as 24 hours; the next once a week scheduled visit as 168 hours.

For example:

A. The agency was notified at 8:30 a.m. that the caregiver cancelled the 8 a.m. scheduled service. The Member Service Preference Level indicated by the member/representative at the time of the call was “1” – Within two hours. The agency was able to get a substitute caregiver to the member’s home by 9:30 a.m. Column 17 should record the length of time to resolve the NPS as one hour.

B. The agency was notified at 8:30 a.m. that the caregiver cancelled the 8 a.m. regularly-scheduled Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 3 – Within 48 hours. The agency is able to have a substitute caregiver there at 8 a.m. Wednesday morning. Column 17 should record the length of time to resolve the NPS as 23.5 hours.

C. The agency was notified at 8:30 a.m. that the caregiver cancelled the 8 a.m. once-a-week Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 4 – Next Scheduled Visit. Column 17 should record the length of time to resolve the NPS as 167.5 hours.

18. **Was Member Service Preference Level Timeline Met** – Place a Y (yes) or N (no) to indicate if the NPS was met within the timeline indicated by the Member Service Preference Level at the time of the notice in Column 11. **The clock on the NPS begins when the provider is notified by the member/representative or caregiver that the caregiver either will not or has not arrived to provide services. NOTE: if an “N” is recorded in Column 18, then Column 19 must be filled out.**

19. **If Member Service Preference Level Timeline Not Met** – List the reason the Member Service Preference Level timeline was not met. Use the corresponding numerical bullet. Provide a brief explanation if “Other” is used in column 22, “Comments”.

If Member Service Preference Timelines Not Met, Explain Why	
Reserved (Do Not Use)	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of NPS	4
Other	5

20. **If total Authorized Hours not replaced, explain why** – List the reason the total authorized units not replaced. Use the corresponding numerical bullet. Provide a brief explanation if “Other” is used in column 22, “Comments.”

If Total Hours Were Not Replaced, Explain Why	
Full replacement hours not needed	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of NPS	4
Other	5

21. **If Unpaid Caregiver used, explain why** – Use corresponding number to indicate the reason an unpaid caregiver was used. Note if there is an “E”, “F” or “H” used in Column 14 then Column 21 must be completed. For example, the agency is notified that the caregiver cancelled, the agency calls the member/representative to determine the Member Service Preference Level and discusses getting another caregiver out to the member. The member refuses and states they wish to use an unpaid caregiver. A number 1 would be recorded in Column 21. Provide a brief explanation if “Other” is used in column 22, “Comments.”

If Unpaid Caregiver Used, Explain Why	
Consumer Choice	1
No Agency Staff Available	2
Other	3

## Interpreter Services

UHCCP provides translation and interpreter services for more than 140 non-English languages and hearing impaired to ensure that all Long Term Care members and their families understand the member’s diagnosis and course of recommended treatment in a culturally sensitive manner. Providers may use this service in their office for no charge. Providers can access the language interpretation line by calling UnitedHealthcare Member Services at 800-348-4058, TTY 711.

If the UnitedHealthcare Community Plan enrollee needs interpreter services, UnitedHealthcare Community Plan prefer you use a professional interpreter through the Language Line. The instructions to access the Language Line are below:

### Language Line Interpreters:

- UnitedHealthcare Community Plan is contracted with the Language Line for Interpreter service.
- Please use the language line for our members who need an interpreter.

To access an interpreter contact Customer Service at 877-261-6608 please use “244162” as client ID, this will let us know you are using the Language Line for an UnitedHealthcare Community Plan member.

Sign Language Interpreter in Tucson: Community Outreach Program for The Deaf (COPD) provides sign language interpretive services within the Tucson area. Please complete the service request form at [copdaz.org](http://copdaz.org) for members who need sign language interpretive services.

For Phoenix Metro area and outside of Tucson: Valley Center of the Deaf (VCD) 602-267-1921 is located in Phoenix and provides interpretation services for the rest of the state outside of Tucson.



### Language Line Offers:

- Over 22 years of experience with unmatched industry knowledge.
- Over 140 languages available 24-hours-a-day, seven-days-a-week.
- Over 2,000 interpreters, only company with medically certified interpreters in top 22 languages.
- 94 percent of all calls are handled by scheduled employee interpreters.
- Language Line offers sign language interpreter services.

### To do a Sample Call:

Language Line Services Demonstration Line  
800-821-0301

## Cultural Competency

As a physician or health care provider, UnitedHealthcare Community Plan reminds you to be culturally sensitive to the diverse population you serve. There are diverse cultural preferences that we ask providers to keep in mind when serving our enrollees. All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the enrollee's cultural heritage and appropriately utilizes natural supports in the enrollee's community.

All providers shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. Providers shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. (Federal regulations, State Executive order number 99-4 & AAC R9-22-513).

Some cultural preferences to remember include:

- Ask what language the enrollee prefers to help eliminate communication barriers and, when necessary, use the interpretation services available to you.
- Understand the enrollee's religious and health care beliefs.
- Understand the role of the enrollee's family and their decision-making process.
- Don't assume the diets of similar countries are the same.

There are just a few reminders. Your UnitedHealthcare Community Plan Provider Advocate can provide additional education to you on cultural awareness. For more information on cultural competency, please refer to cultural competency links on UnitedHealthcare Community Plan's website at [UHCCommunityplan.com](http://UHCCommunityplan.com) entitled Culturally Competent Patient Care: A Guide for Providers and Their Staff by Georgia Hall, PhD. Some additional resources for information on Cultural Competency are:

[cms.hhs.gov/ocr](http://cms.hhs.gov/ocr) – Office of Civil Rights.

[LED.gov](http://LED.gov) – Promotes importance language access to federal programs and federally assisted programs.

[crosshealth.com](http://crosshealth.com) – Quarterly newsletters on cultural competence topics for staff.

[diversityrx.org](http://diversityrx.org) – Promotes language and cultural competence to improve the quality of health care for minorities.

[ncihc.org](http://ncihc.org) – Organization to promote culturally competent health care.

[focusondiversity.com](http://focusondiversity.com) – Provides statistics.

## Member Advisory Councils

To promote a collaborative effort to enhance the service delivery system in local communities while maintaining an enrollee focus, UnitedHealthcare Community Plan has established a member advisory council in each of the geographic service areas. The council is chaired by the UnitedHealthcare Community Plan Executive Director or designee and meets quarterly. Enrollees and providers are encouraged to attend the advisory councils. The advisory councils allow enrollees and providers to give UnitedHealthcare Community Plan critical feedback on:

- The effectiveness of policies and programs related to the delivery of health care services to UnitedHealthcare Community Plan enrollees.
- Satisfaction survey results and quality improvement measures.
- Opinions on the quality and accessibility of UnitedHealthcare Community Plan's networks.
- The usefulness of external communications, including the Enrollee Handbook, Provider Manual, enrollee and provider newsletters and other mailings.

Contact your Provider Relations Advocate for upcoming advisory council dates and locations. The advisory council is held quarterly and in all geographic service areas with UnitedHealthcare Community Plan members. Your provider relations advocate is always in attendance.

## Provider Responsibility During Termination of Provider Agreement

If the physician or health care provider terminates their provider agreement without cause, the provider is required to continue to care and treat for the enrollees until the enrollee's care has been transitioned to another provider or until the treatment course is completed.

# Ch. 4 Covered Services

## UnitedHealthcare Community Plan Covered Services

UnitedHealthcare Community Plan follows the AHCCCS guidelines as set forth in the AHCCCS Medical Policy (AMPM). You can view the entire manual on the AHCCCS website: [azahcccs.gov](http://azahcccs.gov). This chapter is an overview of covered and non-covered health care services, requirements and limitations, which are subject to change. Please refer to the AMPM for further details on the current ALTCS benefits.

Physicians and health care providers should contact the Customer Call Center or the enrollee's Case Manager for additional eligibility, referral and provider authorization requirements. Further explanation of services can also be found in the Prior Authorization and Behavioral Health Services sections of this Provider Manual.

Physicians and health care providers that perform services for UnitedHealthcare Community Plan enrollees must have a valid AHCCCS ID number, NPI number if applicable, must be properly licensed according to state and federal regulations and must have documentation indicating compliance with local fire and sanitation codes and regulations.

All physicians and health care providers must ensure each enrollee's privacy is protected, in accordance with the privacy requirements in 45 CFR parts 160 and 164 when providing coordination of services for enrollees with other entities.

All enrollees residing in a nursing facility or assisted living facility are assigned a Level of Care (LOC) by the UnitedHealthcare Community Plan Case Manager, who assists in determining the appropriate level and amounts of services for the enrollee. Providers that receive payment based on an enrollee's LOC must bill accordingly.

UnitedHealthcare Community Plan follows Medicare guidelines for all Medicare-eligible services. Emergency services that meet Medicare guidelines do not require prior notification. Urgent and routine services may require prior notification. Please refer to the Prior Authorization chapter of this Provider Manual for details. Please contact your UnitedHealthcare Community Plan provider relations advocate if you have further questions.

## Acute Care Health Services

### 1. Audiology

- Adults 21 and older can receive medically necessary audiology services only for identification and evaluation of hearing loss unless the hearing loss is due to an accident or injury-related emergent condition.
- Enrollees under 21 can receive medically necessary audiology services including the identification and evaluation of hearing loss and rehabilitation of the hearing loss through other than medical or surgical means (e.g. hearing aids).

### 2. Behavioral Health – refer to the Behavioral Health chapter in this Provider Manual

### 3. Children's Rehabilitative Services – referred by UnitedHealthcare Community Plan and administered by the Arizona Department of Health Services

### 4. Chiropractic Services

- Enrollees under 21 can receive medically necessary chiropractic services when prescribed by the enrollee's PCP and approved by UnitedHealthcare Community Plan.
- Qualified Medicare beneficiaries may receive chiropractic services if prescribed by the enrollee's PCP.

5. Dental – Adults 21 and older can receive medical and surgical services furnished by a dentist only to the extent that such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician. For members 21-years-of-age and older, the services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Certain pre-transplant services (e.g. dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.
6. Dialysis – Medically necessary dialysis, supplies, diagnostic testing and medication for enrollees when provided by Medicare-certified hospitals or Medicare-certified end stage renal disease (ESRD) providers.
7. EPSDT Services – refer to the EPSDT chapter in this Provider Manual.
8. Emergency Medical Services – UnitedHealthcare Community Plan monitors emergency services utilization and will implement corrective action plans for providers with inappropriate utilization of these services. Emergency medical services include:
  - Medical services necessary to rule out an emergency condition;
  - Emergency transportation;
  - Enrollee access by telephone 24-hours-per-day, seven-days-per-week for advice by a physician, nurse practitioner or physician assistant.
9. Family Planning – For those who voluntarily choose to delay or prevent pregnancy, covered services include birth control pills, supplies and devices, and surgical procedures to cause sterility, delay or prevent pregnancy.
10. Health Risk Assessment and Screenings.
11. Hospital – Inpatient hospital services.
12. Immunizations
  - Adults may receive diphtheria-tetanus, influenza, pneumococcal, rubella, measles and hepatitis B immunizations;
  - Enrollees under 21: Refer to the EPSDT chapter in this Provider Manual.
13. Laboratory Services.
14. Maternity services – Includes pre-conception counseling, pregnancy identification, prenatal care, treatment of pregnancy-related conditions, labor and delivery services, and postpartum care for members. Members may select or be assigned to a PCP specializing in obstetrics.
15. Medical supplies, durable medical equipment, orthotic and prosthetic devices. Benefit limitations for orthotic and prosthetic devices apply to adults 21 and older.
16. Nutrition services, including medical foods, assessments and therapies.
17. Physician Services – Including medical assessments, treatments and surgical services.
18. Podiatry Services – For adults 21 and older, foot and ankle services provided by a podiatrist are no longer covered. Those services may be reimbursed if rendered by another clinician such as a physician, NP, or PA.
19. Post-Stabilization Care Services.
20. Prescription Medications.

21. Primary Care Provider (PCP) – A physician, nurse practitioner or physician assistant assigned to the enrollee. PCP's assigned to enrollees that have UnitedHealthcare Community Plan as primary must be contracted with UnitedHealthcare Community Plan. All PCP's are responsible for the following activities:

- Supervision, coordination and provision of care to each assigned enrollee;
- Initiation of referrals for medically necessary specialty care;
- Maintaining continuity of care for each assigned enrollee;
- Maintaining the enrollee's medical record, including documentation of all services provided to the enrollee by the PCP, as well as specialty or referral services;
- Making every effort to refer enrollees within the UnitedHealthcare Community Plan network.

22. Radiology and Medical Imaging.

23. Therapies including: occupational, physical, respiratory, auditory and speech. Limitations apply.

24. Transportation – All providers that transport UnitedHealthcare Community Plan enrollees must have the minimum liability insurance amounts as mentioned in the provider agreement. Medically necessary non-emergent transportation (car, wheelchair, van or stretcher van) requires prior authorization. Emergency transportation does not require prior authorization.

25. Triage, Screening and Evaluations – when provided by acute care hospitals, IHS facilities and urgent care centers to determine whether or not an emergency exists, assess the severity of the enrollee's medical condition and determine services necessary to alleviate or stabilize the emergent condition.

## Behavioral Health Services

Behavioral Health services are provided in collaboration with the enrollee, family representative and entities involved in the enrollee's care. See the Behavioral Health chapter of this Provider Manual for more details.

1. Behavior management (personal care, family support/home care training, peer support)
2. Behavioral health case management services (with limitations)
3. Behavioral health nursing services
4. Emergency behavioral health care
5. Emergency and non-emergency transportation
6. Evaluation and assessment
7. Individual, group and family therapy and counseling
8. Inpatient hospital services (contractors may provide services in alternative inpatient settings that are licensed by ADHS/DLS, in lieu of services in an inpatient hospital. These alternative settings must be lower in cost than traditional inpatient settings)
9. Behavioral health inpatient facilities
10. Laboratory and radiology services for psychotropic medication regulation and diagnosis
11. Opioid agonist treatment
12. Partial care (supervised day program, therapeutic day program and medical day program)
13. Psychosocial rehabilitation (living skills training, health promotion, supportive employment services)
14. Psychotropic medication
15. Psychotropic medication adjustment and monitoring.
16. Respite care (with limitations).
17. Substance abuse transitional facility services
18. Screening
19. Home care training to home care client
20. Behavioral health therapeutic home



## Long Term Care (LTC) Services

The Case Manager will evaluate the enrollee's health care needs to determine the appropriate residential setting, Level of Care (LOC) and services necessary to safely maintain the enrollee in the least restrictive environment. All LTC services require prior notification by the UnitedHealthcare Community Plan Case Manager.

All facility settings require the appropriate registration, licensure and insurance liability coverage. All providers are required to send copies of updated licenses and certificates upon renewal. Failure to provide this information may result in non- payment of rendered services and termination of your UnitedHealthcare Community Plan Agreement.

Case Managers will conduct on-site assessments of enrollees to ensure the appropriateness of the caregiver and of the type and amount of services being rendered to the UnitedHealthcare Community Plan enrollee. If UnitedHealthcare Community Plan has been made aware that a provider's performance is unsatisfactory, it will contact the provider with the findings and care issues. The provider is responsible to address the issues and follow up with UnitedHealthcare Community Plan promptly. If a Quality Management issue becomes evident, UnitedHealthcare Community Plan will follow appropriate procedures to ensure the highest quality of care is provided to the enrollee.

Enrollees residing in nursing facilities or assisted living facility settings are responsible for the Enrollee Share of Cost (MSOC) or Room and Board (R&B) payment as applicable. There are three long-term care settings:

1. **Nursing Facility** – Case Management enrollee evaluations are completed every 180 days or as enrollee conditions change. Nursing facility placements must be prior authorized by the

Case Manager.

- Nursing facilities, including skilled nursing.
- Behavioral Health Level 1.
- Inpatient Psychiatric Residential, only for enrollees under 21 years of age.
- Institution for Mental Disease.

2. **Assisted Living Facility** – Case Management enrollee evaluations are completed every 90 days or as enrollee conditions change. See "HCBS Alternative Residential Settings" of this chapter for more details. In some instances, an enrollee may be eligible to receive HCBS services while residing in an Assisted Living Facility. The Case Manager will evaluate the enrollee's health care needs and determine if an HCBS services is appropriate. Assisted Living Facility placement must be prior authorized by the Case Manager.

3. **Home and Community Base Services (HCBS)** – Case Management enrollee evaluations are completed every 90 days or as enrollee conditions change. Enrollees residing in a private home or apartment may receive the following services based upon the Case Manager's evaluation and authorization of services:

- **Adult Day Health Care** – includes supervision, medication assistance, recreations and socialization, personal living skills training, health monitoring and preventive, therapeutic and restorative services. This service may be available to enrollees residing in ALTCS approved alternative residential settings upon the Case Managers evaluation and approval for the service.

- **Attendant Care** – includes supervision, bathing assistance, food preparation and feeding assistance, housekeeping services, medication reminders, recreation and socialization.
- **Behavioral Management Services** – See the Behavioral Health chapter of this Provider Manual.
- **Community Transition Service** – The Community Transition Service is a fund to assist ALTCS-institutionalized members to reintegrate into the community by providing financial assistance to move from an ALTCS Long Term Care (LTC) institutional setting to their own home.
- **Durable Medical Equipment** – Custom and standard items require an order by the enrollee's physician and must be prior authorized by the enrollee's UnitedHealthcare Community Plan Case Manager and/or the Prior Authorization Department. This service is limited to a one-time benefit per five years per member.
- **Emergency Alert System** – Monitoring devices for enrollee's who live alone, are at risk of emergent care and are unable to access emergency assistance. Emergency alert system equipment may not be provided without orders from the member's PCP. A physician order is also required to discontinue the provision of the Emergency Alert System.
- **Group Respite** – An alternative to adult day health care.
- **Habilitation** – Provision of training independent living skills or special developmental skills: sensory-motor development; orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services.
- **Home Delivered Meals** – Provides nutritious food to enrollees who live in their own home but are in jeopardy of not eating adequate amounts of nutritious food to maintain good health. Only one meal may be approved for an enrollee on any given day. Provider of home-delivered meals, and those employed, must have applicable food handling/preparation permits.
  - **Menus:** Must be planned for a minimum of four consecutive weeks and rotated three times before changing menus, taking seasonal foods into consideration; must be available for audit at the providers place of business for at least one year following meal services; must be available in the predominant languages of the group serviced, with reflection of ethnic choices; must be approved by a registered dietician prior to posting – any possible substitutions must be included.
  - **Meals:** Must reflect 1/3 of the current recommended daily allowance of nutrients dietary recommendations for sugar, salt and fat intake must be maintained; must be delivered in a safe and sanitary manner directly to the enrollee; frozen meals may be provided in advance for days when no delivery is available; enrollee must have the ability to store three meals; must be prepared therapeutically in accordance with the PCP order if a special diet is ordered; must be signed for upon delivery.
  - **Other:** Case records must be maintained confidentially; services not provided are documented with reasoning; printed educational materials must be delivered to enrollees with meals at least two times per quarter; provider must respond to consultant concerns and initiate corrective action within three weeks.

- **Home/Environmental Modifications** – Allows modifications to enrollee’s existing residences to enable an enrollee to function safely and as independently as possible in the community. UnitedHealthcare Community Plan Case Managers will conduct on site assessments to determine the appropriateness of an environmental modification or repair.
- **Home Health Services** – Includes home health aides, home health skilled nursing, private-duty nurses for ventilator dependent enrollees only, medically necessary supplies and therapy services. See “Medical Supplies Included in FFS Home Health Nursing Visits” for supplies that are included in the agencies Fee-For-Service (FFS) rate, at the end of the chapter.
- **Home Health Aide** – Provides nursing-related services under the direction of a registered nurse or physician. These services must be ordered by the PCP and authorized by the Case Manager. Home Health Aides must have current certification through the Arizona Board of Nursing, CPR and First Aid. A Home Health Aide visit may include one or more of the following:
  - Assessment of the enrollee’s health or functional level.
  - Monitoring and documentation of vital signs.
  - Assistance with contingency osmotic programs.
  - Assistance with self-administration of medications.
  - Assistance with feeding.
  - Assistance with ambulation, transfer, range of motion and use of equipment.
  - Assistance with Activities of Daily Living.
  - Enrollee or family training of health care tasks.

- **Home Health Nurse** – Provides skilled nursing services ordered by the PCP and must be provided by a licensed nurse under the supervision of a physician. These services can only be provided on an intermittent basis. These services are considered as skilled.

If a licensed/Medicare certified home health agency is not available in an enrollee’s community, does not have adequate staff, or will not provide services through UnitedHealthcare Community Plan, a licensed home health agency that is non-Medicare certified or an independent RN may provide skilled nursing services. RNs providing these services will be required to provide documentation of services performed via PCP orders. UnitedHealthcare Community Plan will monitor the service deliver and quality of care.

Skilled nursing assessments and care for enrollees with pressure sores, surgical wounds, tube feedings, etc., must be provided by a Medicare-certified home health agency or independent nurse. Written monthly reports must be submitted to the PCP and UnitedHealthcare Community Plan Case Manager. Skin assessments must be performed at least monthly for enrollees prone to breakdown of skin integrity due to their health status or care needs.

- **Private Duty Nurse** – Home Health Private Duty Nurse services are provided on a continuous basis to avoid hospitalization or institutionalization when care cannot be safely managed intermittently. Private Duty services must be ordered by the PCP and authorized by UnitedHealthcare Community Plan. If a LPN provides services, a physician must provide supervision. Home Health Private Duty Nursing services are only available to ventilator dependent enrollees.

- **Homemaker Services** – May be provided to preserve or improve upon the safety and sanitation of an enrollee’s living condition, nutritional value of meals and to maintain or increase the enrollee’s self-sufficiency. A homemaker is only to provide services that pertain to the enrollee. A homemaker may clean the enrollee’s living space, such as his or her bedroom; conduct meal planning, shopping, and food preparation with clean up; and clean and put away the enrollee’s laundry.
- **Home Maintenance Program** – If an enrollee’s restoration potential is evaluated as insignificant or at a plateau, a Home Maintenance Program can be initiated. A licensed therapist, the enrollee, family, caregiver or non-skilled personnel is trained to help to maintain the enrollee’s functioning level. UnitedHealthcare Community Plan will authorize the initial establishment of the Home Maintenance Program via a licensed therapist if the service is determined appropriate by the PCP, UnitedHealthcare Community Plan Medical Director, and UnitedHealthcare Community Plan Utilization Management.
- **Hospice** – Includes physician services, nursing services, medication for the terminal illness, therapies, aid services, homemaker services, medical social services, medical supplies and appliances, short-term respite and counseling including bereavement and support. The enrollee’s physician must certify that the enrollee is terminally ill with a prognosis of six (6) months or less, and enrollee desires palliative versus curative treatment. Hospice is a prior-authorized service. If the enrollee is receiving services under Medicare, the services do not require PCP orders or UnitedHealthcare Community Plan Case Management prior authorization. However, the UnitedHealthcare Community Plan Case Manager is responsible to monitor the enrollee’s care, therefore the hospice provider

must notify the UnitedHealthcare Community Plan Case Manager of the hospice election. Hospice services must be provided through a Medicare-certified agency. If the enrollee has Medicare, hospice benefits must be chosen instead of regular Medicare benefits.

- **Partial Care** – Structured, coordinated programs designed to provide therapeutic activities that promote coping, problem solving, and socialization skills.
- **Personal Care** – Includes bathing assistance, food preparation and feeding assistance, homemaker services, medication reminders, and recreation and socialization. Personal Care services may assist with bathing, toileting, dressing, nail care and feeding; assistance with transferring, ambulating and use of special equipment; and conduct training of family/caregivers.
- **Respite Care** – Is provided in both inpatient and outpatient settings for a short-term period to relieve the family. Respite services can be available up to 24-hours-a-day and is limited to 600 hours per fiscal year up to 25 days.

## HCBS Alternative Residential Settings

Enrollees residing in these settings are responsible for their room and board payment at the beginning of each month. The room and board amount is determined by UnitedHealthcare Community Plan in accordance with AHCCCS guidelines.

1. Alzheimer's Treatment Assisted Living.
2. Assisted Living Facilities – licensed by ADHS (Arizona Department of Health Services).
  - “AFC” or Adult Foster Care – up to four residents in the home. The sponsors, or homeowners, reside in the home with the residents.
  - “ALH” or Assisted Living Home (formerly Adult Care Home) – up to 10 residents in the home. Owners of ALH's typically do not reside in the residence. ALH's must be staffed 24 hours per day, seven days per week.
  - “ALC” or Assisted Living Center – more than 10 residents in the center. ALC's must be staffed 24 hours per day, seven days per week. Enrollees residing in ALC's must be offered the choice of single occupancy rooms. If no single occupancy rooms are available at the time of move-in, or in situations where an enrollee is offered a single occupancy room and declines but later requests to move into a single occupancy room, the enrollee must be placed on a wait list for a single occupancy room and may not be passed over by other residents (regardless of payor source) on the wait list. ALC's that have varying sizes and layouts for single occupancy rooms may designate a room size/layout for ALTCS enrollees, in which if a single occupancy room size/layout that is not designated becomes available, the ALC is not required to place the ALTCS enrollee in that specific unit.
3. Adult Development Home – licensed by DES (Department of Economic Security) – up to three adults (18 or older) in the home
4. Adult Therapeutic Foster Home – for behavioral health enrollees only – up to three adults in the home
5. Behavioral Health Level II (Residential Treatment Center) – licensed by ADHS – 24-hour supervision and counseling or other therapeutic activities for individuals who do not require the intensity of treatment services or on-site medical services found in a Level 1 behavioral health facility
6. Behavioral Health Level III (Residential Treatment Center) – licensed by ADHS – 24-hour supervision and supportive protective oversight, behavior management or psycho-social rehabilitation and assure that enrollees receive required medications, obtain needed treatment and have transportation to outside treatment agencies if necessary. Life skills training, social and recreational activities may be provided directly or by referral to outside treatment agencies.
7. Child Development Foster Home – licensed by DES – up to three children in the home.
8. Group Home for Developmentally Disabled – licensed by DES – up to six adults in the home.
9. Rural Substance Abuse Transitional Agency.
10. Traumatic Brain Injury Treatment Facility – licensed by ADHS.



## Therapeutic Leave and Bed Hold

UnitedHealthcare Community Plan enrollees residing in skilled nursing facilities may receive up to 12 days per AHCCCS contract year (beginning October 1) while the enrollee is hospitalized or otherwise not occupying a bed in the skilled nursing facility and is expected to return to the facility, in accordance with UnitedHealthcare Community Plan's Therapeutic Leave/Bed Hold Policy. Of the 12 days allowed, no more than nine days shall be for Therapeutic Leave. All requests for payment of Therapeutic Leave and Bed Hold days must be prior authorized by the Case Manager.

Enrollees less than 21-years-of-age may use any combination of Bed Hold and Therapeutic Leave per AHCCCS contract year with a limit of 21 days per year. The total days may include Therapeutic Leave and Bed Hold days in multiple facilities.

## Medical/Acute Care Only Services

Medical/acute care services and case management services are provided to those enrollees eligible for ALTCS, but are residing in an uncertified or unauthorized facility, refuse long-term care services, are awaiting disenrollment from the ALTCS program, or have not received long-term care services for more than 30 days. These enrollees do not qualify for full long-term care benefits. Services provided will be only those allowable under the auspices of AHCCCS ambulatory plans and case management services (e.g. DME, medically necessary transportation, physician services, prescriptions, laboratory, x-rays, behavioral health, outpatient services, inpatient acute services). These services do not include nursing facility placement, assisted living placement or home and community-based services.

## Emergency Services

A medical emergency is something that happens suddenly and with very severe and serious symptoms. Without immediate medical attention, an emergency could place an enrollee's health in serious danger. Minor problems like a cold, rash or small cuts and bruises are not considered an emergency and can usually be treated by scheduling an appointment with the enrollee's PCP.

Emergency services are covered for all UnitedHealthcare Community Plan enrollees. However, providers should educate the members regarding appropriate and inappropriate use of the emergency room. Non-emergency services should be treated by the PCP or in an urgent care setting. Non-emergency services, such as: sprains/strains, stomach aches, ear aches, fever, cough and colds, sore throats, should be treated by the PCP.

For a list of urgent care centers, contact Customer Services at 800-293-3740.

**In the case of a true emergency, call 9-1-1 for help.**

If one of the following happens, call 9-1-1 or take the enrollee to the nearest hospital emergency room immediately:

- Danger of losing life or limb
- Loss of speech
- Chest pains
- Unconsciousness
- Poisoning or overdose of medicine or drugs
- Car accident
- Choking or problems breathing
- Suddenly not able to move
- Heavy bleeding
- Criminal attack (e.g. mugging)
- Fainting

If you are not sure if the symptoms are life threatening, you can call the enrollee's PCP or case manager.

Emergency transportation is available 24-hours-a-day, seven-days-a-week.

## Non-Covered Services

Services not covered by ALTCS include, but are not limited to:

1. Services provided by non-approved physicians or health care providers.
2. Services or items furnished solely for beauty or cosmetic reasons.
3. For persons 21 or older, hearing aids, eye exams for glasses/lenses, dentures, and non-emergency dental services, unless deemed medically necessary and approved by the medical director.

4. Services defined by AHCCCS as experimental or provided solely for the purpose of research.
5. Sex-change operations.
6. Reverse of self-requested sterility.
7. Care not deemed medically necessary by AHCCCS, UnitedHealthcare Community Plan or the physician, and/or care not covered under ALTCS.
8. Medical services provided to an enrollee who is an inmate or who is in the care of a state mental health center.
9. Man-made hearts or xenografts.
10. Organ transplants, except those identified under the "Covered Services" chapter of this Provider Manual or stated in ALTCS benefits.
11. Services provided in a center or facility in an area of a center or facility that is not Medicare/Medicaid certified for such services.
12. Room and Board in AFC's, ALH's, ALC's or other alternative residential settings.
13. HCBS services that are not approved by the UnitedHealthcare Community Plan Case Manager.
14. For adults 21 and older, foot and ankle services provided by a podiatrist.
15. Well visits/well exams for adult members 21 years of age and older have been reinstated as a covered service. Well visits, such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older. For members under 21 years of age, AHCCCS continues to cover medically necessary services under the EPSDT Program.

## Medical Supplies Included in FFS Home Health Nursing Visits

In accordance with Chapter 1240 of the AMPM (AHCCCS Medical Policies Manual), the following supplies are included in the AHCCCS Fee-For-Service (FFS) Home Health Nurse visit rate. DME equipment should not be included in the visit rate. This list is not all-inclusive and its purpose is a general reference only.

- Adhesive spray
- Adhesive tape
- Antiseptics
- Bandage, cling type 6"
- Colostomy care
- Cotton balls, non-sterile
- Cotton balls, sterile
- Diabetic daily care
- Diabetic Diagnostics and tape, cloth 2"x10 yds
- Dressing, N-Adhering with adhesive 2x3"
- Dressing, transparent
- Gauze bandage roll 1"x10yds Tape, cloth 2"x10yds
- Gauze pads, sterile
- Gauze pads, sterile 4 x 4
- Gauze pads, sterile with gel 1/2" x 72"
- Gauze pads, sterile with gel 6" x 36"
- Gauze sponges, non-sterile 4 x 4
- Gloves, plastic disposable
- Glucose care starter kit
- Glucose reagent strips
- Hydrogen peroxide
- Iodoform packing 1/2" x 5yds
- Isopropyl alcohol swabs
- Lancets
- Lubricating jelly, 1 oz
- Packaging gauze, plain 1/4" x 5yds
- Petroleum jelly, 1 oz
- Petroleum jelly gauze 1" x 8"
- Syringes
- Syringes/needles
- Tape, paper 1" x 5yds
- Tape, plastic 1" x 5yds
- Tape, standard adhesive 2" x 5yds
- Tape, standard adhesive 11/2" x 10yds
- Tape, waterproof adhesive 1" x 5yds
- Tape, waterproof adhesive 11/2" x 5yds
- Tape, waterproof adhesive 1"
- Urine test strips
- Wood applicator with cotton tips

# Ch. 5 Behavioral Health Services

## Making a Referral for Behavioral Health Services

If an UnitedHealthcare Community Plan provider or the enrollee identifies a need for Behavioral Health services, they should contact the enrollee's Case Manager directly to discuss the referral. If the provider does not know the Case Manager's name, they can call the UnitedHealthcare Community Plan Customer Service Center at 800-377-2055. If the Case Manager's name is known but not their phone number, call the main UnitedHealthcare Community Plan number at 602-255-8908 or 800-293-3740 and ask to be connected to the Case Manager's office phone number.

UnitedHealthcare Community Plan provides a wide range of medically necessary behavioral health services, in accordance with AHCCCS policies. Covered behavioral health services include those listed under Behavioral Health Services in Chapter four.

Long Term Care Placement Services for Persons with Behavioral Health Disorders and or Traumatic Brain Injuries.

- a. Behavioral Health Residential Facility
- b. Assisted Living Homes or Centers for Persons with Cognitive Impairments and or Traumatic Brain Injuries.
- c. Institution for Mental Disease (IMD)
- d. Group Home for Developmentally Disabled (A Specific Licensed DD Group Home providing services for Elderly/PD ALTCS members must only provide services to persons who are not in the DES-DDD ALTCS Program.)
- e. Behavior Units in Skilled Nursing Facilities

Other services and settings, if approved by CMS and/or the Director of AHCCCS, may be added as appropriate. Exclusions and limitations of ALTCS covered services are discussed in AHCCCS and ALTCS Rules and the AMPM.

## Role of the UnitedHealthcare Community Plan Case Manager in Behavioral Health Services

The UnitedHealthcare Community Plan Case Manager plays a central role in coordinating services within UnitedHealthcare Community Plan's network to ensure a smooth flow of services and maximum accessibility to services.

UnitedHealthcare Community Plan's approach to behavioral health is designed to ensure that eligible enrollees receive timely and necessary behavioral health services in the least restrictive environment, as well as eliminate barriers to care delivery that may prohibit individuals from receiving needed care.

These services are provided by coordinating a service plan through collaboration with the enrollee, their family, significant other or legally authorized decision-maker, along with the enrollee's PCP, Case Manager and any community resources that may be serving the enrollee.

The UnitedHealthcare Community Plan Case Manager is responsible to ensure that providers are aware of the member's ongoing behavioral health plan. If you have any questions or concerns, please feel free to call the Case Manager at any time. In order to enhance your awareness of the behavioral health services your member is receiving and effectively coordinate his or her care, the Case Manager will send you regular correspondence that includes:

1. Name of the behavioral health provider and methods to contact.
2. List of all current medications so that you are aware of what the behavioral health provider is prescribing.
3. Name of any other provider significantly involved in the member's behavioral health care.

In turn, the behavioral health provider will also receive the same correspondence, indicating the list of current medications and the name of the PCP and methods to contact.

## Role of the Non Behavioral Health Care Provider

Primary Care Providers and other providers should play an active role in the enrollee's behavioral health treatment. One of the most important things to remember is that no matter the circumstances, the enrollee and their family must be a part of the treatment planning process. Discussing with the enrollee and their family regarding how they are doing in treatment can reinforce the importance of continuing treatment and also provide them the opportunity to discuss issues. Another key to success is to be aware of what types of treatment (both in terms of services and medications) the enrollee is receiving. This will help support the behavioral health treatment plan.

Non behavioral health providers will receive regular correspondence from the Case Manager concerning psychotropic medications the enrollee is prescribed. This information should be filed in the enrollee's medical record for easy reference. The PCP should establish a separate record for behavioral health information. Our Quality Management program incorporates monitoring of the PCP's referral to, coordination of care with, and transfer of care to behavioral health providers.

## Initial Behavioral Health Evaluation Consultation

After the referral has been made, the UnitedHealthcare Community Plan Case Manager will ensure that the enrollee receives a behavioral health evaluation consultation. A behavioral health evaluation is the assessment of an enrollee's medical, psychological and psychiatric history and social needs to establish a treatment plan for all medically necessary services. This evaluation consultation with the UnitedHealthcare Community Plan case manager must be performed by

a behavioral health professional as specified in A.A.C. R9-10-101, as an individual licensed under A.R.S. Title 32, Chapter 33.

## Ongoing Behavioral Health Evaluation Consultation

To ensure that the enrollee is being provided effective behavioral health care, a quarterly review is completed between the Case Manager and a licensed behavioral health professional that works for the health plan. The process documents the ongoing reasons for treatment. In addition, enrollees who are in special placements, such as a behavioral health group home or specialized behavioral health care unit in skilled nursing facility, receive case management from a person trained in high acuity behavioral health care services. The Medical Director for UnitedHealthcare Community Plan is available to help Case Managers with complex behavioral health care situations and provides a standing case review time schedule to evaluate and direct the care for members receiving or needing behavioral health treatment.

## Psychotropic Medication Management

Enrollees who require psychotropic medications that cannot be managed by a PCP, will be provided services from either a psychiatrist or a nurse practitioner with psychiatric care experience.

## Behavioral Health Services Appointment Availability Standards

Enrollees in an emergency will be scheduled an appointment within 24 hours. Routine care appointments are within 30 days of referral.



## Behavioral Health Crisis Services

During business hours, it is best to first try contact the Case Manager. If the case manager cannot be reached, or if it is after business hours the following are the crisis contact numbers, by county:

Mercy Maricopa Integrated Care Maricopa County	602-222-9444 800-631-1314 – toll free 800-327-9254 – TTY Hearing Impaired
Cenpatico Integrated Care Pima County Santa Cruz County Yuma County LaPaz County	866-495-6735 – toll free 877-613-2076 – TTY Hearing Impaired
Health Choice Integrated Care Coconino County Mohave County Apache County Navajo County Yavapai County	877-756-4090 800-367-8939 TTY Hearing Impaired

## Specialized Behavioral Health Case Management

In most instances enrollees requiring behavioral health services can easily be assisted by regular case managers. In certain circumstances, the enrollee may require the services of Case Manager trained in behavioral health services.

Specialized Behavioral Health Case Managers have extensive knowledge in dealing with persons with serious mental illnesses; traumatic brain injury and/or cognitive disorders that can cause aggressive behaviors.

Referrals to specialized behavioral health case management are decided on a case-by-case basis and are reserved for those enrollees whose behaviors seriously interfere with their ability to live in a long-term care setting or to effectively utilize long-term care services. Enrollees who receive specialized behavioral health case management have aggressive behaviors or behaviors that can cause harm to themselves and the harm or aggression is a result of a mental illness, brain injury or cognitive impairment, including some forms of dementia.

# Ch. 6 Utilization Management

UnitedHealthcare Community Plan's Utilization Management Program encompasses activities directed toward prospective, retrospective and concurrent utilization review. Prospective review (prior authorization) determines the medical necessity and appropriateness of the service before it is provided. Concurrent review occurs periodically throughout an enrollee's inpatient stay. Retrospective review often involves aggregate and provider specific assessment of the appropriateness of medical services after the services have been provided.

## Concurrent Review

UnitedHealthcare Community Plan conducts concurrent utilization review on each UnitedHealthcare Community Plan primary enrollee who is admitted to an inpatient facility and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the enrollee's medical record assesses medical necessity for the admission and appropriateness of the level of care. Admission certification is conducted within 24 hours after the admission. Continued stay reviews are conducted before the expiration of the assigned length of stay. Discharge planning is coordinated with case management. For UnitedHealthcare Community Plan members who have another primary insurance payor that is not a UnitedHealthcare Community Plan, Utilization Management (UM) coordinates discharge planning with case management.

## Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of re-admissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the enrollee and involving the enrollee, family and the UnitedHealthcare Community Plan Case Manager in implementing the plan.

The UnitedHealthcare Community Plan concurrent review nurse works peripherally with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but not be limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for enrollees with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of contracted UnitedHealthcare Community Plan providers.
- Informing hospital staff and attending physician of covered benefits as indicated.

## Physician Medical Review

The UnitedHealthcare Community Plan Medical Director conducts medical review for each case with the potential for an adverse decision. The UnitedHealthcare Community Plan concurrent review nurse or the prior authorization nurse review the documentation for evidence of medical necessity according to established criteria.

When the criteria are not met, the case is referred to the Medical Director. The medical director reviews the documentation, discusses the case with the nurse and may call the attending or referring physician for more information. The requesting physician may be asked to submit additional information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service.

Utilization Management decisions are based only upon appropriateness of care and service. UnitedHealthcare Community Plan does not reward practitioners or other individuals involved in utilization review, for issuing denials of coverage or service. The decision to deny a service request will only be made by the medical director.

For inpatient denials, attending physician and hospital are notified in writing. The attending or referring physician may dispute the finding of the medical director by phone informally or formally in writing. If the finding of the medical director is disputed, a formal grievance may be filed according to the established UnitedHealthcare Community Plan grievance procedure.

For denial of outpatient authorizations, the referring physician, the PCP (if not the referring physician) and the enrollee are notified in writing. An expedited appeal may be initiated by the enrollee or by the practitioner acting on behalf of the enrollee for any treatment denial, suspension or reduction in services. See the "Claims Disputes and Appeals" chapter of this Provider Manual for more information.

# Ch. 7 Prior Authorization

UnitedHealthcare Community Plan has streamlined its prior authorization requirements across all UnitedHealthcare Community Plan products to provide enrollee's with easier access to health care, to allow health care providers greater freedom for determining and implementing treatments plans and to enhance the enrollees and health care providers experience with UnitedHealthcare Community Plan. The requirements are outlined in the "Authorization Guide to In-Network Providers." You can access a copy of the "Authorization Guide to in-Network Providers" at [UHCCCommunityPlan.com](http://UHCCCommunityPlan.com). UnitedHealthcare Community Plan may be the enrollee's primary payer, in which case, prior authorization may be required on some services or UnitedHealthcare Community Plan may be the secondary payer, in which case, UnitedHealthcare Community Plan is responsible for member copays and deductibles and prior authorization is not required. You may not balance bill an UnitedHealthcare Community Plan member per AHCCCS guidelines.

Prior authorization services can be obtained from UnitedHealthcare Community Plan from one of four sources:

## 1. UnitedHealthcare Community Plan Utilization Management (Prior Authorization) Department: (Phone: 602-255-8788; toll-free 800-377-2055; Fax: 800-278-2907)

The Prior Authorization department may approve:

- Elective admissions.
- Durable medical equipment over \$500.
- Prosthetic and orthotic devices over \$500.
- Professional services: PN is not required for contracted providers.
- Rehabilitative services.

For UnitedHealthcare Community Plan enrollees, the general rule of thumb is if the primary payer reimburses the provider, UnitedHealthcare Community Plan does not require prior authorization for the enrollee's copay and deductibles. If the provider cannot secure payment from the primary carrier, and the service is such that UnitedHealthcare Community Plan would normally require prior authorization in a situation where UnitedHealthcare Community Plan is primary, the provider needs to obtain prior authorization from UnitedHealthcare Community Plan prior to rendering the service.

If the enrollee has UnitedHealthcare Community Plan for their Medicare and AHCCCS providers, (dual enrollee), only one prior authorization request needs to be submitted to the UnitedHealthcare Community Plan Medicare line of business. UnitedHealthcare Community Plan will pay off the UnitedHealthcare Community Plan Medicare authorization. Requests that are not approved by UnitedHealthcare Community Plan Medicare programs are referred to UnitedHealthcare Community Plan for AHCCCS benefit determination.

## 2. The UnitedHealthcare Community Plan Case Manager:

The UnitedHealthcare Community Plan Case Manager may approve:

- Home Health nursing services
- Home and community-based services
- Respite care
- Residential placement in a nursing facility (needs to be approved by Medical Director)
- Home modifications (needs to be approved by Director of Case management and Medical Director)



**3. Optum Rx: (877-305-8952). UnitedHealthcare Community Plan utilizes a pharmacy benefit manager (PBM), for coordination and administration of the plan’s formulary. The PBM may approve:**

- Non-formulary medications.
- Quantity limit overrides.
- Early renewals.

**4. Pharmacy- Preferred Drug List (PDL):**

The UnitedHealthcare Medicaid Preferred Drug List (PDL) was developed to assist providers in selecting medically appropriate, high-quality and cost-effective drugs for members. The PDL applies only to prescription medications dispensed by contracted pharmacies to outpatient members; it does not apply to inpatient medications. The PDL is organized by therapeutic class. Providers are required to prescribe and encourage the substitution of generic drugs included in the preferred drug list whenever appropriate. If a non-preferred medication is required for a member’s treatment, the care provider must call the Pharmacy Prior Authorization Service at 800-305-0023, or fax a Pharmacy Prior Notifications Request form to 866-940-7328 to make the request. A medical director will promptly consider the request and the provider will be notified of the decision. Care providers may also initiate requests to add a drug to the UnitedHealthcare PDL. To submit a PDL addition request for consideration, the prescriber should complete the PDL Change Request Form, sign it, and mail or fax it to the UnitedHealthcare Pharmacy Director, or the office of the Chief Medical Office. The requests will be considered at the Pharmacy and Therapeutic Committee meeting. Results of the review will be sent to the requesting provider. PDL information, including updates when changes occur, will be provided in advance to providers and a summary of changes posted to the UnitedHealthcare website. The PDL, Pharmacy Prior Notification Request form, and PDL Change Request Form can all be found on UHCCP’s website at UHCCCommunityPlan.com and can be printed or

saved. To obtain a print copy of the UnitedHealthcare PDL, contact the Provider Service Center.

**5. UnitedHealthcare Dental also known as Dental Benefit Providers (DBP):**

UnitedHealthcare Dental provides prior authorization on dental services and claims processing. UnitedHealthcare Community Plan is responsible for providing dental care to all members under the age of 21 with all medically necessary dental coverage for emergency dental services, dental screening and preventive services.

Call to Inquire About	Telephone Number	Hours of Operation
UnitedHealthcare Dental IVR Provider Services and Interactive Voice Response	877-816-3596	Provider Services 8 AM to 11 PM EST Mon–Fri IVR = 24 Hours: 365 days
UnitedHealthcare Community Plan Prior Authorization Number	602-255-8188	Mon–Fri 8:00 AM to 5:00 PM Arizona Time

**Deadlines for Requesting Authorization from UnitedHealthcare Community Plan**

It is UnitedHealthcare Community Plan’s policy that all requests for prior authorization must be made prior to the service being rendered.

UnitedHealthcare Community Plan covers emergency medical services for members when there is a demonstrated need, and/or after triage, emergency medical services assessment indicates an emergency condition. Providers are not required to obtain prior authorization for emergency services.

## UnitedHealthcare Community Plan's Time Frames for Responding to Authorization

It is the policy of UnitedHealthcare Community Plan to respond to routine requests with an approved, pended or denied status within 14 calendar days of receipt. The prior authorization may be pended for further review if inadequate information accompanies the request. If the supporting documentation for a pended authorization is not received in a timely manner, the authorization request will be denied.

Urgent service requests will be decided within three business days after receipt of the clinical information needed by UnitedHealthcare Community Plan staff to render an appropriate decision. Urgent or stat requests should be limited to those conditions or situations where an enrollee's health or well-being is in jeopardy. Stat or urgent requests should not be made as a result of the timing of the request in relation to the scheduled service.

## Approved Requests

Approved authorization requests are faxed to the requesting provider for all outpatient services and elective admissions.

- The approved authorization will remain effective for 60 days from the date of issue unless otherwise indicated on the approval.
- The authorization approval is only effective for the services approved on the request and for the identified date range.
- All approvals are contingent upon the enrollee's eligibility status on the date the service is provided.
- Prior authorization is not a guarantee of payment.
- For services not included under the approved request, the provider must contact UnitedHealthcare Community Plan to amend the original request and receive a new authorization.

UnitedHealthcare Community Plan follows physician referral requirements and conditions defined in the Social Security Act, sections 1903, 1877, and as defined in 42 CFR parts 411, 424, 425 and 455. Enrollees may seek a second opinion within the UnitedHealthcare Community Plan network of providers.

Prior authorization is not a guarantee of payment. UnitedHealthcare Community Plan reserves the right to request medical records and/or other documentation to substantiate any charges billed to UnitedHealthcare Community Plan. Payment is based upon enrollee eligibility at the time of service and substantiating documentation of appropriateness of the care, service, or treatment. If the claim and documentation review fails to establish medical necessity and/or appropriateness of the care, service, or treatment payment will be denied.

## Denied Requests

All requests submitted to the UnitedHealthcare Community Plan prior authorization department which do not meet criteria, are referred to the medical director for review. Only the Medical Director may make a decision to deny a request. Criteria include eligibility, contracted provider or AHCCCS ID number, covered benefit, and medical necessity. Professionally recognized criteria are utilized in determining medical necessity.

Denied requests will generate denial authorizations to be sent to the requesting provider and the UnitedHealthcare Community Plan enrollee within 3 business days of the decision. The denial authorization will be faxed to the requesting provider, if the provider's fax number is indicated on the request form. Enrollee appeal and grievance rights, including denial rule references, are included with the enrollee's denial authorization.

If the enrollee files a written request for an appeal within 15 days of the date of notice, UnitedHealthcare Community Plan will continue to provide the current level of service during the appeal. For additional information, refer to the “Claims Disputes and Appeals” chapter of this Provider Manual.

## **UnitedHealthcare Community Plan Sample Prior Authorization Request Forms**

The following are copies of the Prior Authorization Request Forms general prior authorizations and therapy that are utilized by UnitedHealthcare Community Plan. Complete the appropriate form in its entirety and fax to the fax number listed on the form.

**LONG TERM CARE PRIOR AUTHORIZATION REQUEST**

Phone 1 (800) 377-2055 OR 1 (602) 255-8188 (M-F 8am to 5pm) Fax 1 (800) 278-2907 (M-F 8am to 5pm)  
**FOR AFTER HOURS URGENT PRIOR AUTHORIZATION PLEASE CALL 1 (800) 377-2055 or 1(602)787-3305**  
**PBM-Medication Notification Phone: 1(800) 788-7871**

\*\*\* Use the Therapy Prior Authorization Request Form for ALL Therapy Requests\*\*\*

Date \_\_\_\_\_ Requesting Provider \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 DOB \_\_\_\_\_ AHCCCS ID # \_\_\_\_\_

**Is Medicare or other payer the Primary Payer?**  **Yes** *If Yes, Prior Authorization is not required from UHC Community Plan LTC for outpatient services when you have secured payment from Medicare or other party liability.*  
 **No** *If No, please complete the rest of this form.*

Routine (14 calendar days)  Urgent (3 business days) *This means using the standard (routine) timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.*

\*\*\*Attach supportive medical documentation, labs and drug history as necessary\*\*\*

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

PCP AHCCCS ID # \_\_\_\_\_ Is the PCP referring?  Yes  No

**Service Provider Information**

Service Provider (First and Last Name) \_\_\_\_\_ AHCCCS # \_\_\_\_\_  
 Provider Specialty \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Service Facility Name/Address \_\_\_\_\_ AHCCCS # \_\_\_\_\_ NPI # \_\_\_\_\_  
 Date of Service (if scheduled) \_\_\_\_\_  
 DX Codes \_\_\_\_\_ (Must be completed)  
 DX Description \_\_\_\_\_  
 History: \_\_\_\_\_

**1st Time Consult**  **Follow-up**  **Procedure / Service / Surgery** (Check all that apply)  
 Procedure / Service / Surgery Description \_\_\_\_\_  
 CPT/HCPCS Codes \_\_\_\_\_  Outpatient  Inpatient

When UHC Community Plan LTC is the primary payer, SPECIALISTS must have an authorization PRIOR to ANY services being rendered. Elective Surgery Requests REQUIRE a 5-day notification. Prior authorization is not a guarantee of payment. Failure to do so may result in a denial and NON-PAYMENT for services.  
 \*\*Member eligibility must be determined on date of services\*\*

THIS SECTION FOR UHC COMMUNITY PLAN LTC USE ONLY	
Date:	Comments:
_____	_____
_____	_____
_____	_____
Authorization: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Duplicate Request	Entered _____ Date _____
<input type="checkbox"/> <b>COB Required – UHC Community Plan LTC is not primary and will not pay balance of allowable without EOB from primary carrier</b>	
<input type="checkbox"/> <b>Benefit does not require prior authorization by Utilization Management</b>	
Authorization Staff Signature _____	Date _____

## LONG TERM CARE THERAPY PRIOR AUTHORIZATION REQUEST

Phone 1 (800) 377-2055 OR 1 (602) 255-8188

Fax 1 (800) 278-2907

To: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Member's Name: \_\_\_\_\_ ID #: \_\_\_\_\_  
 Ordering Physician: \_\_\_\_\_  
 Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 DX Description: \_\_\_\_\_ DX Code (ICD-10) \_\_\_\_\_ Onset Date: \_\_\_\_\_

- Routine (14 days)       Urgent (3 business days) This means using the standard (routine) timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

**Please include a copy of the initial evaluation, clinical notes and physician orders  
 (Further visits will be based on guidelines in the ALTCS Provider Manual and must show a reasonable expectation of improvement in a predictable time frame).**

- Physical     Occupational     Speech     Nutritional     Respiratory     Psych Services

Requested sessions: \_\_\_\_\_ Total of days per week: \_\_\_\_\_ Number of weeks: \_\_\_\_\_

Date of service for requested auth: \_\_\_\_\_ to \_\_\_\_\_

CPT Code: \_\_\_\_\_ # of units per session: \_\_\_\_\_

CPT Code: \_\_\_\_\_ # of units per session: \_\_\_\_\_

CPT Code: \_\_\_\_\_ # of units per session: \_\_\_\_\_

CPT Code: \_\_\_\_\_ # of units per session: \_\_\_\_\_

Comments: \_\_\_\_\_

Therapists Name: \_\_\_\_\_ Facility: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Facility / Provider ID Number: \_\_\_\_\_

*THIS SECTION FOR UHC COMMUNITY PLAN LTC USE ONLY*

<u>Date:</u>	<u>Comments:</u>

Authorization:     Approved     Denied     Duplicate Request    Entered \_\_\_\_\_ Date \_\_\_\_\_

**COB Required – UHC Community Plan LTC is not primary and will not pay balance of allowable without EOB from primary carrier**

**Benefit does not require prior authorization by Utilization Management**

Authorization Staff Signature \_\_\_\_\_ Date \_\_\_\_\_



# Ch. 8 Case Management

## Case Management Coordination

UnitedHealthcare Community Plan makes every effort to foster an enrollee-centered approach while promoting enrollee independence, individuality, dignity, privacy, respect and choice. The UnitedHealthcare Community Plan approach to Case Management is designed to ensure that eligible enrollees receive timely and medically necessary health care services in the least restrictive setting as well as eliminate barriers to health care delivery that may prohibit individuals from receiving needed care.

UnitedHealthcare Community Plan's case managers play a central role in the member's plan of care. They are responsible for initiation, coordination and monitoring of long-term care services, including institutional placements, Home and Community-Based Services (HCBS), Assisted Living Facility (ALF) services in the community setting, acute care, behavioral health services, discharge planning as well as other ancillary needs and support services to establish a comprehensive plan of care. The review with the member and/or their representative is designed to result in a mutually agreed upon, appropriate and cost-effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting that may increase the member's level of functioning, health status and all around quality of life. Case management begins with a respect for the member and member's family/representative preferences, interests, needs, cultural considerations, language and belief system.

Case managers are expected to use a holistic approach regarding the member assessment and needs taking into account not only ALTCS covered services but also other needed community resources as applicable. Case managers are expected to:

- Respect the member's rights;
- Provided adequate information and training to assist the member/representative/family in making informed decisions and choices;
- Provide a continuum of services options that support the expectations and agreements established through the care plan process;
- Facilitate access to non-ALTCS covered services available throughout the community;
- Educate the member/representative/family on how to report unplanned gaps or other problems with service delivery to the program contractor in order that unmet needs can be addressed as quickly as possible;
- Advocate for the member/family/representative and others as the need occurs;
- Allow the member/representative/family to identify their role in interacting with the service system;
- Provide members with flexible and creative service delivery options;
- Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering, and monitoring services;
- Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the member.

## When to Contact the UnitedHealthcare Community Plan Case Manager

Providers must contact the UnitedHealthcare Community Plan Case Manager should any of the following conditions occur:

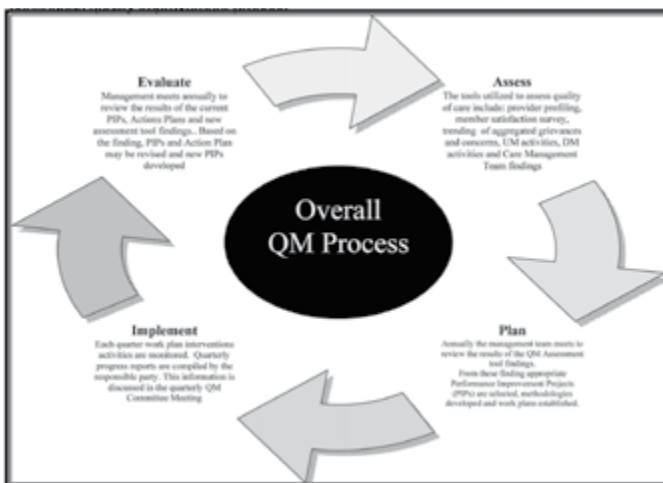
- Inability to contact member
- Inability to provide services
- Change in the enrollee's condition
- Enrollee unexpectedly leaves their place of residence or without notification
- Death of the enrollee
- Enrollee is transferred to the hospital
- Enrollee suffers a fall
- Skin integrity issues
- Behavioral health issues
- Hospice election
- Bed hold and therapeutic leave requests (Skilled Nursing Facilities only)
- Enrollee needs dental or vision services
- Enrollee needs therapies including PT/OT/SP/RT

# Ch. 9 Quality Management

## Overview

UnitedHealthcare Community Plan utilizes the Continuous Quality Improvement (CQI) approach for processing quality management information. CQI has the potential to positively impact every aspect of UnitedHealthcare Community Plan's health care delivery of services. It is used to accomplish goals such as improving member outcomes and processes. CQI encourages all functional areas to see beyond their own immediate tasks and to be aware of the larger work process of which they are a part. It keeps the team focused on shared goals. By its very definition, CQI is an ongoing organization wide frame work in which UnitedHealthcare Community Plan and its employees are committed to and involved in monitoring and evaluating all aspects of service rendered in order to continuously improve them. To put into daily practice the spirit of CQI, UnitedHealthcare Community Plan utilizes the APIE (Assess, Plan, Implement and Evaluate) model to develop the structural framework of its QM Program.

**Figure One:** An illustration of the APIE Model as it applies to UnitedHealthcare Community Plan QM Plan's continuous quality improvement process.



## Process for QM Provider Profiling

UnitedHealthcare Community Plan monitors the quality of care provided to our members by our contracted providers. QM monitoring and evaluation activities are a continuous ongoing process. Whenever possible, UnitedHealthcare Community Plan will align QM activities with those of AHCCCS, CMS, ADHS, and other program contractors. This is done to focus our providers' quality improvement activities on areas of state and nationwide importance and to reduce duplication of service.

There are several steps used by UnitedHealthcare Community Plan in the QM provider profiling process. They are as follows:

### Step One: Data Collection for Provider QM Profiling

There are four methods used to evaluate contracted providers:

- Provision of care monitoring (e.g. mortality reviews, site reviews, acute care review, member satisfaction surveys, and grievances/concerns trending).
- Regulatory agency findings, when applicable.
- Disease management compliance rates, when applicable.
- Member trust fund monitoring, when applicable.
- Medical records monitoring, when applicable.

### Provisions of Care Monitoring:

Documentation reviews and/or onsite visits are coordinated to assure member issues are dealt with in a time-appropriate manner based upon the nature of the issue and the geographical location of the provider. For some provision of care reviews there are selection criterion. Not every case triggered for review by the selected criteria will prove to be a problem. These reviews also give UnitedHealthcare Community Plan an opportunity to identify areas of good performance.

Each provision of care review has a data collection tool to evaluate key indicators of the care. Each key indicator of care has points attached. The points are totaled and a final score is given, the best possible score being 100 points.

Upon completion of onsite investigations, identified problems are shared with the facility director/manager. UnitedHealthcare Community Plan will attempt to resolve problems through education and technical support whenever possible.

- **Mortalities**

Mortalities review selection criteria includes: relative expectation of death and discretion of the Medical Director. Reviews for facilities and attending physicians are conducted by licensed professionals and results reviewed with the medical director.

- **Acute Care Site Reviews**

This review is specific to home health agencies and is done by the UnitedHealthcare Community Plan QM Specialist every three years. Please refer to the Home Health Monitoring Section of this document and the QM Manual.

- **QM Site Monitoring Service**

Sites are monitored at least annually to collect data indicative of quality and/or delivery of service. Depending upon the provider type and nature of the review, the reviews can be conducted by UnitedHealthcare Community Plan QM Specialists, other UnitedHealthcare Community Plan staff as appropriate or delegated to an external agency (e.g. Foundation for Senior Living).

If significant problems are identified, or a provider and/or service site scores 85 percent or lower on an audit an Improvement Action Plan (IAP) will be requested of the service provider. The action plan should address the following:

- Specify the type of problem(s) that require action.
- Person(s) or body (e.g., committee) responsible for making the final determination regarding quality issues.
- Type(s) of member/provider actions to be taken (e.g., education, monitoring, process changes, etc).
- How the effectiveness of the plan will be evaluated.
- Method(s) of communication of findings and resulting changes to staff and providers.
- Method(s) of communication of pertinent information to AHCCCS and/or other agencies.

The effectiveness of the improvement actions taken by providers is determined during subsequent monitoring visits by the QM and/or CM staff. Intensive monitoring reviews can occur weekly, monthly or quarterly depending on the pattern and scope of the deficiencies noted during an onsite review.

It is the goal of the QM staff to provide education and support to providers to develop changes in their policies, procedures and internal monitoring to effect lasting improvement in areas found to be deficient. If a pattern of deficiency is noted that impacts several members, a decision can be made within the health plan to limit future admissions or referrals to the provider until corrective action has been completed and the provider has demonstrated that identified issues have all been resolved.

- **Member Satisfaction**

Periodically a survey may be mailed by Member Services to the members/family. Member satisfaction with the care being provided by our network providers affords feedback. From this feedback, areas for improvement can be determined. Should the survey be provider-specific, the results of the surveys will be shared with the provider for inclusion in their QM efforts.

- **Complaints and Concerns (QOC)**

Concern reports are received as problems are identified. All concern reports are investigated. Clinical quality of care issues will be investigated by licensed personnel. Aggregating concerns and complaints help to identify problems within the provider network. A quarterly summary by provider is run for all complaints. This aggregated complaint data is reviewed for trends by the QM Specialist and QM Committee. If a trend is noted, the QM Committee will determine what further actions are needed to address the trend.

### Regulatory Agency Findings

- **ADHS Annual Survey and ADHS Deficiency Reports**

The annual ADHS survey and deficiency report results are compared to issues identified by our provision of care monitoring.

- **Medicare Compare**

CMS' website [cms.gov](http://cms.gov) posts quarterly reports showing the CMS Nursing Home Quality Initiatives. Selected quality measure rates will be ranked by provider. Reports are run by the facility along with the contracted providers' state and federal survey results to use in identification of trends.

### Disease Management Compliance Rates

- **Provider Specific**

The annual objective/goal for measures, established by AHCCCS, will be used as the benchmark. Those providers falling below the goal may require intervention by the medical director, EPSDT coordinator or QM Nurse as indicated.

Flu Vaccine Compliance Rate:

- Nursing Facility.....75%
- HCBS.....50%

Diabetic Care Compliance Rate:

- Annual HgA1c.....80%
- Annual Lipids.....72%
- Annual Dilated Eye.....60%
- EPSDT Participation.....55%

### Medical Records Monitoring

Primary Care Providers and Obstetricians/ Gynecologist will have a medical record audit at least every three years in conjunction with the re-credentialing process. Specialists with 50 or more referrals per contract year will also have a medical record audit at least every three years.

### Peer Review

The UnitedHealthcare Community Plan Provider Advisory Committee (PAC) Peer Review Committee meets, (at minimum) quarterly, or more frequently, to improve the quality of medical care provided to members by practitioners or providers. The scope of PAC includes cases where there is evidence of a quality deficiency in the care or services provided, or the omission of care or services by a participating or non-participating health care professional or provider.



The PAC is comprised of the UnitedHealthcare Community Plan Medical Director (chairperson), contracted providers/physician members from the community, the Director of Quality Management, and specialty providers if an issue requires their presence. If a behavioral health specialty is being reviewed, a behavioral health provider will be a part of the review process. UnitedHealthcare Community Plan will use peers of the same or similar specialty through external consultation should that specialty not be represented on the committee. Committee members involved in the quality of care issue being discussed are not involved in the discussion of the case.

The Peer Review process compares the health care professional or provider's performance with that of peers or with community standards. The committee will recommend if any further follow up action is indicated. Minutes are maintained and kept confidential. Any provider may file a grievance as the result of a peer review decision with the Medical Director. A provider who is adversely affected by a committee's decision/action may file a formal appeal.

It is the responsibility of the Medical Director to report to the appropriate licensing board any concerns regarding UnitedHealthcare Community Plan network practitioners

## Member Fraud Investigation

Reports of alleged abuse against UnitedHealthcare Community Plan members require immediate action to ensure the member's safety. Member safety is the first concern when a potential/actual case of abuse has been identified. UnitedHealthcare Community Plan and their providers will take all actions necessary to secure our members' safety. Members' risk status within the facility/home in question will determine the time frame for initiation of the concern report investigation.

Providers will be encouraged to self-report cases of alleged abuse to the appropriate regulatory

agencies or boards (e.g. Arizona Department of Health Services (ADHS), Adult Protective Services (APS)/Child Protective Services (CPS), law enforcement agency, Board of Nursing, Board of Medical Examiners (BOMEX), etc.). Failure of providers to self-report will result in UnitedHealthcare Community Plan notifying the appropriate authorities.

## Reporting Cases of Fraud

All providers are required to abide by applicable law, rules, and regulations and to maintain and furnish required records and documents as required by law, rules and regulations.

Contracts are not awarded or renewed for any provider terminated from Medicare, Medicaid or debarred from the Department of Health and Human Services.

### Detection and Prevention Tips

Providers are encouraged to visit HHS Office of Inspector General's website at [oig.hhs.gov/](http://oig.hhs.gov/) for information on detection and prevention of fraud.

### Reporting

Pursuant to R9-22-511 "all contractors, providers, and non-providers shall advise the AHCCCS Office of Inspector General, immediately, in writing, of any cases of suspected fraud or abuse." Referrals can be made at: [azahcccs.gov/fraud/reporting/reporting.aspx](http://azahcccs.gov/fraud/reporting/reporting.aspx).

Providers are encouraged to view the on-line video at this link "Fraud Awareness for Providers." [azahcccs.gov/fraud/default.aspx](http://azahcccs.gov/fraud/default.aspx).

Providers are encouraged to make a self-referral if fraud is detected within their organization or if they should suspect UnitedHealthcare Community Plan member of defrauding Medicaid or Medicare.

## Member and Provider Rights and Responsibilities

### Advance Directives

Members must be informed of their right to determine their end of life care through education on advance directives. During the initial visit or PCP visit, members must be explained in layman's terms an explanation of: Cardiopulmonary Resuscitation (CPR), artificial hydration and nutrition, intubation, and comfort measures. Documentation supporting the member education must be recorded in the member's medical records. Signed copies of advanced directives should be kept in the member's medical records and accompany the member when transferring care.

UnitedHealthcare Community Plan case managers also provide the members with Aging with Dignity Pamphlet, "Five Wishes." This pamphlet is also available in Spanish. "Five Wishes" discusses selecting the right person to be their power of attorney, what to do when they change their mind, the kind of treatment they want, comfort measures, how they wish to be treated, and what they want their loved ones to know. When completed, "Five Wishes" includes the member signature, witness statement and a notary seal.

### Availability and Accessibility of Services

Members have the right to have availability and accessibility of services equal to or better than community norms. Network Operations staff assesses access to service. This is accomplished through quarterly provider office visits and regional conferences. When an area is found to be in need of additional services, Network Operations develops an outreach program to encourage providers to join the UnitedHealthcare Community Plan provider network.

Appointment availability of services accessibility of care is monitored to assure that members can access needed care. Care is provided within the network whenever possible. If a service is unavailable

within our network, the member is referred out of the area and transportation is provided. When a medically necessary service is provided outside the geographical area or network, it will be provided by non-contracted UnitedHealthcare Community Plan providers or by UnitedHealthcare Community Plan affiliated providers.

**Providers contracted with UnitedHealthcare Community Plan are required to maintain member accessibility within specified time limits outlined in their contract. This is monitored through the trending of member concerns related to availability of providers.**

## Cultural Competency

UnitedHealthcare Community Plan recognizes cultural competency as a necessary component of member rights. It is our desire to integrate cultural competency into all systems of UnitedHealthcare Community Plan including quality improvement efforts.

Providers are encouraged to review the Office of Minority Health website for National Standards on Culturally and Linguistically Appropriate Services (CLAS) at [minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15](http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15).

## Re-credentialing

### Individual Providers

All licensed individual providers (LIPs) are re-credentialed every three years. Six months prior to the re-credential due date, Corporate Credentialing will identify LIPs due for re credentialing. A re-credentialing application is initiated and sent to the LIP. UnitedHealthcare Community Plan's QM department will review all providers due for re-credentialing for information regarding quality of care issues (e.g. outcomes of provision of service monitoring, grievances and complaints, utilization and member satisfaction survey results, when available).

## **Organizational Providers**

UnitedHealthcare Community Plan Corporate Credentialing will perform an assessment of each organizational provider (e.g. hospitals, home health agencies, skilled nursing facilities and free standing surgical center) prior to initiating a participation agreement to confirm that the organizational provider is in good standing with state and federal regulatory bodies, has been reviewed and approved by an acceptable accrediting body and, if not accredited, has successfully completed a site assessment.

The Primary Source Verification (PSV) process for organizational providers includes:

- Verification of state licensure, if applicable.
- Absence of exclusion or debarment from participation in Medicare, Medicaid, or other state or federal health care programs, including the Office of Inspector General (OIG) and General Services Administration (GSA), warranting denial of participation status through a review of the Healthcare Integrity and Protection Data Bank (HIPDB) report.
- Absence of a history of sanctions or other actions warranting denial of participation status through a review of the HIPDB report.
- Verification of valid accreditation or certification.
- If the organizational provider is not accredited or certified by a recognized agency, a site review of the organizational provider is required. Results must be found satisfactory. The assigned Corporate Credentialing Specialist submits request to the UnitedHealthcare Community Plan Credentialing Coordinator or designee for completion of the Site Visit assessment.

Upon completion of the PSV process, the Corporate Credentialing specialist assures receipt of the Site Visit assessment and exception approval for deviated liability from the Site Credentialing coordinator or designee, if applicable. Upon completion of the PSV process, the credentialing specialist assures receipt of the visit assessment, quality management documentation for all subsequent three-year cycle reviews and exception approval for deviated liability.

# Ch. 10 EPSDT/Prevention

EPSDT is a federally mandated program specifying medical standards of care for primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems. EPSDT services are defined as Early and Periodic Screening, Diagnosis and Treatment services for enrollees under the age of 21 years. Arizona law (A.R.S Statute 36-135) requires physicians to report all immunizations given to children in the age group at least monthly. More information can be accessed at [azdhs.gov/phs/asiis/](http://azdhs.gov/phs/asiis/).

**Early** – As early as possible in the child's life, or as soon after the enrollee's eligibility with UnitedHealthcare Community Plan has been established.

**Periodic** – Intervals established by the AHCCCS Administration for screening to assure that a condition, illness, or injury is not incipient or present.

**Screening** – Regularly scheduled examination and evaluation of the general physical and behavioral health, growth, development and nutritional status of infants, children and youth and the identification of those in need of a more definitive evaluation. Screening and diagnosis are not synonymous.

**Diagnosis** – Determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and X-rays, when appropriate.

**Treatment** – Type of health care or services recognized to prevent or ameliorate a condition, illness, and injury or to prevent or correct abnormalities detected by screening or diagnostic procedures. Services must be recognized under the State Plan and Title XIX of the Social Security Act.

## EPSDT Screening Components

1. UnitedHealthcare Community Plan EPSDT requirements will be conducted according to the time frame identified in the EPSDT periodicity schedule, and inter-periodic screenings as appropriate for all enrollees under the age of 21 years. The physician or health care provider shall perform the following:
  - A comprehensive health and developmental history (including physical, nutritional and behavioral health assessment).
  - A comprehensive disrobed physical exam.
  - Appropriate immunizations according to age and health history.
  - Laboratory tests (including blood lead screening assessment appropriate to age and risk, tuberculosis screening appropriate to age and risk, anemia testing, and if appropriate, diagnostic testing for sickle cell trait).
  - Health education.
  - Appropriate dental screening.
  - Appropriate vision, hearing and speech testing.
2. Diagnosis and medically necessary treatment or referral to an appropriate community resource.

## Physical Examinations

EPSDT services will be provided according to community standards of practice and the EPSDT periodicity schedule. AHCCCS EPSDT tracking forms will be used to document services provided and physician compliance with standards.

The physical examination is a comprehensive disrobed examination performed according to acceptable medical practice. The provider should consider the age of the enrollees when conducting the physical examination. The provider will initiate appropriate referrals according to their findings.

The purpose of the EPSDT physical examination is to:

- Evaluate the form, structure, and function of particular body region and systems.
- Determine if these region(s) and systems are normal for the child's age and background.
- Discover those diseases and health problems for which no standard screening test has been developed, including evidence of child abuse and/or neglect.

The complete physical examination and screenings will include a developmental/behavioral health screening, comprehensive history, dental screening and appropriate vision testing, hearing testing, laboratory tests, dental screenings, laboratory tests and immunizations. EPSDT providers must document immunizations into ASIIS and enroll every year in the Vaccine for Children program. Examination with further guidance on obtaining necessary dental care, accurate measurement of height and weight and appropriate lab tests according to age and risk. Use of a growth chart developed by the National Center of Health Statistics (NCHS) is recommended for each EPSDT enrollee. The Centers for Disease Control and Prevention (CDC) website provides

access to both growth charts and Body Mass Index (BMI) calculation tools. Charts for estimating BMI measurements are also found in Appendix I of the AHCCCS Medical Policy Manual.

## Developmental Assessment

The developmental assessment is designed to determine whether a child's developmental progress falls within a normal range of achievement according to age and cultural background. Screening for developmental assessment will be done at each EPSDT visit. The assessment will include obtaining a relevant developmental history, assuring accurate and informative observation of enrollees and attending to parental concerns. Emphasis will be placed on monitoring development within the context of the enrollee's overall well-being, rather than viewing development in isolation during a testing session. An objective developmental test must be administered as a 'second-stage' screening instrument when the history and/or physical examination are suspicious.

The following elements will be assessed:

- Gross motor development, focusing on strength, balance, locomotion.
- Fine motor development, focusing on eye-hand coordination.
- Communication skills or language development, focusing on expression, comprehension and speech articulation.
- Self-help and self-care skills.
- Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents and other adults.
- Cognitive skills, focusing on problem solving or reasoning.



Throughout school age, focus on:

- Visual-motor integration.
- Visual-special organization, visual sequential memory.
- Attention skills, auditory processing skills.
- Auditory sequential memory.

For adolescents, focus on:

- Potential presence of learning disabilities.
- Peer relationships.
- Psychological/psychiatric problems.
- Vocational skills.

Anytime the enrollee's assessment falls out of the normal range of achievement according to age and cultural background, the provider will refer the enrollee to the appropriate specialist, state program or community resource for follow up evaluation, diagnosis and treatment.

## Nutritional Assessment

EPSDT covers assessment of nutritional status by the EPSDT provider as specified in the EPSDT periodicity schedule as part of the EPSDT screenings and on an inter-periodic basis as determined necessary by the enrollee's PCP. Assessments are accomplished through questions regarding dietary practices, assessment of overall health, measurement of height and weight, review of body mass index (BMI) scores and environmental factors.

Nutritional assessments by a registered dietitian require an order by the PCP and completion of prior authorization protocol.

UnitedHealthcare Community Plan covers supplemental nutritional feedings, provided on either an enteral, parenteral or oral basis, when determined medically necessary. Medical necessity is determined

on an individual basis by the Medical Director. Documentation must be present of unsuccessful trials in utilizing alternatives such as blenderized foods when making the determination of medical necessity of supplemental nutritional feedings.

When requesting authorization for commercial oral nutritional supplements the provider must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements." The provider must document that the PCP or attending physician has provided nutritional counseling as part of the EPSDT service and specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies. In addition, documentation that at least two of the following criteria have been met must also be present when determining medical necessity:

- The enrollee is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more.
- The enrollee has reached a plateau in growth and/or nutritional status for more than six months (prepubescent).
- The enrollee has already demonstrated a medically significant decline in weight within the last three months (prior to the assessment).
- The enrollee is able to consume/eat no more than 25 percent of nutritional requirements from age-appropriate food sources.
- Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss, and intolerance to milk or formula products have been ruled out.
- The enrollee requires nutritional supplements on a temporary basis due to an emergent condition; e.g. post-hospitalization. (PA is not required for the first 30 days).

- Enrollee receiving supplemental nutritional feeding will be referred to case management for follow up, coordination with the PCP providing information and assistance as needed to ensure appropriate referrals for home health education regarding weaning from supplemental feedings.

## Tuberculin Testing

Tuberculin skin testing is to be provided as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include:

- Any child born outside the United States in developing countries.
- Any child with any medical condition which would increase the incidence of TB infection such as HIV infection, chemotherapy treatment, diabetes, renal disease or treatment which suppresses the immune system.
- Any child living in a household with
  - Anyone confirmed or suspected case of TB;
  - An HIV-infected person or the child is infected with HIV;
  - Anyone in jail or prison during the last five years;
  - Anyone traveling/immigrating from or with significant contact with indigenous persons from endemic countries.

## Blood Lead Screening

EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 24 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test result equal to or greater than 10ug/dl obtained by capillary specimen

(finger stick) must be confirmed using a venous blood sample. A verbal risk assessment must be completed at each EPSDT visit for children ages 6 months through 72 months (6 years) to assist in determining risk. Appropriate follow-up must be provided.

## Immunizations

EPSDT covers all child and adolescent immunizations as specified in the EPSDT periodicity schedule. Each appropriate immunization must be provided to bring, and maintain, each EPSDT enrollee's immunization status up-to-date. Physicians or health care providers must coordinate with the ADHS Vaccine for Children Program in the delivery of immunization services. Immunizations are provided according to the Advisory Committee on Immunization Practices (ACIP) recommended schedule.

Providers must document each member's immunization in the Arizona State Immunization Information System (ASIIS) and maintain the ASIIS immunization record in accordance with Arizona state statutes.

## Vision Screening

The PCP will assess vision screening at each EPSDT visit as appropriate to age according to the EPSDT periodicity schedule and as medically necessary. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered under the EPSDT screening process. The PCP will initiate appropriate referrals to an Ophthalmologist for further evaluation when an EPSDT enrollee fails the vision screening.

## Hearing/Speech Screening

The PCP, according to the periodicity schedule, will assess hearing screening at each EPSDT visit. Further necessary evaluations such as impedance testing are referred to an ear, nose and throat (ENT) specialist as needed. Speech screening for language development will also be assessed at each EPSDT visit. Medically necessary and appropriate speech therapy is a covered service.

## Physical Therapy

Physical Therapy for enrollees under the age of 21 years to restore, maintain or improve muscle tone, joint mobility or physical function is a covered service when determined medically necessary. The condition for which the therapy is prescribed must have the potential for improvement due to rehabilitation.

## Occupational Therapy

Occupational therapy is a covered service when determined medically necessary for EPSDT enrollees to improve and restore functions that have been impaired by illness or injury or have been permanently lost or reduced by illness or injury. The condition for which the therapy is prescribed must have the potential to improve the enrollee's ability to perform tasks required for independent functioning.

## Behavioral Health Screening

Screening for behavioral health and substance abuse is assessed at each EPSDT visit. The provider may refer to AHCCCS Behavioral Health Screening Guidelines. For further details on behavioral health services, refer to the Behavioral Health Services chapter of this Provider Manual.

## Dental Screening

Oral screenings must be conducted by the provider as part of the physical exam. The screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis and treatment plan. Providers should refer enrollees for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of the referral should be documented on the EPSDT tracking form. Enrollees are allowed to self-refer to a dentist.

## Health Education

Health counseling and education is provided at each EPSDT visit through the anticipatory guidance section of the EPSDT tracking form. The anticipatory guidance is to assist parents and guardians in what to expect in terms of the enrollee's development and information about the benefits of healthy lifestyles, accident and disease prevention.

## Circumcisions

Circumcisions of newborn male infants are not a covered service unless determined to be medically necessary. The procedure requires prior authorization.

## Organ and Tissue Transplantation Services

Medically necessary and approved non-investigational solid organ and tissue transplantation is an EPSDT covered service.

## EPSDT Forms

Each EPSDT form is reviewed by the EPSDT/MCH coordinator to assess quality and level of care, monitor PCP's EPSDT compliance regarding completion of the EPSDT forms, identify children in need of EPSDT services or special programs and assist the PCP in initiation of referrals when indicated. UnitedHealthcare Community Plan will provide all covered medically necessary services.

- Special needs enrollees are identified upon review of the EPSDT forms sent from the PCP offices monthly or upon notification from the prior notification department of a request for service. The EPSDT/MCH coordinator works with the providers and case managers to ensure appropriate referrals to other agencies and programs are completed.

Scheduling of the next enrollee appointment is completed at the time of the current office visit, for children 24 months and younger. Compliance will be reinforced and monitored through a variety of activities including, but not limited to, review of EPSDT tracking forms received from the PCP offices for children newborn to 21 years of age. The PCP office staff is educated regarding EPSDT requirements including scheduling of enrollees' office appointments, EPSDT tracking form submission and periodicity tables.

## EPSDT Dental Services

UnitedHealthcare Community Plan enrollees aged 1 to 21 years are entitled to receive routine dental care services that include emergency, preventive and therapeutic dental services through the federally funded EPSDT program. Authorization or referrals for routine, usual and customary services for this age group are not required. However, it is expected that the provider will complete gross oral exams at every EPSDT visit, encourage routine dental visits, and provide referrals when emergent dental problems are identified.

UnitedHealthcare Community Plan enrollees within this age group who request dental referrals are advised that a referral is not necessary, and that the enrollee or parent may call the dentist directly to schedule an appointment.

Providers may refer members younger than 1 year for a dental assessment if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.

The following EPSDT dental services are covered:

### Emergency Dental

Emergency dental services are covered benefits for all UnitedHealthcare Community Plan enrollees and do not require prior authorization. A retrospective review of emergency services is performed to determine the medical necessity and appropriateness of the services. Emergency dental includes:

1. Treatment for pain, infection, swelling or injury;
2. Extraction of symptomatic, infected and non-restorable primary and permanent teeth, and retained primary teeth; and
3. General anesthesia, conscious sedation or anxiolysis (minimal sedation patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires anesthesia.

### Routine Dental

Enrollees may receive annual routine dental examinations by a dental provider who reports all findings and resulting treatment to the PCP and UnitedHealthcare Community Plan. The examination includes the following:

1. Instruction in self-care oral hygiene procedures.
2. Complete intra-oral examinations.
3. Diagnostic radiology procedures, including panoramic or full-mouth x-rays: supplemental bitewing x-rays and occlusal or periapical films.

4. Oral prophylaxis performed by the dentist or a dental hygienist.
5. Application of topical fluorides (use of prophylaxis paste containing fluoride is not considered a separate fluoride treatment).
6. Dental sealants on all non-carious permanent first molars.
7. Space maintainers when posterior primary teeth are lost permanently.

### **Therapeutic Dental**

Therapeutic dental services are covered when medically necessary. These services include:

1. Periodontal procedures, scaling/root planning, curette, gingivectomy, osseous surgery.
2. Stainless steel crowns for both primary and permanent teeth; composite crowns for only anterior primary teeth; plastic or acrylic crowns for anterior primary teeth.
3. Cast non-precious or semi-precious crowns for enrollees 18 through 21-years-of-age on all functional permanent endodontically treated teeth, except third molars.
4. Pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar.
5. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the enrollee is 18 through 21-years-of-age and has endodontic treatment.
6. Dentures, orthodontics and orthognathic surgery when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan agreed upon by the PCP and in consultation with the dentist.

## **EPSDT Immunizations**

Comprehensive periodic immunization compliance shall be addressed at each EPSDT visit. The immunization compliance will be conducted according to the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practice (ACIP). EPSDT visits should occur at birth, 2-4 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, and annually starting at 2 years.

All UnitedHealthcare Community Plan physicians and health care providers of EPSDT services shall meet the following immunization conditions:

1. Provide immunization services at no charge to UnitedHealthcare Community Plan enrollees.
2. Obtain EPSDT Immunization Vaccines through the Arizona Department of Health Services (ADHS) Vaccines for Children Program (VFC).
3. Utilize all clinical encounters with enrollees to screen, and when indicated, immunize as per ACIP schedule.
4. Educate parents and/or responsible parties about immunizations at each EPSDT visit. This includes explaining the importance of immunizations, the true contraindications of vaccines, and the risks and benefits of the immunization.
5. Adhere to only true contraindications to vaccine, as specified in the ACIP recommended Standards for Pediatric Immunization Practices.
6. Administer to enrollees all vaccine doses needed according to the ACIP Schedule.
7. Record the following, as required by Arizona Revised Statute (ACIP standard):
  - Vaccine and dosage given.
  - Date the vaccine was given (month/day/year).
  - Name of the manufacturer of the vaccine.

- Lot number of the vaccine.
- Signature of the person administering the vaccine.
- Edition date of the vaccine, information materials distributed and the date those materials were provided.

This information shall be kept in the child's medical record at the PCP's office.

8. Ensure that all immunizations are entered into the Arizona State Immunization Information System (ASIS) as required by state statutes.
9. Encourage parents and/or responsible parties to maintain a copy of their child's personal immunization record. The physician or health care provider's office will update this record at each EPSDT visit, documenting what vaccine was given, the date (month/day/year) of the vaccine, and who administered the vaccine.
10. If an enrollee receives their immunizations from any other source than the PCP, UnitedHealthcare Community Plan will provide this record to the assigned PCP for inclusion in their chart.

### Exemptions From Immunization

UnitedHealthcare Community Plan and state regulations allow for exemption based on medical or personal beliefs. However, such exemptions are not intended to be used to achieve compliance. Claiming exemptions is not a substitute for protection that can only be gained from immunization. Documentation of exemption for personal or medical reasons may be written in the provider's progress notes on the enrollee's chart.

- **Medical Exemption:** An ADHS approved form must be signed by the child's provider stating that the child has a medical condition such that the required immunizations would seriously endanger his or her well-being. This statement must be disease specific, state whether the condition is permanent or temporary, and include the date.

- **Personal Exemption:** The parent or guardian must submit a signed statement, using an approved ADHS form, stating that he or she has read and understands the risks and benefits of the disease(s) and immunization(s) and refuses consent of the immunization of the child.

EPSDT Tracking Forms can be found at: [azahcccs.gov/shared/Downloads/MedicaidPolicyManual/AppendixB.pdf](http://azahcccs.gov/shared/Downloads/MedicaidPolicyManual/AppendixB.pdf).

## Arizona Early Intervention Program (Az EIP)

The Arizona Early Intervention Program is a system of professionals working together with parents and families of children, from birth to age three (3), with developmental delays and/or disabilities. AzEIP provides assistance encouragement and treatment and allows early intervention and developmental services to occur in a family's natural environment.

UnitedHealthcare works in collaboration with AzEIP and DD support coordinators, PCPs, servicing providers (therapist/facilities), CRS and member families. This is to ensure that the child is provided with medically eligible services, such as physical therapy, speech therapy and/or occupational therapy, in accordance with EPSDT guidelines. Providers working with this population will receive an AzEIP Request for EPSDT Services and documentation completed by an AzEIP service coordinator. The AzEIP Request for EPSDT Services and documentation is faxed to UnitedHealthcare for review and then faxed to the provider for medical necessity review. If provider feels that services are medically necessary, then the provider will fax back the request with signature, date and diagnosis codes related to the therapy request. The EPSDT coordinator at UnitedHealthcare will coordinate prior authorization and notify AzEIP service coordinator of approved services.



# Ch. 11 Claims Billing

Effective April 1, 2016, UnitedHealthcare Community Plan, Long Term Care, transitioned to a new claims system. Please make sure to check our website for updates and how-to's. Remember to submit claims with dates of service on/after April 1, 2016 with the members new group number. Claims submitted to UnitedHealthcare Community Plan shall be compliant with claims processing rules as defined by AHCCCS. Claims submitted shall include:

- The submission of a clean claim
- Current Federal Tax Identification Number (TIN)
- Servicing location
- National Provider Identification Number (NPI)
- AHCCCS Medicaid ID for atypical providers who do not have a registered NPI.
- Valid service-specific diagnostic and procedure codes
- Modifier, CPT, diagnosis and HCPCS codes shall be current and accurate where appropriate
- Appropriate number of units
- Operative report for surgical procedures
- Physicians orders and progress notes for durable medical equipment (DME)
- All Explanation of Benefits (EOBs) that relate to the claim. The provider must bill and obtain a copy of the EOB or Remittance Advice (RA) when a member has coverage from any other private insurance. IF claim is denied or paid in full from primary carrier, the claim should still be submitted to UHCCP.

Claims submitted without the above information or with inaccurate codes will be returned to the provider for proper resubmission and/or denied.

## AHCCCS Provider Identification Number and NPI Number

All providers for UnitedHealthcare Community Plan enrollees requesting reimbursement for services must be properly registered with AHCCCS and have a

valid AHCCCS Physician or Health Care Provider Identification Number.

Physicians or health care providers can find AHCCCS registration information at:

<https://www.azahcccs.gov/PlansProviders/NewProviders/registration.html>

Claims submissions that are missing the National Provider Identification Number (NPI) numbers will be denied for payment. All providers are impacted with the exception of a few excluded providers such as housekeeping, home care, personal care, non-emergency transportation, adult day health care. To verify if you are a provider who is excluded, please go to [azahcccs.gov](http://azahcccs.gov) to reference page 29 of Provider Affiliation Transmission User Manual. This section identifies all provider types that do require an NPI. If you're provider type is not listed, then you do not require an NPI.

Providers must communicate their NPI's to health plans, clearing houses, other providers and AHCCCS well before the compliance date.

If you have obtained your NPI number, please contact your provider relations advocate. If you have any changes to your NPI or AHCCCS registration numbers, please contact your provider relations advocate to update your records.

## ALTCS Enrollee Billing and Encounter Submission

In accordance with Arizona Administrative Codes R9-22-702, R9-27-702, UnitedHealthcare Community Plan enrollees cannot be billed. Enrollees may also not be billed for services that are not paid due to the failure of the provider to comply with UnitedHealthcare Community Plan's authorization or billing requirements.

AHCCCS rules prohibit physicians and health care providers from billing enrollees for any AHCCCS-covered services. Providers cannot request additional payments from the enrollee or family for any Medicaid-covered service. If a member requests a service that is not covered by AHCCCS, providers should have the member sign a release form indicating they understand that the service is not covered by AHCCCS and the member is financially responsible for all applicable charges.

## Acceptable Claim Forms

UnitedHealthcare Community Plan requires all providers to use one of two forms when billing for services whether they are capitated for fee-for-service as per AHCCCS requirements and guidelines.

- Effective April 1, 2014, all paper claims submitted are required to be submitted on the new 02/12 1500 Claim Form. The 02/12 1500 Claim Form is to be used for all professional services, including ancillary services, ambulatory surgery centers, urgent care centers, professional services billed by a hospital and other providers as required by AHCCCS. A CMS-1500 form is to be used for the above mentioned services prior to April 1, 2014.
- A UB-04 form is used to submit claims for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other providers as required by AHCCCS. UnitedHealthcare Community Plan will not process claims received on any other type of claim form. All AHCCCS billing guidelines and requirements must be followed.

## AHCCCS Approved Codes, Units and Values

Valid and approved AHCCCS codes should be used when submitting claims to UnitedHealthcare Community Plan. This includes but is not limited to:

- Place of service codes
- Revenue codes
- Diagnosis codes
- CPT codes
- Modifiers
- ICD-10 procedure and condition codes

UnitedHealthcare Community Plan will apply AHCCCS billing and payment requirements to all claims submitted. This applies to the application of max-unit guidelines, age/gender guidelines, place of service/procedure combinations, procedure/ modifier combinations, duplicate claim billing, duplicate line-item, and revenue/procedure/ modifier combination guidelines.

## Billing Multiple Units

Reminder when billing multiple units

- If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form with the appropriate number of units.
- The units field is used to specify the number of times the procedure was performed on the date of service.
- The total bill charge is the unit charge multiplied by the number of units.

## EDI/Electronic Claims Submission

UnitedHealthcare Community Plan requires Electronic Claims Submission for most of our contracted providers.

EDI offers providers several advantages, including less paperwork, reduced postage, less time spent handling claims, decreased turn-around time on claims processing, HIPAA compliant and flexibility to submit your claims 24-hours-per-day.

To submit claims electronically simply contact your clearinghouse or software vendor and request that Primary and Secondary UnitedHealthcare Community Plan Claims be sent electronically. UnitedHealthcare Community Plan Claims Payer ID is 03432.

If you are interested in billing electronically, please go to [unitedhealthcareonline.com](http://unitedhealthcareonline.com).

## EDI Support Services

EDI Support Services provides support for all electronic transactions involving claims and electronic remittances. Please call us for assistance with any of these transactions at 800-210-8315 or e-mail at: [ac\\_edi\\_ops@uhc.com](mailto:ac_edi_ops@uhc.com).

## Electronic Payments and Statements (Direct Deposit)

You can take advantage of a free, electronic system that streamlines and simplifies the payment process for your UnitedHealthcare Community Plan claims.

Electronic Payments and Statements (EPS) reduces your administrative burden and creates more time for patient care. With EPS, claim payments are conveniently transferred into the checking account you designate, eliminating the need to physically deposit checks and significantly reducing the time your staff spends on manual processing and claim payment reconciliation.

EPS also eliminates countless stacks of mail and paper from your office, by providing online remittance advices for each claim that you can view, print or save electronically. And, you can download a free, consolidated HIPAA 835 that shows all claims for a given day's deposit and can be posted automatically into your Practice Management System.

Registration is easy: Just visit us on the web at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com). When enrolling online, choose "Claims & Payments" from the top bar navigation, and then select "Electronic Payments & Statements." From the "Welcome to Electronic Payments and Statements" page, choose "Continue" to register/login to Electronic Payments and Statements, and an enrollment form will appear. When your registration is complete we'll email you a confirmation, and payments will begin to be processed electronically in approximately seven-to-ten days

If you have any questions, please call the UnitedHealthcare Connectivity Help Desk at 866-842-3278 and select option 5. We're available from 7 a.m. to 6 p.m. Central Time, Monday through Friday, and would be happy to explain how EPS can work for you.

## Initial Claims Filing Time Limits

UnitedHealthcare Community Plan requires that all initial claims must be submitted within 90 days following the date that the services are rendered or the date of discharge, or eligibility posting, whichever date is later. UnitedHealthcare Community Plan is always the payer of last resort and thus you must bill any other insurance, including Medicare, first before submitting your claim to us.

Claims involving coordination of benefits must be submitted within 60 days from the date of the Explanation of Benefits (EOB) from the primary and/or secondary payer. Providers must attach a copy of the payer's EOB with your UnitedHealthcare Community Plan claim, even if the claim was originally denied. Please refer to your physician and health care Provider Agreement for further clarification.

## Clean Claim

A clean claim is a claim that has all the required fields filled out correctly and is legible. Claims that are not completely filled out or are illegible will be returned unprocessed to the provider and are not considered as received by UnitedHealthcare Community Plan. Claims that have inaccurate or inappropriate information in the fields will be processed and denied. The provider can then resubmit a corrected claim for processing.

## Where to Mail Your Claims

UnitedHealthcare Community Plan is always the payer of last resort. Physicians and health care providers must bill any other health care insurance carrier that the enrollee has prior to billing UnitedHealthcare Community Plan, including Medicare.

Mailing to the street address will delay the processing of the claim and as a result may be denied for untimely filing. Any claims that are received at the street address will be returned to the sender for proper mailing of the claims.

Primary and secondary UnitedHealthcare Community Plan claims, including medical records, should be submitted to:

UnitedHealthcare Community Plan  
P.O. Box 5290  
Kingston, NY 12402-5290

## Claims, Copayments and Deductibles for UnitedHealthcare Community Plan Dually Enrolled Members

Providers billing for services for enrollees that have primary coverage with United Healthcare Dual Complete), UnitedHealthcare Community Plan will

process the single claim for both primary and secondary coverage. All other plans must submit a separate claim to UnitedHealthcare Community Plan for the Long Term Care coverage.

### **If you are not sure who the enrollee's primary insurance is, contact UnitedHealthcare Community Plan's Customer Call Center.**

UnitedHealthcare Community Plan will coordinate payment of benefits of UnitedHealthcare Community Plan enrollees that have a primary carrier. In accordance with the requirements of the Balanced Budget Act of 1997, UnitedHealthcare Community Plan will pay co-payments, deductibles and/or coinsurance for AHCCCS covered services up to the lower of either the AHCCCS fee for service schedule or the primary insurance allowed amount.

## Coordination of Benefits

### **Standard COB**

UnitedHealthcare Community Plan is considered the payer of last resort. Providers should identify and verify any other insurance coverage for the member. Other coverage that is identified should be billed as the primary carrier. When billing UnitedHealthcare as the final payer, submit the primary payer's Explanation of Benefits or remittance advice on the claim. Claims are processed according to the AHCCCS Contractor Operations manual (ACOM), Chapter 400, section 434.

## Medicare Dual Cost Sharing

Dual Eligible members (having both Medicare and Medicaid) will be paid according to the AHCCCS Contractor Operations Manual (ACOM), Chapter 200, section 201. UnitedHealthcare will not be responsible for cost sharing should the payment to the primary payer be equal to or greater than what the provider would have received under Medicaid.

## Medical Claims Review

Medical claims review (MCR) nurses evaluate practitioners' and providers' claims before the claims are paid. The MCR nurses use medical review criteria to confirm that the services being billed are a covered benefit for the member and were medically necessary. Medical claims review evaluates claims for emergency room, transportation, and inpatient and outpatient medical services.

Proper Documentation and Medical Review Medical review is performed to determine if services were provided according to policy, particularly related issues of medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided.

Please note the following scenarios where the appropriate documentation is required to process the claim:

- A. Out-of-state providers corrected claims, please include itemization of charges.
- B. Inpatient claims with extraordinary cost-per-day thresholds may qualify for an outlier reimbursement. For an inpatient claim to be paid the outlier payment, the facility must bill a Condition Code 61 in any of the Condition Code fields (18-28) on the UB-04. All hospitals for inpatient claims that may qualify for outlier payment please include itemization of charges.
- C. When billing unlisted procedures, including any documentation, providers must include: the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used that details what service was provided.
- D. Medicaid services:
  1. Behavioral Health/Substance Abuse
    - a) ER notes.
    - b) Physician orders, MD, RN and social work notes.

- c) MARS for each day of hospitalization.
  - d) Discharge orders and/or Instructions.
  - e) Psychiatric evaluation and psychiatric discharge summary.
2. Cardiology services
  3. Radiological service interpretation
  4. Home health visits
  5. Injectable drugs
  6. Urgent care
  7. Pharmacy supplies
  8. Prosthetics
    - a) Surgical Procedures with Modifier 22 indicating unusual procedural service.
    - b) Itemized bill for claims where member is eligible for part of the date span but not the entire date span.
    - c) Elective Abortions require a Certificate of Medical Necessity and Operative.

## Prior Period Coverage (PPC) Claims

Prior Period Coverage (PPC) is the period of time, prior to UnitedHealthcare Community Plan's notification of an enrollee's enrollment, during which UnitedHealthcare Community Plan is retroactively liable for payment of covered services received by the enrollee. Physicians and health care providers can bill UnitedHealthcare Community Plan for medically necessary services incurred by our enrollees during the PPC period, if the service is a PPC-covered benefit. Prior authorization is not required during the PPC period for medically necessary services that are an AHCCCS PPC-covered benefit. Providers must have a valid AHCCCS ID number. Claims must be submitted to UnitedHealthcare Community Plan on the appropriate CMS1500 or UB-04 claim form. Please contact the enrollee's UnitedHealthcare Community Plan Case Manager or the Customer Call Center for more information or to verify the enrollee's PPC eligibility status.

Eligible PPC services include medications, physician visits, hospitalizations, therapies, durable medical equipment, medical supplies, home and community-based services (HCBS) and skilled nursing facility (SNF) care. For members who have HCBS in place prior to enrollment (during the PPC enrollment) a documented retrospective assessment must be conducted to determine whether those services are medically necessary, cost-effective and if they were provided by a registered AHCCCS provider. If so, a care service plan must be developed to indicate that services will be retroactively authorized and reimbursed by the program contractor.

PPC claims should be directed to the following address:

UnitedHealthcare Community Plan  
P.O. Box 5290  
Kingston, NY 12402-5290

## Reconsiderations/ Resubmissions of Claims

Rejected claims must be corrected and sent via the designated reconsideration/resubmission process. Do not resubmit these claims via EDI. Claims will be rejected or processed in error. Resubmitting a claim via EDI may not correct the issue and could delay processing time.

Providers have no more than 12 months from the date of service or 12 months after eligibility posting, whichever is later, to resubmit a corrected claim. All claims resubmissions should include, at a minimum, the following information:

- Reconsideration Form detailing the reason for reconsideration (e.g. corrected claim, timely filing documentation, COB information, authorization information, incorrectly processed claim, etc.).
- A copy of this form can be obtained at: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or by calling your Provider Advocate.

- Corrected claim form (if applicable) with the original claim number written in box 22 of the CMS 1500 form, or box 80 of the UB04
- Copy of the remittance advice from the denied claim
- There should be one Reconsideration form for each resubmitted, corrected, or reconsideration claim
- Claims should be resubmitted to UnitedHealthcare Community Plan at the following address:  
UnitedHealthcare Community Plan  
P.O. Box 5290  
Kingston, NY 12402-5290
- Note: The reconsideration process does not take the place of the dispute process nor does it extend the dispute filing deadline.
- Note: This Reconsideration Process is not to be used for DRG Outlier Payment Reconsideration. Please submit reconsiderations for DRG Outlier Payments to Med Review as documented on the Med Review letter received.

## Optum Cloud Dashboard and Claim Reconsideration

Through our partnership with Optum, UnitedHealthcare is taking another step forward in helping to ease our providers' administrative burden with the addition of new features and functions on Optum Cloud Dashboard.

Optum Cloud is a cloud-based website where registered providers can submit reconsideration requests electronically when attachments, such as medical notes, are required.

Registration is required to access Optum Cloud Dashboard. To access the Cloud Dashboard, or for more information, please visit [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com). Click on Tools & Resources, select Health Information Technology and then 'Optum Cloud Dashboard'



## Claims Submission Education

Please contact your Provider Relations Advocate for technical assistance on how to bill UnitedHealthcare.

## Claims Filing Requirements

- Use codes that are within your AHCCCS registration (Category of Service). Billing codes not within your category of service will cause a claim denial.
- Use the CPT, HCPCS and ICD-10 codes that were approved for the date of service.
- When filing claims to UnitedHealthcare Community Plan as a secondary payer, you must include the primary insurer's EOB with the claim submission, or your claim will deny.
- Use a separate claim for each enrollee.
- The member's UnitedHealthcare Community Plan Group Number is required on the claim form (Box 11 on the CMS-1500 form or Box 62 on the UB-04 form). The member's Group Number is listed on their Member ID Card. You may also call your provider relations advocate or the Provider Call Center to obtain this information.
- Make sure to file the claim within the timely filing limits. For contracted providers: 90 days from the date of service or 60 days from the date of the primary carriers EOB.
- Complete all required fields and ensure that the claim is legible. Please see our instructions on the following pages for how to fill out your claim form.
- The state of Arizona requires that providers submit claims with 99 lines or less. Any claims submitted that contain more than 99 lines are rejected by the state when submitted as part of encounter data.

## CMS 1500 Instructions

The CMS 1500 (formerly HCFA 1500) claim form is used to bill for professional services, transportation, durable medical equipment, ancillary services, and assisted living facilities.

The following instructions explain how to complete the CMS 1500 claim form and whether a field is required, required if applicable, or not required. Failure to complete the form as required may cause your claim to be denied.

1	<b>Program Block</b> Check the second box labeled "Medicaid."	<b>Required</b>
1A	<b>Insured's ID Number</b> Enter the enrollee's AHCCCS ID number.	<b>Required</b>
2	<b>Patient's Name</b> Enter the enrollee's last name, first name, and middle initial as shown on the AHCCCS ID card.	<b>Required</b>
3	<b>Patient's Date of Birth and Sex</b> Enter the month, day and year (MM/DD/YYYY) of the enrollee's birth. Check the appropriate box to indicate the enrollee's gender.	<b>Required</b>
4	<b>Insured's Name</b>	<b>Not Required</b>
5	<b>Patient Address</b>	<b>Not Required</b>
6	<b>Patient's Relationship to Insured</b>	<b>Not Required</b>
7	<b>Insured's Address</b>	<b>Not Required</b>
8	<b>Reserved for NUCC Use</b>	<b>Not Required</b>
9	<b>Other Insured's Name</b> If the enrollee has no coverage other than AHCCCS, leave this section blank. If other coverage exists, perhaps through the enrollee or spouse's employment or some other source, enter the name of the insured. If the other insured is the enrollee, enter "Same."	<b>Required if Applicable</b>
9A	<b>Other Insured's Policy or Group Number</b> Enter the group number of the other insurance.	<b>Required if Applicable</b>
9B	<b>Reserved for NUCC Use</b>	<b>Not Required</b>
9C	<b>Reserved for NUCC Use</b>	<b>Not Required</b>
9D	<b>Insurance Plan Name or Program Name</b> Enter the name of the insurance company or program name that provides the insurance coverage.	<b>Required if Applicable</b>

10	<p><b>Is Patient's Condition Related to</b></p> <p>Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>10. IS PATIENT'S CONDITION RELATED TO:</p> <p>a. EMPLOYMENT? (CURRENT OR PREVIOUS)</p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>b. AUTO ACCIDENT?      PLACE (State)</p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO         </p> <p>c. OTHER ACCIDENT?</p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> </div>	<b>Required if Applicable</b>
11	<b>Insured's Group Policy or FECA Number</b>	<b>Required</b>
11A	<b>Insured's Date of Birth and Sex</b>	<b>Required if Applicable</b>
11B	<b>Other Claim ID (Designated by NUCC)</b>	<b>Not Required</b>
11C	<b>Insurance Plan Name or Program Name</b>	<b>Required if Applicable</b>
11D	<p><b>Is There Another Health Benefit Plan</b></p> <p>Check the appropriate box to indicate coverage other than AHCCCS. If "Yes" is checked, you must complete Fields 9A-D.</p>	<b>Required if Applicable</b>
12	<b>Patient or Authorized Person's Signature</b>	<b>Not Required</b>
13	<b>Insured's or Authorized Person's Signature</b>	<b>Not Required</b>
14	<b>Date of Illness or Injury</b>	<b>Required if Applicable</b>
15	<b>Other Date</b>	<b>Not Required</b>
16	<b>Dates Patient Unable to Work in Current Occupation</b>	<b>Not Required</b>
17	<b>Name of Referring Provider or Other Source</b>	<b>Required if Applicable</b>
17A	<p><b>ID Number of Referring Provider</b></p> <p>The ordering provider is required for:</p> <p>Laboratory  Drugs (J-codes)  Radiology  Temporary K and Q codes  Medical and surgical supplies  Orthotics  Respiratory DME  Prosthetics  Enteral and Parenteral Therapy  Vision codes (V-codes)  Durable Medical Equipment  97001 – 97546</p> <p>Ordering providers can be an M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist or Certified Nurse Midwife.</p>	<b>Required if Applicable</b>

17B	<b>NPI # of Referring Provider</b>	<b>Required if Applicable</b>																																															
18	<b>Hospitalization Dates Related to Current Services</b>	<b>Not Required</b>																																															
19	<b>Reserved for Local Use</b>	<b>Not Required</b>																																															
20	<b>Outside Lab</b>	<b>Not Required</b>																																															
21	<b>Diagnosis Codes</b> Enter at least one ICD-10 diagnosis code describing the recipient's condition. Behavioral health providers must not use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.	<b>Required</b>																																															
22	<b>Medicaid Resubmission Code</b>	<b>Required if Applicable</b>																																															
23	<b>Prior Authorization Number</b> If a service requires prior authorization, either from the UnitedHealthcare Community Plan case manager or Utilization/Prior Authorization department, enter that number.	<b>Required if Applicable</b>																																															
24A	<b>Dates of Service</b> Enter the beginning and ending service dates.  <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="6">24. A</th> <th>B</th> <th>C</th> <th colspan="2">D</th> </tr> <tr> <th colspan="6">DATE(S) OF SERVICE</th> <th>Place</th> <th rowspan="2">EMG</th> <th colspan="2">PROCEDURE, SERVICES, OR SUPPLIES</th> </tr> <tr> <th colspan="3">From</th> <th colspan="3">To</th> <th>of</th> <th colspan="2">(Explain Unusual Circumstances)</th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>Service</th> <th>CPT/HCPCS</th> <th>MODIFIER</th> </tr> </thead> <tbody> <tr> <td>02</td> <td>15</td> <td>13</td> <td>02</td> <td>15</td> <td>13</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	24. A						B	C	D		DATE(S) OF SERVICE						Place	EMG	PROCEDURE, SERVICES, OR SUPPLIES		From			To			of	(Explain Unusual Circumstances)		MM	DD	YY	MM	DD	YY	Service	CPT/HCPCS	MODIFIER	02	15	13	02	15	13				<b>Required /NDC if Applicable</b>
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24B	<b>Place of Service</b> Enter the two-digit code that describes the place of service. Refer to the Current Procedural Terminology (CPT) Manual for a complete listing.	<b>Required</b>																																															
24C	<b>EMG Emergency Indicator</b> Mark this box with a checkmark, an "X" or a "Y" if the service was an emergency service, regardless of where it was provided.	<b>Required if Applicable</b>																																															
24D	<b>Procedures, Services or Supplies</b> Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the same date of service, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT coding manuals.  For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment.	<b>Required</b>																																															
24E	<b>Diagnosis</b> Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the letter of the appropriate diagnosis. Enter only the reference letter from Field 21 (A-L), not the diagnosis codes itself. If more than one letter is entered, they should be in descending order of importance/relevance to the reason for the service.	<b>Required</b>																																															

24F	<p><b>Charges</b> Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is \$50.00 and three units were provided, enter "\$150.00" in this Field and "3" units in Field 24G.</p>	<b>Required</b>
24G	<p><b>Units</b> Enter the number of units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line.</p>	<b>Required</b>
24H	<b>EPSDT/Family Planning</b>	<b>Not Required</b>
24I	<b>ID Qualifier</b>	<b>Required if Applicable</b>
24J	<p><b>COB/Rendering Provider ID SHADED AREA – Use for COB Information (Required if Applicable)</b></p> <p>Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient' Deductible has been met, enter zero (0) for the Deductible amount.</p> <p>For recipients and service covered by a third party payer, enter only the amount paid.</p> <p>Always attach a copy of the Medicare or other insurer's EOB to the claim.</p> <p>If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.</p>	<b>Required if Applicable</b>
	<p><b>NON-SHADED AREA – Rendering Provider ID (Required)</b></p> <p>Rendering Provider's NPI is required for all providers that are mandated to maintain an NPI #.</p> <p>For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS.</p>	<b>Required</b>
25	<p><b>Federal Tax ID</b> Enter the tax ID number and check the box "EIN." If you do not have a tax ID, enter your SSN and check the box labeled "SSN."</p>	<b>Required</b>
26	<p><b>Patient Account Number</b> Number that the Provider has assigned to uniquely identify this claim in the provider's records.</p>	<b>Required if Applicable</b>
27	<b>Accept Assignment</b>	<b>Not Required</b>
28	<p><b>Total Charge</b> Enter the total for all charges for all lines on this claim.</p>	<b>Required</b>
29	<p><b>Amount Paid</b> Enter the total amount that you have been paid for this claim by all sources other than UnitedHealthcare Community Plan. Do not enter any amounts expected to be paid by UnitedHealthcare Community Plan.</p>	<b>Required if Applicable</b>

30	<b>Reserved for NUCC use.</b>	<b>Not Required</b>
31	<b>Signature and Date</b> The provider or his/her authorized representative must sign the claim form. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.	<b>Required</b>
32	<b>Service Facility Location Information</b>	<b>Required if Applicable</b>
32A	<b>Service Facility NPI #</b>	<b>Required if Applicable</b>
32B	<b>Service Facility AHCCCS ID #</b>	<b>Required if Applicable</b>
33	<b>Billing Provider Name, Address and Phone</b> Enter your provider name, address and telephone number. If a group is billing, enter the group's name, address and telephone number.	<b>Required</b>
33A	<b>Billing Provider NPI #</b>	<b>Required if Applicable</b>
33B	<b>AHCCCS ID #</b>	<b>Required if Applicable</b>



## UB-04

The UB-04 claim form is to be used to bill all hospital inpatient, outpatient, emergency room and hospital-based clinic services (including pharmacy services provided as an integral part of a hospital service), dialysis clinic, nursing facility, free-standing birthing center, residential treatment center and hospice services.

The following instructions explain how to complete the UB-04 claim form and whether a field is required, required if applicable, or not required. Failure to complete the form as required may cause your claim to be denied.

1	<b>Provider Data</b> Enter the name, address and telephone number of the provider rendering the service.	<b>Required</b>
2	<b>Unassigned</b>	<b>Not Required</b>
3	<b>Patient Control Number</b>	<b>Required if Applicable</b>
4	<b>Bill Type</b> Facility type (1 <sup>st</sup> digit), bill classification (2 <sup>nd</sup> digit), and frequency (3 <sup>rd</sup> digit).	<b>Required</b>
5	<b>Fed Tax No.</b> Enter your federal tax ID number.	<b>Required</b>
6	<b>Statement Covers Period</b> Enter the beginning and ending dates of the billing period in MM/DD/YY or MM/DD/YYYY format.	<b>Required</b>
7	<b>Covered Days</b> Enter the total number of days covered by a primary payer. If UnitedHealthcare Community Plan is the enrollee's only coverage, leave blank.	<b>Not Required</b>
8	<b>Patient Name</b> Enter enrollee's last name, first name, and middle initial as they appear on the Member's ID Card.	<b>Required</b>
9	<b>Patient Address</b>	<b>Required</b>
10	<b>Patient Birth Date</b> Enter the month; day and year (MM/DD/YYYY) of enrollee's birth.	<b>Required</b>
11	<b>Patient Sex</b> Enter "M" (male) or "F" (female).	<b>Required</b>
12	<b>Admission/Start of Care</b> Enter the admission date in MM/DD/YY or MM/DD/YYYY format.	<b>Required</b>
13	<b>Admission Hour</b>	<b>Required if Applicable</b>

14	<p><b>Admit Type (Priority Type of Admission/Visit)</b>  Required for all inpatient claims. An Admit Type of "1" is required for all emergency inpatient and outpatient claims.</p> <ol style="list-style-type: none"> <li>1. Emergency: Enrollee requires medical intervention for severe, life-threatening or potentially disabling conditions. Documentation must be attached to claim.</li> <li>2. Urgent: Enrollee requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.</li> <li>3. Elective: Enrollee's condition permits time to schedule services.</li> <li>4. Newborn: Enrollee is newborn. Newborn source of admission code must be entered in Field 20.</li> <li>5. Trauma Center: Visit to a trauma center/hospital as licensed or designated by the State or local government authority to do so, or as verified by the American College of Surgeons and involving a trauma activation.</li> </ol>	<b>Required</b>
15	<b>Point of Origin for Admission or Visit</b>	<b>Required</b>
16	<p><b>Discharge Hour</b>  Enter the code which best indicates the enrollee's time of discharge.  Required for all inpatient claims when the enrollee has been discharged.</p>	<b>Required if Applicable</b>

17	<p><b>Patient Discharge Status</b>  Required for all inpatient claims. Enter the code that best describes the recipient's status for this billing period:</p> <ul style="list-style-type: none"> <li>01. Discharged to home or self-care (routine discharge).</li> <li>02. Discharged/Transferred to a short-term general hospital for inpatient care.</li> <li>03. Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled care.</li> <li>04. Discharge/Transferred to a facility that provides custodial or supportive care.</li> <li>05. Discharge/Transferred to a designated cancer center or children's hospital.</li> <li>06. Discharge/Transferred to home under care of organized home health service organization in anticipation of covered skilled care.</li> <li>07. Left against medical advice or discontinued care.</li> <li>08. Not for use/unassigned.</li> <li>09. Admitted as an inpatient to this hospital.</li> <li>20. Expired.</li> <li>21. Discharged/Transferred to Court/Law Enforcement.</li> <li>30. Still a Patient.</li> <li>40. Expired at home.</li> <li>41. Expired in a medical facility (hospital, SNF, etc.).</li> <li>42. Expired, place unknown (hospice only).</li> <li>43. Discharged/Transferred to a federal health care facility.</li> <li>50. Discharged to Hospice – home.</li> <li>51. Discharged to Hospice – medical facility (certified).</li> <li>61. Discharged/Transferred within this institution to a hospital-based Medicare-approved swing bed.</li> <li>62. Discharged/Transferred to an inpatient rehabilitation facility (IRF).</li> <li>63. Discharged/Transferred to a Medicare-certified long term care hospital.</li> <li>64. Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare.</li> <li>65. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part/unit of hospital.</li> <li>66. Discharges/Transfers to a Critical Access Hospital.</li> <li>70. Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list.</li> </ul>	<b>Required</b>
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18-28	<p><b>Condition Codes</b> Enter the appropriate condition codes that apply to this bill. In state, non-HIS inpatient hospitals may request outlier consideration for a claim by entering "61" in any Condition Code Field.</p> <p>To bill for self-dialysis training, freestanding dialysis facilities approved to provide self-dialysis training must enter "73" in any Condition Code Field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).</p> <p>To bill for multiple distinct/independent outpatient visits on the same day facilities must enter "GO".</p>	<b>Required if Applicable</b>
29	<b>Accident State</b>	<b>Required if Applicable</b>
31-34	<b>Occurrence Codes and Dates</b>	<b>Required if Applicable</b>
35-36	<b>Occurrence Span Codes and Dates</b>	<b>Required if Applicable</b>
38	<b>Responsible Party Name and Address</b>	<b>Required if Applicable</b>
39-41	<b>Value Codes and Amounts</b>	<b>Required if Applicable</b>
42	<p><b>Revenue Code</b> Enter the appropriate revenue code(s) that describe the service(s) provided. Accommodation day should not be billed on outpatient bill types. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes.</p>	<b>Required</b>

43	<p><b>Revenue Code Description/NDC Code (effective 07/01/12)</b> Enter the description of the revenue code billed in Field 42. To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):</p> <ul style="list-style-type: none"> <li>- The NDC qualifier of N4 in the first 2 positions on the left side of the field.</li> <li>- The NDC 11-digit numeric code, without hyphens.</li> <li>- The NDC Unit of Measurement Qualifier (as listed above).</li> <li>- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.</li> </ul> <p>The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.</p>	<b>Required/NDC if Applicable</b>
44	<p><b>HCPCS/Rates</b> Enter the inpatient (hospital or nursing facility) accommodations rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for certain lab, radiology and pharmacy codes. Hospitals must enter the appropriate CPT/HCPCS code when billing for outpatient therapy services.</p>	<b>Required if Applicable</b>
45	<p><b>Service Date</b> The dates the indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not equal to each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.</p>	<b>Required if Applicable</b>
46	<p><b>Service Units</b> If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 17) and statement covers period (Field 6). If the enrollee has been discharged, UnitedHealthcare Community Plan covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the enrollee expired or has not been discharged, UnitedHealthcare Community Plan covers the admission date through the last date billed.</p>	<b>Required</b>
47	<p><b>Total Charges</b> Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to \$999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed \$999,999.99.</p>	<b>Required</b>
48	<p><b>Non-covered Services</b> Enter any charges that are not payable by UnitedHealthcare Community Plan. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.</p>	<b>Required if Applicable</b>

49	<b>Unassigned</b>	<b>Not Required</b>
50A-C	<b>Payer</b> Enter the name and identification number, if available, of each payer who may have full or partial responsibility of the charges incurred by enrollee and from which provider might expect some reimbursement.	<b>Required</b>
51A-C	<b>Health Plan ID</b> Enter the facility's ID number as assigned by the Payer(s) listed in Fields 50A, B, and/or C. Your six-digit AHCCCS service provider ID number should be listed last. Behavioral health providers must not enter their BHS provider ID number.	<b>Required</b>
52A-C	<b>Release of Information</b>	<b>Not Required</b>
53A-C	<b>Assignment of Benefits</b>	<b>Not Required</b>
54A-C	<b>Prior Payments</b> Enter the amount received from Medicare Part B (Inpatient only) or any other insurance or payer other than UnitedHealthcare Community Plan, including the patient, listed in Field 50. If the enrollee has other insurance but no payment was received, enter "0." The "0" indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only the actual payments received. Do not enter any amounts expected from UnitedHealthcare Community Plan.	<b>Required if Applicable</b>
55A-C	<b>Amount Due</b>	<b>Not Required</b>
56	<b>National Provider Identifier – Billing Provider</b>	<b>Required</b>
57	<b>Other Billing Provider Identifier</b>	<b>Required if Applicable</b>
58A-C	<b>Insured's Name</b> Enter the name of the insured (enrollee) covered by the payer(s) in Field 50.	<b>Not Required</b>
59A-C	<b>Patient's Relationship to Insured</b>	<b>Not Required</b>
60A-C	<b>Patient CERT. – SSN – HIC – ID No.</b> Enter the enrollee identification number related to the payer(s) in Field 50. The enrollee's AHCCCS ID number must be listed last.	<b>Not Required</b>
61	<b>Group Name</b> Enter insured's group name.	<b>Not Required</b>
62A-C	<b>Insurance Group Number</b>	<b>Required</b>
63A-C	<b>Treatment Authorization</b> If a service requires prior authorization, either from the UnitedHealthcare Community Plan case manager or Utilization/Prior Authorization department, enter that number in this field.	<b>Required if Applicable</b>
64	<b>Document Control #</b>	<b>Not Required</b>
65A-C	<b>Employer Name</b>	<b>Not Required</b>
66	<b>Diagnosis &amp; Procedure Code Qualifier</b>	<b>Required</b>



67	<b>Principle Diagnosis</b> Enter the principal ICD-10 diagnosis code. Behavioral health providers must <b>not</b> use DSM-4 diagnosis codes.	<b>Required</b>
69	<b>Admitting Diagnosis</b> Required for inpatient bills. Enter the ICD-10 diagnosis code that represents the significant admitting diagnosis.	<b>Required</b>
70	<b>Patient's Reason for Visit</b>	<b>Not Required</b>
72	<b>E-Codes</b> Enter trauma diagnosis code, if applicable.	<b>Required if Applicable</b>
74	<b>Principal Procedure Code and Dates</b> Enter the ICD-10 procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.	<b>Required if Applicable</b>
76	<b>Attending Provider Name and Identifiers</b>	<b>Required if Applicable</b>
77	<b>Operating Physician Name and Identifier</b>	<b>Required if Applicable</b>
78-79	<b>Required if Applicable</b>	<b>Not Required</b>
80	<b>Remarks</b>	<b>Required if Applicable</b>
81	<b>Other Procedure Codes</b> Enter other procedure codes in descending order of importance.	<b>Required if Applicable</b>

## Provider Remittance Advice

A Provider Remittance Advice (PRA) will be returned for every claim processed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each PRA carefully and compare to prior remittance advices to ensure proper tracking and posting of adjustments. We recommend that you keep all PRA's and use the information to post payments and make correction for any claims requiring resubmission. Keeping your PRA will also ensure that you have an accurate record of claims that have been received for processing and assist you in tracking any adjustments.

The PRA provides a legend that identifies the key items, such as denial reasons, on the remit. Your provider relations advocate will review a PRA with you upon contracting with UnitedHealthcare Community Plan. Please contact the Customer Service Center if you need assistance with reading a PRA.

**The following pages include a sample UnitedHealthcare Community Plan Provider Remittance Advice.**

Arizona Physicians IPA, Inc.  
 DBA UnitedHealthcare Community Plan  
 PO Box 7550  
 Phoenix AZ 85011-7550  
 PHONE: 1-800-293-3740  
 URL: UnitedHealthcareOnline.com

STD-PRA



Arizona

**PROVIDER  
 REMITTANCE ADVICE**

PAYMENT DATE: PAYEE TAX NUMBER: PAYEE NPI: PAYEE ID: PAYEE NAME:  PAYMENT NUMBER: PAYMENT AMOUNT: GRP ID: RA REFERENCE ID:
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**PROVIDER REMITTANCE AT A GLANCE**

<b>NET PAYABLE</b>	
<b>OVERPAYMENT AMOUNT</b>	
<b>RECOVERED AMOUNT</b>	
<b>NET PAID AMOUNT</b>	

STD-PRA  
**PROVIDER  
 REMITTANCE ADVICE**



Arizona

PAYMENT DATE:  
 PAYEE TAX NUMBER:  
 PAYEE ID:  
 PAYEE NAME:  
 PAYMENT NUMBER:  
 PAYMENT AMOUNT:  
 GRP ID:  
 RA REFERENCE ID:

**PATIENT:**

SUBSCRIBER ID: SUBSCRIBER NAME: PROMPT PAY DISC: CLAIM NUMBER: PATIENT ACCOUNT:  
 MEMBER ID: INTEREST AMOUNT: PCP NUMBER: REMIT DETAIL: Professional Claim PRODUCT DESC.:  
 SERVICING PROV NPI: SERVICING PROV NM: COVERAGE DATE: PCP NAME: BILLING NPI:  
 COB PRIMARY INS: CARRIER ID:

POLICY NUMBER:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	DISCOUNT AMT	ALLOWED AMT	DEDUCT AMT	CO PAY/COINS AMT	COB AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/RSN CD
04/16/16 - 04/22/16	billing code S5125-U4 POS/ Bill Type 11	96	\$852.51			\$852.51			\$0.00	\$0.00	\$852.51	\$0.00			
CLAIM NUMBER: 1eC960056900			\$852.51			\$852.51			\$0.00	\$0.00	\$852.51	\$0.00			
SUBTOTAL															

SUBSCRIBER ID: SUBSCRIBER NAME: PROMPT PAY DISC: CLAIM NUMBER: PATIENT ACCOUNT:  
 MEMBER ID: INTEREST AMOUNT: PCP NUMBER: REMIT DETAIL: Professional Claim PRODUCT DESC.:  
 SERVICING PROV NPI: SERVICING PROV NM: COVERAGE DATE: PCP NAME: BILLING NPI:  
 COB PRIMARY INS: CARRIER ID:

POLICY NUMBER:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	DISCOUNT AMT	ALLOWED AMT	DEDUCT AMT	CO PAY/COINS AMT	COB AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/RSN CD
04/23/16 - 04/28/16	billing code S5125-U4 POS/ Bill Type 11	84	\$308.45			\$308.45			\$0.00	\$0.00	\$308.45	\$0.00			
CLAIM NUMBER: 1eC960056000			\$308.45			\$308.45			\$0.00	\$0.00	\$308.45	\$0.00			
SUBTOTAL															

STD-PRA  
**PROVIDER  
 REMITTANCE ADVICE**



Arizona

PAYMENT DATE:
PAYEE TAX NUMBER:
PAYEE ID:
PAYEE NAME:
PAYMENT NUMBER:
PAYMENT AMOUNT:
GRP ID:
RA REFERENCE ID:

**PATIENT:**

SUBSCRIBER ID: SUBSCRIBER NAME: PROMPT PAY DISC: CLAIM NUMBER: PATIENT ACCOUNT:  
 MEMBER ID: INTEREST AMOUNT: PCP NUMBER: REMIT DETAIL: Professional Claim PRODUCT DESC.:  
 SERVICING PROV NPI: SERVICING PROV NM: COVERAGE DATE: PCP NAME: BILLING NPI:  
 COB PRIMARY INS: POLICY NUMBER: CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	DISCOUNT AMT	ALLOWED AMT	DEDUCT AMT	CO PAY/COINS AMT	COB AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/RSN CD
04/11/16 - 04/11/16	billing code T4527-NU POS/ Bill Type 11	180	\$271.80	\$163.80		\$108.00			\$0.00	\$0.00	\$108.00	\$0.00			CO45
CLAIM NUMBER: 16C342315000			\$271.80	\$163.80		\$108.00			\$0.00	\$0.00	\$108.00	\$0.00			
SUBTOTAL:															

**PATIENT:**

SUBSCRIBER ID: SUBSCRIBER NAME: PROMPT PAY DISC: CLAIM NUMBER: PATIENT ACCOUNT:  
 MEMBER ID: INTEREST AMOUNT: PCP NUMBER: REMIT DETAIL: Professional Claim PRODUCT DESC.:  
 SERVICING PROV NPI: SERVICING PROV NM: COVERAGE DATE: PCP NAME: BILLING NPI:  
 COB PRIMARY INS: POLICY NUMBER: CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	DISCOUNT AMT	ALLOWED AMT	DEDUCT AMT	CO PAY/COINS AMT	COB AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/RSN CD
04/11/16 - 04/11/16	billing code A4649-NU POS/ Bill Type 11	1	\$22.41	\$22.41					\$0.00	\$0.00	\$0.00	\$0.00		N350	CO251
CLAIM NUMBER: 16C342696800			\$22.41	\$22.41					\$0.00	\$0.00	\$0.00	\$0.00		N350	
SUBTOTAL:															

**REMARKS**

- CO197 Precertification/authorization/notification absent.
- CO45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- PH197 Precertification/authorization/notification absent.
- CO251 The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.
- N640 Exceeds number/frequency approved/allowed within time period.

STD-PRA-860898863-520000000005972916

Page

STD-PRA  
**PROVIDER  
REMITTANCE ADVICE**



Arizona

PAYMENT DATE:
PAYEE TAX NUMBER:
PAYEE ID:
PAYEE NAME:
PAYMENT NUMBER:
PAYMENT AMOUNT:
GRP ID:
RA REFERENCE ID:

**PROVIDER COMMUNICATIONS**

To contact Provider Services, please call 1-800-293-3740 or you may reach out to your Provider Advocate.

**NATIONAL PROVIDER IDENTIFIER INFORMATION**

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. When covered health care providers, health plans, and health care clearinghouses submit claims/encounter data, they will use the NPI in the administrative and financial transactions adopted under HIPAA.

The NPI is required on all claims submissions and subsequent encounters. Claims may be denied if the rendering provider's NPI is missing or invalid (if required for the AHCCCS Provider Type). Atypical providers are not required to have an NPI, and must bill with their AHCCCS Medicaid ID. Failure to do so may result in a denied claim. If an atypical provider has obtained an NPI and registered it with AHCCCS, it may be used.

**BALANCE BILLING**

Billing or balance billing UNITEDHEALTHCARE COMMUNITY PLAN Medicaid members is prohibited and may violate federal and state medical assistance rules and regulations. See Arizona Administrative Code (AAC) R9-22-702.

**EDI, ERA, & EFT: GET CONNECTED**

Getting connected with ERA, EDI and EFT will reduce the time and cost associated with paper claims submission, remittance advice reconciliation, and claims reimbursement processing. Let us help you get connected with EDI, ERA, and EFT by contacting us at:

EDI PERFORMANCE MANAGEMENT  
1-800-210-8315  
AC\_EDI\_OPS@UHC.COM

**UNITEDHEALTHCARE COMMUNITY PLAN ONLINE SERVICES**

Please visit us at [www.UNITEDHEALTHCAREONLINE.com](http://www.UNITEDHEALTHCAREONLINE.com) for valuable resources such as: Provider Manual, Reimbursement Policies, Newsletters, Bulletins, Forms, Billing and Clinical Practice Guidelines. Did you know you can submit batch claims, adjustment requests and check the status of your claims online through the provider portal? This is your best source for submitting adjustment requests. You can check member eligibility information, secondary coverage, view panel rosters, remittance advices, and obtain copies of authorizations. You can also change the information we have about your practice and register for electronic funds transfer (EFT).

**UNITEDHEALTHCARE COMMUNITY PLAN PROVIDER SERVICES**

Many of the above transactions can also be completed by calling our toll free provider customer service line at 1-800-293-3740.

Before filing a provider claim dispute, please contact provider customer service at 1-800-293-2740 to clarify reasons for denials and get help with possible resubmission of a modified claim. A claim inquiry or research request does not extend the claim dispute filing deadlines. If you wish to file a claim dispute, please follow the instructions below under Claim Disputes.

**Appeals Procedures**

**CORRECTED CLAIM RESUBMISSIONS AND CLAIM ADJUSTMENTS**

Corrected claim resubmissions – a previously submitted claim requiring additional documentation or correction (e.g. EOB, corrected CPT code, diagnosis code, provider ID, member ID, etc.). Please submit corrected



STD-PRA  
**PROVIDER  
REMITTANCE ADVICE**



Arizona

PAYMENT DATE:
PAYEE TAX NUMBER:
PAYEE ID:
PAYEE NAME:
PAYMENT NUMBER:
PAYMENT AMOUNT:
GRP ID:
RA REFERENCE ID:

claims for reconsideration no more than 12 months from the date of service or 12 months after eligibility posting, whichever is later.

Claim Adjustments – a previously paid claim that requires additional research due to an overpayment or underpayment.

For either a corrected claim resubmission or claim adjustment, please submit your claim and supporting documentation along with a reconsideration form addressing the specific issue to:

UNITEDHEALTHCARE COMMUNITY PLAN  
P.O. BOX 5290  
KINGSTON, NY 12402-5290

You can locate a copy of the reconsideration form at [www.UNITEDHEALTHCAREONLINE.COM](http://www.UNITEDHEALTHCAREONLINE.COM) > TOOLS & RESOURCES > FORMS.

**CLAIM DISPUTES**

If you wish to file a claim dispute to maintain your rights, follow the instructions provided below:

All providers of services to UNITEDHEALTHCARE COMMUNITY PLAN members may file a claim dispute based on a claim denial, dissatisfaction with a claim payment, or recoupment action by UNITEDHEALTHCARE COMMUNITY PLAN. Pursuant to AHCCCS guidelines, all claim disputes must be filed in writing no later than 12 months from the date of services, 12 months after the date of eligibility posting, or within 60 days after the payment, denial, or recoupment of a timely claim submission, whichever is later. The claim dispute must state with particularity the factual and legal basis for the relief requested, along with all supporting documentation such as claims, remits, medical records, etc. Incomplete submissions, or those which do not meet the criteria for a claim dispute, will be denied. Additional sources of information on the claim dispute process include the UNITEDHEALTHCARE COMMUNITY PLAN Provider Manual, Arizona Revised Statutes (ARS) 36-2903.01(B)(4), and Arizona Administrative Code (AAC) R9-34-401 et seq.

All claim disputes must be submitted in writing to:  
UNITEDHEALTHCARE COMMUNITY PLAN  
APPEALS & CLAIM DISPUTES DEPARTMENT  
1 E. WASHINGTON STREET  
SUITE 900  
PHOENIX, AZ 85004-2582

If the provider disagrees with UNITEDHEALTHCARE COMMUNITY PLAN's decision, the provider may request a hearing within 30 days of the decision. UNITEDHEALTHCARE COMMUNITY PLAN will forward the hearing request to AHCCCS, Office of Grievance and Appeals.

# Ch. 12 Claims Disputes and Appeals

## Claims Research

UnitedHealthcare Community Plan can assist providers in resolving claims issues. The provider should call the Customer Call Center at 800-293-3740 for any questions regarding claims status on previously submitted claims.

## Claim Disputes

Physicians and health care providers are required to submit claims timely or the claim may be subject to denial. Contracted providers must submit their original claim(s) within the contractual deadline of 90 days from the date of service or 60 days from the date of the primary carrier's EOB. Please remember that submitted means the date the claim is received by the UnitedHealthcare Community Plan.

Should the provider receive a denial or reimbursement that does not meet the provider's expectations for the submitted claim, the provider should exhaust all processing procedures before filing a claim dispute. If the physician or health care provider has exhausted all processing procedures and still has a disputed claim, the provider has the right to file a claim dispute with UnitedHealthcare Community Plan.

Providers are encouraged to contact the Customer Call Center or their provider relations advocate if they need assistance with understanding the payment amount or denial reason. UnitedHealthcare Community Plan asks providers to consider the following when determining if a claims dispute should be filed:

- Was the claim submitted timely, according to your provider agreement?

- Did you receive a provider remittance advice (PRA) with the claim in question listed?
- Was the claim resubmitted with the corrected information as identified on the PRA?
- Have you contacted the Customer Call Center or your provider relations advocate to discuss the claim in question?

## Provider Claim Dispute Standards

**ACKNOWLEDGEMENT:** Claim disputes are acknowledged in writing and within five business days of receipt.

**DECISION:** A copy of the Contractor's Notice of Decision "Decision" shall be mailed to all parties no later than 30 days after the provider files a claim dispute with UnitedHealthcare Community Plan, unless the provider and UnitedHealthcare Community Plan agree to a longer period.

**PAYMENT:** If the claim dispute is overturned, in full or in part, UnitedHealthcare Community Plan shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the decision.

## Time Limits for Filing a Claim Dispute

A physician or health care provider must submit any claim dispute challenging the claim payments, denials or recoupments (adverse actions) in writing within 12 months (365 days) from the end date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. Upon receipt, the Claim Dispute coordinator will date stamp the request and that date will be considered the filing date for timeliness purposes. Refer to AAC R9-34-405 and ARS 36-2903.01(B)(4) for additional information.

If your claim has not been paid or denied, your letter will be returned.

### Definitions:

- A timely submitted claim is one that has been originally submitted within the contractual deadline of 90 days from the date of service or 60 days from the date of the primary carrier's EOB.
- An **adverse action** is a claim denial or payment reduction.
- **Submitted** means the date the claim is received by UnitedHealthcare Community Plan for processing.

## Dispute Process

Please follow these steps to ensure proper review of your dispute:

1. Submit a cover letter indicating why you think your claim was under-paid or denied. Please include the following:
  - The date you wrote the letter.
  - Details of the reason for the dispute and your outcome/resolution expectations.
  - Any documentation supporting the facts.
  - The enrollee's AHCCCS ID number, name, and date of service in question.
  - The writer's signature.
2. A typed letter is preferred; however if you choose to handwrite your letter, make sure that it is legible.
3. Please use letterhead paper or include a correspondence address on your letter so we know where to send the resolution letter.
4. Include with the letter, if available:
  - A copy of the PRA from UnitedHealthcare Community Plan
  - A copy of the original claim
  - A copy of the Medicare EOB (if applicable)
  - A copy of the authorization (if applicable)
  - If you are a contracted provider and have specific rates associated to your contract, please include a copy of the rates page of your contract.
5. Mail the letter and attachments to:

UnitedHealthcare Community Plan  
Attn: Provider Claim Disputes  
1 East Washington, Suite 900  
AZ009-900E  
Phoenix, AZ 85004

Upon receipt of a dispute, UnitedHealthcare Community Plan will mail an acknowledgement to the party identified on the request. This letter should be retained for future reference.

Upon investigation, UnitedHealthcare Community Plan will issue the provider a decision notice or a request for additional information and/or extension.

If UnitedHealthcare Community Plan makes a decision on the same day we open your dispute, an acknowledgement/decision letter will be mailed to the party identified on the request.

## Dispute Resolution/Decision Letter

### Reversal

If the physician or health care provider receives a decision letter in their favor, the claim will be forwarded to the claim unit for processing. All claims are subject to all routine claims processing edits and audits. If the submitted claim contains errors, omissions, or does not have the required documentation, the claim may be denied even though the decision was in your favor.

## Denial

If the physician or health care provider receives a denial resolution/decision letter, the provider will have 30 days from the postmark to request, in writing, to the UnitedHealthcare Community Plan dispute coordinator, a state fair hearing. The provider must reference the dispute number and indicate that a request for state fair hearing is being filed. Further instructions are outlined in the decision letter.

## Hearing Process

Upon receipt of a request for state fair hearing, UnitedHealthcare Community Plan will forward all documentation on file pertaining to the issue (e.g. claim, medical records, and decision) to the AHCCCS Administration.

When a hearing is requested, the AHCCCS administration will notify the provider in writing of a hearing date, time and location.

The Office of Administrative Hearings (OAH), an independent state agency, conducts all AHCCCS hearings. An administrative law judge (ALJ) from the OAH will conduct the hearing, review the facts, apply law, and make a recommendation to the AHCCCS Administration.

All requests and motions concerning the case must be submitted to the assigned ALJ. All requests must also be copied to any other party involved, including requests to appear telephonically.

The ALJ submits a "Recommended Decision" to the AHCCCS Administration within 20 days following the closure date of the hearing. AHCCCS will then issue a final decision 30 days from the date they receive the recommendation of the ALJ.

## Dispute Submission Suggestions/Reminders

The following are a few suggestions that will help prevent errors commonly made by providers when filing disputes:

- If a provider files a dispute concerning nonpayment but payment is made before a decision is rendered, the provider should submit a letter withdrawing the dispute.
- Once the claim is paid, if the provider is dissatisfied with the reimbursement, an additional dispute may then be entertained within the required time frames.
- Providers may not submit a dispute for claims that have not been submitted, paid or denied. These dispute letters will be returned to the providers.
- If a provider submits a dispute regarding timely filing of a claim, the provider should submit proof of timely filing (e.g. certified mail receipt/bill of lading) with the dispute documents or your dispute may be denied.
- If a dispute involves medical necessity/level of care, the provider should submit documentation to support medical necessity and/or the level of care requested.
- All disputes must be filed with specificity. The provider must explain why the dispute is being filed and why the provider believes that the claim was not processed or paid correctly AAC R9-34-404.
- Disputes should also include a copy of the original claim submission and all necessary payment information.
- The claim dispute department will not review requests for a retro authorization.

Claim dispute regulations and requirements are detailed on the provider remittance advice.

# Ch. 13 Corporate Compliance - Fraud and Abuse

UnitedHealthcare Community Plan is committed to joining the Centers for Medicare & Medicaid Services (CMS) and AHCCCS in the prevention and detection of fraud. We also encourage our providers to do the same.

## Definitions

**Abuse of a member:** Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual or emotional abuse or sexual assault. (A.R.S. § 46-451 and 13-3623).

**Abuse by a provider:** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program. (42 CFR 455.2).

**Fraud by a member or provider:** Intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2).

## Examples of Fraud

**Falsifying Claims/Encounters:** Alteration of a claim, incorrect coding, double billing, and false data submitted.

**Falsifying Services:** Billing for services/supplies not provided, misrepresentation of services/supplies, or substitution of services.

**Administrative/Financial:** Kickbacks, falsifying credentials, fraudulent enrollment practices, fraudulent Third Party Liability (TPL) reporting, fraudulent recoupment practices.

## Member Issues (Fraud) Eligibility

**Determination Issues:** Resource misrepresentation (transfer/hiding), residency, and household composition.

## UnitedHealthcare Community Plan Responsibilities

UnitedHealthcare Community Plan Medicare and Medicaid Services (CMS) and AHCCCS are committed to the prevention and detection of fraud. Unchecked fraud has the potential for diverting dollars which could otherwise be spent to safeguard the health and welfare of people with limited income.

Each department of UnitedHealthcare Community Plan has a part in detection and prevention of Medicaid and Medicare fraud and abuse. To detect potential case of fraud and abuse, the various departments of UnitedHealthcare Community Plan do the following.

### Provider Services is required to:

- Ensure a careful review of all participating providers during the credentialing/certification process (including re-credentialing),
- Monitor providers for non-compliance with UnitedHealthcare Community Plan and/or AHCCCS rules, policies and procedures.

### Prior Authorization is required to verify:

- Member eligibility,
- Medical necessity,
- Appropriateness of service being authorized
- The service being requested is a covered service, and
- Appropriate provider referral

**Claims Editors are Required to Review Claims During the Initial Processing for Items Such as:**

- Member eligibility
- Covered services
- Excessive or unusual services for sex or age
- Duplication of services
- Prior authorization
- Invalid procedure codes
- Duplicate claims

Claims over a certain amount and any unusual items found during this review process will cause the claim to pend for review.

**Post Processing Claims Reviewers Look Retrospectively at a Sample of Paid Claims to Determine the Following:**

- Reasonable charges were made for services provided.
- Appropriateness of inpatient and outpatient care.
- Appropriate level of care.
- Excessive diagnostic testing or ancillary referrals.
- Payments are being prepared correctly.
- Payments are not being made to providers for services not performed, not authorized, or otherwise inappropriate.
- Test validity of the original claims process for detecting fraud and misuse.

**Utilization/Quality Management controls include:**

- Prior authorization and/or pre-admission review.
- Admission review.
- Concurrent review.
- Discharge review.

- Retrospective reviews for under and over service utilization.

Quality Management conducts regularly scheduled and ad hoc on-site reviews for concern report investigation and medical record audits.

If at any time during above processes an “unusual incident” is suspected or discovered, the matter would be referred to the UnitedHealthcare Community Plan, Compliance/Fraud and Abuse Officer or designee. The Contractor agrees to immediately (within 10 business days of discovery) inform the OIG in writing of instances of suspected fraud or abuse [42 CFR 455.1].

**Provider Responsibilities**

UnitedHealthcare Community Plan encourages providers to join in the prevention and detection of fraud and abuse. Summarized below are things providers can do to help preserve the Medicaid/Medicare systems for future generations.

**Providers are asked to:**

- Complete a pre-application for participation in the contract process, to be reviewed by UnitedHealthcare Community Plan provider relations. Credentialing criteria include, but are not limited to:
  - A complete, accurate and verified application,
  - Current Arizona professional license,
  - Proof of completion of education and training commensurate with the provider’s field of practice,
  - Review of any history of limitations, suspensions or restrictions of privileges,
  - Review of any felony convictions, substance abuse, and suspensions or terminations from the Medicaid or Medicare programs and/or debarment from the Department of Health and Human Services.



- Comply with all applicable federal, state and local laws, rules and regulations,
- Notify UnitedHealthcare Community Plan of any credentialing/licensure change,
- Maintain professional standards,
- Maintain and furnish records and documents as required by law, rule and regulation,
- Abide by contract provisions to avoid termination of the contract,
- Self-report errors in which fraud has unknowingly been committed,
- Report cases in which members are suspected of fraud,
- Refrain from engaging in kickbacks.

## Reporting of Fraud and Program Abuse Involving Title XIX Funds or AHCCCS Registered Providers

Upon becoming aware of a suspected incident of fraud or abuse, including a suspected incident committed by the UnitedHealthcare Community Plan contractor or AHCCCS contracted provider, an UnitedHealthcare Community Plan contractor or provider has 10 working days to inform the Office of Inspector General of the suspected fraud or abuse in writing to the address below, or by submitting an online form. To report suspected member eligibility fraud or suspected provider fraud contact UnitedHealthcare Community Plan Fraud and Abuse Coordinator at 602-255-8065 or report directly to:

AHCCCS Office of Inspector General  
801 E. Jefferson  
Mail Drop 4500  
Phoenix, AZ 85034

Phone (602) 417-4193 or (602) 417-4045  
FAX: (602) 417-4102  
Toll Free: 888-487-6686 or  
800-654-8713 ext. 4045

In addition, the UnitedHealthcare Community Plan provider should advise the UnitedHealthcare Community Plan, Compliance/Fraud and Abuse Officer of the report to AHCCCS by writing to the contact information below:

UnitedHealthcare Community Plan  
Attention: Compliance/Fraud and Abuse Officer  
1 East Washington Suite 800  
Phoenix, AZ 85004

## Self-Reporting to External

### Agencies

If the affected UnitedHealthcare Community Plan enrollee is in a skilled nursing facility, assisted-living facility, or a home and community-based setting (HCBS), the following agencies must be notified of the suspected abuse, fraud, negligence or exploitation, as appropriate:

- Adult Protective Services/Child Protective Services.
- Arizona Department of Health Services (except for incidents involving financial matters).
- Arizona health Care Cost Containment System (AHCCCS).
- Centers for Medicare and Medicaid Services (CMS).
- Local police department.

Notification of these agencies is not considered confirmation of abuse, fraud, negligence or exploitation. UnitedHealthcare Community Plan providers are required to notify these agencies so they may begin their own investigations of the incident as soon as possible. If the provider fails to notify the above agencies, it is UnitedHealthcare Community Plan's duty to report cases once they have been discovered.

## Provider Training & Awareness

Providers are encouraged to take the training on the AHCCCS website, "Fraud Awareness for Providers": [azahcccs.gov/fraud/reporting/reporting.aspx](http://azahcccs.gov/fraud/reporting/reporting.aspx).

Billing Educational Opportunities

New Provider Education

Ongoing Training

**Additional educational information may be found on the following websites:**

[cms.hhs.gov/home/medicaid.asp](http://cms.hhs.gov/home/medicaid.asp)

[medicare.gov/FraudAbuse/HowToReport.asp](http://medicare.gov/FraudAbuse/HowToReport.asp)

[ahccs.state.az.us/Site/RptFraud.asp](http://ahccs.state.az.us/Site/RptFraud.asp)

[cms.hhs.gov/FraudAbuseforProfs](http://cms.hhs.gov/FraudAbuseforProfs)

## References:

- Section 1903(q) of the Social Security Act
- Title 42 of the Code of Federal Regulations (42 CFR) 1007.1 through 1007.21
- 42 CFR 455.1 through 455.23
- Arizona Revised Statutes (A.R.S.) § 46-451
- A.R.S. § 13-3623
- Arizona Administrative Code R9-22, Article 5
- AHCCCS Contractors Operations Manual, Chap 100, 103-1 to 103-5

# Ch. 14 Deficit Reduction Act/Federal False Claims Act

All employees and management to include contractors and agents will receive written information regarding the False Claims Act. The False Claims Act and Whistle-blower Training includes information on the following:

## **False Claims Act (FCA): United States Code Title 31 § 3729-3733:**

- The False Claims Act, also known as the “Lincoln Law,” dates back to the Civil War.
- The original law included “qui tam” provisions that allowed private persons to sue those who defrauded the government and receive a percentage of any recovery from the defendant.
- Providers are required to train their staff on the following aspects of the Federal False Claims Act provisions:
  - a. The administrative remedies for false claims and statements;
  - b. Any state laws relating to civil or criminal penalties for false claims and statements;
  - c. The whistleblower protections under such laws

## **Activities Covered by the FCA:**

- Knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment;
- Knowingly using (or causing to be used) a false record or statement to get a claim paid by the federal government;
- Conspiring with others to get a false or fraudulent claim paid by the federal government; and;
- Knowingly using (or causing to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government;
- In general, the False Claims Act covers fraud involving any federally funded contract or program, with the exception of tax fraud

## **Liability for Violating the FCA:**

- Three times the dollar amount that the Government is defrauded (i.e., treble damages) and civil penalties of \$5,500 to \$11,000 for each false claim.

## **Types of Fraud Prosecuted Under the FCA:**

It is impossible to list all of the frauds that have been prosecuted under the False Claims Act, but the following list gives some idea of the scope of the false claims on the government that have been uncovered to date:

- Billing for goods and services that were never delivered or rendered.
- Billing for marketing, lobbying or other non-contract related corporate activities.
- Submitting false service records or samples in order to show better-than-actual performance.
- Presenting broken or untested equipment as operational and tested.
- Performing inappropriate or unnecessary medical procedures in order to increase Medicare reimbursement.
- Billing for work or tests not performed.
- Billing for premium equipment but actually providing inferior equipment.
- Automatically running a lab test whenever the results of some other test fall within a certain range, even though the second test was not specifically requested.
- Defective testing - Certifying that something has passed a test, when in fact it has not.
- “Lick and stick” prescription rebate fraud and “marketing the spread” prescription fraud, both of which involve lying to the government about the true wholesale price of prescription drugs.

- Unbundling - Using multiple billing codes instead of one billing code for a drug panel test in order to increase remuneration.
- Bundling - Billing more for a panel of tests when a single test was asked for.
- Double billing - Charging more than once for the same goods or service.
- Upcoding - Inflating bills by using diagnosis billing codes that suggest a more expensive illness or treatment.
- Billing for brand - Billing for brand-named drugs when generic drugs are actually provided.
- Phantom employees and doctored time slips: Charging for employees that were not actually on the job, or billing for made-up hours in order to maximize reimbursements.
- Upcoding employee work: Billing at doctor rates for work that was actually conducted by a nurse or resident intern.
- Yield burning - skimming off the profits from the sale of municipal bonds.
- Falsifying natural resource production records - Pumping, mining or harvesting more natural resources from public lands that is actually reported to the government.
- Being over-paid by the government for sale of a good or service, and then not reporting that overpayment.
- Misrepresenting the value of imported goods or their country of origin for tariff purposes.
- False certification that a contract falls within certain guidelines (e.g. the contractor is a minority or veteran).
- Billing in order to increase revenue instead of billing to reflect actual work performed.
- Failing to report known product defects in order to be able to continue to sell or bill the government for the product.

- Billing for research that was never conducted; falsifying research data that was paid for by the U.S. government.
- Winning a contract through kickbacks or bribes.
- Prescribing a medicine or recommending a type of treatment or diagnosis regimen in order to win kickbacks from hospitals, labs or pharmaceutical companies.
- Billing for unlicensed or unapproved drugs.
- Forging physician signatures when such signatures are required for reimbursement from Medicare or Medicaid.

#### **How and when an individual can receive an award for blowing the whistle under the FCA?**

- You must file a qui tam lawsuit. Merely informing the government about the False Claims Act violation is not enough.
- The whistleblower that files a False Claims Act suit receives an award only if, and after, the government recovers money from the defendant as a result of the lawsuit.

#### **How much money can an individual receive for filing a qui tam lawsuit?**

- Generally, the court may award between 25 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement.
- The amount of the award depends, in part, upon: if the government participates in the suit and the extent to which the person substantially contributed to the prosecution of the action.

#### **Is A Whistle Blower Protected Under the FCA?**

- Under Section 3730(h) of the False Claims Act, any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.

**Contracted Providers are required by contract to train their staff on the following aspects of the Federal False Claims Act provisions:**

- The administrative remedies for false claims and statements;
- Any state laws relating to civil or criminal penalties for false claims and statements;
- And the whistleblower protections under such laws.

UnitedHealthcare Community Plan will provide the required information at least annually through dissemination of written information through our Provider Newsletters and/or information distributed and documented at provider site visits.

Contracted providers' compliance with AHCCCS DRA training requirements is accomplished through a combination of contract amendment to add detailed training requirements and/or provider attestations statements. Monitoring of provider compliance will be conducted by the Office of Inspector General.

UnitedHealthcare Community Plan will research potential overpayments identified by the AHCCCS Office of Inspector General. After conducting a cost-benefit analysis to determine if recoup action is warranted, UnitedHealthcare Community Plan will attempt to recover any overpayments identified. The AHCCCS Office of Inspector General shall be advised of the final disposition of the research and actions, if any, taken by UnitedHealthcare Community Plan.

**Additional information sources available are:**

State statutes relating to false claims: Arizona Revised Statutes (ARS)

- ARS 13-1802: Theft
- ARS 13-2002: Forgery
- ARS 13-2310: Fraudulent schemes and artifices

- ARS 13-2311: Fraudulent schemes and practices; willful concealment
- ARS 36-2918: Duty to report fraud

**Websites for obtaining additional information:**

Arizona Revised Statutes

[azleg.state.az.us/ArizonaRevisedStatutes.asp](http://azleg.state.az.us/ArizonaRevisedStatutes.asp)

Deficit Reduction Act – Public Law 109-171

[gpoaccess.gov/plaws/index.html](http://gpoaccess.gov/plaws/index.html)

(insert public law 109-171 in the quick search box)

## Ch. 15 Advanced Directives

All adult ALTCS enrollees in hospitals, nursing facilities, hospices and other health care settings have certain rights, including those defined in federal law as an “Advance Directive.” All contracted hospitals, nursing facilities, home health agencies, hospices and other organizations responsible for providing personal care must comply with federal and state law regarding Advance Directives for adult enrollees.

Each provider must provide written information to adult enrollees regarding medical care and the health care provider's written policies concerning Advance Directives. Providers must document in the enrollee's medical record whether an Advance Directive has been executed. Providers may not discriminate against an enrollee because of his or her decision to execute or not execute an Advance Directive and cannot make it a condition for provision of care. These providers must also provide education to staff on issues concerning Advance Directives including notification of direct care provider of services, such as home health care and personal care, of any Advance Directives executed by enrollees to whom they are assigned to provide services.

All contracted PCPs must document in the UnitedHealthcare Community Plan enrollee's medical record whether or not the adult enrollee has been provided the Advance Directive information and whether an Advance Directive has been executed. Hospitals, nursing facilities, home health agencies, hospice and organizations responsible for providing personal care will provide a copy of the enrollee's executed Advance Directive, or documentation of refusal to the enrollee's PCP for inclusion in the enrollee's medical record.

UnitedHealthcare Community Plan is required to provide written information to adult enrollees that describe the enrollee's rights relating to Advance Directives. The narrative set out below is given to ALTCS enrollees by AHCCCS to inform them of their Advance

Directive rights and is quoted directly to inform health care providers of ALTCS enrollees' rights in this regard:

“You have the right to have your personal and medical records kept private. You also have the right to know what treatment you will receive. As of Dec. 1, 1991, per federal law, you have the right to fill out a paper known as an “Advance Directive.” The paper says, in advance, what kind of treatment you want, or do not want. This paper is very useful when you are unable to tell medical staff of your wishes.”

The questions and answers below will help explain this law. It requires hospitals, nursing centers and other health care providers to inform you of Advance Directives. It will explain your legal choices in making decisions about medical care. The law is intended to increase your control over medical treatment decisions.

### **Q: Who has the right to make health care decisions?**

A: You do, if you are able to make and let health care providers know of your health care decisions. You decide what health care, if any, you will not accept.

### **Q: What if I become unable to make or let health care providers know of my health care decisions?**

A: You can still have some control over these decisions if you have signed an Advance Directive. Your health care provider must include in your medical record whether you have signed an Advance Directive. If you have not named someone in your Advance Directive, your doctor must seek a person authorized by law to make these decisions.



**Q: What is an Advance Directive?**

A: It is a written statement about how you want your health decisions made. Under Arizona law, there are three common types of Advance Care Directives. These are:

**1. A Health Care Power of Attorney** – a written statement in which you have an adult to make health care decisions for you only when you cannot make or let others know of such decisions.

The Health Care Power of Attorney must:

- State the name of the person you have permitted to make health care decisions for you.
- State that this person can only make health care decisions for you when you cannot, if that is what you want.
- Be dated and signed by you.

Your Health Care Power of Attorney may also:

- Include any details or guidance about health care you want or do not want. This could include withholding or withdrawing procedures if you are in a “terminal condition.” A “terminal condition” is when a patient cannot be cured and will die without life-sustaining procedures (this must be stated in writing by two doctors). A patient is also in a “terminal condition” if that patient is in a permanent vegetative state or an irreversible coma.
- Name a second person to make these decisions if the first person is not able to do so.
- Include signatures of witnesses and a notary public that saw you sign the Power of Attorney.

**2. A Living Will** – a written statement about health care you want or do not want that is to be followed if you cannot make these decisions. For example, a Living Will can say whether you would want to be fed through a tube if you were unconscious and unlikely to recover. A Living Will may direct doctors to withhold/withdraw or continue life- sustaining procedures if you are in a “terminal condition.” For instance, a Living Will can tell whether you want to be fed through tubes if you cannot eat or drink. You can also tell doctors whether to use other life-sustaining procedures. Your doctors will use your Living Will only if you are not able to make or state your health care decisions. Even if you have a Living Will, you can be kept comfortable with drugs and other procedures if this is what you want. To make a valid Living Will:

- Sign and date your Living Will in front of two witnesses who must also sign it.
- Neither witness may be directly involved in your care.
- In addition, one of the witnesses must not be related to you by blood or marriage; have a right to receive any of your estate; have a claim against the estate; or directly pay for your medical care.

**3. A Pre-Hospital Medical Care Directive** – a directive refusing certain lifesaving emergency care given outside a hospital or in a hospital emergency room. To make one, you must complete a special orange form. A Pre-Hospital Medical Directive must be completed as required by law. The form will list the following treatments you may refuse:

- Chest Compression (chest pressure to restart your heart)
- Defibrillation electronically correcting the heart beat)

- Assisted ventilation (breathing by machine)
- Intubations (supplying air through a tube down the throat)
- Advanced life support medications

You should talk to your doctor about Pre-Hospital Directives if you are thinking about signing one. In addition, a Pre-Hospital Directive must:

- Be signed or marked by you and dated
- Be signed by a licensed physician or health care provider and a witness

If you have signed an orange Pre-Hospital Medical Directive, you may also wear a special orange bracelet. It must state your name, your doctor's name, and the words "Do not resuscitate." The bracelet will call to the attention of emergency medical personnel that you have completed the form and that you do not want the emergency medical care you have checked on the form. These directives used separately or together, can help you say "yes" to treatment you want and "no" to treatment you do not want.

**Q: Must my Advance Directives be followed?**

A: Yes. Both health care providers and the person you name in your directive must follow valid Advance Directives.

**Q: Must a lawyer prepare my Advance Directive?**

A: No. There are local and national groups that may provide you with facts on Advance Directives, including forms. Be sure any Advance Directive you use is valid under Arizona law.

**Q: Who should have a copy of my Advance Directive?**

A: Give a copy of your Advance Directive to your doctor and to any health care center upon your admission. If you have a Health Care Power of Attorney, give a copy to the person you have named on it. You should also keep extra copies for yourself.

**Q: Can I be required to make an Advance Directive?**

A: No. Whether you make an Advance Directive is entirely up to you. A health care provider cannot refuse care based on whether or not you have an Advance Directive.

**Q: Can I change or cancel my Advance Directives?**

A: Yes. If you change or cancel your Advance Directive, let anyone know who has a copy of it.

**Q: What if I already have an Advance Directive?**

A: You may want to review it or have it reviewed. If it has been prepared in another state, make sure it is valid under Arizona law. If you prepared it before September 1992, you should know the law has changed, and new choices are available to you.

**Q: Does Arizona law limit what can be done under an Advance Directive?**

A: The Arizona law does not allow actions or inactions, which may lead to the injury, or death of physically or mentally impaired adults. It is unclear whether this law will be applied to the health care decision-making process. It is important to have a properly prepared Advance Directive that state your wishes as to the treatment(s) you do/do not want.

**Q: Who can legally make health care decisions for me if I cannot make those decisions and I have no Advance Directive?**

A: A court may appoint a guardian to make health care decisions for you. Otherwise, your health care provider must go down the following list to find someone else to make health care decisions for you:

- Your husband or wife, unless you are legally separated
- Your adult child. If you have more than one adult child, a majority of them
- Your mother or father
- Your domestic partner, unless someone else has financial responsibility for you
- Your brother or sister
- A close friend of yours (someone who shows special concern for you and knows your health care views)

If your health care provider cannot find a person able to make health care decisions for you, then your doctor can decide. Your doctor can do this with the advice of an ethics committee, or with the approval of another doctor.

You can keep anyone from making decisions for you by saying so in writing. The person you name in your Advance Directive will not have the right to refuse the use of tubes to give you food or fluids unless:

- You have appointed that person to make health care decisions for you in a Health Care Power of Attorney
- A court has appointed that person as your guardian to make health care decisions for you
- You have stated in an Advance Directive that you do not want this “specific treatment”

# Ch. 16 Credentialing/Re-Credentialing

All physician and health care providers providing health services to UnitedHealthcare Community Plan enrollees must be credentialed in accordance with UnitedHealthcare Community Plan's policies and procedures. Beginning in 2009, all credentialing will take place through United HealthCare's National Credentialing Committee.

Under CMS regulation, the credentialing process and approval must be completed before providing care to a UnitedHealthcare Community Plan enrollee. In addition, UnitedHealthcare Community Plan follows this policy for all contracted ALTCS providers.

Re-credentialing will occur every three years thereafter for all contracted physicians, other health care providers, facilities, and hospitals.

The following items are required to complete primary source verification:

## Physician and Health Care Providers

- Five-year work history
- State License
- DEA & CDS (controlled dangerous substances) certificates
- Malpractice Insurance Coverage and History
- Education and Training
- Board Certification
- Hospital Privileges
- NPDB/HIPDB query
- Medicare/Medicaid Sanctions
- Disclosure Statement and Signed Attestation
- Verification of "Opt Out" or Private Contract from Medicare participation

## Skilled Nursing Facility Credentialing

- Medicare, Medicaid, CARF, CHAPS, or JCAHO accreditation
- Copy of License
- Copy of Professional Liability Certificate

The credentialing process is considered complete when the credentialing committee approves the credentialing application. The physician or health care provider will be notified by Provider Relations and issued a UnitedHealthcare Community Plan provider number once the credentialing process has been completed.

## Medical Record Review

PCPs and mid-level practitioners (e.g. NPs and PAs) that have more than 50 UnitedHealthcare Community Plan enrollees under their care will have 5 percent of their medical records reviewed to meet the re-credentialing criteria. The medical record review will be audited for the following 14 items:

1. Identifying information on the enrollee
2. Identification of all physician and health care providers participating in the enrollee's care and information on services furnished by these physician and health care providers
3. Is there a completed problem list?
4. Are all entries signed/initialed?
5. Are all entries dated?
6. Is the record legible?
7. Are allergies/adverse reactions prominently displayed?
8. Is there evidence of an advanced directive in the enrollee's chart?

9. Is there evidence of prescribed medications, including dosages and dates of initial or refill prescriptions?
10. Is there evidence of past medical history, physical examination treatments, treatments necessary, and possible risk factors for the enrollee relevant to the particular treatment?
11. Are problems from previous visits addressed?
12. Evidence of follow up for abnormal test results
13. Evidence of presenting complaints, diagnoses and treatment plan

### **Office Visits for PCP's and High Volume Specialists**

All PCP's and high-volume specialists that see non-institutionalized UnitedHealthcare Community Plan enrollees may be required to have an office visit to complete initial credentialing or re-credentialing, if not captured during initial credentialing. An office visit will consist of an UnitedHealthcare Community Plan representative walking you through your office or clinic and assessing handicap accessibility and safety of the clinic. You will be notified in advance if you will have an office visit. This office visit is a regulatory requirement.

### **Adverse Credentialing Determination Appeals**

Physicians or other health care providers must meet UnitedHealthcare Community Plan's rules for continued participation in UnitedHealthcare Community Plan. Physicians or other health care providers receive written notice of such rules in the contract between the physician and UnitedHealthcare Community Plan (provider contract), in UnitedHealthcare Community Plan's credentialing policies and procedures, and other communication vehicles from time to time. If UnitedHealthcare Community Plan makes an adverse determination regarding a physician's continued participation, the physician will be notified of such decision in writing and given an opportunity to initiate a formal appeal.

# Ch. 17 Provider Relations and Network Development

## Network Development

The Network Management Department is responsible for developing the UnitedHealthcare Community Plan network in Apache, Coconino, Maricopa, Mohave, Navajo, Pima, Santa Cruz, Yuma, La Paz, and Yavapai Counties. Network Management conducts contract negotiations and re-negotiations and considers many factors in potential contracting decisions are:

- Geographic needs based on AHCCCS standards
- Geographically convenient flow of patients among providers
- Access to at least equal to or better than community norms for UnitedHealthcare Community Plan members
- Accessible services in terms of timeliness, amount, duration and scope as those available to non-ALTCS person within the same service area
- Amount of membership versus number of providers or provider types in a given area
- Enrollee accessibility
- Quality and reputation of the provider
- The needs and service requirements of AHCCCS' culturally and linguistically diverse member population
- Maximum availability of community based primary care and specialty care access that can reduce emergency room services and hospital admissions

If you are interested in becoming a contracted provider, please submit a letter of interest to:

UnitedHealthcare Community Plan  
Attn: Provider Relations  
1 East Washington, Suite 800  
AZ009-800E  
Phoenix, AZ 85004

UnitedHealthcare Community Plan will review your request. If UnitedHealthcare Community Plan determines the need to contract, you will need to submit additional information (such as a W9, sample claim form, licensure, proof of insurance) in order to proceed with the contract. If UnitedHealthcare Community Plan declines your request to contract, you will receive a letter informing you of why your request was declined.

Once a provider is contracted, the provider is assigned to a provider relations advocate in the Provider Relations department.

## Utilizing Your Provider Relations Advocate

New providers will receive an initial orientation as well as periodic focused training by provider type. Your provider relations advocate is available to assist you with your contract, training and orientation needs. For questions concerning the status of a claim, please contact the UnitedHealthcare Community Plan Customer Call Center. If the Customer Call Center is unable to resolve your question, you will be referred to your appropriate provider relations advocate for additional assistance.

Provider relations meets provider communication needs through site visits, provider meetings, provider newsletters, targeted mailings, provider surveys, provider manuals, provider agreements and conference calls. These communications can include prior authorization processes, claims submissions and dispute processes, contractual issues, fraud and abuse, eligibility verification, behavioral services, advanced directives, credentialing, cultural competency awareness, EPSDT, family planning, training on non-provision of service, appointment accessibility and availability and other Medicare and Medicaid issues of importance to providers. Provider relations also conducts monitoring of credentialing status, appointment standards, claims disputes and encounters, provider network and availability, and licensure verification.



Your provider relations advocate will assist in ensuring that all your necessary provider paperwork is current. UnitedHealthcare Community Plan requires you to supply copies of all updated and current licensures, insurance liability coverage, AHCCCS registration, W-9 form, sample claim form, etc., in a timely fashion as required in your contract. Failure to provide this information may result in non-payment of services rendered or termination of your contract with UnitedHealthcare Community Plan. UnitedHealthcare Community Plan requires you to contact your provider relations advocate immediately upon making a change in AHCCCS registration, business ownership, licensure, or insurance liability coverage to avoid reimbursement discrepancies.

You have only one provider relations advocate for all UnitedHealthcare Community Plan products that you are contracted with. Your Provider relations advocate will schedule periodic visits with you or as needed or requested. During these visits, they will review changes to policies and procedures that affect your office, review your provider information for accuracy and current status, provide initial orientation and follow-up training, perform compliance with office standards for quality purposes, exchange ideas and discuss any issues or problems that have occurred. UnitedHealthcare Community Plan encourages providers to give the provider relations advocate feedback about how UnitedHealthcare Community Plan is doing and how satisfied you are with UnitedHealthcare Community Plan. Provider relations will acknowledge and respond to inquiries within 48 hours of request.

If you are not sure who your provider relations advocate is, please contact UnitedHealthcare Community Plan at **800-377-2055** and listen for the Provider Relations prompt.

Contact your provider relations advocate for questions regarding:

- Changes in physician and health care provider information, including clinic name, address, telephone number or Federal Tax Identification Number

- If you open or close an office
- If your clinic has reached capacity and you are no longer accepting new patients. Please provide the effective date and date anticipated for accepting new patients.
- Contract administration issues
- Credentialing and re-credentialing issues
- Reimbursement issues, fee schedules, coding questions that the Customer Call Center is unable to assist you with
- Specific information about UnitedHealthcare Community Plan's policies and procedures
- Training for billing and claim submission
- To request copies of current benefit plan documents
- General education needs

Visit the UnitedHealthcare Community Plan website for general information about the UnitedHealthcare Community Plan program and to view current information regarding UnitedHealthcare Community Plan's:

- Comprehensive and Abridged Formulary
- Provider Directories
- Provider Forms
- Provider Manual
- Recent changes to Provider Manuals
- Recent Provider Newsletter
- Clinical Practice Guidelines
- General Updates

## Network Management

UnitedHealthcare Community Plan reviews its networks regularly to determine potential gap areas, areas where membership growth requires additional providers and areas where the network is over saturated. The provider relations advocate helps to monitor the services within their assigned territories and work with the Network Development department to obtain additional contracts.

The network is determined by a variety of factors, primarily based on membership and utilization patterns. You can help us keep our network accurate by notifying us of changes to your office or service area locations, additions or terminations of providers within your office, or addition or elimination of services that you provide.

We request that you notify Provider Relations promptly with any changes, including changes that will affect credentialing, certification, liability coverage, AHCCCS registration changes etc. Timely notification will also reduce the risk of reimbursement complications due to the changes.

## Provider Agreements

UnitedHealthcare Community Plan uses a standard provider agreement when subcontracting with physicians, hospitals, ancillary services, nursing and assisted living facilities. This contractual agreement may be changed from time to time in order to conform to current state and federal policies and trends. All provider agreements are “evergreen” and do not have a renewal date. The provider agreements remain in place until either party request in writing otherwise, as outlined in the provider agreement.

All skilled nursing facilities, assisted-living facilities and home and community-based providers are reviewed annually prior to the beginning of a new AHCCCS contract year.

All physician and health care provider agreements comply with the applicable state and federal regulations as applicable to the UnitedHealthcare Community Plan product, such as regulations and policies established by the Centers for Medicare and Medicaid Services, AHCCCS and set forth in the Arizona Administrative Code, Article 4, Contracts, Administration and Standards. Each UnitedHealthcare Community Plan physician and health care provider agreement contains the minimum subcontract provisions established by AHCCCS and are updated annually as AHCCCS updates.

All questions concerning your provider agreement should be directed to your provider relations advocate.

## Contract Concerns or Complaints

If you have a concern or complaint about your agreement with us, please contact the local UnitedHealthcare Community Plan office in writing containing the details of your concern or complaint. Your provider relations advocate will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in our agreement.

## Arbitration

UnitedHealthcare Community Plan will conduct any arbitration proceeding under your agreement under the auspices of the American Arbitration Association, as further described in our agreement. For more information on the American Arbitration Association guidelines, visit its website at [adr.org](http://adr.org). In the event that a customer has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing customer appeals outlined in the customer's benefit contract or handbook.

## ALTCS Change of Program Contractor Policy

The information provided in this chapter is the AHCCCS policy "Enrollment Choice in a Choice County and Change of Contractor Policy", revised Aug. 8, 2001, regarding enrollee enrollment. For more information on AHCCCS policies, visit [azahcccs.gov](http://azahcccs.gov).

UnitedHealthcare Community Plan recognizes that AHCCCS has the exclusive authority to enroll and dis-enroll members. UnitedHealthcare Community Plan does not dis-enroll any members for any reason unless directed to do so by AHCCCS.

### **ENROLLMENT CHOICE IN A CHOICE COUNTY AND CHANGE OF CONTRACTOR POLICY: ARIZONA LONG TERM CARE SYSTEM (ALTCS), ELDERLY/PHYSICALLY DISABLED (EPD) CONTRACTORS**

#### **I. Purpose**

This policy applies to ALTCS/EPD contractors. This policy establishes guidelines, criteria and timeframes for how, when and by whom enrollment choice in a choice county and contractor change requests will be processed for ALTCS enrollees. This policy applies to Arizona Long Term Care (ALTCS) Contractors

only (hereafter referred to as contractors). This policy delineates the rights, obligations and responsibilities of:

- The enrollee
- The enrollee's current contractor
- The receiving contractor, and
- The AHCCCS administration,

In facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding enrollee notification and errors in assignment.

#### **II. Definitions**

**ALTCS Local Office:** The ALTCS local office currently responsible for the enrollee's financial eligibility case record.

**Anniversary Date:** The month for which the enrollee is entitled to make an annual enrollment choice. The anniversary date is typically 12 months from the date enrolled with the contractor and annually thereafter.

**Choice County or Geographic Service Area (GSA):** A county or GSA with more than one ALTCS Contractor.

**County of Fiscal Responsibility:** The county that is financially responsible for the state's share of ALTCS funding.

**Current Contractor:** The contractor with whom the enrollee is enrolled at the time the change request is generated.

**Day:** Day means a calendar day unless otherwise specified.

**Receiving Contractor:** The contractor to whom the enrollee is being changed.

**Requested Contractor:** The contractor to whom the enrollee wants to change.

### III. Policy

Some, but not all, ALTCS applicants and enrollees who reside in a choice county or who are planning to move to a choice county must be offered an opportunity to choose a contractor.

#### A. Enrollment Choice in a Choice County

##### 1. Individual Entitled to Enrollment Choice

- a. An individual is entitled to enrollment choice when:
- b. An applicant resides in a choice county and a choice county is the county of fiscal responsibility.
- c. An enrollee moves from another county to his or her own home in a choice county, unless the enrollee's current contractor is available in the choice county.
- d. An enrollee moves from another county to a nursing facility or alternative residential setting in a choice county and the current contractor has chosen to negotiate an enrollment change.
- e. An enrollee is currently enrolled with a contractor serving a choice county, but a valid condition exists (see Section B) for requesting an enrollment change to another contractor serving a choice county.
- f. A former enrollee resides in a choice county and reestablishes eligibility that results in reenrollment more than 90 days after disenrollment.
- g. An enrollee attains the annual anniversary date.

##### 2. Individual Who Does Not Have Enrollment Choice

- a. This policy does not apply to the following individuals:
- b. An enrollee who is developmentally disabled

- c. An enrollee who is a Native American with on-reservation status
- d. A choice county resident whose county of fiscal responsibility is not a choice county (unless the current contractor chooses to negotiate a change to that choice county)
- e. An enrollee who was disenrolled from a Contractor in a choice county, but subsequently reestablishes ALTCS eligibility that results in reenrollment within 90 days from disenrollment.
- f. Residents of counties other than a choice county, unless a choice county is the county of fiscal responsibility.
- g. An enrollee who moves to a choice county and his or her current contractor is available in that choice county.

##### 3. Initial Enrollment Process

The initial enrollment process is used to obtain enrollment choice from an ALTCS/EPD applicant whose county of fiscal responsibility is a choice county.

Stage	Description
1	<p>ALTCS staff provides the applicant with</p> <ul style="list-style-type: none"> <li>• An explanation of enrollment choice</li> <li>• Marketing materials from the Contractors serving the choice county</li> <li>• Assistance in choosing a contractor</li> </ul>
2	ALTCS staff obtains an enrollment choice before the application is approved
3	<p>Ongoing enrollment is prospective, effective the date the application is approved.</p> <p>Prior period coverage is effective retroactive to the first day of the first eligible month, unless the enrollee is being transferred from an acute contractor to an ALTCS contractor.</p>

#### 4. Re-enrollment After Disenrollment

When an enrollee, whose county of fiscal responsibility is a choice county, is disenrolled due to loss of ALTCS eligibility, but is subsequently determined eligible within 90 days from the date of disenrollment, the enrollee will be reenrolled with the former contractor, if that contractor is still available. If that contractor is not available, the enrollee will be given the opportunity to choose a contractor.

When reenrollment occurs more than 90 days after the disenrollment, or another valid reason for change exists, the enrollee will be given the opportunity to choose a contractor.

When an enrollee is reenrolled within 90 days, the anniversary date is determined by the previous enrollment date. The enrollee may choose to enroll with a different contractor on his/her anniversary date, which is established by the initial enrollment with that contractor.

#### 5. Enrollment Choice Process For Fiscal County Changes

An enrollment choice must be obtained before an enrollee's enrollment can be changed to a contractor serving a choice county. The enrollment choice process applies to an ALTCS enrollee who moves to a choice county to:

- His or her own home
- A nursing facility or alternative residential setting and the current Contractor requests an enrollment choice in order to negotiate an enrollment change with a contractor in a choice county.

The enrollment choice process consists of the following steps:

Stage	Description
1	<p>The ALTCS local office provides the enrollee with:</p> <ul style="list-style-type: none"> <li>• An explanation of enrollment choice</li> <li>• Marketing materials from each of the Contractors serving a choice county</li> </ul> <p>The enrollee is asked to provide a choice prior to actually moving or within 10 days of our request.</p>
2	The ALTCS local office provides the enrollee with assistance in making the decision throughout the process.
3	When the enrollee does not make a choice within 10 days, the ALTCS local office sends an Enrollment Choice Reminder Notice asking the enrollee to provide a choice within the next 10 days.

## B. Identifying and Processing Requests for Contractor Changes Within a Choice County

Generally, once enrollment occurs an enrollee cannot change enrollment until their anniversary date. This is called Annual Enrollment. However, an enrollment change from one choice county contractor to another choice county contractor can be made for certain reasons.

### 1. Medical Continuity of Care Requests

In unusual situations, special contractor changes may be approved on a case-by-case basis to ensure the enrollee's access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment. The following special process is required:

Step	Action
1	The enrollee's PCP must provide documentation to the medical directors of both contractors that support the need for a contractor change. Both contractors must be reasonable in the request for documentation.
2	<p>The medical directors of both contractors must approve the change.</p> <ul style="list-style-type: none"> <li>• In order to provide continuity of care on a temporary basis for the enrollee's period of illness, the current Contractor may agree to reimburse the enrollee's provider for service rather than approve a Contractor change.</li> <li>• If one of the Contractors denies the request, the change request is forwarded to the AHCCCS Medical Director for a final decision.</li> </ul>
3	<p>When both contractors approve the change the receiving contractor sends the completed Program Contractor Change Request Form (DE-621) to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations.</p> <p>When the requested contractor denies the request, the DE-621 is returned to the current contractor who may forward the DE-621 to the AHCCCS medical director.</p>

Step	Action
4	If the AHCCCS medical director approves the change, the DE-621 is returned to the current contractor to negotiate the effective date of the change. The current contractor sends the DE-621 to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations.
5	The Program Contractor Change Request Coordinator processes the change
6	If the Change request is denied by the AHCCCS medical director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the enrollee and to both the current and receiving/requested contractors.

### 2. Valid Conditions (Excluding Medical Continuity of Care)

When any of the following conditions exist, an ALTCS local office may authorize a change of contractors within a choice county.

- a. Erroneous network information or agency error: The applicant or representative made an enrollment choice based on erroneous information regarding facility, residential setting, PCP or other provider contracting with the chosen contractor based on information supplied by the network database, marketing materials, or agency error. Erroneous information includes omissions or failure to divulge network limitations and restrictions in the contractor's marketing material or database submissions.
- b. Lack of initial enrollment choice: An ALTCS applicant residing in a choice county is, for any reason, not offered a choice of contractors during the application process.



- c. Lack of annual enrollment choice: The enrollee was entitled to participate in an Annual Enrollment Choice but was not sent an Annual Enrollment Choice notice or the notice was not received, or was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the enrollee's control (e.g., enrollee or representative was hospitalized, anniversary date fell within a 90 day disenroll/reenroll period).
- d. Family continuity of care: The enrollee, either through auto-assignment or the choice process, is not enrolled with the same contractor as the other family enrollees. To promote continuity of care, family enrollees, such as married couples, may choose to be enrolled with the same contractor.
- e. Continuity of institutional or residential setting: The enrollee's contractor terminates their contract with the institutional or residential setting in which the enrollee resides, and the enrollee or the enrollee's representative requests to change to a contractor who contracts with their institutional or residential setting. The enrollee must be enrolled and living in the facility at the time of the contract termination.
- f. If the provider (nursing facility or alternative residential setting) terminates the contract, the Local Office will request instructions from the Division of Health Care Management/ALTCS Unit before making any changes.
- g. Failure to correctly apply the 90-day reenrollment policy: The enrollee lost ALTCS eligibility and was disenrolled, was subsequently reapproved for ALTCS within 90 days of the disenrollment date, but was enrolled with a different contractor.

### 3. Processing Enrollment Change Requests

The following procedures apply when an enrollee requests a change of contractors within a choice county.

When...	Then...
The enrollee makes the request for a change to the contractor and claims a valid condition exists	The contractor will report the request to the Local ALTCS Office using the ALTCS Enrollee Change Report Form (DE-701).
The ALTCS local office receives a change request from a contractor or an enrollee.	The ALTCS local office will investigate the request to determine if a valid condition exists
The ALTCS local office determines that a valid change condition exists.	The ALTCS local office will change the enrollee's enrollment to the contractor the enrollee chooses. The enrollment change is effective the day the change is processed by the ALTCS local office
The ALTCS local office determines that the nursing facility or alternative residential setting terminated the contract.	The ALTCS local office will send written request to the DHCM ALTCS Unit Manager and my change the enrollment only if approved in the response.
The ALTCS local office determines that a valid situation does not exist.	The ALTCS local office will: <ul style="list-style-type: none"> <li>Send the enrollee a Denial of Program Contractor Change Request (DE-548) denying the request and giving the enrollee the right to appeal the decision.</li> <li>Refer the enrollee to his or her current contractor for resolution of existing issues.</li> </ul>

**C. Fiscal County and Enrollment Change Policies**

**1. Placements by a Contractor**

When a contractor places an enrollee in a nursing facility or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the contractor’s county), the county of fiscal responsibility and enrollment do not change.

**2. Moves Initiated by the Enrollee or the Enrollee’s Family**

When an enrollee moves from one county to another county, the county of fiscal responsibility and enrollment are determined according to the following:

If the Enrollee Moves to...	Then...
His or her own home	<p><b>County of Fiscal Responsibility</b></p> <ul style="list-style-type: none"> <li>• The county of fiscal responsibility changes to the (new county) county in which the home is located.</li> </ul> <p><b>Enrollment</b></p> <ul style="list-style-type: none"> <li>• Enrollment remains unchanged if the same contractor serves both counties.</li> <li>• Enrollment changes if the enrollee moves to a county served by a different contractor.</li> <li>• The Enrollment Choice process must be completed prior to enrollment and Fiscal County changes if the home is located in a choice county and the current contractor is not available in that choice county.</li> </ul>
A nursing facility or an alternative residential setting	<ul style="list-style-type: none"> <li>• The county of fiscal responsibility and enrollment will remain unchanged unless the current contractor successfully negotiates a change with a contractor serving the new county.</li> <li>• The Enrollment Choice process must be completed prior to the negotiation process when the enrollee moves to a choice county.</li> </ul>

### 3. Uncoordinated Moves by the Enrollee

The contractor is responsible for explaining the service limitations and exclusions to enrollees who move out of the contractor's service area.

The current contractor is liable only for those services authorized by an ALTCS enrollee's case manager.

### D. Enrollee Moves to Own Home in Another County

When an enrollee resides in his or her own home the following policies apply:

- The county of fiscal responsibility is the county where the enrollee or child's parent's home is located.
- Enrollment is with a contractor serving the geographic service area (or fiscal county) where the home is located.
- When the enrollee moves to his or her own home in a choice county, and is not already enrolled with a contractor serving that choice county, the enrollee must be given an opportunity to choose a contractor. The enrollee will be enrolled with the contractor selected through the enrollment choice process.
- The enrollment change and the change in county of fiscal responsibility cannot occur until the enrollment choice process is completed.

#### 1. Enrollee's Responsibilities

The enrollee is responsible for reporting the move or anticipated move to the current contractor and the ALTCS local office.

#### 2. Contractor Responsibilities

The current contractor is responsible for:

- a. Notifying the ALTCS local office that the enrollee moved by sending an enrollee Change Report (DE-701),
- b. Explaining service limitations and exclusions to an enrollee who moves out of the contractor's service area, and

- c. Transitioning the enrollee to the new contractor, this includes forwarding medical records and other materials to the receiving contractor.

### 3. ALTCS Local Office Responsibilities

The ALTCS local office is responsible for:

- a. Completing the enrollment choice process for enrollees changing to a choice county,
- b. Changing the enrollee's living arrangement (if appropriate) and address when the move occurs,
- c. Making necessary changes in the county of fiscal responsibility and enrollment, and
- d. Making changes to eligibility and share of cost arising from the change in the enrollee's living arrangement.

### 4. Enrollment Change Procedures

The ALTCS local office will complete the following steps:

Step	Action
1	Determine if the county of fiscal responsibility and enrollment need to be changed. (The county of fiscal responsibility and enrollment may already be correct). <ul style="list-style-type: none"><li>• If a change is required, proceed to Step 2.</li><li>• If no change is needed, update the address and living arrangement, and share of cost, if necessary.</li></ul>
2	Complete the Enrollment Choice Process if enrollment needs to be changed to a contractor serving a choice county. When the enrollee is unable or unwilling to make a choice, the current ALTCS local office will either select a contractor for the enrollee or permit auto assignment to a contractor by PMMIS in accordance with the criteria in the Eligibility Policy Manual.
3	Process fiscal county and enrollment changes.
4	Determine if the eligibility case record should be transferred according to the criteria in the Eligibility Policy Manual.

## **E. Enrollee Moves to a Nursing Facility or Alternative Residential Setting in Another County**

When the current contractor provides services to the county where the enrollee is moving, the enrollment and county of fiscal responsibility do not change.

When the current contractor chooses to contract with the nursing facility or alternative residential setting, the enrollment and county of fiscal responsibility do not change.

When the current contractor requests an enrollment change, the approval of both the current and the requested/receiving Contractor is required.

When the enrollee moves to a choice county, the enrollment choice process must be completed before the current Contractor can initiate negotiations with a requested Contractor.

When the receiving/requested Contractor does not agree to the change, the current Contractor may request a decision from the AHCCCS Medical Director.

### **1. Enrollee's Responsibilities**

The enrollee is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

### **2. Current Contractor Responsibilities**

a. When the current contractor is notified that an enrollee has moved to another county or plans to move to another county, and the enrollee resides or plans to reside in a nursing facility or alternative residential setting, and the current Contractor does not serve the other county, the current Contractor has the following options:

- Retain the enrollee and contract with an out of county provider,
- Negotiate an enrollment change, or

- Pay facility expenses for a limited number of days while plans are being made to move the enrollee to a contracted facility. If the enrollee refuses to move to a contracted facility, follow the non-user procedures in the AHCCCS Eligibility Policy Manual.

b. When enrollment change is the preferred option, the current Contractor is responsible for:

- Calling the ALTCS local office and requesting an enrollment choice when the move is to a choice county
- Completing a Program Contractor Change Request (DE-621) and sending it to the contractor serving the GSA or the requested choice county Contractor, and
- Transitioning the enrollee when a change is approved.

### **3. ALTCS Local Office Responsibilities**

a. General Responsibilities The ALTCS local office is responsible for:

- Assuring that the current contractor is aware of the move or the enrollee's plan to move, by contacting the current contractor and advising the enrollee to contact the current contractor
- Informing the enrollee that the current contractor:
  1. Must be involved in the placement change
  2. Is only liable for services authorized by the case manager
- Changing the enrollee's address when the move is verified, and
- Determining whether to retain or transfer the eligibility case file based on the case file transfer policy in the Eligibility Policy Manual.

b. Enrollment Choice for Transfers to a Choice County

When enrollment choice is requested by the current contractor, the ALTCS local office is also responsible for:

- Informing the enrollee about enrollment choice
- Providing marketing materials to the enrollee
- Providing assistance to the enrollee as necessary, and
- Obtaining an enrollment choice from the enrollee and notifying the current contractor.

**4. Requested Contractor’s Responsibilities**

When a Program contractor Change Request (DE-621) is received the requested Contractor is responsible for:

- a. Approving or denying the change request by completing the DE-621, and
- b. Transitioning the enrollee when the change request is approved or the AHCCCS Medical Director directs the change.

**5. AHCCCS Medical Director’s Responsibilities**

The AHCCCS medical director determines whether an enrollment change is appropriate when the receiving/requested Contractor denies the enrollment change and the current contractor requests review by the AHCCCS medical director.

If approved, a written decision is issued to the current contractor. If denied, a written notice of the denial including notice of appeal rights is issued to the current contractor, the receiving/requested contractor and the enrollee.

**6. AHCCCS Central Office Field Operations Responsibilities**

The AHCCCS Central Office Field Operations is responsible for:

- a. Processing enrollment and county of fiscal responsibility changes, and
- b. Sending the ALTCS local office a copy of the DE-621.

**F. Enrollment Change Process**

The following steps are involved in the enrollment change process:

Step	Action
1	The enrollee moves or indicates a desire or plan to move to a nursing facility or alternative residential setting in another county.
2	When advised of the move the ALTCS office: <ul style="list-style-type: none"> <li>• Notifies the current contractor,</li> <li>• Advise the enrollee to contact the current contractor, and</li> <li>• Warns the enrollee about limitations on services received from out-of-network providers.</li> </ul>
3	When the move has been verified, the ALTCS local office changes only the enrollee’s address/living arrangement, not the county of fiscal responsibility
4	When the move is to a choice county: <ul style="list-style-type: none"> <li>• The current contractor asks the ALTCS local office to complete the Enrollment Choice Process.</li> <li>• The ALTCS local office obtains an enrollment choice and informs the current contractor.</li> </ul>
5	The current Contractor completes a Program Contractor Change Request (DE-621) and sends it to the Contractor serving the new county of residence. In a choice county, this will be the requested contractor.  If the contractor serving the new county of residence denies the request, the current contractor may forward to the AHCCCS medical director for a final decision.

Step	Action
6	When the contractors or the AHCCCS medical director approves a change, the Program Contractor Change Request Coordinator at AHCCCS Central Office processes the enrollment and county of fiscal responsibility changes and notifies the ALTCS local office. The current contractor will forward medical records and other materials to the receiving contractor.
7	If the change request is denied by the AHCCCS Medical Director, the Division of Health care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the enrollee and to both the current and receiving/requested contractors.  When the change is denied, the current contractor continues to provide services to the enrollee.
8	The ALTCS local office determines if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual.

## G. The Contractor's Responsibilities

### 1. Provide Contractor Change Policy

Contractors are responsible for providing information on the contractor change policy in:

- The Enrollee Handbook for new and existing enrollees, and
- The Provider Manual for providers

### 2. Address Enrollees' Concerns

The current contractor is responsible for promptly addressing enrollees' concerns regarding availability and accessibility of services and quality of medical care. These issues include but are not limited to:

- Quality of care
- Case management responsiveness
- Transportation service availability
- Institutional care issues

- Physician or provider office hours
- Office waiting time, and
- Network limitations and restrictions.

### 3. Refer Unresolved Issues

When quality of care and delivery of medical service issues raised by the enrollee cannot be solved through the normal case management process, the current contractor must refer the issue for review by:

- The current contractor's Quality Management Department and/or
- The AHCCCS medical director

### 4. Transitioning Between Contractors

The current contractor is responsible for:

- Reporting the enrollee's address and living arrangement changes to AHCCCS
- Encouraging enrollees to report anticipated moves to another county or geographic service area to them (current contractor) and to the ALTCS local office prior to moving. Advance notice will facilitate continuity of service delivery.
- Advising enrollees to contact the ALTCS local office to request an enrollment change between contractors serving a choice county if a valid reason other than medical continuity of care is claimed.
- Accepting an enrollee's request for an enrollment change to another county. The request may be verbal or in writing and may be addressed to the enrollee's Case Manager.
- Forwarding medical records and other materials to the receiving contractor

Both the current contractor and the receiving contractor are responsible for assuring a safe transition for the enrollee when an enrollment change occurs. The contractors will transition within the requirements and protocols in the AHCCCS Medical Policy Manual, Chapter 500.



## 5. Process Enrollees' Enrollment Change Requests

The contractor will process enrollment change requests from enrollees as follows:

When the Enrollee Requests a Contractor Change...	Then the Current Contractor...
Within a choice county and the enrollee claims a valid condition exists.	Refers the issue to the ALTCS local office for review using the ALTCS Enrollee Change Report (DE-701).
That requires the approval of both the current and the receiving Contractors.	<p>Notifies the ALTCS local office if the enrollee lives in a choice county or is moving to a choice county to initiate the Enrollment Choice Process.</p> <p>Negotiates the change with the requested Contractor.</p> <p>Completes a DE-621 and forwards it to the requested Contractor.</p> <p>Notifies the enrollee if the change is approved.</p> <p>May forward the DE-621 to the AHCCCS Medical Director if the requested Contractor denies the change.</p> <p>Notifies the enrollee in writing if the enrollment change is denied at the Contractor level. The denial notice must include:</p> <ul style="list-style-type: none"> <li>• The AHCCCS Program Contractor Grievance Policy, and</li> <li>• Timeframes for filing a grievance.</li> </ul>

## 6. Notify Hospitals of Certain Enrollment Changes

When an enrollment change occurs while the enrollee is hospitalized, the current contractor must notify the hospital of the enrollee's disenrollment prior to the enrollment with the receiving contractor.

If the current contractor fails to provide such notice to the hospital, the current contractor will continue to be responsible for payment of hospital services provided to the enrollee until the date notice is provided to the hospital as required in the AHCCCS Medical Policy Manual, Chapter 500.

## 7. Process Grievances

When an enrollment change requested by the enrollee is denied by the contractor (not the AHCCCS medical director), the current contractor is responsible for processing any resulting grievances.

## H. AHCCCS Administration's Responsibilities

### 1. Enrollment Change Requests Received From Enrollees

Except for valid changes within a choice county or a change due to the enrollee moving to his or her own home, the AHCCCS administration or the ALTCS local office will refer an enrollee's request for an enrollment change to the current contractor.

### 2. Process Enrollment Change Requests

The AHCCCSA will process enrollment change requests within five days after the request is received, or all conditions for processing an enrollment change have been met, whichever is later.

### 3. Issue Decisions

The AHCCCSA will notify contractors of enrollment change approvals via the daily recipient roster. AHCCCSA will mail a new AHCCCS ID card to the enrollee. AHCCCSA will send notification to both the current and receiving contractors and the enrollee when an enrollment change is denied by the AHCCCS medical director. When approved by the AHCCCS medical director, notification will be sent to the current contractor.

### 4. Process Grievances

When an enrollment change is denied by the AHCCCS Medical Director, AHCCCSA is responsible for processing all resulting enrollee grievance.

The Division of Health Care Management, ALTCS Unit sends the enrollee a denial notice, which explains the Grievance System under 9 A.A.C. 34.

### 5. Monitor Policy Compliance

The AHCCCS Division of Health Care Management (DHCM) will monitor contractor compliance with this policy. Any violations of this policy, especially attempts to deny care or steer high cost or difficult enrollees to another contractor, will be considered contract violations and will be subject to sanctions up to and including contract termination.

### IV. References

- Arizona Administrative Code R9-28, Article 7
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual Chapter 500
- ACOM Chapter 400

# Ch. 18 Formulary Medicare Part D

## UnitedHealthcare Community Plan Formulary

An up-to-date formulary for UnitedHealthcare Community Plan can be found at [UHCCommunityPlan.com](http://UHCCommunityPlan.com). Changes to the formulary will be identified on the UnitedHealthcare Community Plan website.

## Medicare Part D Benefit

Medicare Prescription Drug coverage is available through Medicare Advantage Prescription Drug Plans (MA-PD) and standalone Prescription Drug Plans (PDP). The drug benefit, known as Medicare Part D, is a substantial enhancement for Medicare-only UnitedHealthcare Community Plan enrollees, as these enrollees have never had coverage for prescription drugs.

Dual-eligible UnitedHealthcare Community Plan enrollees (enrollees with both Medicare and Medicaid) will receive their primary drug coverage through Medicare Part D. UnitedHealthcare Community Plan will provide wrap-around prescription drug coverage for UnitedHealthcare Community Plan enrollees that are on medication in drug classes not covered through Medicare Part D.

Medicare Part D is a built-in benefit integrated with UnitedHealthcare Community Plan's existing Medicare plans, and those enrollees will automatically receive Medicare Part D coverage. There are no forms to fill out or selections to make. UnitedHealthcare Community Plan handles the paperwork for all enrollees participating in an UnitedHealthcare Community Plan Medicare plan.

Optum RX is the pharmacy benefits administrator for UnitedHealthcare Community Plan's Medicare Part D plans. Our national, extensive Medicare Part D network includes retail stores, mail order services, long-term care pharmacies and specialty pharmacies.

The Medicare Part D formulary is evidence-based, customer-centered, and reflects the specialized needs of geriatric and disabled enrollees. The formulary is guided by a Pharmacy and Therapeutics Committee of medical experts from several specialties. It accommodates clinical choice and medical best practices, with medication options within each drug class. Formulary administration focuses on patients, with a temporary fill process that ensures emergency access and a therapy management program to reduce potential drug interactions.

# Ch. 19 UnitedHealthcare Community Plan Dental

Important Information	
<b>UnitedHealthcare Dental IVR Provider Services and Interactive Voice Response</b>	1-877-408-0166 Provider Services: 8 a.m. – 11 p.m. EST Monday – Friday IVR = 24 hours; 365 days
<b>Claims</b>	UnitedHealthcare Community Plan Medicaid PO Box 2185 Milwaukee, WI 53201
<b>Prior Authorizations</b>	UnitedHealthcare Community Plan Medicaid PO Box 2020 Milwaukee, WI 53201
<b>UHC Dental Provider Relations: (Correspondence regarding your participation, contractual issues, dentist changes or office changes)</b>	UnitedHealthcare Dental Provider Relations 6220 Old Dobbin Lane Columbia, MD 21045
<b>Claims Dispute for Providers</b>	UnitedHealthcare Community Plan Medicaid PO Box 1382 Milwaukee, WI 53201

\*Please Note: The member ID cards are medical plan specific. There will not be a UnitedHealthcare Community Plan Dental ID card issued. Please use the claims and prior authorization addresses above for all dental services

## Important Electronic Claims Submission Information

Claim Filing Indicator Field	EDI Payer Number
<b>Enter MC in the Claim Filing Indicator Field</b>  <b>Note: Failure to enter “MC” in the Claim Filing Indicator field may result in delays in claim payment.</b>	GP133

## Important Electronic Claims Submission Information

<b>UnitedHealthcare Dental</b>	<a href="http://uhcproviders.com">uhcproviders.com</a>
<b>Arizona Health Care Cost Containment System</b>	<a href="http://ahcccs.state.az.us.com">ahcccs.state.az.us.com</a>

UnitedHealthcare Community Plan Medicaid is available in Maricopa, Mohave, Coconino, Navajo, Apache, LaPaz, Pima, Santa Cruz, Yavapai, and Yuma Counties.

**UnitedHealthcare Community Plan – Medicaid Only for Children**

The Arizona Long Term Care System (ALTCS) was created through the Arizona Health Care Cost Containment System (AHCCCS) to provide quality long-term care for all people in Arizona who cannot pay for services. The plan covers children from birth until their 21<sup>st</sup> Birthday. These services are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT). A list of these services can be found in the AHCCCS medical policy manual chapter 400. **Members must use a UnitedHealthcare Dental AHCCCS Medicaid provider for all services. Certain Select Medicaid services require prior authorization.**

Service Categories	Benefit Guidelines
Oral Exams	One exam every 6 months
Prophylaxis	One cleaning every 6 months
Dental X-Rays	One series every 12 months
Restorative Services	As medically necessary*
Oral Surgery	As medically necessary*
All Other Dental Services	As medically necessary*

\*Medically necessary care is described as: The reasonable and appropriate diagnosis, treatment, and follow-up care (including supplies, appliances, and devices) as determined and prescribed by qualified, appropriate health care providers in treating any condition, illness, disease, and injury or birth developmental malformations.

**UnitedHealthcare Community Plan – Medicaid Only for Adults**

Effective Oct. 1, 2010 the adult emergency dental services benefit for eligible adults ages 21 and older has been eliminated; except under certain circumstances. There remains a limited adult benefit under certain circumstances like organ transplant. **Any covered Adult Service will require prior authorization.** Adults are age 21 and over. The list below confirms which services can be covered with Prior Authorization. **Members must use a UnitedHealthcare Dental AHCCCS Medicaid provider for all services. Please call the provider services number at 877-408-0166 for details regarding the Adult Medicaid benefit.**

**Adult Services Requiring Prior Authorization Are:**

Diagnostic	Oral and Maxillofacial Surgery	Adjunctive General Services
• D0140	• D7285 • D7440 • D7485 • D7560 • D7671 • D7771 • D7990	• D9220
• D0220	• D7286 • D7441 • D7510 • D7610 • D7710 • D7780 • D7997	• D9221
• D0230	• D7140 • D7450 • D7511 • D7620 • D7720 • D7810	• D9230
• D0240	• D7411 • D7451 • D7520 • D7630 • D7730 • D7820	• D9241
• D0250	• D7412 • D7460 • D7521 • D7640 • D7740 • D7830	• D9242
• D0260	• D7413 • D7471 • D7530 • D7650 • D7750 • D7910	• D9248
• D0330	• D7414 • D7472 • D7540 • D7660 • D7760 • D7911	• D9410
	• D7415 • D7473 • D7550 • D7670 • D7770 • D7912	• D9420

## Prior Authorization Guidelines

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before performing those procedures. To request clinical criteria utilized for each prior authorization service, please call UnitedHealthcare Dental Provider Relations Department at 877-408-0166.

Requesting a Prior Authorization Complete a standard American Dental Association (ADA) claim form and check the box marked "Pre-Treatment ESTIMATE." Mail the form, along with any required supplemental information (films, narrative, perio-charting, etc). Your office will then receive an Explanation of Benefits (EOB) outlining the denial or approval of requested treatment and plan payment amounts when applicable.

### Prior Authorization for Medicaid

UnitedHealthcare Community Plan Medicaid  
PO Box 2020  
Milwaukee, WI 53201

### Prior authorizations are subject to the following conditions:

1. Total benefit maximums may not be exceeded. Actual dates of service may alter benefits payable.
2. The member must be eligible for benefits when the services are incurred. An expense is incurred when a service is performed.
3. Allowances may vary based on results of post-treatment clinical review.

When submitting for payment, please include the approved EOB, including the actual date(s) of service.

## Timeframes and Written Notification

### Standard Decisions

When a provider has submitted a prior authorization, UnitedHealthcare Dental must render a decision within 14 business days of receipt. In addition, a denial letter (if applicable) must be sent within one business day of the decision.

### Urgent Decisions

When a provider has submitted an urgent request for a prior authorization, UnitedHealthcare Dental must render a decision within three business days of receipt. In addition, a denial letter (if applicable) must be sent within one business day of the decision.

## Provider Claim Dispute Resolution

For assistance and instructions, please contact the UnitedHealthcare Dental customer service center at 877-408-0166 prior to filing a claim dispute.

A provider may file a claim dispute with UnitedHealthcare Dental if the provider meets the requirements below:

Per ARS 36-2903.01, paragraph B.4, A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the UnitedHealthcare Dental within:

1. Twelve months after the date of service
2. Twelve months after the date that eligibility is posted
3. Sixty days after the date of the denial of a timely claim submission, whichever is later AAC R-9-34-404 indicates that the written claim dispute must state the factual and legal basis for the dispute and the relief requested. Failure to meet these requirements shall result in the denial of a claim dispute.



All claim disputes must be in writing and mailed to:

UnitedHealthcare Community Plan Medicaid  
PO Box 1382  
Milwaukee, WI 53201

A claim inquiry or research request does not extend the claim dispute filing deadlines.

In the event that the provider disagrees with the contractor's decision, the provider may request a Hearing within 30 days of the decision. UnitedHealthcare Dental will forward the Hearing request to AHCCCS, Office of Grievance and Appeals.

## Ch. 20 Clinical Practice Guidelines

All UnitedHealthcare Community Plan Clinical Practice Guidelines can be obtained online at [uhcommunityplan.com](http://uhcommunityplan.com). They can be found by selecting “provider”, then selecting “Clinical Practice Guidelines” and then accepting the terms and conditions. If you need to request a hard copy of the Clinical Practice Guidelines, they can be obtained by contacting your Provider Relations Advocate.

# Glossary/Acronyms

## **Abuse (of Enrollee)**

Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

## **Abuse (by Provider)**

Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

## **ADHS**

Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

## **AHCCCS**

Arizona Health Care Cost Containment System (pronounced “access”) is a State agency that manages the state Medicaid Program. AHCCCS utilizes a competitive bid process to select prepaid Program Contractors such as UnitedHealthcare Community Plan to provide services to eligible enrollees. AHCCCS is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person defined by A.R.S 36-2932.

## **AHCCCSA**

Arizona Health Care Cost Containment System Administration. The state agency, which acts as the contracting and regulatory body for the State.

## **ALTCS**

Arizona Long Term Care System (pronounced “all-teks”) is a program administered under AHCCCSA. ALTCS provides long term, acute, behavioral health care and case management services to eligible enrollees. Enrollees are primarily the elderly and/ or physically disabled who meet financial eligibility criteria and are at risk for institutionalization.

## **AMPM**

AHCCCS Medical Policy Manual

## **Annual Enrollment Choice**

The time period based upon the anniversary of an enrollee’s enrollment in which the enrollee may select a different health plan/Program Contractor.

## **Appeals**

A request for a standard or expedited reconsideration of the denial of a requested service or payment of a service.

## **Authorization**

A process whereby services are reviewed prospectively to determine if they are medically necessary and appropriate. This review also includes verification of enrollee enrollment, verification that the request is a covered benefit, and determination of the provider’s eligibility to perform the service.

## **Billed Charges**

Charges billed by a provider for rendering services to an UnitedHealthcare Community Plan enrollee.

## **Capitation**

A prepaid, periodic payment to providers, based upon the number of assigned enrollees that is made to a provider for providing covered services for a specific period.

**Case Manager**

The individual responsible for coordinating the overall service plan for an enrollee in conjunction with the enrollee, the enrollee's representative and the enrollee's Primary Care Provider (PCP).

**Claim Dispute**

A dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

**Clean Claim**

A claim that may be processed without obtaining additional information from the provider of service or from a third a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

**Centers for Medicare and Medicaid Services (CMS)**

Formally known as the Health Care Financing Administration (HCFA). CMS is a division within the U.S. Department of Health and Human Services, which administers the Medicaid, Medicare and State Children's Health Insurance programs throughout the country.

**CMS 1500**

Formerly the HCFA 1500, the CMS 1500 is the reimbursement form used to report all outpatient medical service encounters and claims.

**Covered Services**

Covered services are medically necessary health and medical services (which may vary by product) that are delivered to UnitedHealthcare Community Plan enrollees at the direction of the enrollee's Primary Care Provider.

**Discharge Planning**

Identification of the need and provision for an enrollee's health care needs after discharge from the hospital or skilled nursing setting.

**Disenrollment**

The discontinuance of an enrollee's right to receive covered services.

**Durable Medical Equipment (DME)**

Items that can withstand repeated use, are designed to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, such as hospital beds, wheelchairs, walkers and crutches.

**Dual Eligible**

An enrollee who is eligible for Medicare Part A and/or Part B, and Medicaid.

**Eligibility Determination**

A process of determining whether an applicant meets the requirements for federal or state eligibility.

**Emergency Dental Services**

Emergency adult dental services are eliminated. However, in accordance with federal law and the State Plan, AHCCCS will cover medical and surgical services furnished by a dentist only to the extent that such services may be performed under State law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician. For members 21 years of age and older, the services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Certain pre-transplant services (e.g. dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.

**Emergency Medical Condition**

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; c) serious dysfunction of any bodily organ or part.

**Emergency Medical Service**

Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition.

**Encounter**

A record of health care related services rendered by a provider or providers registered with AHCCCS to an enrollee who is enrolled with UnitedHealthcare Community Plan on the date of service. Providers are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan in turn, electronically reports these encounters to AHCCCSA. The State audits encounter submission accuracy and timeliness on a regular basis.

**Enrollee**

Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

**Enrollment**

The process by which a person who has been determined eligible to receive Medicaid or Medicare benefits becomes an enrollee of a health plan.

**EOB**

Explanation of Benefits

**EPD**

Elderly and/or Physically Disabled

**EPSDT**

Early and Periodic Screening, Diagnosis and Treatment is a federally mandated program for persons under 21 years of age. EPSDT includes general screening, diagnostic and treatment services including vision, dental and hearing services. The purpose of the EPSDT program is to provide comprehensive health care through primary prevention, early intervention, diagnosis, and medically necessary treatment of physical and mental health problems, identified by an EPSDT screening.

**Fee For Service (FFS)**

A method of payment to providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

**FHC**

Family Health Center

**Formulary**

A formulary is a preferred list of drugs selected to meet patient needs.

**Fraud**

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**Grievance System**

A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.

## **HCBS**

Home and Community Based Services – Care provided in a non-institutionalized setting, as defined in A.R.S. 36-2931 and 36-2939.

## **HIPAA**

Health Insurance Portability and Accountability Act of 1997. HIPAA has many provisions impacting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities, specifically providers who transmit health care information electronically, health plans and health care clearinghouses.

## **Health Maintenance Organization (HMO)**

HMO is a network of physicians and other health care providers that provide or coordinates an individual's health care services. Physicians that participate within the HMO network are reimbursed on a flat-rate monthly basis based on specific capitation models. Individuals pay a specific co-payment based on the benefit plan.

## **Medicaid**

A federal/state program authorized by Title XIX of the Social Security Act providing federal matching grants, at state's option, for a medical assistance program for recipients of federally aided public assistance and SSI benefits and medically indigent.

## **Medically Necessary**

"Medically necessary" refers to those covered services provided by a physician or other licensed practitioner within the scope of their practice under state law to preserve and maintain the health status of an enrollee; prevent death, treat/cure disease, and ameliorate disabilities or other adverse health conditions; and/or Prolong life. Only services that are deemed to be medically necessary and covered will be authorized.

## **Medicare**

A federal program authorized by Title XVIII of the Social Security Act that provides health insurance for persons aged sixty-five (65) and older and for other specified groups. Part A is for hospitalization and is compulsory; Part B is for outpatient services and is voluntary. Part D is a prescription benefit and is voluntary.

## **Medicare Part A**

Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

## **Medicare Part B**

Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A).

## **Medicare Part D**

Medicare Prescription Drug coverage available through Medicare Advantage Prescription Drug Plans (MA-PD) and standalone Prescription Drug Plans (PDP). The benefit provides coverage for prescription drugs.

## **Non-Participating Provider (Non-Par)**

Non-Par refers to a non-participating provider. This describes a physician or other health care provider who has not signed an agreement with United HealthCare or UnitedHealthcare Community Plan to be a participating provider of health care. Also known as an out-of- network provider.

## **Notification**

Used interchangeably with "authorization" or "prior authorization"



**NPI**

National Physician Identifier. Required by CMS for all providers who bill, prescribe or refer for health care services and is to be used on all electronic transactions. It is a single unique provider identifier assigned to a provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

**Out of Network**

Coverage for treatment obtained from a non-participating provider.

**PCP**

Primary Care Provider. This term is used interchangeably with “primary care physician”. The PCP is a provider who is responsible for the overall management of an enrollee’s health care. PCPs may include, but are not limited to: a physician who is a family practitioner, general practitioner, internist, pediatrician, obstetrician or gynecologist; a certified nurse midwife or nurse practitioner; or, under the supervision of a physician, a physician’s assistant.

**PPO**

Preferred Provider Organization (PPO) Physicians and other health care providers under such agreements are referred to as preferred providers. Usually, the PPO benefit contract provides significantly better benefits and lower costs for services received from preferred physicians and other health care providers, thus encouraging enrollees to use these physicians and providers. Enrollees generally are allowed benefits for non-participating physician and provider services, usually on an indemnity basis. There is no requirement to elect a primary physician to serve as gatekeeper for network services.

**Program Contractor**

Health Plan approved by AHCCCS to administer ALTCS and/or AHCCCS programs.

**Quality Management**

Activities that focus on measuring, monitoring and improving the quality of care and outcomes for enrollees.

**Rate Code**

An alpha/numeric classification that identifies the enrollee’s eligibility category status within ALTCS.

**Room and Board**

The amount paid for food and/or shelter. Medicaid funds can be expended for room and board only when a person lives in an institutional setting (nursing facility, ICF/MR). Medicaid funds cannot be expended for room and board when an enrollee resides in an alternative residential setting (e.g. Assisted Living Facilities, Behavioral Health Level 2) or an apartment like setting that may provide meals. The enrollee is responsible for payment of room and board in these settings.

**Share of Cost**

ALTCS enrollees are required to contribute toward the cost of their care based on their income and type of placement. Generally, only institutionalized ALTCS enrollees have a share of cost. Some enrollees, either because of their limited income or the methodology used to determine the share of cost, have a zero share of cost. The ALTCS Eligibility Office determines the amount of an enrollee’s share of cost. Except with a trust, a HCBS member may have a share of cost.

**Third Party Liability**

The resources available from an individual, entity program that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an applicant, eligible person or enrollee.

**UB-04**

A universal billing form for claims. Skilled nursing facilities, hospital inpatient, outpatient and emergency room claims are filed on this form. The UB-04 is not to be confused with a “universal claim form” for filing pharmacy claims.

**UnitedHealthcare Community Plan**

UnitedHealthcare Community Plan is an affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.



STD-PRA  
**PROVIDER  
REMITTANCE ADVICE**



Arizona

PAYMENT DATE:	10/16/16
PAYEE TAX NUMBER:	
PAYEE ID:	
PAYEE NAME:	
PAYMENT NUMBER:	
PAYMENT AMOUNT:	
GRP ID:	AZLT
RA REFERENCE ID:	2016101612400357

claims for reconsideration no more than 12 months from the date of service or 12 months after eligibility posting, whichever is later.

Claim Adjustments – a previously paid claim that requires additional research due to an overpayment or underpayment.

For either a corrected claim resubmission or claim adjustment, please submit your claim and supporting documentation along with a reconsideration form addressing the specific issue to:

UNITEDHEALTHCARE COMMUNITY PLAN  
P.O. BOX 5290  
KINGSTON, NY 12402-5290

You can locate a copy of the reconsideration form at [www.UNITEDHEALTHCAREONLINE.COM](http://www.UNITEDHEALTHCAREONLINE.COM) > TOOLS & RESOURCES > FORMS.

**CLAIM DISPUTES**

If you wish to file a claim dispute to maintain your rights, follow the instructions provided below:

All providers of services to UNITEDHEALTHCARE COMMUNITY PLAN members may file a claim dispute based on a claim denial, dissatisfaction with a claim payment, or recoupment action by UNITEDHEALTHCARE COMMUNITY PLAN. Pursuant to AHCCCS guidelines, all claim disputes must be filed in writing no later than 12 months from the date of services, 12 months after the date of eligibility posting, or within 60 days after the payment, denial, or recoupment of a timely claim submission, whichever is later. The claim dispute must state with particularity the factual and legal basis for the relief requested, along with all supporting documentation such as claims, remits, medical records, etc. Incomplete submissions, or those which do not meet the criteria for a claim dispute, will be denied. Additional sources of information on the claim dispute process include the UNITEDHEALTHCARE COMMUNITY PLAN Provider Manual, Arizona Revised Statutes (ARS) 36-2903.01(B)(4), and Arizona Administrative Code (AAC) R9-34-401 et seq.

All claim disputes must be submitted in writing to:  
UNITEDHEALTHCARE COMMUNITY PLAN  
APPEALS & CLAIM DISPUTES DEPARTMENT  
1 E. WASHINGTON STREET  
SUITE 900  
PHOENIX, AZ 85004-2582

If the provider disagrees with UNITEDHEALTHCARE COMMUNITY PLAN's decision, the provider may request a hearing within 30 days of the decision. UNITEDHEALTHCARE COMMUNITY PLAN will forward the hearing request to AHCCCS, Office of Grievance and Appeals.

## Claim Dispute Acknowledgement

<Today's Date>

<Claim Dispute Submitter Name>

<Provider Name>

<Address>

<City, State, Zip>

**RE:** Member:  
Member I.D.:  
Claim Dispute#:  
Date of Service:

Dear <Claim Dispute Submitter Name>

We are in receipt of your claim dispute received on <Received Date>. Research and review are in process and a decision will be forthcoming as soon as possible.

If you have additional documentation you would like to submit related to this issue please submit it to the Appeals and Claim Dispute address listed below.

Sincerely,

UnitedHealthcare Community Plan  
Appeals & Claim Disputes Department  
1 East Washington Suite 900  
Phoenix, AZ 85004

**NOTICE OF DECISION**

**RE:** Claim Dispute #: \_\_\_\_\_ Member: \_\_\_\_\_  
Provider: \_\_\_\_\_ Member I.D.: \_\_\_\_\_  
Provider ID: \_\_\_\_\_ Date of Service: \_\_\_\_\_  
Provider Contracted: Yes  No

**ISSUE(S):**

Dear \_\_\_\_\_,

UnitedHealthcare Community Plan received your claim dispute dated \_\_\_\_\_, on \_\_\_\_\_.

**PROVIDER'S ISSUE:**

**ANALYSIS:**

**DECISION:** Based on our review, we have determined that your claim dispute is

If the claim dispute is overturned, in full or in part, we will reprocess and pay the claim in a manner consistent with the decision within 15 business days of the date of this decision.

**LEGAL CITATION:**

**STATE FAIR HEARING RIGHTS:** If you disagree with this decision, you may submit a written request for State Fair Hearing within 30 days of receipt of this Notice of Decision to the following address:

UnitedHealthcare Community Plan  
State Fair Hearing Coordinator  
Appeals & Claim Disputes Department  
1 East Washington, Suite 900  
Phoenix, AZ 85004

If you have any further questions, please contact me at \_\_\_\_\_.

Respectfully,

UnitedHealthcare Community Plan





HAND DELIVERED

Mr. Matt J. Devlin  
AHCCCS Grievance and Appeals  
701 East Jefferson, 3rd Floor  
Phoenix, Arizona 85034

Re: Claim Dispute Number:

Provider:  
Provider ID:  
Provider Phone:  
Member:  
Member ID:  
DOS:

Provider/Address:

Date Claim Dispute received:  
Summary of actions taken to resolve the Claim Dispute:

Claim/Claim Dispute filing history reviewed. Claim Dispute \_\_\_\_\_ and claim appropriately processed, per claim submission guidelines. In addition, denial of request for hearing upheld for lack of timeliness in accordance with A.A.C. R9-34-405.

Dear Mr. Devlin:

By the provider's letter dated, \_\_\_\_\_, the above referenced provider requested a State Fair Hearing of UnitedHealthcare Community Plan's Claim Dispute decision. The provider's request for hearing was untimely received by UnitedHealthcare Community Plan on \_\_\_\_\_. Enclosed please find a copy of UnitedHealthcare Community Plan's Claim Dispute file.

If I may be of any further assistance in this regard, please contact me at \_\_\_\_\_.

Respectfully,

Appeals Coordinator  
Appeals and Claim Disputes Department

cc:

HAND DELIVERED

Mr. Matt J. Devlin  
AHCCCS Grievance and Appeals  
701 East Jefferson, 3rd Floor  
Phoenix, Arizona 85034

Re: Claim Dispute number:

Provider:

Provider ID:

Provider Phone:

Member:

Member ID:

DOS:

Provider/Address:

Date Claim Dispute received:

Summary of actions taken to resolve the Claim Dispute:

Provider request verified as appropriate for Claim Dispute. Claim/Claim Dispute filing history reviewed and documented. Denial of claim dispute for \_\_\_\_\_, in accordance with

Dear Mr. Devlin:

By the provider's letter dated \_\_\_\_\_ received by UnitedHealthcare Community Plan on \_\_\_\_\_, the above referenced provider requested a State Fair Hearing of UnitedHealthcare Community Plan's Claim Dispute decision. Enclosed please find a copy of UnitedHealthcare Community Plan's Claim Dispute file.

If I may be of any further assistance in this regard, please contact me at \_\_\_\_\_.

Respectfully,

Appeals Coordinator  
Appeals and Claim Disputes Department

cc:

## 12. Information Technology (IT) Systems Demonstration

### **PARTICIPATION IN INFORMATION TECHNOLOGY SYSTEMS DEMONSTRATION**

UnitedHealthcare acknowledges that our participation in the IT Systems Demonstration beginning on, January 24, 2017, constitutes fulfillment of Submission Requirement No. 12 (RFP references No.11, per Amendment 2 this is No 12.).

UnitedHealthcare acknowledges that we will comply with the stated guidelines and calendar for this process.

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

### **IT Systems Demonstration Preparedness**

Our corporate and Arizona health plan IT teams are collaborating in preparation for the IT Systems Demonstration. Our portfolio delivery director, Gabriel Moreno, will coordinate our participation in the demonstration with AHCCCS and lead the project management team. Our senior project manager, Jeff Greenspan, manages our local functional teams (e.g., enrollment, claims, encounter data, reports and finance) that will perform the various data exchanges, user testing and problem solving activities, supporting Mr. Moreno. Our chief information systems administrator, Mohan Basavapatna, will provide oversight of our demonstration participation activities.

In preparation for the IT Demonstration, we have:

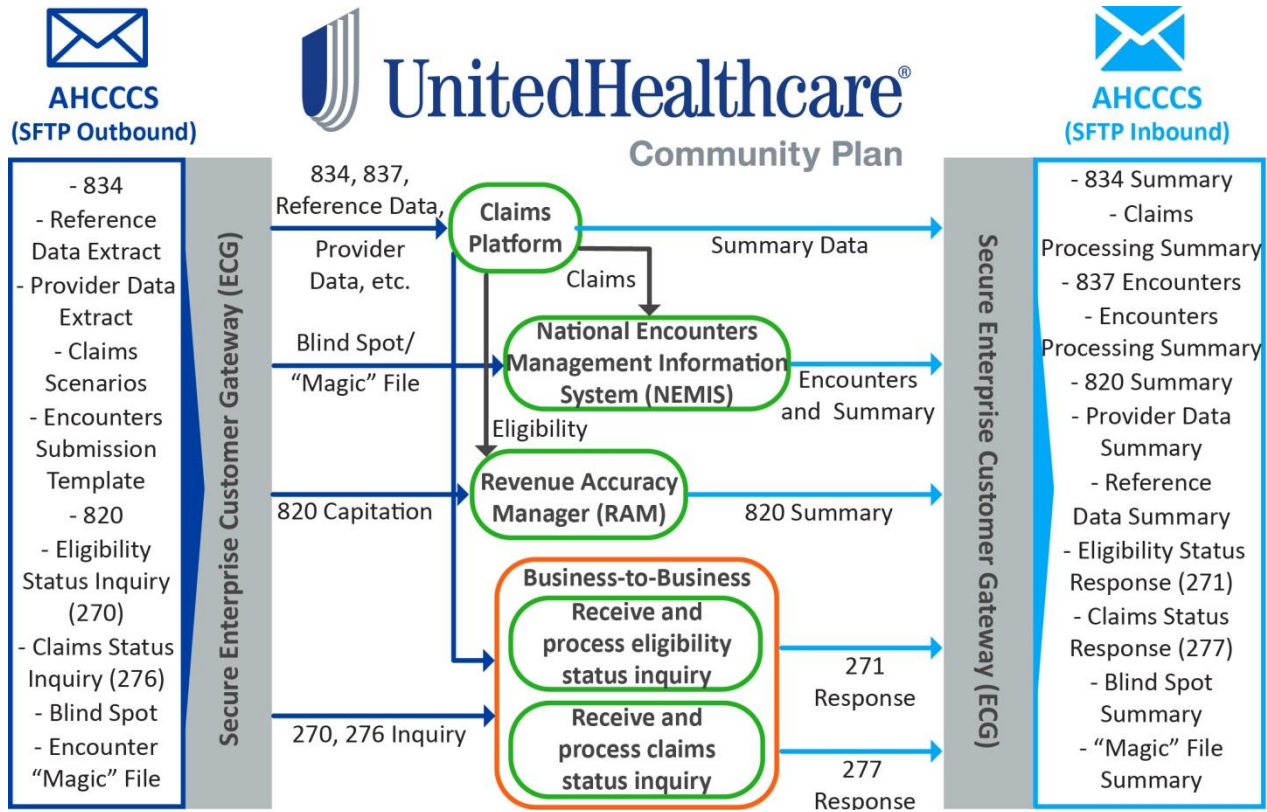
- Dedicated local health plan and corporate IT project managers to manage our efforts
- Developed a project plan
- Allocated appropriate local and corporate IT resources
- Developed written plans to receive reference data from AHCCCS
- Set up a test environment to load the State's test data and respond appropriately
- Developed scripts and checklists to verify accurate and timely demonstration data is exchanged with AHCCCS

We have reviewed the guidelines, 10-day calendar, as well as the user guides and manuals supplied in the Bidder's Library and our IT systems meet or exceed all requirements. We continually work with AHCCCS to implement and adjust new data exchange requirements and data exchanges that support the cultural values and privacy of the members we serve along with our initiatives to transform service delivery that is truly person-centered and quality-focused.

### **PROCESS DATA EXCHANGED WITH AHCCCS**

During previous IT systems demonstrations with AHCCCS, we demonstrated our understanding of the State's specific rules regarding data exchanges and processing data. We successfully proved the data processing and information exchange capabilities of our IT systems. We are applying lessons learned from these experiences to guide our preparation for this IT Systems Demonstration. For example, with the HIPAA 5010 implementation, we anticipated and positioned ourselves to implement future X12 versions. Similarly, we will closely monitor the progress of the HIPAA 7030 proposal and plan accordingly for its implementation. We are confident our thorough preparation will result in a successful demonstration for the ALTCS E/PD Program that will bolster the State's confidence in our ability to deliver unsurpassed service and quality to our ALTCS members and our AHCCCS clients and stakeholders.

The following diagram depicts how data flows into our systems, is processed and conveyed to appropriate subsystems.



**Figure 2.** Data we receive from AHCCCS (left column) is securely accepted, processed and distributed to functional areas through our IT systems; then we send confirmation to AHCCCS (right column) via summary and status reports.

### ADMINISTRATION OF ACTIONS USING PROCESSED DATA

For over 28 years, we have maintained an integrated management information system (MIS) supporting the ALTCS program. Our MIS enables the day-to-day functionality of key operations, promoting efficient and effective delivery of health care services to our members and compliance with ALTCS Contract requirements. Our core MIS architecture is Community Strategic Platform (CSP), a TriZetto Facets claims platform with interfaces that optimize information exchange with other key systems for service integration, utilization management, network management and care coordination of the Medicaid, Medicare Dual-Special Needs Plan (D-SNP) and Long-Term Services and Supports (LTSS) programs we administer. We invested in the Oracle Exadata X5 platform, which supports CSP and is the most advanced hardware for managing large and complex database loads. The X5 platform enables faster in-memory databases with redundant hardware and the fastest failure recovery times possible. It enhances data freshness for reporting by day, week or in real-time. The X5 platform provides capability for zero planned downtime hardware maintenance, which means we maintain business continuity and can effectively serve our members and providers 24 hours a day, seven days a week across all of our operational areas.

We continually work to improve data accuracy and streamline our processes to increase overall satisfaction and simplify program administration. During the demonstration, our technology enhancements will reveal our ongoing commitment to deploying innovative, transformative and person-centered service solutions. In recent years, we have:

- Implemented a functional statewide health information exchange in collaboration with Health Information Network of Arizona (HINAz)
- Implemented new data exchange requirements, such as HIPAA 5010, national provider ID (NPI) and National Drug Code (NDC) codes

- Deployed our proprietary Accountable Care Patient Registry that gives our clinical teams access to real-time and profile clinical information on an assigned patient population
- Implemented a multi-channel process for provider inquiries, ensuring response to providers within three days and inquiry closure within 30 days of initial receipt, known to us as the 3/30 process
- Customized provider portal to provide inquiry status and track and report our operational **Performance** to meet AHCCCS' 3/30 goals
- Transitioned from ICD-9 to ICD-10 code sets in October 2015 and comply with current International Classification of Diseases (ICD-10) and EDI requirements as defined by CMS regulation and policy
- As an incumbent contractor, completed and submitted the EDI Trading Partner Agreement and have a Transmission Submitter Number (TSN) for encounter submissions

## Our Comprehensive Service Integration Solution

Evidence of our commitment to invest in and evolve our IT systems comes with the January 1, 2017 enhancement of our person-centered, HIPAA-compliant, secure information sharing system collectively known as CommunityCare. CommunityCare is our comprehensive electronic care management system consisting of a highly flexible system architecture enabling us to tailor all aspects of the care management programs we administer to meet the unique geographic, demographic and cultural characteristics of the members and providers we serve. It integrates members' acute and preventive care, chronic disease management, medical, behavioral, social and LTSS into a comprehensive record.

CommunityCare enables care coordination by giving the care team updated and shared access to members' care plan and supports alignment of clinical problems, goals and interventions. It enables web-based access for the care team, PCPs, specialists, members, caregivers and others—as permitted by the member—to view and communicate information about the member's medical information, 24 hours a day, seven days a week.

In addition to care and utilization management, CommunityCare enables functionality of the following activities:

- Authoritative source of authorizing and monitoring services used to capture the required clinical data for medical, behavioral health, and home and community-based services
- Manages authorizations from the providers for reference by the care team
- Accepts member eligibility and provider data feeds from CSP
- Integrates evidence-based medicine gaps in care and progress assessments

CommunityCare enables electronic tracking of members' assessments, care preferences, prioritized health concerns, issues, intervention strategies, and self-sufficiency goals along with how well the member understands and is progressing toward achieving goals. It contains the member/family/caregiver's contact information and maintains each member's condition list, medications, service dates and outcomes, history, provider visits, diagnoses, issues, progress notes and case conference notes, lab results, gaps in care and medication adherence.

## ENHANCEMENTS TO MEMBER AND COMMUNITY ENGAGEMENT

In recent years, as we augmented and expanded our IT system capabilities to be more user-friendly and accessible to our members and providers, our guides have been initiatives relating to emerging trends, social determinants of health and the State's priorities. These initiatives have driven our decisions in investing in IT systems with the capability and capacity to support our members in a person-centered environment, yet have the flexibility to be adjusted midstream to address the ever-changing needs of the AHCCCS and ALTCS programs. For example, we recognize that electronic visit verification (EVV) is undergoing consideration at the State level. As we have done in six other states, we proactively prepared our IT systems to be able to work with any vendor the State determines at a future time. Below we describe the engagement tools we offer for the ALTCS E/PD program currently and those being deployed in 2017.



## Member Website: [myuhc.com](http://myuhc.com)

Our member website, [myuhc.com](http://myuhc.com), is a secure and HIPAA compliant hub for our decision support, collaborative, transactional, clinical and educational resources. [Myuhc.com](http://myuhc.com) website design meets the unique needs and challenges of our ALTCS members, with appropriate Flesch-Kincaid reading levels, multiple language offerings and culturally appropriate materials. We continually enhance website accessibility for individuals with disabilities as technology standards and industry requirements evolve. For example, in 2016 we added the “click to call” feature, which allows members to request and receive a call back from our member services team within an estimated 10 seconds. The permanent survey feature on [myuhc.com](http://myuhc.com) collects online visitor feedback, enabling us to obtain immediate feedback to improve user experience going forward. We customize content on [myuhc.com](http://myuhc.com) to align with ALTCS program requirements and our internal standards related to the provision of clear, accurate, culturally competent communication to members.

**Mental Health and Substance Use Disorder Toolkits:** Through our member website, we offer three recovery toolkits to enable members’ wellness and to support their families—particularly during the period between visits or in use with a peer support. Toolkits are focused on mental health, substance use disorders and families and contain links and information about free self-care resources. Other tools available through our member portal include exclusive access to Pat Deegan’s Recovery Library; over 75 short videos of members in recovery sharing their stories of hope and encouragement; dozens of apps to support addiction recovery; Resiliency and Empowerment Activation Choices (REACH) grid that helps members and providers select a self-care/activation tool; videos to educate newly diagnosed individuals; Maryland Assessment of Recovery Scale-12 (MARS-12) to assess where members are on their recovery journey; Recovery Planning Tool to use as a guide when communicating with providers for members who do not use a computer; Whole Health Tracker; Interactive Self-Help Programs; Mental Health Condition Centers and much more.

*Myuhc.com has won multiple awards, including Gold for Member Education Portal website from Digital Health Awards, and the highest honor from World Wide Web Health Awards for excellence in web-based consumer health content.*

**Caregiving and Disability:** Also on our member website, we provide numerous educational articles and links to resources geared to the needs of caregivers. A few examples of educational articles specific to caregiving include:

- Becoming a Caregiver for your Adult Son or Daughter
- Personal Care: Assisting a Person in the Late or Middle Stages of Dementia with Daily Needs
- Caring for a Person with Alzheimer’s: Challenges and Coping Strategies
- Depression after Brain Injury: A Guide for Patients and Their Caregivers
- Caregiver Stress Fact Sheet
- Finding Satisfaction in Caregiving
- Caregivers Need Care, Too

## Tools to Engage ALTCS Members, Caregivers or Providers

We find that LTC populations have the widest spectrum in terms of using computers and mobile devices. Persons generally are at one end of the scale (e.g., comfortable accessing the web and using mobile devices) or the other (e.g., does not use/have a computer or mobile device). Therefore, we make information available in a variety of ways to accommodate differing preferences, so each person can gain access to information in the way they prefer. We describe some of our innovative and popular tools below:

**Health4Me:** Members can download our free mobile application, Health4Me, to use our powerful online tools with features that can help them understand their health plan and make informed, timely choices for their medical care.

**Community Resource Tool:** The community resource tool is a web-based tool easily accessible by mobile phone or tablet that helps case managers and community health representatives connect members to relevant and available social

resources that deliver services (such as, food, housing, employment assistance, energy, support groups, child care and clothing) to individuals at risk for poor health outcomes or excessive health care utilization.

**Uhcforcaregivers.com:** We designed *Uhcforcaregivers.com* to provide comprehensive support to family caregivers and offers a combination of educational resources, functionality to share information with other care providers, family and friends and a task/calendar manager. Following extensive research on family caregiver needs, the site helps caregivers solve common problems in a holistic way. We will launch this intuitive, interactive website for ALTCS members in 2017.

**eLTSS Tool:** To facilitate the electronic exchange of service plan information across multiple LTSS care settings, we are participating in the CMS eLTSS initiative by developing an eLTSS tool. We are designing the tool to exceed the requirements of the CMS TEFT Program and other federal initiatives. Our eLTSS tool will generate an electronic member service plan based upon assessment data and will contain information often not captured in a care plan, such as social and behavioral determinants to include work, community inclusion, decision-making and personal finance information. We are constructing our eLTSS tool to be fully customizable to accommodate changing CMS requirements as well as state-specific requirements.

**WRAP Mobile App:** Our Wellness Recovery Action Plan (WRAP) mobile device application (app) allows individuals to

The screenshot shows the Myuhc.com website with several callouts pointing to specific features:

- Your health plan name and numbers you may need.** Points to the member information section on the left.
- Quick access to the things you need most.** Points to the central navigation menu with options like 'Look up My Benefits', 'Find a Doctor', 'Print an ID Card', 'Health Assessment', and 'Ask a Question'.
- Take your Health Assessment.** Points to the 'Health Assessment' button in the central menu.
- Links to related websites.** Points to the 'Related Web Sites' section at the bottom.
- Information about services and programs.** Points to the 'Information Center' section at the bottom left.

create and share with others their personalized wellness and crisis plans to better manage their medical issues, mental health symptoms, cope with triggers and to prepare for psychiatric emergencies. The free WRAP app is available to any plan member to iOS and Android devices via Apple’s App Store or Google Play. The WRAP app allows members to create a “Wellness Toolbox” comprised of tasks they may need to do every day to stay well. Members can develop an individualized crisis plan to guide others on how to respond when they cannot make decisions for themselves. Members can also develop a post-crisis plan to serve as a guide during the aftermath of a crisis.

**Figure 3. Myuhc.com** enables members to easily find information, contact us, and link to other resources.

our ALTCS, AHCCCS Acute, CRS and D-SNP members. Our Arizona health plan has the highest telehealth use among our 24 Medicaid markets. We expanded our telehealth service delivery model in rural Arizona; providing primary, specialty, behavioral health and therapy services. For example, we deliver high definition imaging and audio enabling Phoenix-based pediatric neurologists to serve children living on the Navajo Nation who previously traveled more than 200 miles each way to receive these services. Through the Arizona Telemedicine Program, in 2016 and beyond, we are extending the reach of specialty providers by offering telehealth clinic services to members living in Flagstaff, Tucson and Yuma.

**Telehealth in Arizona:** In 2015, we delivered approximately 22,000 telehealth visits for

**SUMMARY**

Health care is a very complex business, and the integration of a health care delivery system is no small undertaking. We recognize the challenges of developing and integrating health care delivery systems, including working with external partners and providers with various levels of expertise and different, often incompatible, technologies and interfaces. We have significant experience working with regional and statewide partners in numerous states in assuring effective implementation, self-sustainability and adoption of new technologies.

## Names and Titles of Participating Individuals

Below please find a list of names and titles of the individuals who will participate in the Oral Presentation:

- Joseph G. Gaudio – CEO, UnitedHealthcare Community Plan
- Stephen D. Chakmakian, D.O. – Chief Medical Officer
- Karen A. Saelens – Chief Operating Officer, UnitedHealthcare Community Plan
- Jesse Eller – LTC Administrator/Chief Executive Officer (CEO)
- Francine Pechnik – Case Management Administrator/Manager
- Theresa Robben – Behavioral Health Coordinator

Please see the resumes for each individual following this page.

## JOSEPH G. GAUDIO, CPA – CHIEF EXECUTIVE OFFICER

### OVERVIEW

Challenge-oriented finance executive with more than 20 years of broad and diverse experience in senior leadership positions. Expertise in strategic financial management, reporting, budgeting, acquisition due diligence, capital financing, cash management, receivables management and healthcare benefit consulting. Proven track record of delivering results and recognized for leadership ability. Responsible for financial component of state contract bids including capitated rate proposal, financial projections and best and final offer negotiations. Notable accomplishments include:

- Improved market share by more than 200 basis points in the first year as CEO of UnitedHealthcare Community Plan of Arizona through multiple community engagement strategies
- Reduced accounts receivable days sales outstanding for Soporex Inc., from 105 to 45 days, which played a key role in sustaining business operations in the wake of significant reductions in Medicare reimbursement
- Led an airline industry vertical affordability engagement, developing unique care management solutions that played a meaningful role in obtaining the US Airways business, approximately 55,000 members, for UnitedHealth Group
- Key participant of UnitedHealthcare national senior leadership teams that increased its Public Sector membership by 282,000 lives, 42 percent above net growth target, and increased West Region membership by 175,000 lives, 70 percent above net growth target
- Successfully bid and was awarded numerous Arizona Health Care Cost Containment System (AHCCCS) contracts covering both long-term care and acute care services, growing Arizona Physicians IPA into the largest AHCCCS plan in Arizona

Improved AIGB's working capital in excess of \$5.5 million over a seven-month period, driven primarily by a reduction in days sales outstanding from 89 to 50 days and reducing payroll and related expenses by approximately \$600,000. The excess cash was used to reduce outstanding long-term debt and fund a strategic investment in Arizona. [CFO West](#)

### PROFESSIONAL EXPERIENCE

#### **UnitedHealthcare Community Plan – Phoenix, AZ**

##### *Chief Executive Officer, Arizona/September 2014 – Present*

Responsible for financial performance and all aspects of a managed care health plan that serves more than 525,000 Medicaid and Medicare Dual Eligible members in the State of Arizona under multiple contracts with AHCCCS and the Centers for Medicare and Medicaid Services. Other core responsibilities include rate and program advocacy with key State leaders, community engagement and thought leadership.

##### *Chief Financial Officer – Central Region/January 2010 – August 2014*

Responsible for strategic financial management, budgeting, and forecasting for the organization's central region covering approximately 1.2 million Medicaid beneficiaries and representing \$6.8 billion in total revenue. Key participant on national senior leadership teams, working closely with operations, network and actuarial to meet net growth and profitability targets. During tenure, the central region grew from 685,000 Medicaid beneficiaries and \$2.4 billion in total revenue primarily through the successful bidding of Medicaid contracts in Texas, Ohio and Kansas. Supervised five market chief financial officers.

#### **American Institute of Gastric Banding, Inc. – Dallas, Texas**

##### *Chief Financial Officer/January 2009 – October 2009*

Senior leader of a \$50 million ambulatory surgery company with direct responsibility for finance, human resources, information technology, insurance verification, billing and collections. Reported directly to the chief executive officer

and actively participated in monthly board of director meetings. Worked with senior lenders to establish revised debt covenants and successfully negotiated the removal of collateral requirements for a short-term, unsecured credit line. Supervised the controller, vice president of information technology, director of business operations and human resources.

### **Soporex, Inc. – Dallas, Texas**

#### *Chief Financial Officer/January 2008 – September 2008*

Key senior management team member of a \$40 million respiratory management company, assisting with development of strategic direction and company objectives. Reported directly to the company president and was responsible for all financial aspects of the company including financial and tax reporting, treasury, financial control, inventory management, budgeting, forecasting, financial analysis and audit coordination. Directed the strategic negotiation and management of revolving credit facilities and responsible for acquisition analysis. Served as main financial contact for investment bankers and potential investors during the company's recapitalization effort. Supervised the controller and director of compliance, billing and collections.

### **UnitedHealthcare – Dallas, Texas**

#### *Vice President of Affordability – South Region/April 2005 – December 2007*

Led the affordability engagement teams for the organization's south region, which consisted of approximately 80 customers. Affordability engagements included direct customer and consultant interaction with detailed analyses covering financial, clinical and network performance and developing solutions that target improving affordability and health outcomes. Customer-specific engagements included Cracker Barrel, Southwest Airlines, US Airways, The Coca-Cola Company and Sabre Holdings.

#### *Chief Financial Officer, West Region – Public Sector/January 2000 – March 2005*

Led regional finance team responsible for strategic financial management, budgeting and forecasting for UnitedHealthcare segments that totaled 3.2 million lives and approximately \$5.7 billion in revenue. Served on senior leadership teams, working closely with sales, network, and underwriting teams to meet net growth and profitability targets. Assumed additional companywide responsibility in 2004 as capability owner, receivables manager. Directed a team of collection specialists responsible for receivables management with \$27 billion in total revenue. Reduced days sales outstanding from 4.5 to 2.5 over one year and consistently met quarterly cash flow and receivables targets. Supervised four market chief financial officers and two financial analysts.

## **EDUCATION/CREDENTIALS**

- B.S, Accounting (Magna Cum Laude), Arizona State University, 1987
- C.P.A., State of Arizona, Certificate No. 6935-E
- UnitedHealthcare President's Leadership Development Program, Wharton School of Business, 2004
- UnitedHealth Group, General Manager Program, 2011



## STEPHEN D. CHAKMAKIAN, D.O. – CHIEF MEDICAL OFFICER

### OVERVIEW

Accomplished, mature, ethical physician executive with more than 12 years of executive, clinical and diverse professional leadership experience. Excellent communication, interpersonal and problem-solving skills; builds trust, consensus and promotes innovation, change and teamwork. Proven ability to adapt within a competitive health plan environment, refining managed care strategies, assessing requests for proposals and strategic partner selections. Adept at integrating delivery systems, developing structure, process and policy, and creating, implementing and improving innovative quality and utilization management programs.

Excels in oversight and development responsibility for the full scope of health plan medical operations, including but not limited to: accountable care and community-based clinical care models; inpatient concurrent review; integrated medical and behavioral services; pre-certification and post-service review; disease and case management; high-risk/high-needs member care coordination; maternal child health/EPSTD; behavioral health, dental/oral health; quality improvement; performance management; credentialing; pharmacy programs; transplant services; appeals and grievances; contracting and network development (including alternative payment models/payment transformation); and claims analysis (including fraud, waste and abuse assessment).

Proficient in Arizona public sector insurance programs, including regulatory and state and federal customer requirements and expectations. Current responsibilities include oversight of Medicaid and Dual Eligible Special Needs (D-SNP) Medicare programs, including individuals with developmental disabilities, specialized and complex medical conditions, long-term care, and home and community-based services.

### PROFESSIONAL EXPERIENCE

#### *UnitedHealthcare Community Plan – Phoenix, Arizona*

##### *Chief Medical Officer/January 2011 – Present*

Responsible for health plan clinical and quality operations and performance oversight for health plans that serve more than 530,000 Medicaid and Medicare D-SNP members in Arizona under multiple contracts with the Arizona Health Care Cost Containment System (AHCCCS) and the Centers for Medicare and Medicaid Services (CMS), including five distinct State programs (i.e., Acute Medicaid, Children's Rehabilitative Services, Individuals with Developmental Disabilities, Arizona Long-Term Care Services, and D-SNP). Accomplishments include:

- Consistently sustain performance and improvement in compliance with contract requirements and state partner expectations
- Lead significant and sweeping expansion of health plan clinical partnerships and deployment of value-based contracts across the state for all plan types with Accountable Care Communities
- Awarded three UnitedHealth Group Innovation awards, as well as a UnitedHealth Group Leadership Shadow award for increasing employee engagement
- Lead and mentor a core clinical leadership team and extended clinical and quality support teams

#### **Health Choice Arizona/Health Choice Generations – Phoenix, Arizona**

##### *Chief Medical Officer/October 2006 – November 2010*

Gained nine years of progressive and cumulative medical administrative experience, growth and development at this AHCCCS managed care health plan.

- Successfully supported successive competitive AHCCCS bid awards and led medical services departments through progressive plan membership and geographic expansion from approximately 35,000 covered lives in two metropolitan counties, to more than 200,000 lives across 10 Arizona counties



- Supported the implementation and management of Health Choice Generations, a D-SNP Part D Medicare Advantage health plan serving dual-eligible members
- Collaborated on Request for Proposal (RFP) development, issuance and selection processes for new plan service delivery vendors
- Supported successful post-implementation of selected vendor partners, demonstrated by operational success, improved appropriateness of utilization, reduced cost, improved data collection and quality control

#### *Medical Director/March 2004 – September 2006*

- Redeveloped health plan clinical department policies and procedures, including medical and dental clinical coverage criteria, provider pre-certification denial language and regulatory provider and member correspondence materials
- Added and trained two additional medical directors and defined the health plan pharmacy director role as a result of growth and expansion
- Collaborated on RFP issuance, selection and contract negotiations for a Pharmacy Benefit Management (PBM) vendor, including oversight of a two-stage implementation (Medicare Part D and AHCCCS Acute)
- Updated processes and scalability, improved compliance and timeliness, and reduced costs associated with the provider credentialing program

#### *Associate Medical Director and Pharmacy Director/November 2001 – February 2004*

- Oversaw medical and dental clinical coverage criteria development and standardization processes
- Managed Pharmacy and Therapeutics, Drug Utilization Review and related programs; expanding and structuring a robust, safe, cost-effective preferred drug list

#### **IASIS Healthcare – Phoenix, Arizona**

##### *The Centre Clinics, Family Practice Offices/September 2000 – February 2004*

#### **Catholic Healthcare West/St. Joseph's Hospital and Medical Center**

##### *Hospital Emergency Department and Intermediate Care Annex/July 1999 – June 2000*

- Served as a dedicated, board-certified, Family Practice Physician with seven years of outpatient, inpatient and emergency department/urgent care practice experience within the Phoenix metropolitan tertiary and quaternary health centers
- Served in a successful private group Family Medicine practice environment with more than 5000 inner-city, primary care patients with diverse insurance coverage and fee for service care
- Oversaw ongoing education to students, residents, physician assistants and family nurse practitioners

#### **EDUCATION/CREDENTIALS**

- Family Practice Residency, St. Joseph's Hospital and Medical Center Phoenix, Arizona, 1997–2000
- Doctor of Osteopathic Medicine, Midwestern University/Chicago College of Osteopathic Medicine, Downers Grove, Illinois, 1993–1997
- Bachelor of Arts, Biology (minors in Chemistry and Philosophy), University of San Diego, 1989–1993

#### **PROFESSIONAL AND COMMUNITY AFFILIATIONS**

- Arizona Board of Osteopathic Medical Examiners (license #3521) 1/31/2000 – 12/31/2016
- American Academy of Family Practice Board Recertification 2007 – 2017
- American Academy of Family Practice Board Certified 2000 – 2007
- Arizona Osteopathic Medical Association

#### **VOLUNTEER BOARDS**

- March of Dimes, Greater Arizona Chapter, September 2014 to present

## KAREN A. SAELENS – CHIEF OPERATING OFFICER

### OVERVIEW

Highly accomplished leader with experience in varying plan operations, business analysis, information technology (IT) and software development. Results-oriented, decisive leader with proven success building organizations, strategic business planning, project implementation and building solutions for complex problems. Recognized track record building strong processes that exceed operational metrics. Thrive in dynamic and fluid environments while remaining focused on primary business goals.

### PROFESSIONAL EXPERIENCE

#### **UnitedHealthcare Community Plan – Phoenix, Arizona**

##### *Chief Operating Officer/July 2015 – Present*

Responsible for operational performance of UnitedHealthcare Community Plan of Arizona, both internally and with state regulator. Responsible for financial, operational and people goals. Responsible for improving operational performance and increasing member and provider satisfaction. Responsible for successful implementation of key business changes whether regulatory or internally driven. Accomplishments include:

- Consistently exceed state performance measures
- Created operational scorecards for at-a-glance view of key metrics
- Increased employee engagement
- Empowered team to focus on operational excellence resulting in exceeding metrics

##### *Executive Director, Long-Term Care and Medicare/August 2012 – July 2015*

Led the long-term care (ALTCS) and Medicare Advantage products for UnitedHealthcare Community Plan in Arizona. Responsible for setting and managing financial, operational and people goals, and for improving operational performance. Responsible for increasing member and provider satisfaction. Reported product operational performance to corporate executives and health plan leadership. Accomplishments included:

- Exceeded state performance measures
- Increased staff visibility on broader UnitedHealthcare company goals
- Improved multiple work flow processes to increase employee engagement
- Reduced administrative costs around manual processes
- Aligned Medicaid and Medicare processes for long-term care members
- Empowered team to focus on operational excellence resulting in exceeding metrics
- Oversaw the successful implementation of key business regulatory-/internally-driven changes

##### *West Region Director, Health Plan Operations/March 2009 – August 2012*

Provided regional oversight for health plan operations in Arizona, Hawaii, New Mexico and Washington with additional oversight responsibilities for national Long-Term Care and Medicare operations. Responsible for adherence to regulatory requirements for claims, call center, enrollment and network operations. Responsible for improving operational performance and increasing member and provider satisfaction. Reported operational status and performance outcomes to corporate executives and health plan leaders. Responsible for driving implementation of key business changes both regulatory and corporate driven. Accomplishments included:

- Implemented RFP awards for multiple products with minimal operational impact

- Created performance metric scorecards to monitor performance of operations, which led to improved operations affecting call center, claims and network operations
- Built a strong operations team that focused on operational excellence and exceeded metrics expectations
- Implemented multiple communications channels for changes affecting call center teams, resulting in improved performance

#### *Vice President, Operations/March 2008 – March 2009*

Led the claims, member and provider operations teams of our AHCCCS Acute managed care health plan (APIPA) to achieve operational excellence. Implemented operational processes that adherence to AHCCCS regulatory requirements and for claim payment accuracy per contractual agreements among physicians, hospitals and governing agencies.

Reported operational status and performance outcomes to corporate executives and the board of directors. Managed key vendor relationships, with a focus on improving performance and achieving and exceeding metrics.

Accomplishments included:

- Retained key provider relationships within health plan, enabling strong membership growth for the health plan
- Built strong operations teams that focused on operational excellence and exceeded metrics
- Implemented Children's Rehabilitative Services (CRS) program for AHCCCS
- Exceeded the regulator's performance bonus expectations

#### *Vice President, Claims Cost Management/January 2006 – March 2008*

Managed a team of more than 55 professionals while implementing new cost-containment tools and processes for improving claims adjudication accuracy. Led configuration of claims payment system operations to achieve accurate and timely entry of business rules that affect benefit packages, authorizations, provider enrollment rules, membership rules and security rules. Coordinated claims payment quality testing of physician and hospital contracts. Accomplishments included:

- Directly responsible for cost-containment dollars exceeding 2007 goals by 150 percent
- Exceeded cash recovery targets in 2007 by 30 percent
- Created metrics and control processes surrounding configuration of key data in claims payment system, leading to improved process and quality
- Created processes to monitor system fixes, achieving accurate payment first time; process included control chart reporting for ongoing monitoring of fixes
- Built intake and tracking systems for all requests for work from the research/audit team

#### *Senior Director, System Configuration/March 2004 – January 2006*

Directed business rules-based system setup to verify physician and hospital contracts, enrollment, and provider rules were loaded into the system for optimal handling of expected rules and claims payment. Accomplishments included:

- Restructured organization to gain efficiencies via automation, mentoring and cross-training
- Reduced turnaround time for configuration work within service levels for 75 percent of customers
- Developed executive training program that addresses claims payment complexities; trained majority of corporate executives on the basics of our claims payment system
- Oversaw end-to-end quality of system configuration, from business rules to testing, improving quality metrics 50 percent in the first year
- Built intake and tracking systems for all requests for work from the configuration team
- Created metrics and a monitoring system for service level agreements among departments

- Created and maintained budgets within corporate expectations
- Developed resource planning tools against expected volume of work
- Built relationships with key individuals in other departments resulting in a successful enhancement of the overall configuration process

#### *Project Director/February 2003 – March 2004*

Led teams during migration of health plans from mainframe system to client-server based claims payment system. Reported migration status to executive management and escalated issues. Accomplishments included:

- Led the timely migration of two health plans from mainframe system to new claims payment system, involving IT, call centers, health plans, claims processing teams and pertinent business processes
- Created resource plan and budget for migrations – exceeded budget goals

#### *Director, Application Services/April 1999 – February 2003*

Translated client business requirements into technical requirements. Scheduled staff to perform necessary technical changes and directed the projects to completion. Accomplishments included:

- Reviewed and contributed to decision of claims payment vendors to replace mainframe system, with focus on systems capabilities and processes
- Led the three IT implementations from mainframe system to new claims payment system within eight months
- Implemented reusable application development and project management templates, which increased efficiencies in subsequent implementations of the new claims payment system
- Led HIPAA implementation for required federal changes in EDI transaction sets
- Designed creative solutions for IT systems

### **EDUCATION/CREDENTIALS**

- B.S., Computer Science, Winona State University, 1983
- B.S., Secondary Mathematics Education, Winona State University, 1983

### **PROFESSIONAL AND COMMUNITY AFFILIATIONS**

- Toastmasters Competent Communicator
- Toastmasters Advanced Communicator

## JESSE ELLER – LTC ADMINISTRATOR/CHIEF EXECUTIVE OFFICER

### OVERVIEW

More than 25 years as a health and human services administrator with experience in Financial Management, Leadership Development, Contracts/Provider Relations, Medicaid/Medicare, P&L Management and Government Relations.

### PROFESSIONAL EXPERIENCE

#### **UnitedHealthcare Community Plan – Phoenix, Arizona**

##### *Executive Director, Long Term Care and Medicare/August 2015 – Present*

Lead and responsible for all operations of the UnitedHealthcare Community Plan long-term care and Medicare programs we administer in Arizona on behalf of the Arizona Health Care Cost Containment System (AHCCCS). Our long-term care plan is one of three managed care organizations contracted with AHCCCS to administer the Arizona Long-Term Care System Elderly & Physical Disability (ALTCS E/PD) program. We operate in 10 of 15 Arizona counties serving more than 10,000 elderly and physically disabled members. Responsible for oversight of staff to provide support and coordinate care for our members to allow them to safely remain in their home- or community-based setting as long as possible. Oversee our Medicare Dual Special Needs Plan (D-SNP) with more than 40,000 members, verifying our members receive timely and appropriate access to high-quality health care.

#### **AmeriHealth Caritas VIP Plans – Philadelphia, Pennsylvania**

##### *Director, Long Term Care Strategy/March 2014 – August 2015*

Served as the subject matter expert (SME) in Long Term Care (LTC) and Long Term Services and Supports (LTSS). Led the evaluation of LTC/LTSS opportunities to expand AmeriHealth Caritas product lines. Canvassed the states and monitored their activities in the development of LTC and LTSS services as stand-alone programs or integrated services. Led the evaluation of LTC and LTSS providers for networks in Medicaid or Medicare that call for LTC or LTSS benefits. Participated as SME in readiness reviews for Medicaid or Medicare products where LTC and LTSS services and benefits are part of the review and describe AmeriHealth plans, protocols and procedures related to LTC and LTSS benefits

#### **City of Seattle, King County Area Agency on Aging – Seattle, Washington**

##### *Director, Aging and Disability Services/March 2012 – February 2014*

Responsible for a staff of 160 with another 80 contracted private agencies authorizing more than \$14 million in services a month so more than 10,000 seniors and disabled adults could remain safely and independently in their homes. Member of the City of Seattle Human Services Executive Leadership Team that oversees the Aging and Disability Services, Community Services and Supports, Transitional Living, Public Health and Youth & Family Empowerment programs. Responsible for the Mayor's Council of African American Elders and the Mayor's Office of Senior Citizens.

#### **AmeriHealth Caritas – Philadelphia, Pennsylvania**

##### *Consultant/December 2011 – March 2012*

Worked directly with the health plan president and chief marketing and development officer. Researched, analyzed and provided extensive information and direction to help the organization develop a long-term care line of business.

#### **Yavapai County Government – Prescott, Arizona**

##### *Director, Yavapai County Long Term Care/January 2008 – October 2011*

Provided oversight of a staff of 55 with an annual budget of \$45 million and more than 400 contracted providers. Responsible for planning, monitoring and directing operations of this department serving the elderly and physically disabled in Yavapai County. Units included Provider Relations, Member Services, Care Management, Medical Management, Utilization Management, Finance and Administration.

**Mesa Community Action Network – Mesa, Arizona***Executive Director/September 2006 – December 2007*

Managed the acquisition of MesaCAN, the federally designated community action agency for the City of Mesa, by A New Leaf, Inc. Responsible for all operations, state contracts, federal compliance and program development.

**A New Leaf, Inc. – Mesa, Arizona***Vice President Community Services/April 1990 – December 2007*

Held several progressively responsible positions at A New Leaf, a comprehensive community service agency based in Mesa Arizona serving all of Maricopa County and most of Arizona. The most recent position was as vice president of Community Services, responsible for the oversight of more than 40 percent of the entire agency budget and approximately 180 employees. Services included two outpatient clinics; foster care; medical management; detention alternative program; after school programs; two youth police alternative centers serving Mesa and Glendale; school-based drug and violence prevention programs; homeless men's shelter and job readiness program; and a community action program for the City of Mesa.

**EDUCATION/CREDENTIALS**

- MBA, University of Phoenix, 2006
- BS, Business Management and Marketing, University of Phoenix, 2004



## FRANCINE PECHNIK – CASE MANAGEMENT ADMINISTRATOR/MANAGER

### OVERVIEW

Twenty-seven years of long-term care experience; 27 years of Elderly Physically and Disabled (E/PD) experience, including more than 27 years serving the ALTCS program; 17 years in a managerial or director level position in the health care field; eight years in a case manager position; six years of managerial experience in the commercial industry; and two years in a finance position.

### PROFESSIONAL EXPERIENCE

#### **UnitedHealthcare Community Plan – Phoenix, Arizona/September 2005 – Present**

##### *Vice President Long-Term Care/Case Management Administrator/March 2006 – Present*

- Oversee the implementation, maintenance and monitoring of operational processes within the UnitedHealthcare Community Plan case management programs to assure the plan meets and exceeds federal and state regulatory and contractual requirements
- Conduct formalized review of the delivery of case management services for Medicare and ALTCS Medicaid membership. Responsible for all the systems supporting this review
- Monitor the access to effective treatment modalities that meet member needs and comply with standards of care and appropriate state and federal regulations
- Assist in the timely reporting to government agencies such as AHCCCS, ADHS, CMS and other regulatory agencies
- Direct a system of monitoring progress to meet the goal of participating in initiatives to increase the number of members living in a home community setting
- Monitor the training and ongoing professional development of case management staff to meet department business goals
- Assure that key staff members are knowledgeable concerning state regulations and contractual requirements for their area of responsibility
- Develop and implement a case management work plan submitted to the state Medicaid plan for approval on an annual basis
- Complete an annual assessment and evaluation of the case management program including the case management annual plan
- Develop and implement the annual Advisory Council Plan that includes conducting quarterly meetings in eight counties across the State of Arizona
- Complete an annual evaluation of the plan and its effectiveness in each of the respective counties, which is submitted to the state Medicaid plan annually for approval
- Develop and maintain Case Management policies and procedures to comply with regulatory standards and adhere to UnitedHealthcare Community Plan goals and objectives
- Implement and maintain systems and procedures necessary to effectively control and monitor case management performance
- Assist in the budget and manage resources allocated to obtain optimum budgetary results

##### *Case Management Manager/September 2005 – March 2006*

- Managed, mentored and supported case management staff responsible for the support of the ALTCS population
- Developed clear goals and objectives for performance management and effectively communicated accountability

- Recruited, hired, supervised and evaluated case managers and support staff
- Identified areas of strength and concerns, and developed specific goals to improve performance and established systems for tracking performance
- Assisted in strategic development of processes to create and execute efficient and systematic operational plans
- Managed the utilization program as a result of day-to-day management
- Managed successful implementation of several initiatives
- Created a team oriented management environment, enhancing the integration and communication between departments
- Oversaw standardized execution of workflow processes, such as authorizations and non-certifications and analyze outcomes of standardized audits for CQI purposes
- Acted as regional interface with other departments to coordinate workflow processes and implementation plans (e.g., Claims, Medical Policy, Contracting)
- Participated in the development and execution of educational programs for staff development
- Monitored performance metrics specific to functional area
- Evaluated metrics in addition to developing action plans to address variance from standards
- Participated in the development of department policies and procedures

### **Maricopa Long Term Care Plan – Phoenix, Arizona**

*Case Management Administrator/November 2004 – September 2005*

*Case Management Manager/June 1999 – November 2004*

*Case Manager/February 1991 – June 1999*

*Account Clerk III, Department of Finance/Income Management/June 1989 – February 1991*

### **EDUCATION/CREDENTIALS**

- B.S., University of Connecticut-Storrs, Connecticut, 1985
- MBA coursework, University of Phoenix, Phoenix, Arizona

## TERESA ROBBEN – BEHAVIORAL HEALTH COORDINATOR

### OVERVIEW

Skilled professional with 40 years of experience managing social service and health care programs in Arizona, including UnitedHealthCare, three government agencies and a large local non-profit social service agency. Specialized skills include knowledge about the continuum of care needed for persons who are elderly and have behavioral health needs, health care budgeting, statistical analysis, contract compliance, grant management, social service planning, contract negotiations and knowledge of Medicaid and Medicare regulations.

### PROFESSIONAL EXPERIENCE

#### **UnitedHealthcare Community Plan/Long-Term Care – Phoenix, AZ**

##### *Director of Behavioral Health Services/August 2006 – Present*

Director position responsible for the operation and quality management of behavioral health services for Arizona Long Term Care System (ALTCS) program beneficiaries. Duties include overseeing Medicaid and Medicare compliance and providing oversight of the high-risk behavioral health portion of the plan, comprising 12 behavioral health case managers, a clinical specialist and two case managers. High-risk program members are either on a mental health court order or would otherwise be institutionalized if not for the specialized behavioral health services. An integral part of this role includes confirming all staff and providers have access to behavioral health resources.

#### **Arizona Department of Economic Security – Phoenix, AZ**

##### *Grant Administrator- Arizona Aging and Disabilities Resource Center/February 2006 – August 2006*

Grant-funded position to develop the Arizona Aging and Disabilities Resource Center (ADRC). Duties included developing promotional materials, setting up and staffing the advisory council for the grant, confirming requirements in the contract with CMS were followed; attended monthly meetings with CMS to fully implement the grant per federal regulations.

#### **Maricopa Health Plan/University Physicians Health Care – Phoenix, AZ**

##### *Behavioral Health Case Worker/October 2005 – February 2006*

Responsible for the daily operation of behavioral health services for the Maricopa Health Plan. Duties included coordinating medical and behavioral health care for plan members who have behavioral health disorders, writing informational materials about behavioral health services and assisting plan members with health care needs.

#### **Maricopa Integrated Health Systems/Maricopa County Long Term Care Plan – Phoenix, AZ**

##### *Behavioral Health Administrator/October 2002 – October 2005*

Management position overseeing the operation of behavioral health services for the managed care health plans operated by Maricopa Integrated Health Systems. The plans included the Maricopa Long Term Care Plan and the Maricopa Health Plan, and a Medicare Choice-funded plan. Duties included ensuring ALTCS/Medicaid compliance and supervising a team of 12 behavioral health case managers serving high-risk members. An integral part of daily operations included ensuring that the provider network was adequate to meet the needs of each health plans' membership.

#### **Maricopa Managed Care Systems – Phoenix, AZ**

##### *Financial Analyst/October 2001 – October 2002*

Responsible for analyzing health care costs for the three managed care health plans operated by Maricopa Managed Care Systems, including the Maricopa County Long Term Care Plan.

**Arizona Department of Health Services/Div. of Behavioral Health Services – Phoenix, AZ***Chief of Planning/March 1994 – September 2001*

Responsible for strategic planning, policy development and provider network analysis for the Division of Behavioral Health Services. Confirmed the Annual Behavioral Health Service Plan met the requirements of the Governor's office and provided professional support to the Division's planning councils. Duties included mediating behavioral health treatment appeals, monitoring Regional Behavioral Health Authority contracts, managing federal grants and serving as a member of the Arizona Behavioral Health and Aging Coalition.

**EDUCATION/CREDENTIALS**

- B.S., Social Work/Psychology (double major), Kansas State University, 1975
- Licensed Baccalaureate Social Worker, State of Arizona - #LBSW-10553-Current

EXHIBIT F: A.R.S. §35-393.01 ATTESTATION

Recognizing legislation has been enacted to prohibit the State from contracting with companies currently engaged in a boycott of Israel, to ensure compliance with A.R.S. §35-393.01, this form must be completed and returned with the response to the solicitation and any supporting information to assist the State in making its determination of compliance.

As defined by A.R.S. §35-393.01:

1. "Boycott" means engaging in a refusal to deal, terminating business activities or performing other actions that are intended to limit commercial relations with Israel or with persons or entities doing business in Israel or in territories controlled by Israel, if those actions are taken either:
  - (a) In compliance with or adherence to calls for a boycott of Israel other than those boycotts to which 50 United States Code section 4607(c) applies.
  - (b) In a manner that discriminates on the basis of nationality, national origin or religion and that is not based on a valid business reason.
2. "Company" means a sole proprietorship, organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, limited liability company or other entity or business association, and includes a wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate.
3. "Direct holdings" means all publicly traded securities of a company that are held directly by the state treasurer or a retirement system in an actively managed account or fund in which the retirement system owns all shares or interests.
4. "Indirect holdings" means all securities of a company that are held in an account or fund, including a mutual fund, that is managed by one or more persons who are not employed by the state treasurer or a retirement system, if the state treasurer or retirement system owns shares or interests either:
  - (a) together with other investors that are not subject to this section.
  - (b) that are held in an index fund.
5. "Public entity" means this State, a political subdivision of this STATE or an agency, board, commission or department of this state or a political subdivision of this state.
6. "Public fund" means the state treasurer or a retirement system.
7. "Restricted companies" means companies that boycott Israel.
8. "Retirement system" means a retirement plan or system that is established by or pursuant to title 38.

All Offerors must select one of the following:

  X   My company **does not** participate in, and agrees not to participate in during the term of the contract a boycott of Israel in accordance with A.R.S. §35-393.01.


       My company **does** participate in a boycott of Israel as defined by A.R.S. §35-393.01. :

By submitting this response, proposer agrees to indemnify and hold the State, its agents and employees, harmless from any claims or causes of action relating to the State's action based upon reliance on the above representations, including the payment of all costs and attorney fees incurred by the State in defending such an action.

UnitedHealthcare Community Plan  
 \_\_\_\_\_  
 Company Name

1 East Washington, Suite 900  
 \_\_\_\_\_  
 Address

Phoenix	AZ	85004
_____	_____	_____
City	State	Zip

  
 \_\_\_\_\_  
 Signature of Person Authorized to Sign

Joseph G. Gaudio  
 \_\_\_\_\_  
 Printed Name

CEO, UnitedHealthcare Community Plan  
 \_\_\_\_\_  
 Title